UNIVERSITY OF PORT HARCOURT

STILLBIRTHS:

THE PERILS AND SOCIETAL INDIFFERENCE

Valedictory Lecture

By

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PROGRAMME

1. GUESTS ARE SEATED

2. INTRODUCTION

3. THE VICE-CHANCELLOR'S OPENING REMARKS

4. CITATION

5. THE VALEDICTORY LECTURE

The lecturer shall remain standing during the citation. He shall step on the rostrum, and deliver his Valedictory Lecture. After the lecture, he shall step towards the Vice-Chancellor, and deliver a copy of the Valedictory Lecture and return to his seat. The Vice-Chancellor shall present the document to the Registrar.

6. CLOSING REMARKS BY THE VICE-CHANCELLOR

7. VOTE OF THANKS

8. DEPARTURE

DEDICATION

To God Almighty,

To my Grand pearls,

To the souls of all
the still borns in
ever green memory,

To all the mothers
who live with the
sad memory of
stillbirth.

ACKNOWLEDGEMENT

Thanks to God Almighty, the creator and keeper of life, fountain of wisdom and knowledge of all opportunities for me. Lord, your dependable grace and fullness have shaped my life and seen me thus far.

My dear Vice Chancellor sir, I thank you profusely for this honor and opportunity to deliver this valedictory lecture, I appreciate it. May I thank the Vice Chancellors in whose tenures I have worked through the ranks: Prof. Kelsey Harrison, Prof. Nimi Briggs, Prof. Don Baridam, Prof. Joseph Ajienka, Prof. Ndowa Laale, Prof Steve Okodudu and Prof. Owunari Georgewill.

I pay my respect to the past Provosts, late Prof. T. I. Francis, Abiye Obuoforibo, Nimi Briggs and Datubo Brown. Prof. C. O. Anah, Prof. Odia, Prof. Didia, Prof. C. Mato, Prof. Iyeopu Siminalayi and current provost Prof. Angela Frank-Briggs.

My gratitude goes to my parents, His Royal Highness, Ohia Chi - Eni of Rumuola, Chief Eziwhuo Akani and Madam Grace Wuchegbule Akani of blessed memories - hero and heroine who made my education their priority. I owe great regards to Chief Okogbule Wonodi who strongly advised against my two scholarship offers abroad, with the fear that I may 'japa' not to come back. I took it with reservation but later borrowed a leaf from this context and insisted that all my four children (a lawyer, an architect and two medical doctors) take their university education in Nigeria before any post graduate study abroad and they faithfully returned to settle or work in Nigeria.

Let me thank my mentors on whose shoulders I perched in the early years of my career; Prof. Vincent Aimakhu, Dr. Adewunmi, Prof. Oladosu Ojengbede, Prof. Ojo and Prof. Nylander, whose skills wet my appetite and interest in Obstetrics and Gynaecology.

To all my teachers and mentors at different levels of my academic career, I sincerely thank you all. I salute you all because you laid the foundation of this day. To the first-generation lecturers of this department from whom I gained a lot from their combined wealth of experience viz - Emeritus Prof. Kelsey Harrison, Late Emeritus Prof. Nimi Briggs, Prof. C. T. John, Dr. Duncan Lolomari, Chief M. T Memberr of special mention is Late Prof. Edwin Elechi, who frantically encouraged me as if that was the only tonic I needed to be where I am today, I thank him immensely.

Permit me to appreciate all the development partners/agencies: UNICEF, UNFPA, IPAS, APIN, FHI, University of Columbia, Global Funds whose grants, projects and programs garnished and added great value to my research landscape and impacted the communities.

To my other consultant colleagues with whom I shared a lifelong friendship and enormously productive collaboration, residents, medical students, nurses and midwives, and patients who had crossed paths with us in practice for research and teaching, I say a big thank you.

My home front has been very comfortable and conducive for academic pursuit and other endeavors in life. Let me specially thank my hardworking, understanding, amiable and ever caring wife and friend of about 50 years, Prof. Nwadiuto Afonne Akani and God loving children; Barrister Wobia Akani,

Architect Dr. Chizy Akani (PhD), Dr. Mrs. Chituru Okwu and Dr. Ugochukwu Akani, I join in this recognition Engr. Ohochukwu Okwu, Architect Chioma Akani, Jessica Akani, I hail you all.

I will not forget the second-generation children, Annabel, Amira, Callyn, Azariah, and Skye. You have all made my life pleasant and peaceful and rewarding.

The University and hospital community have been a wonderful working environment and I cherished the harmonious pleasant working relationships I received.

Let me at this point appreciate my General overseer- Rev. Dr. Felix Akara and his dear wife- Rev. Barr. Gloria Akara and God's Heritage family. May God bless you all abundantly.

To my siblings: Mrs. Abigail Pepple, Dorathy Akani, Mr. Nyenweze Akani, Barr. Uche Akani, Engr. Azunda, Alex Akani, Chief Barr. Kingsley Nnamdi Akani, Mr Chukwuma Ryan Akani, Mr. Peterson Aham Akani and Late Mr. David Worgu Akani, I salute you all.

Mr. Vice Chancellor Sir, His Eminences, Captains of Industries, my Lords most Spiritual and Temporal, Distinguished Ladies and Gentlemen, The Press, permit me to thank you all with a bow.

CONTENTS

PREAMBLE

Obstetrics deals with one client and two or more lives in case of multiples gestation. Most times the obstetrician is looking after the mother, fetus and the expectant father whose concerns and panics are heaped on the attending physician.

In the days of our fore fathers, the uncertain or unpredictable outcome of birth compelled them to have many pregnancies - not certain which pregnancies will have a life birth. The journey of conception, maturity to delivery is tortuous and the determinants of success is multifactorial in nature.

The nature and process of conception and delivery (birth) is irrevocable for meaningful population dynamics.

The choice of an appropriate point of birth is paramount to better outcome as emergent intrapartum challenges/ crisis would receive prompt and appropriate intervention to avert a still birth. Avoidance of births attended by Traditional Birth Attendants, and other unskilled birth attendants, abdominal massages and unorthodox attempts at versions would impact the birth process positively.

The discontinuation of life of a baby after the age of fetal viability which in our context is 28 weeks leaves a lot of unpleasant experiences for the obstetrician and family. Incidents of still births cut across boundaries of culture, education, ethnicity, economy and age. Most information about it is relatively obscured to the public since only few persons are privileged to know the actual information as it occurred.

About 8 million still births and early neonatal deaths occur annually due to women's poor health, and inappropriate interventions during pregnancy. Stillbirths in our community setting are often dismissed on grounds of apathy or forgotten as bad news or silence- driven for cultural reasons.

Publicity of stillbirth events in most health facilities in urban settings are subdued or suppressed to avoid stigmatization of the hospital and its service delivery. The unorthodox maternity setting would at the occurrence of it so quickly transfer care to another facility to preserve their "integrity". So it is either underreported or not reported at all.

After the Inaugural lecture of "Right births as our birth rights" in January 2015, 1 expected that better days will come.

I consider the topic of this lecture appropriate for several reasons. First, it exemplifies some of the fine prints/challenges for which I labored for most of my career- one of the sore points of the obstetrician's distress, the hidden story of the unfulfilled mother, the social and psychological trauma of the family and its direct impact on the national developmental indices.

INTRODUCTION

It is my pleasure to follow the noble tradition of academia by delivering the 37th valedictory lecture of the University of Port Harcourt.

I am highly honored to be here today to share my thoughts on the subject – "Still birth: The Perils and Societal Indifference" My mission in the presentation is to amplify silenced occurrence, decipher the problem and point out the alternative potential solutions. These solutions will point fingers to areas that need attention ranging from the midwifery team, the community and the nation at large.

Can we identify the problems and needs of the society, attempt to find solutions within the context of our national development is a question begging for answer!

Vice chancellor sir, l am aware that I am addressing great minds responsible for the educational and social transformation of our national health. The human quest for procreation and reproducing new generation of beings continue to affect or impact outcome of pregnancies. The quality of babies born impact the wisdom, wealth and productivity of a nation. We note that sorrow, sober regrets, painful reflections mark the birth of the "silent baby." If we can hear the voice of the stillborn, we will probably note clearly:

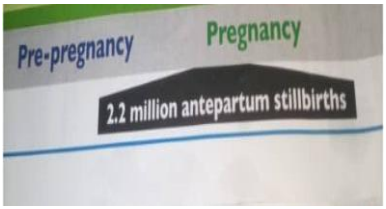
"**The Day I was Born, I Cried and Everybody Jubilated in Joy and Now I Die, I May Smile but the World Mourns**."-

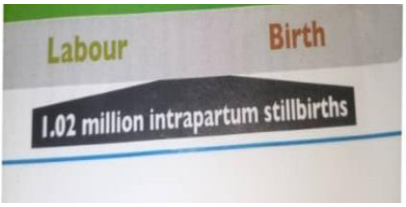
Here I am a stillborn.

But for these babies, when they are alive, the place is charged with joy but when there is no life, only the family and friends

mourn in isolation and silence. The Science of Obstetrics which I have practiced for more than four decades is intended to produce a happy mother, healthy baby and community. However, in some instances we are faced with the sad reality of the silent baby- the stillborn.

Stillbirths are defined as fetal deaths after 22,24 or 28 weeks of gestation depending on the location of practice. The most commonly used is 28 weeks but ICD (international classification of disease and related health problems) puts it at 22weeks. The stillbirth constitutes a major part of the perinatal mortality indices of a nation. Around the world and Nigeria, there are 2.02million cases of antepartum stillbirths and 1.02 million intrapartum stillbirths recorded annually.





These statistics are grievous and eliminate joy and comfort among many families.

Reproductive health failures embodied in stillbirth raise concerns that transcends clinical medicine, and must be addressed as a public health concern. The thinking that stillbirths are an issue solely on the table of the obstetrician should be changed. In as much as that may appear true, other determinants that make it a public health issue need to be buttressed.

The public health dimensions of stillbirth have escaped general attention. Nigeria has one of the highest still birth rates in the

world with the world health organization putting the still birth rate as high as 33 stillbirths per 1000 total births. These however varies from region to region depending on the accessibility to health care and the region of the country being reviewed.

Health system failures often add significantly to the burden of stillbirth. The modus operandi through which this occurs weighs heavily on the access to quality prenatal care. Inadequate monitoring and screening, inadequate skilled attendants, poor healthcare infrastructure, coordination potentials, in addition to poor health education and awareness are associated factors. This is compounded by the lack of appropriate statistics and data management to make impactful policy statements that will change the narrative in improving the abysmal statistics in the country as it concerns stillbirth rates.

WRONG BIRTHS AND RIGHT BIRTHS

The terms "right birth" and "wrong birth" can be interpreted in different ways depending on the context in which the issue is looked at.

Philosophically a "wrong birth" refers to an existence, particularly in relation to suffering and the challenges of life. Some philosophies may argue that if a person suffers greatly or if life is filled with pain, being born may be considered a "wrong" or unfortunate event. Conversely, "right birth" could imply the idea of coming into the world in favorable circumstances, where opportunities for growth, happiness, and fulfillment are abundant.

In ethical and social perspective, discussions of social justice, topics such as privilege, opportunity, and systemic inequality

can play a role. "Right birth" could refer to being born into circumstances that provide advantages (wealth, health, social status), while "wrong birth" might denote being born into disadvantaged or oppressive conditions. Speaking for the silent foetus at birth on a personal level, individuals may reflect on their own life experiences and consider whether they feel their life is aligned with their expectations or desires. The feelings associated with being in the "right" or "wrong" place in life can stem from various factors, including family background, upbringing, and personal circumstances, these can count if the baby delivered is allowed to live even a minute of its life exterior. However, these external factors still play great part in the eventual outcomes during the birth process.

In the context of the birth process, the terms "right birth" and "wrong birth" can relate to different aspects of childbirth, including the method of delivery, the health of the mother and baby, and the overall experience surrounding the birth. The concept takes into consideration the Healthy Outcome of birth: A "right birth" often refers to a delivery that results in the healthy birth of the baby and the well-being of the mother. This includes normal vital signs for both the mother and infant. It can also refer to situations where the birth aligns with the parents' wishes or birth plan, including preferences for pain management, environment (home birth vs. hospital), and any desired interventions.

In addition, a supportive environment involving skilled medical professionals who respect the mother's choices, provide adequate care, and respond appropriately to complications can contribute to a positive birth experience. In terms of the level of intervention a “right birth” can be described as one with minimal medical interventions, where

the birth process proceeds smoothly and as naturally as possible with an informed decision-making process.

Conversely a "wrong birth" might refer to a situation where there are significant complications for either the mother or the infant. This could include issues like fetal distress, hemorrhage, or emergency Cesarean sections. Looking at the birth experience a traumatic or any birth process that falls short of the expectations of the parents —due to factors such as lack of support, miscommunication, or disregard for the birth plan may be perceived as a "wrong birth." In addition, if there are significant health risks or negative outcomes associated with the birth, such as congenital malformations conditions or maternal complications, it can lead to a perception of it being a "wrong birth."

Furthermore, a situation where parents feel disempowered or not in control of the birthing process can lead to feelings of regret or dissatisfaction. In some contexts, practices like non-consensual procedures or a lack of respect for cultural birth traditions might lead to a perspective that the birth process was wrong.

Ultimately, the notions of "right" and "wrong" births are subjective and can be interpreted differently based on individual experiences, cultural beliefs, and personal values. A supportive, safe, and healthy birthing environment, along with clear communication and informed consent, tend to lead to more positive evaluations of the birth experience. Each birth is

unique, and what is "right" or "wrong" can vary greatly from one family to another.

Nevertheless, the precipitating factors for a wrong birth are the resume′ for a still birth with its attending challenges.

Every birth process is expected to give a fulfilling birth experience which should bring joy and happiness to the baby to be born and to the parturient.

The wrong birth in the arena of obstetric practice is thus a choice made, a selected pathway but a major contributor to the phenomenon of the stillbirth.

STILL BIRTHS AND CURRENT REALITIES

DEFINITION

Stillbirths are defined as fetal deaths after 22, 24 or 28 weeks of gestation depending on the location of its occurrence (Complete absence of physical and physiologic activity with no sign of live). The most commonly used is 28 weeks but icd was 22weeks.

Stillbirth can be differentiated into fresh stillbirth and macerated stillbirth depending on the time interval. Macerated stillbirth is associated with some delicate hematological complications to the mother.

CURRENT REALITIES OF STILL BIRTH IN NIGERIA

A. PREAMBLE

1. One can safely say that a nation's health can be determined by the state of its Reproductive Health. This is particularly true in a third world setting like

ours.

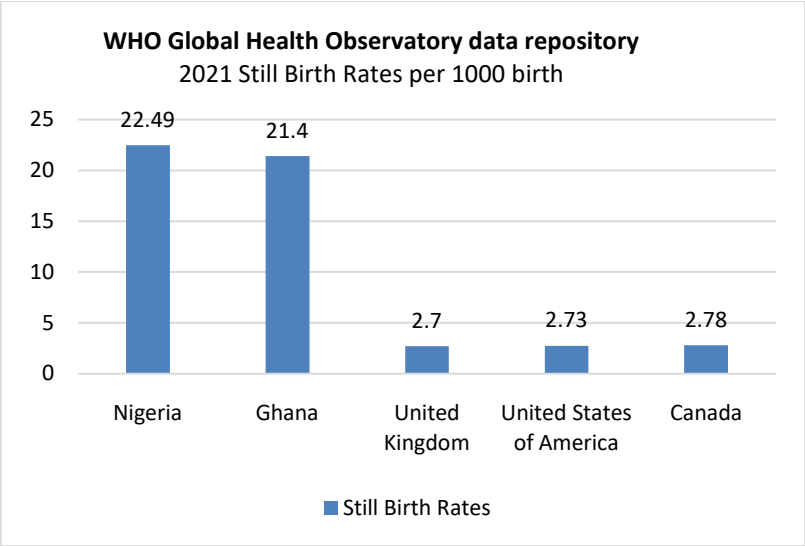
2. Reproductive Health encompasses a spectrum of features and the dominant ones in our setting are high maternal mortality and morbidity rates, very high still birth rates and high birth rates.
3. Underlying these purely health issues is poverty. I don't mean just material poverty but poverty in our education, poverty in the way we think, poverty in our infrastructural development, in our economy, and powerless womanhood.

B. BASIC FACTS

1. Every pregnancy, planned or unplanned, high risk or low risk, in the well-nourished and well-educated or otherwise, can develop life-threatening complications.
2. Nearly 600,000 women die from pregnancy-related complications each year, and most of these, as we know, are in developing countries. **Around the world there are 13.9 stillbirths per 1,000 total births. In Nigeria alone in 2021 the still birth rate was 22.4 per 1000 live births.**
3. Apart from mortalities, we generally discountenance the large numbers of morbidities, depression, and individual tragedies that women go through after the still births.
4. New knowledge, new ideologies, new theories, need to be applied to change attitudes and predict better pregnancy outcome.
5. The bedrock of this problem like poverty, illiteracy, lack of infrastructure, greed, bad and frequent policy somersaults, and our health system needs complete restructuring.

6. The three delays in safe motherhood are still very much in play in our society

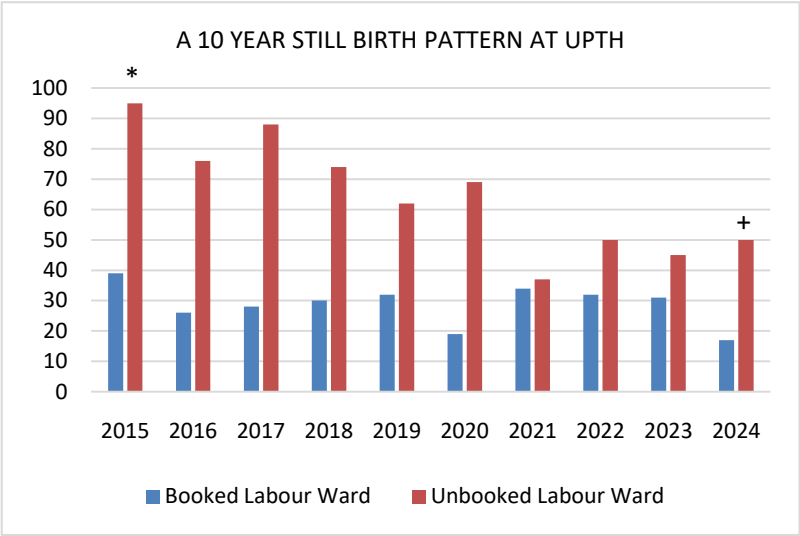
Global still birth statistics extract



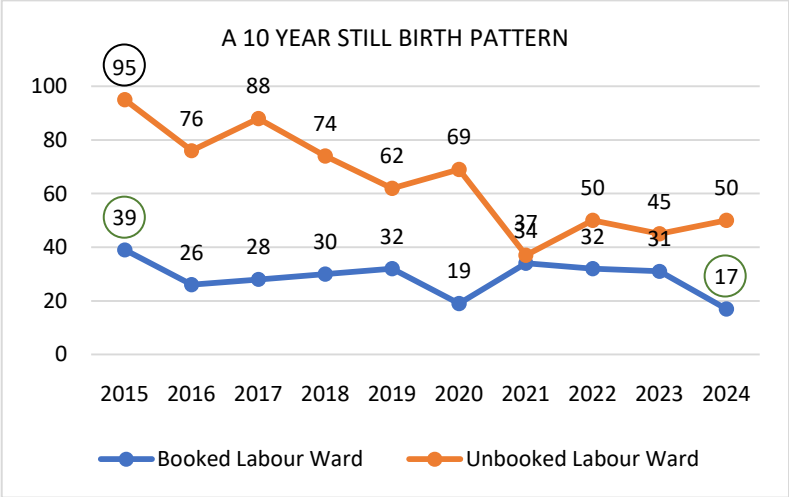
Perinatal Mortality at a glance over 10 years

SUMMARY OF PERINATAL DEATHS IN UPTH FOR 10 YEARS										
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
IUFD	134	102	102	104	94	88	71	82	76	67
PRINATAL DEATHS	182	125	141	131	146	185	132	130	142	101
PERINATAL MORTALITY RATES	101.5	106.2	93.4	94.4	88.1	135.5	130.7	100.2	140.45	112.6

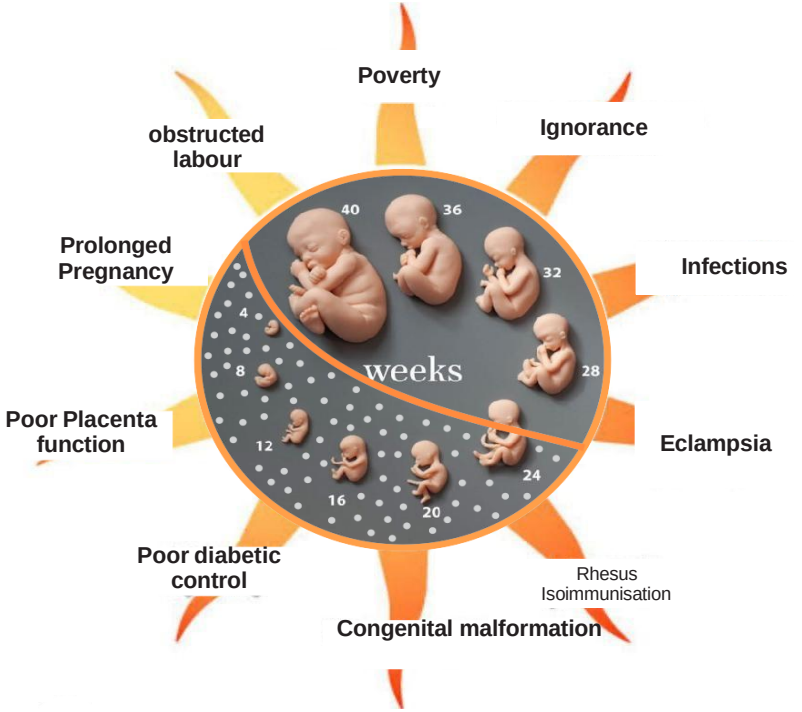
Differential Stillbirth statistics between booked and unbooked



Differential Stillbirth statistics between booked and unbooked



CAUSATIVE FACTORS FOR STILL BIRTH



Multifactorial Contributors to Still Birth

Causes of Stillbirths

Non preventable Causes:

- Congenital abnormalities
- Genetic defects
- Chromosomal abnormalities

Preventable Causes

- Prematurity
- Obstetric/delivery complications

- Medical Disorders; Hypertension, Pre-eclampsia/eclampsia, Diabetes Mellitus
- Infections in pregnancy; Malaria, Sepsis
- Unorthodox Medication
- Unskilled services

Some social and cultural practices that encourage still birth

- Traditional Abdominal massage
- Manual version for abnormal lies (turning the baby)
- Making a way where there is no way (pressing the baby in face of obstruction, sitting and standing on the woman's abdomen)
- Ingestion of herbal concoctions for fetal well-being in labour
- Female genital mutilation in pregnancy and labour
- Hot injections for facilitating contractions/inducing labour
- Social factors include gender-based violence with severe consequences in pregnancy
- Gendercide, fetocide tendencies are increasing with sex-selective abortions, which target female fetuses is a deliberate act of inhumanity.
- Maternal HIV infections/fetal infection has received little attention as the United State Government threatens exit of development partners.
- Non-compliance & medical interventions in obvious medical threats and emergencies.
- Unparallel traditional indulgence and stiff economic constraints at moments of decision
- Lack of articulate birth place and preparedness for the pregnancy, causing delays to care and financing emergencies.

- Widespread ignorance in identifying signs, choice of care, and the expertise appropriate for the time.

Despite these factors, most stillbirths remain enigma as most obstetric antecedents of unexplained still birth fail to produce any concrete answer. Some stillbirths are unpredicted and unpreventable but about 10% which occur in pregnancy and labour under the very nose of midwives and obstetricians.

It has been explained that in the course of pregnancy, labour and delivery, women in every country and population may develop complications while some get prompt and adequate treatment, others may not.

The poor in their lack and economic constraint are likely to lose their babies. Since cost itself is often a barrier to access to available care amongst impoverished families. This discuss may provide new elements in the care of the mothers who lose their babies in pregnancy and childbirth.

PERILS AND SOCIETAL INDIFFERENCE

What is Peril

The entity mentioned above is the recount of experiences of my career life and accounts of many tragedies during pregnancy and childbirth in medical practice. Even the little ones who do not understand the concept and dynamics of child birth, after watching their mothers wail in anguish and torture become hardened and hostile in vengeance to society's neglect. The children later transform to the adults of the society minting out presumed punishment to those that have inflicted pain to them during their early years of development.

Society is composed of three simple categories:

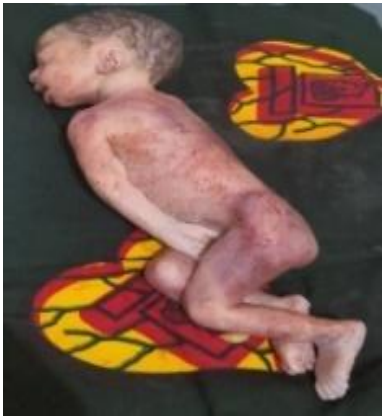
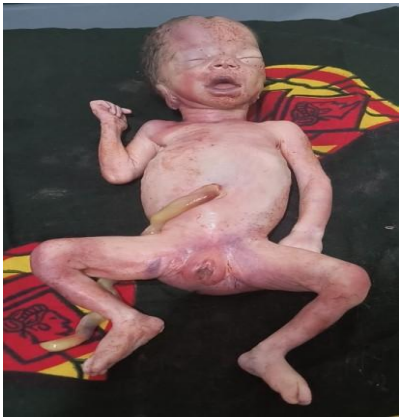
- The Victims: The women that suffer the loss of their babies and the attendant psychological consequences

- The Killers: The institutional bottlenecks, failed health systems, culminating to an inefficient health systems resulting in the still birth spectrum
- The Bystanders: The unconcerned individuals, policy makers, the community and the nation at large, who show no interest to the sufferings of the victims.

Class yourself into which group you cherish!
The killers dish out various degrees of perils to the victims (the women who suffer the burden of the still birth), they wear the cloak of pain of loss of their anticipated loved ones (the still born), the anguish and the psychological trauma of the absence of the warmth and the anticipated suckling of the new born.

The absence of the anticipated bonding and emotional attachment to the new born creates a void and an empty embrace. In addition the shoulders on which the family would have leaned on in future would have been prematurely truncated by the still born exit.

For the nation it adds to the abysmal statistics and unfortunate brain waste.

What is Indifference?
It means having no particular interest or sympathy, unconcerned about events and circumstances. Etymologically, the word means **'no difference'**. A strange and unnatural state in which the lines blur between light and darkness, dusk and dawn, crime and punishment, cruelty and compassion, good and evil. What are its causes and inescapable consequences? Is it a philosophy? Is there a philosophy of indifference conceivable? Can one possibly view indifference as a virtue? Is it necessary at times to practice it simply to keep one's sanity, live normally, enjoy a fine meal and a glass of wine, as the world around us experience harrowing upheavals of the series of obstetric complications and fetal wastages?

Indifference is always the friend of the enemy.
The enemy in this equation are the killers and bystanders, who stand either aloof or add salt to injury increasing the obstetric carnage of stillborn rate

Of course, indifference can be tempting- more than that, seductive. It is so much easier to look away from victims. It is so much easier to avoid such rude interruptions to our work, our dreams, our hopes. It is, after all, awkward, troublesome, to be involved in another person's pain and despair. Yet, for the person who is indifferent, his or her neighbors are of no consequence. And therefore, their lives are meaningless. Their hidden or even visible anguish is of no interest. Indifference reduces the other person to an abstraction.

In a way, to be indifferent to that suffering is what makes the human being inhuman. Indifference, after all is more dangerous than anger and hatred. But indifference is never creative. Even hatred at times may elicit a response but indifference elicits no response. Indifference is not a response.

Indifference is not a beginning; it is an end. Therefore, indifference is always the friend of the enemy. It benefits the aggressor – never its victim, whose pain is magnified when he or she feels forgotten or abandoned.

This is the case in view when there is not a response to the plight of the expectant pregnant woman, not to relieve their solitude by offering them a spark of hope; is to exile them from human memory and deny the torture for humanity- we betray our own. So indifference is not only a sin it is a punishment.

The indifference in our society can be seen in the picture of the disposed new born trashed in a dustbin. This depicts the picture of the future of the society dead, trashed and forgotten. It also illustrates the abject neglect of the health system and the parameters that will improve pregnancy and fetal outcome in our nation.

Where do we go from here?

MANAGING THE STILL BIRTH SPECTRUM

Mishaps and disasters in pregnancy and child birth should attract appropriate enquiry, incident review of case notes and sanctions applied.

Data from a large literature review indicate gross under reporting, neglected incident outside the hospital, reluctance at the private health facilities to disclose incidence of stillbirth, coupled with unreliable clinical audit, even in government hospital.

It is in the above context, that a total reflection of good opportunities, missed opportunities, and mishandled still birth incidence are called up in retrospect.

After an inaugural ten years ago on 'Right birth, Our birth right', today we will take another peep at births, may be wrong births on a topic Perils of Stillbirths, a subject which saddens me in practice after over four decades. Penultimate end of any pregnancy is delivery or expulsion of the baby or fetus. We may view and discuss from act, actions and habits that threaten the wellbeing of baby, which incorporates social, economic constraints and cultural practices and neglect that culminate to fetal demise.

The quality of life of the mother can be affected by her stress and psyche after birth without a baby, what ailments she encounters and how she navigates through.

This valedictory lecture posits that our parturient suffer more than the loss of the physical baby, but the health consequences. There is conspiracy of silence, nonchalance, and utter neglect surrounding the circumstances of stillbirth.

Let's exam our attitudes to stillbirths. Why does child death not raise interest in our press and social media?

Still birth rate is frequently under reported and usually under-estimated. The question is at what level of still birth rate are we prepared to act or react! Or have we resigned or has the challenge become enormous or overwhelming.

In our impoverished circumstances can we re-assert the concept of our births? It is better to light one candle than to cause darkness.

If one of us lights a candle then we will illuminate our paths well.

Some of us can in this audience track or identify our places of birth, be it a maternity home, health center, a five star hospital, a TBAhome or village home nursing point.
Is it still in existence?
Has anything changed? (in structure, service or personnel)
Would you like your children to be born there this day?
Can you influence an upgrade/update or influence a change of that facility?
Can you sensitize your age group, club & society to embark on any development project to upgrade or uplift the facility?

What next?
You discern it!!!
You raise an Alert!
Raise an Alarm!
You denounce it!!
You fight it physically to prevent it, passionately to address it, politically to legislate it and through the press media to change orientation and attitude!

Rise up to the helps of victims of indifference in child birth.
The ambition of every maternal health physician or mid-wife is to prevent every tear from every eye by preventing still-births.
Child's right act 2023, Act No 26, Section 3,4; every child has a right to survival and development. Section 17(1) Rights of the unborn child to protection against harm etc.

'A child may bring an action for damages against a person for harms or injury cause a child willfully, negligently or through neglects during and after the birth of that child'. Who will demand justice for the stillborn, who will answer the cry for help!

Addressing Affliction and Affected
That we all say No, to still birth.
I share life experiences with you that I can enjoy them or endure them to the greatest advantage

- Getting in touch
- Feeling the hurts
- Being an instrument of encouragement and healing.

In managing still born, timely evacuating the uterus is critical to avoid complications like Disseminated Intravascular Coagulopathy. "**Remember that whatever kills the baby can kill the mother".** Delivery can be vaginal, destructive operation or Caesarean section. This requires monitoring and can include massive blood transfusion. Whatever mode of delivery selected must ensure the safety and continuity of the obstetric potential of the mother. Once the baby is expelled, there is need to manage that birth experience appropriately in order not to inflict more pain or peril. The Mother should be made to be aware of occurrence of the demise of the fetus. The after-birth processes include individualized grief management, taking in context the socio-cultural belief of the parents. Our society however encourages limited contact of the parents with the still born which is not good for the psychological well-being of the afflicted.

The practice of complete neglect and forceful oblivion placed on the afflicted has resulted to unexplained psychological trauma. This can be avoided by encouraging, pre-information of the incident, psychosocial support and counselling of the expectant prior to the birth process.

At birth, sighting of the baby and making physical contact can improve the grief outcome and give the woman a sense of fulfilment and inner appreciation of the efforts during the pregnancy. The following are recommended to provide succor in spite of a loss;

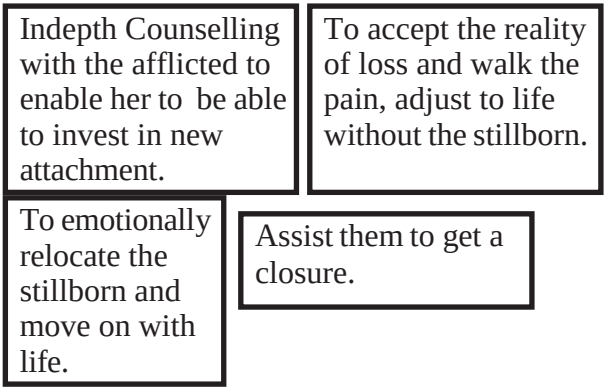
Memories of baby

Obtain momentous (photography, locks of hair foot and handprint silhouettes, name baby (No mementos)

Care of Baby after death

- Religious services (baptism, memorial service/funeral)
- Autopsy to prevent future occurrence and improve the depth of medical knowledge
- Burial processes should be instituted with or without traditional ceremonies to give dignity to the silent still born. The practice of throwing babies to the trash, suck away, pit, toilet should be ultimately abolished.
- Don't leave the corpses of the baby to be marketed for ritual exercises or eaten by wide animals

Still born for burial/cremation



Mother

- Spiritual / grief counseling
- Linkage to friends, family, church folks will make a difference to the deep agony
- Fences must come down
- Welcome signs / helping hands spread out
- Share the weeping and sorrow
- Memorials to be put in place to enlighten people on stillbirth

Charles Wesley said:

Do all the good you can! By all the means you can!! In all the places you can!!! At all times you can!!!! To all the people you can!!!!!

This is more appropriate in handling the afflicted and affected to enable them navigate the rough waters of the obstetric catastrophe that has befallen them.

It calls for all hands to be on deck to ensure a final closure

Still Birth Prevention

- Early booking for antenatal care.
- Regular visit and compliance with medications.
- Good rest and nutrition of Mothers
- Avoid traditional abdominal massage and manipulation in labour and childbirth.
- Sick information, counsel on any unusual development in pregnancy
- Don't insist on vaginal birth against medical advice.
- Plan for every pregnancy and be ready for any minor emergencies.
- Strengthen the health referral system.
- Offer close and intensive care with emergency intervention, special care support for the baby.
- Avoid abdominal massage and manipulative interventions in pregnancy and labour
- Seek information on any unusual development in pregnancy
- Identify those vulnerable or in danger, intervene fast and deliver as quick as possible
- Explore intense counseling to avert stubborn decisions against medical advice
- Don't insist on vaginal birth
- Strengthen an early health system referral system
- Improve quality of care even in villages.

WHAT WE CAN DO

- Patients and Family
- Community
- Health System
- Role of Government
- Foundations, Club, Cultural Age Group, Faith Based Organizations

- Philanthropists and Political Policy Makers

The ultimate tragedy of still birth, reflects the cumulative denial or deprivation of women, child and fetal rights.
We note with reservation that the economic value of fetal life is sadly not captured in our society.

Still birth, a reproductive wrong can sensitize passion to break barriers, walls and sensitize philanthropic individuals, agencies, foundations to institute a difference for the prevention of still birth.

It will also inspire hope and commitment to right this reproductive wrong.

To encourage birth planning for women of reproductive age.
Essential obstetric functions for women at high risk.

Facility for emergency transportation for women with complications.

The reproductive rights as it pertains to pregnancy and childbirth are obligations of the states to respect, to protect and to fulfil these rights. They will ensure appropriate legislative, administrative, budgetary, Judicial measures to prevent still births.

Strategies to address Still Births

A. To restore and maintain a quality maternal health facility for good maternal health, wellbeing of women in pregnancy both in rural and urban communities.
B. To encourage and promote the coordination of maternity services.

C. Encourage sensitivity and respect to victims of stillborn.
D. Prescribe standards for and make regulations for violation of maternal care rules
E. To establish necessary legal and legislative frame work that will ensure maternity care coverage for all pregnant mothers
F. Community sensitization and mobilization
G. Advocacy and collaboration with other countries and international organizations with the sole purpose of domesticating best practices in maternity care.
H. Provision of the necessary funding for the improvement of maternity care facilities and resources in short-, medium- and long-term budgetary allocations.
I. Monitoring and evaluation of private health facilities ability to contend with incidental obstetric challenges
J. Digitalization of maternity care records to provide data for planning and appropriate response
K. Use of electronic templates in registration, tracking and assistance of pregnant women.
L. Elaborate social media sensitization and education for patients and families during pregnancies
M. Watch out and identify the high risk pregnant teenagers or adolescent who are most vulnerable to stillbirths without close marking
N. Regular formal and informal capacity building for doctors and health workers
O. Reorientation and role change for traditional birth attendants and other faith based maternal units.
P. Incorporate family life skills and pregnancy care education in the curriculum as a GES course in our universities and other tertiary institutions

Q. Applying medical interventions like fetal surgery, arrest of obstetric complication, blood transfusion, Rhogam, close surveillance, responsive/intensive SCBU.

Let's all light a candle by giving help, support to pregnant women in our communities instead of being indifferent in the plight of women who are bearing the future of our country. Let the future not be born still.

MY CONTRIBUTIONS IN PREVENTING STILLBIRTH:

A. I have trained thousands of medical doctors - a good number are consultants and professors. They have capacity to prevent still births in medical practice.

B. I have served as external examiner to many medical schools, enhancing quality management for maternity care.

C. Strengthened the fetomaternal Sub-specialty and reproductive health in our university and various post graduate medical colleges.

D. Examined at all three parts of the Fellowship Examination of the West African Postgraduate Examination, hence, improving the national man power development to reduce wrong births.

E. Examined at the National Medical Council Accreditation Board for Foreign Medical graduates to ensure certification of the right skilled personnel.

F. I supervised the Sentinel Survey on Perinatal Transmission of HIV in the Niger Delta Region to reduce fetal losses from the HIV pandemic which is a major contributor of the stillbirth.

G. I supervised the midwifery services scheme for the reduction of maternal and perinatal mortality and morbidity.

H. I attracted the endowment of the Safe Motherhood Chair to move the birth practices and actualize in River State.

I. Participated in several research collaborations to improve maternal and newborn health (University of Columbia, APIN, etc.) all to reduce perinatal mortality.

J. As Chairman of NMA River state, we conducted many Safe birth projects and outreaches to impact the rural population.

K. I have through my career run the Paediatric and adolescent clinic and harvest teenage subjects with pregnancy, provided clinical care, compassionate support through pregnancy and child birth and let them home with healthy live babies

L. **Birthday deliveries**

Every June 9 (My Birth Day), it is usual to assist in the delivery of babies of the day, I visited the labour ward and attended to the deliveries either vaginally or those billed for caesarean section as part of glamour for the day.
Love is within the heart for the babies and the need to prevent stillbirth has driven this passion.

On a lighter note: Birthday celebrations with beheading of **individuals were mentioned twice in the Bible; are mention, first was Pharoah's Birthday, he had the chief baker beheaded and the second one, on King Herod's Birthday, he had John the Baptist beheaded.**

– Bernice T. Cory

Here kings engaged men for sanctions and death. *Today, we shall not behead anybody, we shall all go home with our heads.*

Today we engage babies for safe birth and right to life.
Groomed Men and women for Teaching and Research
Groomed men and women for university Administration
Groomed Men and women for politics
Groomed men and women for government affairs
Groomed men and women for the private sector.

If these will play their best roles, I shall rest my case.

RECOMMENDATIONS

- Every pregnancy counts, every live birth, a jewel and joy, every stillbirth, a sad story for the society and a family sorrow.
- Can we prevent a death of a baby in pregnancy and childbirth?
- Can we make every pregnancy safe and every birth, a pleasant experience?
- Put in place strategic community awareness and ownership of the healthcare facility.
- Sensitization of the healthcare workers.
- Accessible Health-friendly care centers well sited in the community, with humane services.
- Establish community- based insurance scheme. (community health insurance fund).
- Free birth scheme by philanthropist and faith-based organizations.

- Provide conducive staff quarters within the health facility.
- To create a reliable information network and databases to improve pregnancy and births.
- To initiate pregnancy pin codes for tracking in health and challenges.
- Upgrade, update and uplift the structural setting of health environment.
- Women in power and politics should think about safe births and healthy newborns now and always.
- To deliver adequate interventions for safety of pregnant women and during birth.
- Form an enduring network between the health facilities, the consumer and stakeholders.
- Ensure a skilled and well-motivated community friendly staff.
- Medical health facilities should engage, collaborate and partner with community health facilities for effective training and update skills and knowledge.
- For corporate bodies and religious based organization, there should be a shift from health input to health outcome and indices.
- National council of women societies, medical women association of Nigeria should take collaborative concern and interest in what happens to the women at birth.
- University should include some unit courses on safe birth practice for the males and female students to sensitize them on family life in future. This can be captured as GES courses.
- There might be the need to establish a digital birth relief network since more than sixty percent of women have mobile phones in urban and rural areas. To stimulate public health policy development around issues relating to safe birth and safe abortion.

- To build and sustain the right kind of practice and personal to implement these concept / politics.
- Develop software to link our cell phone, voters' card or NIN to health coverage and access more so in pregnancy and childbirth.
- Train more obstetricians and gynecology with midwives and pharmacists and other health workers
- Locate a functional maternity service for every 2 political wards. This implicit cruelty towards the human uterus by their practice. And of course, thinking of the direct physical and economic affliction or the human victims.

Main efforts to mitigate absurd cautions will remain a mirage if a holistic approach is not taken in addressing the neglect.

There should be a local government advocacy to embrace modern birth practices at moderate or affordable cost while eliminating unskilled practices.

Sensitize the social sciences initiative to improve knowledge concepts of under privileged. These are crucial network areas for pregnancy and child births.

MY ADVICE

For the Students

Despite the digital information base, there is a lot to learn from the University and lecturers.

- Plan to pass because if you fail to plan, you plan to fail
- let the University pass through you
- Brain code, Mind code, and Conduct code must be alert
- Indecent dress code may dispose you to disaster
- Abhor absenteeism
- Make Study times above all other social engagements
- Compulsory clinic attendants for good exposure
- Resolve to prevent stillbirths in your career

For My colleagues in teaching,
Be consoled with the following extracts but revive your conscience to the development of the students, programs, faculty, research more than you met them.
Successful teachers … share certain traits that have contributed greatly to their success. For one thing, they prize creativity, for another thing, they know how and when to maintain discipline. They can also judge and evaluate people accurately. They have a sense of humor. And they have open minds – they are alert to new ideas and new developments in teaching. *Patricia Hockstad*

My Appeal to the University

- Construct a modern college complex for the College of Health Sciences
- Construct a befitting medical library with a 300 capacity computer-based hall for Computer-Based Test for the medical students
- Consider completing the second medical students hostel with a foundation already in place with our increasing size of medical students
- Put in place electronics billboards for university events and activities
- Consider a technology park of relevant vocational jobs to help initiate students into alternative income activities. This could be
    a. Automobile technology
    b. Air-conditioned repairs
    c. Screed-ding and painting
    d. Phone accessories and repairs
    e. Indoor farming
    f. Fashion and design
    g. Hair care and styling etc

- Create more departments for medical equipment repair/medical physics, medical records, medical genetics, medical jurisprudence and above all waste management care
- Inculcate a habit of high quality food mall and coffee shops to reduce the makeshift structures.

EPILOGUE

Vice Chancellor Sir, distinguished guests, ladies and gentlemen, I am glad that I have done what I set out to do in this lecture, to highlight the hidden pains and agony of women who are victims of stillbirth in and out of our hospital with multifaceted challenges posed by the **economy**, the **family** and the **society**. It is my hope that these revelations through research, teaching, sensitization and clinical service. We therefore need to jointly promote, prevent, show popular appreciation for intervention and sustainability of stillbirth prevention agenda.

I have impacted knowledge, awakened interest in academics, medical politics and university administration, sensitizing them to pursue their goals.

I am not in the business of growing fetuses but I'm in the business of making life fetuses survive to life babies for "They make our future!"

A great teacher is not simply one who impacts knowledge to his students, but one who awakens their interest in it and makes them eager to pursue it for themselves. He is a spark plug, not a fuel pipe. – M. J. Berrill

The great teacher… performs certain actions, says certain things that create another teacher. This other teacher is the one hidden inside the student. When the master teacher is

finished, the newborn professor inside the youngster takes over, and with any luck the process of education continues until death. – Clifton Fadiman

The mediocre teacher tells.
The good teacher explains.
The superior teacher demonstrates.
The great teacher inspires.
– ***William Arthur War***

CONCLUSION

Mr. Vice Chancellor Sir, we have for over six decades post-independence looked or search in the wrong directions and as a result lost many aircraft full of women and babies at childbirth at natural conceptions for lack of vision, action and inaction.

Women are still negotiating an easy pathway to easy birth, some women have tremendous reproductive potential with appetite to down load many babies, in some cases to unconverted prizes and praises of the community tradition.

In this context, many have taken the path of wrong birth and recorded tragedy and disaster of unimaginable consequences. I have therefore chosen this topic to register my view on how to reduce wrong birth, still birth and handle the afflicted and the affected to relieve the agony and anguish. Whatever has a beginning surely has an end. Entrance and exit of work career are sure certain historical points.

I go, my friends will continue to serve human needs but for the unborn babies, their thoughts are fixed on all of us, their heart goes out to you all and their hopes hang on our individual verdicts for support.
Today, I take a humble bow.


Deeme
Náagò
Sosongho
THANK YOU
Nagode
Sam o
Una do well
ịmelâ
Avo
Msugh
Anya

ANU ***MEKA***

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CITATION

PROF. CHRIS AKANI JP, DSSRS.

Chair, Safe Motherhood Professor of Fetomaternal Medicine
MBBS Ibadan, FWACS, FMCOG, FICS,
FnAMED, FWASOG

Chris Acho Akani was born into the Royal family of Ohia Chi-Eni of Rumuola and Madam Grace Wuchegbulem Akani in Aba on the 9th of June, 1955.

He attended the famous St Michaels Boys School, Aba where he obtained the First School Leaving Certificate with distinction.

Had his Secondary Education at Enitonna High School, Port Harcourt, where he obtained the West African School Certificate – Division One.

He had his medical education at the University of Ibadan, obtained Bachelor of Medicine, Bachelor of Surgery in 1981.

He is a distinguished Professor of Obstetrics and Gynaecology at the College of Health Sciences, and Honorary Consultant in Fetal Medicine and Reproductive Health at the University of Port Harcourt Teaching Hospital. He has deep interest in pediatric and adolescent Gynaecology. He has contributed immensely in reducing maternal and perinatal mortality.

Prof. Chris Akani pioneered and directed the Prevention of Mother to Child Transmission of HIV in the South South Nigeria and supervised the post abortion care activities in the Niger Delta region.

These attracted many development agencies and encouraged numerous academic publications on PMTCT, HIV, FETO-MATERNAL INFECTIONS, and UNSAFE

ABORTIONS, and informed the citing of some development agencies in Rivers State.

He has served as principal investigator and collaborator on various research projects with University of Columbia, Global Funds, FHI.

Prof. Chris Akani has served the University in various capacities. He was elected the pioneer Deputy Provost of the College of Health Sciences from 2000-2006. He was appointed Head Department of Obstetrics and Gynaecology in 2008 - 2010 and elected the fourth Dean of the faculty of Clinical Sciences later.

He was elected Provost of College of Health Sciences in 2011-2015. He was Chairman University Medical Board, Chairman University HIV Committee, Chairman, College 25th Anniversary Committee, Member University/Industry

Advisory Board, Member University Board of Continue Education, Member University Sports Medicine Institute, Chairman Hospital Editorial Board and Chairman Hospital Housing Committee, Member board of University Business School. He was also member Board of University of Port Harcourt Teaching Hospital 2011 – 2015.

He was a member of the Governing council Federal Neuropsychiatric Hospital Calabar, Member National Board for Technology Incubation, Member Rivers State Heath Management Board, Chairman Allied Health Professional of Rivers State. Chairman World Bank Committee for Grant 2012, Member Rivers State Free Medical Board.

A distinguished Obstetrician, a fellow of the West African College of Surgeons, a fellow of the National Post Graduate Medical College of Nigeria, Faculty of Obstetrics and Gynaecology, Fellow of the International College of Surgeons, a fellow of the Nigerian Academy of Medicine, a fellow of International Federation of Obstetrics and Gynaecology, Fellow International Federation of Paeditric and Adolescent Gynaecology, Fellow in Fetal Medicine Foundation, Fellow International Stillbirth Alliance, Fellow International Federation of New Born Health. Member of International Aids Society, He has over 180 publications in peer Review Journals and Chapters in Books. He is a stern advocate for safe birth.

Under his watch over the College, he enriched the University academic platform with new faculty of Allied Health Sciences, School of Public Health, department of medical Biochemistry, Centre for Medical Education and BSC immunology program.

He has supervised several fellowship and doctoral students and continues to play key roles in medical education in Nigeria. He

served as an external examiner to many Universities. He has also been Professorial assessor to many University Colleges of Medicine. He has been a Member and Chairman of National University Commission Accreditation Panels to several universities as well as Medical and Dental Council, Member Accreditation committee of West African Post Graduate Medical College to training centers.

He has made significant contributions to reproductive health and played crucial role in shaping the HIV transmission from mother to child and reducing abortion complications in Nigeria.

Prof. Chris Akani won the first price at all shell national secondary school essay competition in 1974, the Paul Harris Fellows award of Rotary club, the Students Union Government award of excellence of the University of Port Harcourt 2012. He has the Rumuola Community Honors Award, the distinguished award of excellence of Ogbakor Ikwerre ethnic nationality and the Apara clan award of excellence. He is posted on the hall of fame of the West African College of Surgeons and above all He was awarded a distinguished service star of Rivers state by the Rivers state government.

He served as one time NMA secretary and finally NMA chairman Rivers State.

Prof Chris Akani is an ardent believer and a preacher of the Gospel of our Lord Jesus Christ.

He is happily married to his friend of about 50 years and they are blessed with four (4) children.

I have this inestimable sense of pride to present this great scholar. AN ASTUTE CLINICAL RESEARCHER.

A consummate teacher of our time, a trainer of trainers, a mentor of mentors, AND AN EXCELLENT ACADEMIC as our 37th valedictory lecturer.

Prof. Abraham Owunari Georgwill
Vice Chancellor