

OBAFEMI AWOLowo UNIVERSITY, ILE-IFE, NIGERIA.

INAUGURAL LECTURE SERIES 309

**GIVING THE BEST TO AVERT THE
WORST: THE ODYSSEY OF AN
OBSTETRICIAN CUM
GYNAECOLOGIST IN ILE-IFE**

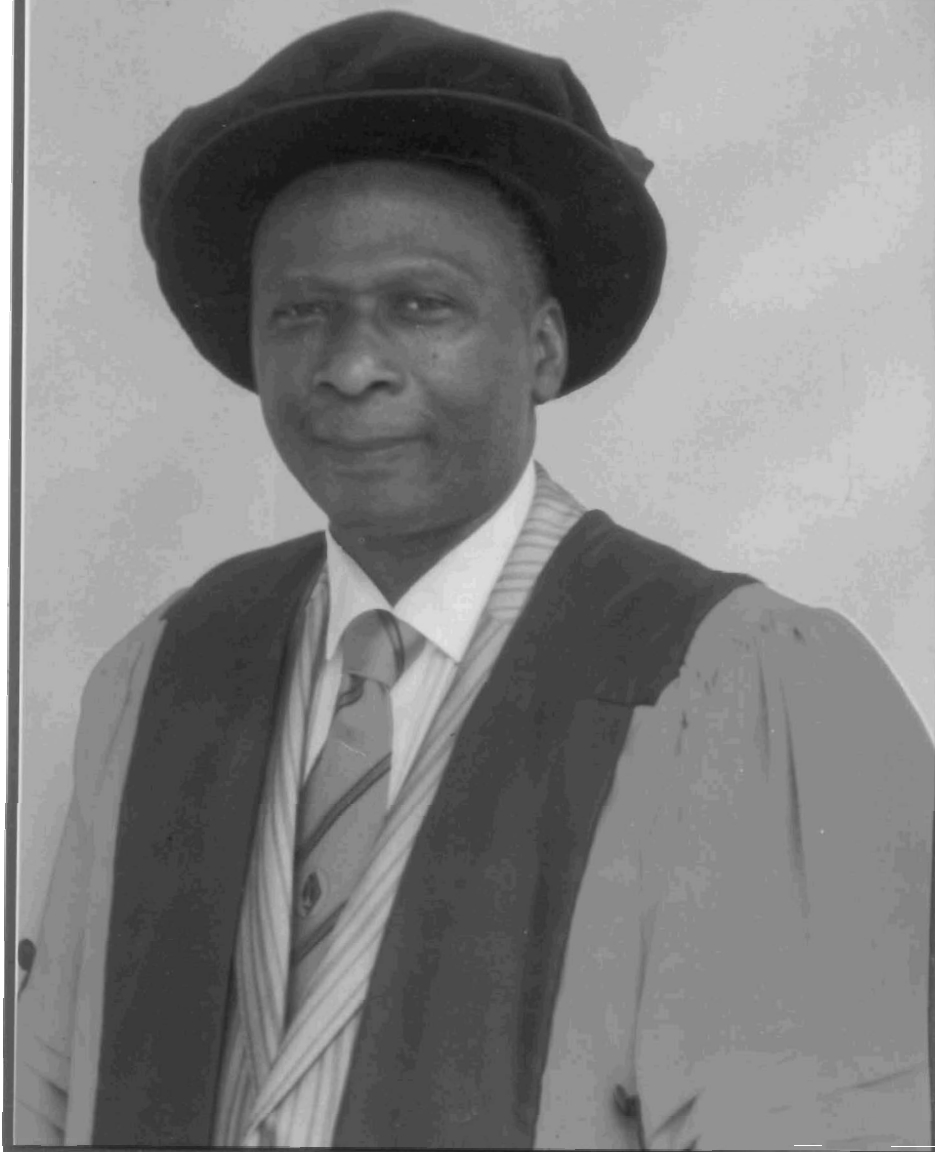
By

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OBAFEMI AWOLowo UNIVERSITY PRESS, ILE-IFE, NIGERIA.





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THE ODYSSEY OF AN OBSTETRICIAN CUM
GYNAECOLOGIST IN ILE-IFE.**

**An Inaugural Lecture Delivered At Oduduwa Hall,
Obafemi Awolowo University, Ile-Ife, Nigeria.
On Tuesday 10th of October, 2017.**

By

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Obafemi Awolowo University
ILE-IFE, NIGERIA.

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“GIVING THE BEST TO AVERT THE WORST: THE ODYSSEY OF AN OBSTETRICIAN CUM GYNAECOLOGIST IN ILE-IFE”.

PREAMBLE

Mr. Vice Chancellor Sir, distinguished ladies and gentlemen, to God alone be the glory for this opportunity to stand before this audience to deliver the 309th Inaugural Lecture, being the sixth from the department of Obstetrics, Gynaecology and Perinatology of the College of Health Sciences. Historically, it is believed that inaugural lecture originated from the University of Oxford, England in 1623 by Digor Whear when he delivered his treatise “Oratio Uaspicalis in the Schola Grammaticae”¹. An inaugural lecture is an occasion of significance in the career of an academic member of staff because he is provided with the tripod opportunity to talk about: (i) **“the state of his discipline” –the progress, current status and challenges.** (ii) **Stewardship of his scholarship** (present his research prior to being promoted a professor). (iii) **Defining the future** (to make a public declaration of the scheme of research which he proposes to follow while occupying the chair)². I am indeed grateful to Obafemi Awolowo University for nurturing me academically from inception as an undergraduate till now having attained the status of a Professor in my chosen discipline of Obstetrics, Gynaecology and Perinatology. It is with humility that I stand before you today to share my experiences as a physician with a bias for the female gender and my modest efforts at conducting relevant research. Indeed, according to late Professor Ade Ajayi, a former Vice Chancellor of the University of Lagos, an inaugural lecture is a debt owed to the academic community that appoints one a professor. Today, that indebtedness is being paid.

Mr. Vice Chancellor Sir, I recall with nostalgia that over four decades ago when we came in, this citadel of learning was autonomous in admitting its own students directly by inviting them by telegrams for admission. The training of health professionals at the then Faculty of Health Sciences was based on the **“If**

Philosophy” which was an eclectic blending of science and services with the community in view³. It will be a great dishonor not to acknowledge the roles of teachers who mentored us both in the pre-clinical and clinical years. These men and women (many are now deceased) were giants in their respective disciplines and were pain-staking to refine us from the “raw materials” we were to the physicians we later became. I am constrained by time and space to mention all their names but **Professors Thomas Adesanya Ige-Grillo** (pre-clinical years) and **Adebayo Owolabi Adeyemo** (clinical years) were giants on whose shoulders we stood. **Professor Mike Akin Bankole**, the doyen of paediatric surgery in Ile-Ife was the one who instilled in us ethics of the medical profession. I recall that afternoon (the last day of the series of lectures on ethics) about 37 years ago when he concluded that after one has finished treating a patient, he or she (the patient) should volitionally say “thank you doctor” because of satisfactory treatment. For over 36 years, I have tried to adhere to this admonition by a medical elder.

In the creation story, and prior to the fulfillment by mankind of the divine injunction to be fruitful, multiply and replenish the earth, Almighty God, the Creator first anesthetized Adam by making him to sleep then performed surgery (excision of a rib or costectomy) on him and thereafter from the rib fashioned out the first woman, Eve⁴. Evidently, that was the first assisted reproductive technology (ART) ever performed. For Adam to fully recover from the anesthesia and surgery, he must have had excellent nursing and physiotherapy care. We have not read from the scriptures that he had post-operative pain, he must have had divine pharmaceutical analgesic. Thus, God the Creator in bringing forth Eve from Adam was “**all in all**” for He was an anaesthesiologist, surgeon, nurse, pharmacist, physiotherapist and a specialist in reproductive technology. This is a pointer to all cadres of health-care workers to work together in unity of purpose and to eschew bitter and acrimonious rivalry in the care of the hapless patients. Patient care is a sacred calling.

THE STATE OF THE DISCIPLINE

Obstetrics, gynaecology and perinatology is a three -in one discipline in which the first is a specialty of medicine that deals with the care of females during pregnancy, parturition and puerperium. The second deals with diseases of the genital tract coupled with endocrinology and reproductive physiology of the female. **Perinatology (Feto - maternal medicine)** is a sub-specialty of Obstetrics that deals with the care of the fetus and high-risk pregnancies. It is germane to point out that a new scientific discipline termed **Sexual and Reproductive Health** was "re-defined" in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt. This new discipline encompasses many aspects of Obstetrics and Gynaecology and more.

Table 1 shows some selected health and demographic statistics from some selected countries in six continents of the world in 2015. Nigeria had the highest maternal mortality ratio (**814 per 100,000 live births**), the highest stillbirth rate (**41.67 per 1,000 total births**), **70% of the populace were adjudged to be poor**, had one of the least health budgets as percentage of total annual budgets (**3.7%**) and the highest life-time risk of maternal death of **1 in 22**. In the triennium from October 2012 to September 2015 at OAUTHC, Ile-Ife, the **maternal mortality ratios were 1,744, 1622 and 1,512 / 100,000 live births respectively**⁵. These ratios are much higher because the hospital is a referral centre handling complicated and high risk cases. The year 2015 was chosen because that was the end of the timeline for the millennial developmental goals (MDGs) during which maternal mortality ratio was expected to have been reduced by 75% but alas this was not so for Nigeria .Other health and demographic statistics did not fare better in that the targeted goals were not fully achieved. Maternal and fetal outcomes at birth are sensitive indicators of the status of a health- care system. They show the quality of care that is available to manage maternal and fetal life- threatening complications which are often unpredictable and need a rapid, skilled response and access to tertiary emergency obstetric

services, including well coordinated team work between obstetricians, midwives and pediatricians.⁶ Each maternal death is a tragedy and most are highly preventable. In 2015, the United Nations Population Division Maternal Mortality Inter-Agency Group⁷ estimated that there were 58,000 maternal deaths in Nigeria, averagely 159 maternal deaths occurred daily. When a plane crashes with 159 people on board on a single day, the whole nation is aghast and there are national and international repercussions but it is unimaginable how the whole world would feel if this occurs every day. Yet 159 females were still dying every day in 2015 in the quest of being mothers in Nigeria and the most it attracts is a national whimper. For each maternal death, many more suffer short or long term consequences of complications that arise during pregnancy, parturition and puerperium. It is therefore note-worthy to point out that during the 1990s, the concept of severe adverse maternal morbidity (SAMM) or “Near Misses” emerged in response to the need for a more sensitive marker of quality of obstetric care. This term has the advantage over maternal death of drawing attention to surviving women’s reproductive health and lives and is equally applicable in developing as well developed countries.⁸

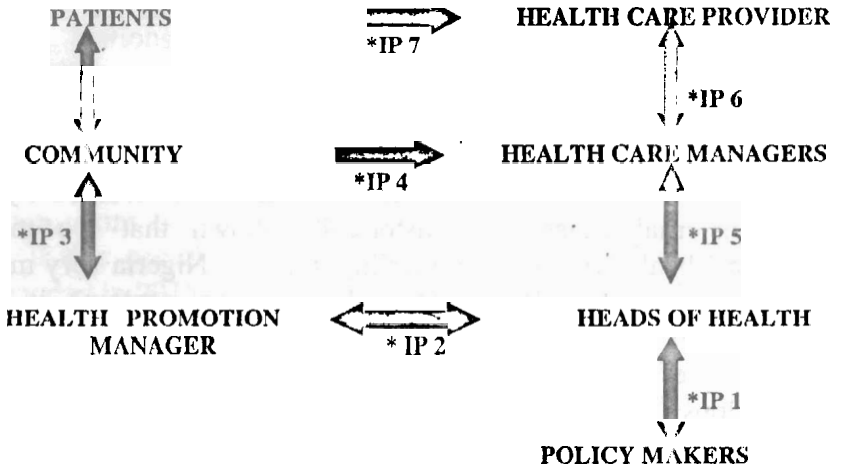
Stillbirth is still one of the most shamefully neglected areas of public health. At OAUTHC, Ife between July and December 2015, the stillbirth rate among booked patients was 13.4 per 1,000 total births and for unbooked cases it was 47.2 per 1,000 (Crude stillbirth rate was 31.6 per 1,000 total births)⁹. This shows that stillbirth is 3.6 times commoner among unbooked pregnant women. Stillbirth is a devastating occurrence for families, and women bear the brunt of the consequences. Hopes and dreams are shattered and expectant women might have depression as they may face scorn, isolation and rejection¹⁰. They can be pressured to become pregnant again too soon and hence face a shortened birth interval with an increased risk to themselves and subsequent pregnancies.¹¹

I have limited this phase of the lecture to issues related to maternal deaths and stillbirths only. It is not as if maternal “Near Misses” and deaths of newly born infants within the first week of life are

not important but to have some focus. Moreover, in a lighter mood, the neonatologist is one step behind the obstetrician since the latter hands over the newly born neonate to the former and the outcome depends on the level of neonatal care!!!

A pregnancy can test nearly all aspects of a health system: preventive care, counseling, surgery, drug administration, follow-up care and emergency treatment. The number of women dying from maternal causes has historically shown that too many countries' health systems were failing that test, Nigeria very much inclusive.¹² A **health system (health-care system)** is the organization of people, institutions and resources that deliver health care services to meet the health needs of target populations.¹³ Figure 1 shows the inter-relationships of various stakeholders that drive a health-care system from policy makers (national, state, local governmental authorities and international donor agencies) to health-care providers (doctors, nurses, pharmacists and laboratory scientists) with the patients occupying a central role.

Figure 1 showing Key Health-system interfaces with the goal of reducing mortality and morbidity.



INTERPHASES (IP): 1-Decide on and convey policy; 2- convey policy, and decide on strategy and messages for the community;3- provide constant messages; 4- ensures community has access to health care to enable implementation of policy; 5- convey policy and decides allocation of resources needed to implement policy; 6- convey policy and provide resources, knowledge and skills needed to implement policy; 7-provider to implement knowledge and skills and use resources to provide care to the patient within the policy guidelines including adequate information to enable discussion and appropriate decisions by the patient. (SOURCE- THE LANCET, APRIL2011).

TABLE 1. SELECTED STATISTICS OF SELECTED COUNTRIES FROM SIX CONTINENTS.

CONTINENT/ COUNTRY	M.M.R	STILL BIRTH RATE	POVERTY LEVEL (%)	GDP PER CAPITA INCOME (US \$)	HEALTH BUDGET AS PERCENTAGE OF TOTAL ANNUAL NATIONAL BUDGET	General Fertility Rate	LIFE TIME RISK OF MATERNAL DEATH
<u>AFRICA</u> NIGERIA GHANA S.AFRICA	814 319 138	41.67 21.97 20.36	70.0 28.5 31.3	2671.7 1369.7 5718.2	3.7 3.6 8.8	5.6 4.1 4.9	1 in 22 1 in 74 1 in 300
<u>ASIA/ MIDDLE EAST</u> INDIA ISRAEL SAUDI - ARABIA	174 5 12	22.1 3.36 7.61	29.8 21.0 NA	1593.3 35,792.4 20,481.7	4.7 7.8 4.7	2.4 3.1 2.7	1 in 220 1 in 6,200 1 in 3,100
<u>EUROPE</u> SWEDEN N'LAND UK	4 7 9	2.74 3.3 3.5	NA 9.1 16.2	50,585.3 44,290.9 43,929.7	11.9 10.9 9.1	1.9 2.2 1.8	1 in 12,900 1 in 8700 1 in 5800
<u>NORTH AMERICA</u> CANADA USA	7 14	3.28 2.95	9.4 15.1	43,315.7 56,115.7	10.4 17.1	1.6 1.8	1 in 8,800 1 in 3,800
<u>SOUTH AMERICA</u> BRAZIL MEXICO	44 38	9.51 4.53	21.4 52.3	8677.8 9005.0	8.3 6.3	1.8 2.2	1 in 1,200 1 in 1,100
AUSTRALIA	6	2.9	NA	56,296.6	9.4	1.8	1 in 8,700

MMR- Maternal Mortality Ratio (per 100,000 live births) - Maternal Mortality Interagency Group. Still Birth rate – THE LANCET (FEB, 2016). Mortality Rate (per 1,000 total births). GDP per capita income - World Bank / OECD. GFR – World Bank Data, 2015. Poverty Level Percentage of Population Below \$2 per day at purchasing power parity (INDEX MUNDI), STILLBIRTH - 2009 chart bin.

The dismal Nigerian health and demographic statistics relative to other selected nations in Table 1 and coupled with very low physician and nurses/midwives density (0.4 per 1000 population) in sharp contrast to the UNICEF recommendation of 1.6 per 1,000 population¹⁴, it is glaring that Nigeria's health care system is very weak and failing. Various researchers from national and international bodies have identified the maladies be-devilling

Nigeria's health care system. This lecturer is of the opinion that all these maladies can be divided into three major groups namely: (i) Maladies in Governance in Federal and State polities (ii) Weak Clinical Governance in public funded hospitals and (iii) Attitudinal maladies of health care workers.

Governance is defined as the provision of the political, social and economic public goods and services that every citizen has the right to expect from his or her state, and that a state has the responsibility to deliver to its citizens. The Ibrahim Index of African Governance (IIAG) is an annually published index that provides a statistical measure of governance performance in every African country. In its "Decade of African Governance" assessment (2006 -2015), Nigeria was ranked 36 out of 54 countries with a score of 46.5% compared with Mauritius which came first with a score of 79.9%¹⁵. It is glaring to all that corruption is pervasive in Nigeria with what we perceive in the news media daily and it appears that kleptocracy is being increasingly entrenched in the polity. That was why decades ago, the recently deceased author, broadcaster and playwright Chief Adebayo Faleti wrote in his Yoruba book "**Nwon ro pe were ni**"¹⁶ that "**Agbemalu ndajo agbedie**" (the person who stole a cow becomes a judge over him that stole a chicken). Mis-governance in Nigeria has resulted in failed institutions and failed infrastructure what with failed road networks, embarrassing electrical power outages and gross inequities in the allocation of national financial resources. These have adversely impacted the health care system and contributed to the intolerably high maternal mortality ratio and still-birth rate in Nigeria. Quoting from Shakespeare's Julius Caesar – "The fault dear Brutus is not in our stars, but in ourselves that we are underlings"¹⁷ The situation in Nigeria is not fortuitous for we are the architects of our own misfortune in the type of leaders and governance we allow in our polity. Over five decades ago, Singapore was a third world country like Nigeria but through visionary and patriotic leadership of the late Prime Minister Lee Kuan Yew and his associates, it is now a very high income country with institutions and infrastructure that are functional. Generally,

there is lack of **health security**¹⁸ in Nigeria. Health security is defined as the provision and maintenance of measures aimed at preserving and protecting the health of the population as well as the policy areas in which national security and public health concerns overlap. We can recall that a few years ago, over 200 Chibok girls were abducted by extremists. Some of these girls had died, many were statutorily raped and coerced in to early marriage and became mothers in their teens and adolescence with sexual and reproductive health sequelae.

We are not to lose hope in Nigeria because it has recently been proved that with a strong political will, things can be made to work in the health-care system. Ondo State was the cynosure of all eyes during the tenure of the past governor Dr. Olusegun Mimiko (an alumnus of Great Ife) in the implementation of the highly laudable Abiye project which has helped to reduce markedly the very high maternal mortality ratio in Ondo state. This notable achievement has proven that giving the best in the allocation of resources coupled with a strong political will, the worst (preventable maternal mortality) can be averted. “Nigeria desperately needs uncompromised leaders with excellent management, strategic planning experiences, and forward thinking vision that will address the multi-faceted challenges within the healthcare system¹⁹”.

In all nations, teaching hospitals are the flagships of the health-care system because they offer specialized tertiary care. This lecturer acknowledges the vital roles in preventive care by primary health care centres and secondary care by general hospitals but having been intimately associated with a tertiary hospital for four decades, I will share of my experiences there-in. Medical tourism to other nations is still thriving due to lack or weak clinical governance in our own institutions which is an offshoot of the maladies of governance in the larger polity of the Nigerian state. **Clinical governance** is the systematic approach to maintaining and improving the quality of patient care within a health system. Our teaching hospitals are be-devilled by a plethora of maladies such as lack of appropriate infra-structural support systems, obsolete

equipment, inability to maintain newly installed major equipment that malfunction no sooner than they were installed, dwindling financial subventions from governments, inter and intra-professional conflicts and rivalries leading to incessant prolonged closures denying hapless patients needed succor. The coverage of the National Health Insurance Scheme (NHIS) is still very poor at 3% such that many patients resort to out of pocket expenses to cater for their health in emergencies and the dilemma is that 70% of the populace is adjudged to be living below the poverty line.²⁰ Consequently, many patients patronize traditional health-care givers and faith-based organizations and are brought to public funded hospitals as a last resort when many would have become moribund.

All these maladies impact training, research and services negatively. In 2013, Makinde et al carried out an 18 – criterion based audit of the management of severe preeclampsia / eclampsia at OAUTHC, Ile-Ife. The performance score for the 18 criteria ranged from as low as 17.3 (laboratory investigations) to 100% with the average being 69.1%.²¹ Obviously, the need for improvement is glaring. To help clinical governance, hospital managers and planners should advisedly have a recourse to a method termed **workload indicator of staffing needs (WISN)**.²² This method enables planners and managers estimate staff requirements, allocate staff among diverse health facilities and monitor staff performance. The job description of each cadre of staff within a health care facility to meet acceptable professional standards of service delivery is specified. The WISN ratio is then determined, the numerator being the calculated or required number of staff in a unit while the denominator is the number of staff actually on ground. If the WISN ratio is 1.0, the actual number of staff on ground is just enough to meet set professional standards. If the ratio is <1.0, then the current staff strength is not sufficient to meet the standards set and if >1.0 then there are more than enough staff to meet standards set.

The hallmark of a good professional health worker especially physicians is exemplified by the following attributes: **compassion for patients, self sacrifice, self effacement, integrity and the quest for scholarship to upgrade knowledge, skills and expertise periodically.** If any of these attributes is lacking in any health worker it constitutes an attitudinal malady. The healthcare terrain in Nigeria is demanding and most times can be very frustrating. To have a modicum of success, each health worker has to be dogged and have the aforementioned attributes. Health managers should ensure that each worker adheres to the **Patient Oriented Provider Efficient services (P.O.P.E) in** which services are made to revolve round the patient efficiently and efficaciously. The patient is catered for like the Queen bee in a beehive and should also be handled with **utmost respect, dignity** and made **comfortable** as much as possible. Indeed, the physician has a fiduciary responsibility to his patient and at no time should this trustworthiness be betrayed. Of course the welfare and wellbeing of each health worker are of paramount importance as well.

Quo Vadis (Where do we go from here)? Why should a woman die because she wants to obey the divine injunction to be fruitful, multiply and replenish the earth? Why? Should preventable maternal death not be considered a human right issue due to systematic inaction by governments in low and middle income countries (LMIC) like Nigeria and also by acquiescent health workers like this lecturer and the Nigerian populace at large? I understand that in places like Sweden, there are professors of Obstetrics who have never witnessed a maternal death in their career. Some have opined that preventable maternal death should be considered a crime against humanity, and I concur. It is in this perspective that this lecturer had on several occasions had to drive himself to the hospital in "the dead of the night" when, because of logistic reasons an ambulance could not be sent to pick him when life threatening emergencies occurred.

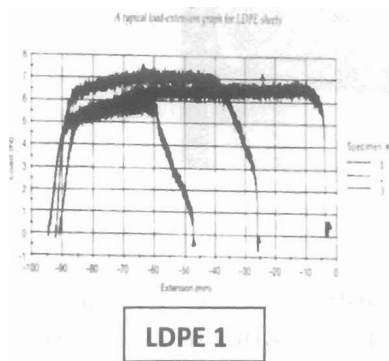
In 1991, at the 13th World Congress of Gynaecology and Obstetrics in Singapore, a prominent African obstetrician,

Professor Mahmoud Fathalla gave a presentation entitled “How much are mothers worth? Taking a cue from this, Staffan Bergstrom has proffered a new concept called ‘**Obstetric Ectoscopy**’”²³. Obstetric ectoscopy is a plea to Obstetricians to look outside the hospital gates and discover all the unmet needs in the less fortunate strata of the world, particularly for pregnant women in Africa. The obstetric profession in Nigeria has an ethical responsibility in not remaining silent, just hospital oriented but should be outward looking in providing politicians and policy makers with the persistent grim statistics of maternal and perinatal mortality and never give up in finding solutions. Obstetricians should also make ourselves more literate in “**obstetric economics**” for there is a price tag for maternal survival. It is noteworthy that at the International Conference on Population and Development (1994) in Cairo, Egypt the stipulated cost for “Reproductive Health Care for All” **per year was 17 billion US dollars**. This sum of money appears very huge but compared with military expenditures globally which was estimated to be **17 billion dollars weekly** during the same period, the former pales into insignificance.²⁴ Homo Sapiens devote more resources to ventures that would cause self-annihilation of the human race than to measures that would maintain and promote health and prevent mortalities. What an irony!!! The days of catchy rhetorical slogans alone should be over and we should really “**walk the talk**” and have **zero tolerance** to maternal and fetal mortalities in Nigeria. We must give the best in resources (human, material and financial), redress the three groups of maladies aforementioned and regularly have “**face-time**” with political movers and shakers to avert the worst (maternal and fetal mortalities). All these are parts of a clarion call for collective responsibility and giving the best to avert the worst.

STEWARDSHIP OF MY SCHOLARSHIP

The discipline of Obstetrics and Gynaecology has a wide array of research issues and topics and over the years, we made a foray in to some of these. We have been able to show that using **appropriate technology** as advocated by the World Health Organization, solutions can be proffered locally to solve challenges

confronting us in low resource centres in the design of a low density poly-ethylene (L.D.P.E) arm glove for usage within the puerperal uterus. This is a medical design useful in a low resource centre. Specifically, we collaborated with colleagues from the departments of Paediatrics and Child Health, Pharmaceutics, Centre for Energy Research and Development (CERD) and National Centre for Technological Management (NACETEM). We designed an affordable, readily available, low density poly-ethylene (LDPE) long arm gloves from virgin polyethylene material for usage within a puerperal uterus to protect the health-care provider from contracting HIV from an infected patient. The glove was sterilized and strengthened using 50 kilo-gray of gamma-irradiation (kGy).²⁵



Bacterial load of gloves

Serial No. of gloves	Log cfu / glove [Before Irradiation]	Log cfu / glove [After Irradiation]	Irradiation value [kGy]
1	2.30	0	83.35
2	3.79	0	50.00
3	2.90	0	35.00
4	0	0	38.133

Mean weight of gloves = 7.9g ± 0.32g

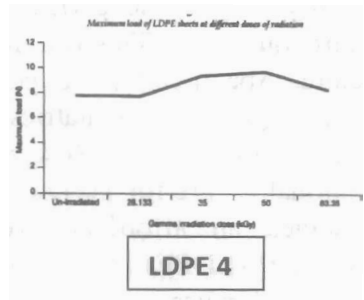
LDPE 2

Organisms isolated from gloves before and after irradiation

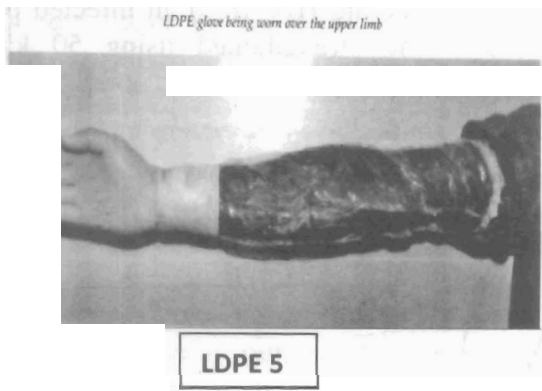
Organisms	Before irradiation	After irradiation
<i>Staphylococcus</i> species	75% of gloves were contaminated by the bacterium	0 [None]
<i>Bacillus</i> species	25% of gloves were contaminated	0
<i>Klebsiella</i> species	50% of gloves were contaminated	0

NB: The packed gloves were sent for irradiation without revealing the contaminating organisms

LDPE 3



LDPE 4



LDPE 5

We highlighted how financial constraints and aversion to Caesarean delivery compel pregnant women to choose unwholesome care centres and birthing places in lieu of well established centres with adequate facilities and personnel with resultant obstetric tragedies ^{6, 7}. Early booking, attendance and proper utilisation of ante-natal care services were identified as part of the solution.

The significant risk factors for preterm delivery and how these can be addressed to reduce their contribution to obstetric and perinatal morbidity and mortality were highlighted.²⁶ Where ultrasonography is unavailable, symphysio-fundal tape measurement could be used to predict birth weight as part of appropriate technology advocated by WHO. To enhance reproductive outcome, the W.H.O partograph is a useful

monitoring tool and it was shown that lower cadre of health workers like Community Health Extension Workers (CHEWS) can be effectively trained to use the partograph.^{27,28}

We researched into the various causes of maternal morbidity and mortality in our environment.^{29,30,31} Increasing incidence of septic abortion and its effective treatment using a newer effective antibiotic at that time (Amoxycilin potentiated by Clavulanic acid) was discussed.³² Other entities researched into included retained placenta and phase 3 treatment delays.³³ We also revealed that Hepatitis B virus infection among antenatal clinic attendees in Ile-Ife is highly prevalent (10.2%) and with a concomitant high perinatal transmission rate if not treated.³⁴ We found the prevalence of T.B. in pregnancy to be 191cases/100,000 deliveries during the study period and also highlighted the pattern of presentation, management and outcome among pregnant women during the first ten years of the Millenium Development Goal – driven intervention.³⁵

We also highlighted in a study that there is evidence of increased metabolism of chloroquine during the early third trimester of human pregnancy by determining blood level profiles of the drug and its major metabolite des - ethylchloroquine.³⁶

Comprehensive emergency obstetric care is one of the pillars of safe mother-hood. We revealed that Caesarean section rate had increased tremendously over the years (2150 cases from 1977-1985 vs 641 in 2005 alone) and that Ante-partum haemorrhage and pre-eclampsia were predictable indications for major blood loss and transfusion.³⁷

We highlighted the important issue of infant feeding intentions by HIV positive mothers recognising that 90% of HIV infections in children are by vertical transmission and about 50% of these are through breast feeding. The study showed that mothers counselled on infant breast-feeding and who chose exclusive breastfeeding (EBF) would keep to it as opposed to those who planned to use exclusive replacement feeding (ERF) but ended up using mixed

feeding that encouraged mother to child transmission. Further highlights were on modalities for counselling and getting commitment from mothers on more preventive measures.³⁸

There was focus on gender-based violence by researching on 6 out of 32 cases reported over a 4-year period in a Nigerian tertiary institution of learning. **Qualitative research** methodology was used. The consequences of this gender-based violence were highlighted so also was the need for training of healthcare workers to give “holistic medical care” to the survivors of the various forms of gender-based violence.³⁹ Female genital mutilation (FGM) was found to still be highly prevalent (41.9%) despite efforts to curb it for over 25 years before the study.⁴⁰

Retrograde ejaculation is a known cause of male-factor infertility. It is a condition in which affected men pass a greater proportion of their spermatozoa in to their bladder but this is amenable to treatment. We found it not to be highly prevalent among the cohort of men studied but would need focused laboratory test to make the diagnosis. We also proposed a retrograde ejaculation ratio (RER) as an extension of the WHO criterion for its diagnosis.⁴¹

Sexual intercourse should be safe, voluntary and mutually enjoyable but this may not be so if there is pain (dyspareunia) during the act. We found a rare cause of deep dyspareunia (pain at deep penile penetration) in a patient with pelvic enchondroma.⁴²

For over 25 years, the inaugural lecturer has had deep interests in hypertensive disorders in pregnancy and uterine fibroids associated with pregnancy. He is a member of the International Society for the Study of Hypertension in Pregnancy (ISSHP) and had attended and presented at conferences in North America, Europe and Asia on several occasions. In 2011, he was invited to Ravello, Italy to present his study on **HELLP (Haemolysis, Elevated Liver Enzymes, Low Platelet Count) syndrome** at the conference on “Interventional Hepatology” under the auspices of A.N.I.C.E. (Associazione Nazionale Di Interventistica E Chirurgia

Ecoguidata) and Second University in Naples, Italy. In 2012, he made an oral presentation at the World Congress on Controversies in Obstetrics, Gynaecology and Infertility (C.O.G.I.) in Singapore on Caesarean myomectomy. These two studies are very relevant to us in Nigeria because the former is still one of the leading causes of maternal and perinatal mortality. The latter is highly prevalent among Nigerian women and it is of immense interest to all (care givers and patients) because it can lead to reproductive morbidity and mortality from time to time. In the light of the aforementioned, our studies on hypertensive disorders of pregnancy and uterine fibroids would be further highlighted.



ISSHP New Orleans, USA 2015.



NASSHP Chicago 2016



**C.O.G.I. conference
Singapore July, 2012.**

HYPERTENSIVE DISORDERS IN PREGNANCY (HDP)

In a 26 year retrospective study carried out at the obstetric unit of the OAUTHC, Ile-Ife, between 1985 and 2010, the prevalence rate of HDP was 4.5%.^{43a} There are several types of hypertensive disorders in pregnancy as shown in Figure II. but the prototype is pre-eclampsia which is the development of hypertension (HT) after 20 weeks of pregnancy with significant proteinuria. Pregnancy induced hypertension (PIH) also develops after 20 weeks of pregnancy but with no significant proteinuria. There can be a continuum from PIH to pre-eclampsia and then to eclampsia (HT+ significant proteinuria and convulsions)^{43b,c,d,e,f,g,h,i}. Eclampsia is the Greek word for “Lightning” and in reality when eclampsia occurs it is as if lightning has occurred in a flash. **Leon Chesley (1908-2000)** has been described as the father of 20th century of understanding of preeclampsia. He followed up 270 eclamptic females for 45 years and worked with the simplest tools but the sharpest powers of observation and an extraordinary memory with a unique ability to conceptualize.⁴⁴

TYPES
• PREGNANCY INDUCED HYPERTENSION(PIH)
PRE-ECLAMPSIA-MILD(B.P<160/110mmHg);
- SEVERE(>160/110mmHg);
- IMMINENT ECLAMPSIA
*ECLAMPSIA
*CHRONIC HYPERTENSION- IDIOPATHIC/SECONDARY
• PRE-ECLAMPSIA SUPERIMPOSED ON CHRONIC HYPERTENSION
*ATYPICAL PRE-ECLAMPSIA/ECLAMPSIA
*TRANSIENT HBP (LATE IN PREGNANCY, LABOUR & PUERPERIUM).
• UNCLASSIFIED

TABLE 2 HYPERTENSIVE DISORDERS IN OAUTHC, ILE-IFE (1985-2004).

Disorder	Cases (n)	Percentage (%)
TOTAL	79	15.3%
MILD PRE-ECLAMPSIA	118	22.8%
SEVERE PRE-ECLAMPSIA	114	22%
IMMINENT ECLAMPSIA	36	7.0%
ECLAMPSIA	127	24.6%
CHRONIC HBP	31	6.5%
PRE-ECLAMPSIA SUPER IMPOSED ON CHRONIC HBP	12	2.3%

Table 3. HELLP syndrome study in Ile-Ife, Nigeria (2009).

HELLP syndrome	Severe PET/eclampsia cases (n = 34)	HELLP syndrome cases (n)	Deaths among positive HELLP syndrome cases (n)	Fatality rate (%)
Severe Pre-eclampsia	12	35.3	4	100
Imminent Eclampsia	10	29.4	1	0
Severe Pre-eclampsia	12	35.3	1	0
Total	34	100	6	17.6

TABLE 4. Classification of HELLP syndrome cases using the Mississippi triple class system

Mississippi class system	Haemolysis, elevated liver enzymes, platelet count	Cases (n)
Class I	<50,000	0
Class II	>50,000 and ≤ 100,000	4
Class III	>100,000 and <150,000	2
Total		6

TABLE 5. PERINATAL MORTALITY AMONG SEVERE PRE-ECLAMPTICS/ECLAMPTICS IN ILE - IFE

Case	AGE (years)	Parity	G. W. (kg)	Smoking status	Diagnosis at presentation	Mode of Delivery	Infant outcome
1	33	P2	33	U	Eclampsia (P-F)	SVD	1 (100%) live, 0 (0%) stillborn (SBA) *
2	23	P0	32	U	Eclampsia (A, P)	SVD	0, 1pg, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0
3	39	P3	33	U	Imminent Eclampsia	SVD	2, 3pg, 1d, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0
4	30	P3	36	U	Imminent Eclampsia	SVD	2, 3pg, 1d, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0 0, 1pg, 1d, 2, 2, 0

TABLE 6. EFFECT OF ANTE - NATAL CARE, BIRTH WEIGHT, PARITY AND MULTIPLE PREGNANCY ON PERINATAL MORTALITY AMONG CASES OF SEVERE PRE-ECLAMPSIA/ECLAMPSIA

	Total no of fetuses	Perinatal death	Perinatal mortality (per 1000 total births)	P-value
(A) Antenatal Care				
Booked	8(18.6%)	0(0%)	0	>0.05
Unbooked	35(81.4%)	6(100%)	5.84	
(B) Birth weight				
< 2.5kg	16(37.2%)	5(83.3%)	4.87	<0.05
≥ 2.5kg	27(62.8%)	1(16.7%)	0.97	
(C) Parity				
1-4	17(41.0%)	1(16.7%)	0.97	<0.05
≥ 5	21(53.0%)	4(66.7%)	3.89	
(D) Multiple				
Pregnancy	36(83.7%)	3(50%)	2.92	<0.001
Singleton	4(9.3%)	0	0	
Twins	3(7.0%)	3(50%)	2.92	
Higher Order				

- FIGURE 3. RISK FACTORS TO DEVELOPING PRE-ECLAMPSIA**
- ☛ PRIMIGRAVIDITY (FIRST PREGNANCY)
 - ☛ AGE <20 YEARS OR >35 YEARS
 - ☛ PREVIOUS HISTORY OF HBP OR PRE-ECLAMPSIA IN PREGNANCY
 - ☛ FAMILY HISTORY OF HBP
 - ☛ MULTIPLE PREGNANCY/MOLAR
 - ☛ BMI ≥ 35 KGM⁻²
 - ☛ NEW MALE FACTOR (PRIMPATERNITY)
 - ☛ MEDICAL DISORDERS- DM, RENAL DX, AUTO-IMMUNE DX

PREECLAMPSIA WARNING SIGNS: (FIGURE 4)

- ☛ HIGH BLOOD PRESSURE
- ☛ PROTEIN IN URINE
- ☛ SUDDEN WEIGHT GAIN
- ☛ HEADACHES

- ☛ **SWELLING OF THE FACE OR HANDS**
- ☛ **BLURRED OR ALTERED VISION**
- ☛ **CHEST PAIN**
- ☛ **PAIN IN THE UPPER ABDOMEN**
- ☛ **NAUSEA AND VOMITING**
- ☛ **BREATHING WITH DIFFICULTY, GASPING, OR PANTING**

PATHOPHYSIOLOGY Figure 5a

- **GENETIC-SUSCEPTIBLE GENES IN CHROMOSOMES 2(2q22), 5,13.**
- **Immunological aspect – the fetus as an allograft (paternal genetic inheritance)**
- **TROPHOBLASTIC INVASION OF THE UTERO-PLACENTAL CIRCULATION DOES NOT OCCUR BEFORE 20 WEEKS OF GESTATION.**
- **ENDOTHELIAL DAMAGE/PLATELET AGGREGATION-THROMBOCYTOPAENIA**
- **ARTERIOLAR VASOSPASM**

PATHOPHYSIOLOGY Figure 5b

- **VASOCONSTRICTIVE PROSTAGLANDINS LIKE THROMBOXANE > VASODILATORS LIKE PROSTACYCLIN**
- **OXIDATIVE STRESS**
- **ISCHAEMIC PLACENTAL CIRCULATION**

PE

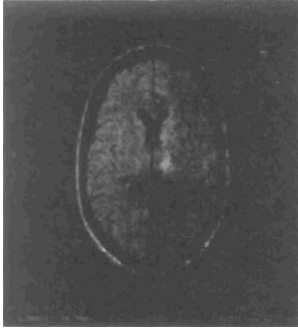
IUGR

ABRI

➤ REDMAN'S MODEL.

COMPLICATIONS. Figure 6a

- COMPLICATIONS MAY ENSUE FROM HEAD TO TOE.
- CRANIAL-POSTERIOR REVERSIBLE ENCEPHALOPATHY SYND(PRES)



ISCHAEMIC STROKES (53) 1991-2000

PREECLAMPSIA/ECLAMPSIA	-11
ARTERIAL THROMBOSIS	- 9
VENOUS THROMBOSIS	- 10
ARTERIAL EMBOLISM	- 4
VASCULOPATHY	- 5
A. FLUID EMBOLISM	- 1
ARTERIAL DISSECTION	- 2
OTHERS/UNKNOW	- 12

COMPLICATIONS Figure 6b.

- HAEMORRHAGE
MFU INJURIES
- VISUAL – BLINDNESS/IMPAIRMENT.
- RESPIRATORY- ASPIRATION
PNEUMONITIS,PULMONARY EDEMA.
- CARDIOVASCULAR
- HEPATIC- SUBCAPSULAR HAEMORRHAGE, RUPTURE.
- RENAL- R.F
- MUSCULO-SKELETAL- FRACTURES/BURNS

From the complications highlighted in Figure 6 which can be from head to toe of patients affected by severe pre-eclampsia / eclampsia, the disease state can be **life threatening, life altering and life ending**. Consequently, the World Pre-eclampsia Day was marked this year on the 22nd of MAY, 2017 with the theme “**Be prepared before lightning strikes**”. Prevention is therefore cheaper and better than cure and these preventive measures are highlighted in Figure 7.

PREVENTION.

Figure 7

- CALCIUM SUPPLEMENTATION IN PREGNANCY IN PEOPLE WITH DIETARY DEFICIENCY.
- LOW DOSE ASPIRIN(75mg daily) by 16 weeks gestation
- PRECOG GUIDELINES-IDENTIFYING RISK FACTORS EARLY AND PROMPT REFERRAL IN PERIPHERAL HOSPITALS/COMPREHENSIVE EMERGENCY OBSTETRIC CARE/MULTIDISCIPLINARY APPROACH/AVOIDANCE OF TREATMENT DELAYS.

Figure 8

- Novel Pharmacological treatment targeting early-onset SPE(EGA 23-30 WEEKS)
 - NO donors(GTrinitrate), ASA,Dietary supplements-Ca,L-arginine,anti-oxidant vitamins,phosphodiesterase-5 inhibitors,statins,CO, H2S.

Daily low dose aspirin has been found to be beneficial in preventing pre-eclampsia when administered to the pregnant women from before 16 weeks of gestation but oral calcium has been found to be beneficial only in those patients with hypocalcemia.⁴⁵ More recent advances are highlighted in Figure 8 especially towards **early-onset preeclampsia (EOPE)** which has been defined to occur before 34 weeks.⁴⁶ Ohkuchi et al, found that the trio of HBP, abnormal uterine artery Doppler (UAD) and high ratio of Sflt-1/PIGF were risk factors to developing EOPE.⁴⁷ It is imperative to point out that pre-eclampsia is a screening test for heart disease later in life because women who have had PE have approximately double the risk for heart disease and stroke

over 5-15 years after the occurrence of PE and hence the need to be closely monitored for many years.⁴⁴ In addition, there may be cerebral cortex affectation leading to memory and cognitive decline later in life.

UTERINE FIBROIDS AND REPRODUCTION

Fibroids are extremely common in women of reproductive age and black females bear a greater disease burden being 3-9 times commoner in them than their Caucasian counterparts.⁴⁸ While many women experience no negative effects of fibroids on their reproductive function, a significant number are at increased risk of infertility, miscarriage, or poor obstetric outcomes. Indeed, a gynaecologist is confronted with a variety of clinical scenarios and decisions regarding management of fibroids in the context of reproduction.^{49,50} I will not bore you with associated risk factors towards the development of uterine fibroids neither would I enunciate all the contemporary treatment modalities varying from just reassurance when indicated to interventional radiology, medical or pharmacotherapy and operative modalities. I would rather present some of our observations over the past 25 years of managing the disease entity for observation is the basic step in research.

Uterine fibroids and some clinical scenarios:

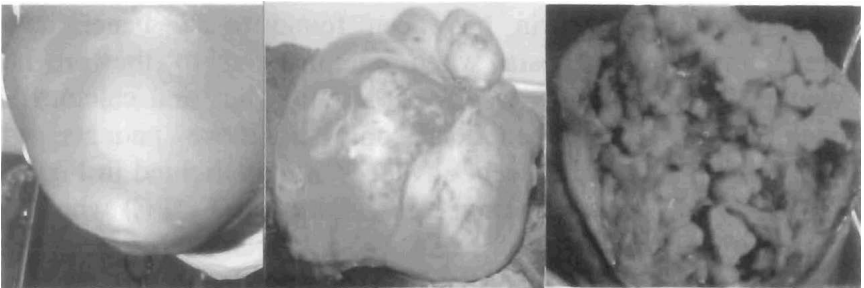


Figure 9a

Figure 9b

Figure 9c

1. Figures 9a and 9b Huge fibroid x 20 years, weight 7.4 kg. Nulligravida who presented when she started having cardio-respiratory embarrassment as a result of splinting of her diaphragm

by the mass. She had total abdominal hysterectomy and intra-operatively, the Fallopian tubes had been stretched out beyond recognition and distorted but she was happy post-operatively to be free of her encumbrances.

2. Figure 9c shows patient with over 200 but small fibroid nodules intra-cavitary. Presented with very severe dysmenorrhoea and dyspareunia that she curled up in fetal position and was not able to attend to her chores during menstruation. She had myomectomy despite the fact that not all the fibroid nodules could be removed at surgery because she wanted her uterus preserved.



Figure 10a



Figure 10b



Figure 10c

3. Figures 10a, b and c showing a patient with infertility for 5 years and huge fibroid. She had her first pregnancy ever at the age of 43years (natural conception) and had prolonged hospitalization because of cardio-respiratory embarrassment in pregnancy. She had elective Caesarean myomectomy and was delivered of a healthy baby boy whose birth weight was 3.1kg while the fibroid weighed 4.8 kg.



Figure 11

4. **Figure 11** showing pedunculated, subserosal, intramural and submucoid fibroids. Patient presented with meno-metrorrhagia. (got socially embarrassed on many occasions proceeded to using clothes instead of sanitary pads). For greater part of the year, she could not fulfill her conjugal vows to her spouse. Consequently, she could not conceive.

5. 47 year old nulligravid with a single intramural, posteriorly situated fibroid. Had ART and had prolonged hospitalization on account of threatened abortion and red degeneration and preterm contractions for which she had tocolysis. Had Elective C/S at term and was delivered of a live female infant.

6. On-going study (not yet published)- 15 consecutive cases of elective myomectomy for huge uterine fibroids (> 8cm in diameter) in females with varying durations of infertility, 8 of these got pregnant either spontaneously or through ART, 7 have been delivered of live infants, 1 spontaneous abortion of twin gestation after ART.

7. Table 7. CAESAREAN MYOMECTOMY STUDY IN ILE-IFE (1992-2011) –Retrospective study.

S/n	Age	Parity	Booking Status	Cadre of surgeon	D.O.S (minutes)/ Type	Blood Loss	Characteristics Of fibroid	Complications	Hosp Stay/Final disposition
1.	33	G2P0 ^{**}	B	C	168' (elective)	1.5L	Huge, 15x18cm, Intramural	Intra-op hypovolaemic Shock	9days discharged
2	30	G1P0	B	C	55' (elective)	0.2L	Single, pedunculated Subserous, 4x6cm	Wound sepsis	9days discharged
3	34	G3P2	B	R	75' (emergency)	0.5L	Single, subserous, 3x3cm	Nil	10days discharged
4.	39	G3P2	B	C	90' (emergency)	1.35L	Multiple, biggest occupying lower uterine segment (12cm)	Intra-operative haemorrhage	3days discharged
5.	28	G2P1	B	SR	75' (emergency)	1.0L	Solitary, 8x8cm intramural at lower uterine segment	Nil	5days discharged
6.*	32	G2P1	B	C	60' (emergency)	0.3L	Large, 8x5cm, subserous, Postero-fundal	Nil	7days discharged
7.**	33	G3P1 ^{**}	B	C	55' (emergency)	1.8L	Solitary, 10x8cm, Intramural at lower uterine segment	Intraoperative Haemorrhage	6days discharged
8.*	40	G3P2	B	SR	55' (emergency)	0.7L	Multiple, largest 6x4cm occupying lower uterine segment	Comorbidity of placenta praevia type 11	6days discharged
9.*	30	G1P0	B	C	150' (emergency)	0.65L	Multiple-intramural, cervical and subserous. Largest enucleated 12x10cm-calcified	Nil	11days discharged
10.*	34	G1P0	B		75' (emergency)	0.4L	Huge, subserous, antero-fundal, 24x16cm with omental adhesion.	Nil	6days discharged

LEGEND- *(General Anesthesia), ******(Spinal anesthesia), **DOS**-Duration of surgery ,**C**-Consultant, **SR**-Senior registrar, **R**-Registrar.

STATISTICS:

☞ **AGE RANGE:** 28-40 (AVERAGE 33.4 YEARS).

☞ **PARITY** < 3.

☞ **INCIDENCE OF CAESAREAN MYOMECTOMY:** 0.2% (11/5466)

☞ **ANESTHESIA:** SPINAL- 18.2%. G.A- 81.8%

☞ **DURATION OF SURGERY-** 55 – 168 (AVERAGE 86 MINUTES).

☞ **ESTIMATED BLOOD LOSS:** 0.2- 1.8 (AVERAGE 0.84 L) ****18.2%TRANSFUSED WITH BLOOD.**

DURATION OF STAY: 3-11 (AVERAGE 6.8DAYS).

CADRE OF SURGEON: CONSULTANT - 72.7%, SENIOR REGISTRAR - 18.2%, WELL EXPERIENCED REGISTRAR- 9.1%.

SIZES OF FIBROIDS EXCISED: 4 X 6 – 24 X 16cm.

**** NO MORTALITY DURING THE 20 YEAR PERIOD.**

In conclusion, Caesarean myomectomy might be inevitable and therefore might become an emergency or it might be selective to prevent future surgery and anesthesia. It is imperative that an experienced skilled surgeon should handle the case and scrupulous attention must be paid to haemostasis. As part of comprehensive obstetric care, adequate units of screened, cross-matched blood

must be provided so also should parenteral oxytocics. Multi-centered large case –controlled studies might be necessary to guide decisions towards best clinical practice.⁵¹

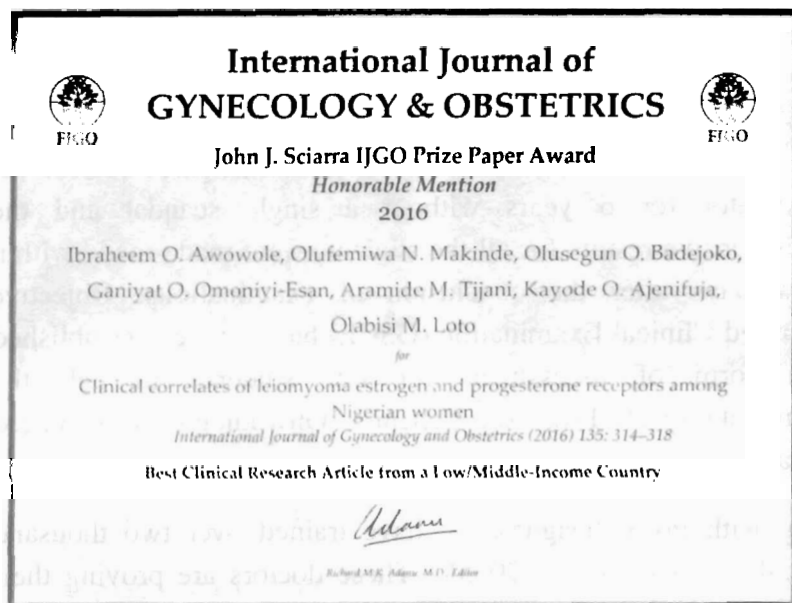
8. Study on clinical correlates of leiomyoma estrogen and progesterone receptors among Nigerian women.

From September 2013 to August 2014, a cross –sectional study was carried out in the department by obtaining intra-operative biopsy samples of leiomyomata and adjacent myometrial specimens from premenopausal women with uterine fibroids. Immuno-histochemistry for Estrogen receptor ($ER \alpha$) and progesterone receptor (PR) was performed on the samples. The immunoscores of both receptors were correlated with the size and symptoms of the leiomyomata. Among 60 pairs of samples, leiomyomata had a higher mean expression of $ER \alpha$ (H score 193.42 ± 64.5 vs 153.29 ± 69.13 ; $p=0.01$) and PR (214.86 ± 66.56 vs 171.53 ± 63.53 ; $p < 0.001$) than did myometrial tissues. The tumour diameter correlated with the immune scores of both receptors irrespective of age, parity, and body mass index, but this was only significant for PR ($= -0.44$; $P < 0.001$). Down regulation of PR on leiomyomata was predicted to occur at a diameter of 11cm. Menorrhagia, dysmenorrhoea and infertility occurred independently of steroid-receptor expression. In conclusion, leiomyomata seem to depend on steroid hormones, but only during early tumour development. This could have implications for the selection of patients for medical management, especially with steroid receptor modulators.⁵²

It is noteworthy to point out that **selective progestin receptor modulators (SPRMs)** such as **Ulipristal acetate (UPA)** are now increasingly being used in the medical management of uterine fibroids. UPA has a direct action on the fibroid by down-regulating the expression of angiogenic growth factors and their receptors in cultured fibroid cells leading to suppression of neo-vascularization, cell proliferation and survival⁵³. The only perceived draw back to the usage of UPA in our environment is its

highly prohibitive cost. Do we need to be reminded that 70% of Nigerians are living below the poverty line?

N.B. The study highlighted above was adjudged to be the best clinical research article from a LMIC and had a honorable mention in 2016 and won the John J. Sciarra Prize Paper Award. This citation is in the International Journal of Gynecology & Obstetrics, the official journal of FIGO (International Federation of Gynecology and Obstetrics). (Figure 12).



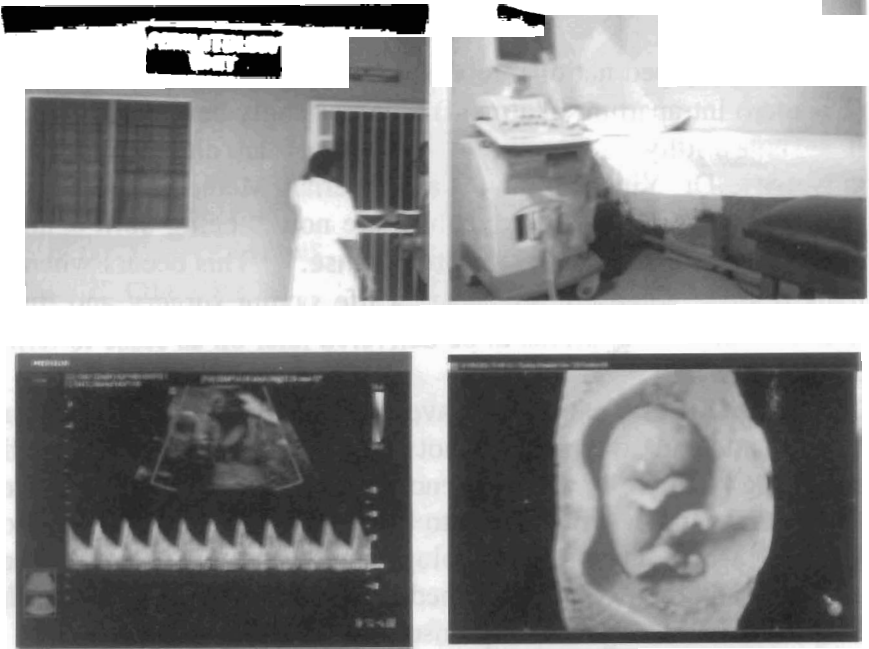
SCHOLARSHIP OF TEACHING.

Going down memory lane as an undergraduate in this medical school, I recall an early evening during the days of Professor Thomas Adesanya Ige- Grillo when he excitedly summoned us to the electron microscope room to show us intracellular organelles- mitochondria, ribosomes, lysosomes, nucleoli and nuclei. I was awed and listened with rapt attention. Professor Grillo spoke with passion and “prophesied” that these organelles would assume great importance in the future. He has been proved right for

mitochondria depletion syndrome has been discovered and its treatment has resulted in “3-parent baby” (a baby with 3 parents !!!) in a form of assisted reproductive technology. From my late teacher I learnt that a lecturer must not only be a “**content expert**”, he must also be skilled in the **transfer of knowledge** and also in getting **feedback** from his protégé in the form of pre-test, post-test and viva voce. etc. I have tried over the years to follow in the path of my late teacher to impact the lives of my students (undergraduates and post graduates) positively in didactic lectures, seminars, running two clinics weekly, bed-side teaching and very close supervision in operating theatre sessions. To the glory of God, I was a “feed-back expert” in being the sole part 5 MB.CH.B. Coordinator for 6 years without a single scandal and the comprehensive results for all the students were made ready within a few days after the conclusion of examinations. Objective Structured Clinical Examination (OSCE) has now been established as a form of assessment for our students through the instrumentality of Professor Uchenna Onwudiegwu who blazed the trail.

Along with my colleagues, we have trained over two thousand medical graduates (1995-2015). These doctors are proving their mettle within Nigeria and in the Diaspora. I have either supervised/co-supervised the theses of 30 medical postgraduate students, 6 Masters and 2 Ph.D students and 3 of my former students are Professors of Obstetrics and Gynaecology and by the grace of God, many more would soon be.

DEFINING THE FUTURE.



Can a mere mortal truly “define the future” for it is only with divine help can one decree a thing and make it to come to pass? Nevertheless, one can look into the future, desire, plan and work assiduously to realize set goals. In the last two decades, there had been explosion in knowledge in virtually every human endeavor especially in the sciences and medicine, obstetrics and gynaecology inclusive. The need for sub-specialization is imperative, in view of the high perinatal mortality rate in Nigeria.⁵⁴ In the department of Obstetrics, Gynaecology and Perinatology of OAUTHC, a functioning perinatology unit has been set up coordinated by Professor Oluwafemi Kuti, a physician with tenacity of purpose and passion. Under his leadership, there is an on-going study to design a Nigerian customized fetal growth chart which would be useful in identifying fetuses with restricted growth and thereafter offer appropriate treatment. Maternal and perinatal death surveillance and response (MPDSR) strategy is also

being vigorously pursued with a view to offering advance perinatal care.

In more developed nations, fetal surgery such as EXIT procedures (Ex- utero intrapartum treatment) is increasingly being carried out. It is noteworthy to recall the exploits of an alumnus of this university, Dr.'Yinka Olutoye, a "Nigerian Medic in Diaspora" along this line. Furthermore, babies are now " being born again" physically and not in the spiritual sense.⁵⁵ This occurs when a fetus is first delivered to have a life saving surgery and then returned back to the uterus to be delivered later on as close to term as possible.

That is the sort of dream that I have for the Perinatology unit in our department and we should not despise the days of "small beginning" and we have commenced in the right direction. More relevant researches would have to be conducted along this line. To have a "world class" perinatology unit, facilities have to be upgraded and the personnel trained and retrained periodically with transfer of knowledge and expertise from better developed climes.

CONCLUSION.



**TEENAGER, TWIN
DELIVERY AND ALL
ALIVE**



OBITUARY



GONE TOO SOON
MRS. XXX YYYY.
DUE TO COMPLICATIONS
DURING CHILD BIRTH .



The pictures shown are self-explanatory. The intolerably high preventable maternal and fetal mortalities in our environment can and should be markedly tackled as human right issues. What have countries like Sweden and Singapore done to have “**near zero mortalities**”? Whatever they have done we can emulate. To achieve this, it is recommended that the following steps be taken:

1. Development and testing of **early warning systems** by relevant health care workers to the obstetric population.⁵⁶ Early warning systems are a set of specific clinical signs and symptoms that trigger the awareness of risk and an urgent patient evaluation with the goal of reducing severe morbidity and mortality through timely diagnosis and treatment. In cases where early warning systems have been established, they should be monitored and evaluated periodically to ensure that set goals are met.
2. Health care professionals in collaboration with different tiers of government should continue to inform, educate and communicate with females within the reproductive age group about the imperativeness of family planning. Pregnancy should be by choice and not by chance or happenstance. Often, the complications that arise as a result of pregnancy in LMIC such as Nigeria revolves round “**too**”: too early (teen-age pregnancy), too late (≥ 40 years), too frequent (short interpregnancy interval), too many (grand-multiparity). Nigeria still has a general fertility rate of 5.5 which is much higher than in better developed countries.

3. Correction of the maladies (governance both in the polity and clinically and attitudinal). Perhaps, now is the time to make a clarion call to generate political priority to reduce the intolerably high maternal and perinatal mortality by identifying and appointing “**political entrepreneurs**”. Political entrepreneurs are politically influential and particularly capable individuals willing to exert efforts to advance a cause due to attributes that they have. Such attributes include vast knowledge about the issue, excellent coalition building skills, articulate vision, and credibility that generates resources and commitment. This might help to achieve the goals within the S.D.G 3.

If all these could be done and sustained it will amount to giving the best to avert the worst and the dividends are likely to be seen within a decade.

CLOSING REFLECTIONS

That I, can stand this day before this august audience is by the making of the Most High God in whom I live, move and have my being. My very caring and loving parents, Papa Victor Aderinoye Makinde and Madam Florence Sulola Makinde both of blessed memory nurtured and trained me in my formative years. They did not spare the rod. My first name is Olufemiwa (The Lord loves me and was determined that my destiny would not end in my mother’s womb and thus allowed my emergence into this world). My mother narrated to me on the day I became a doctor over 36 years ago that she was given an option of terminating my life during my pregnancy because she was so ill but thankfully she refused. Unfortunately, till she died I never inquired about the symptoms that she had during the period. That is why I love women and chose a queen amongst them 34 years ago in the person of Comfort Modesola Amoke Makinde (nee Akintimehin). Of a truth, she had been a pillar of strength to me and we have been through “thick and thin” together. God had granted her the grace and the patience to bear with my imperfections all these years. I thank God for all our children, Oluwakayode, Olasunmbo, Oluwatobi, Damilola,

Oluwadaara, Boluwatife. I also thank God for all members of the Makinde - Amosun clan and Akintimehin -Adebusoye clan. Over the years, all my colleagues in the department have added value to my life and one way or the other have been helpful in my sojourn in academics.

I should finally conclude this lecture by stating that without all the patients I have had the privilege to manage for decades, I would not have been in a position to give this lecture today. That is the truth. Of a truth, a woman is a miracle of versatility: wife, giving succor to her spouse, mother, going through uncharted terrain during each pregnancy associated with complications, an economic burden bearer for her family and a skilled negotiator.

In the light of the above, Mr. Vice Chancellor Sir, may I ask that we all rise and render this ode in honor of all mothers who had been, who are and who will be and over whom we must strive all the time to give the best to avert the worst –“**Iya ni wura iyebiye**” (**Mother is the pearl of inestimable value**).

Song---- Iya ni wura iyebiye ti ako le fowo ra -----.

Mr. Vice Chancellor Sir, distinguished ladies and gentlemen I thank you for your attention.

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