Inaugural Lecture Series 171

IS IT WELL WITH THE NIGERIAN CHILD?

By

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Professor of Paediatrics and Child Health

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An Inaugural Lecture Delivered at Odua Hall
Obafemi Awolowo University, Ile-Ife on Tuesday,
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INTRODUCTION

The Bible students in this audience will easily recognize that many of the words of the topic of my lecture have been borrowed from the Prophet Elisha who when sitting on mount Carmel, sighted a Shunamite woman afar off and sent his servant to ask the woman the triple headed question in II Kings 4: 26

Is it well with thee?
Is it well with thy husband?
Is it well with the child? To which the woman answered “It is well”.

Mr. Vice-Chancellor, distinguished ladies and gentlemen it is my intention to share with you today some of the experiences I have had in my over two and a half decades of hospital and community pediatrics practice in Ijesa land. It is my hope that by the time the lecture is concluded, you will be able to give your own answer to the question “Is it well with the Nigerian Child?”

WHY ARE CHILDREN IMPORTANT AND WHO ARE THE NIGERIAN CHILDREN?

These questions are important because some of the countries of the Western society towards which we often aspire in development have now arrived at an unexpected era with many couples choosing not to have children. This differs from their previous and our own present anguish and heart break of infertility. There is now in some Western countries the emergence of a new species namely the TINKERS – Two incomes, No kids, Early Retirement. It sounds very much like people working and living only and just for themselves.

However, children are important because of emotional, demographic, economic and service related reasons.

Firstly, children are high up in our emotion. Especially in the African culture, every child matters and children are loved. We wish them good health and success in their lives. Postman has said that children are the living message we send to a time we will not see and this has been more vividly illustrated by the statement “All the flowers of the future are in the seed”.

Secondly and demographically, children are vital for personal and national survival. For the first time in many western countries, fewer children are being produced per couple than the number required to maintain indigenous populations at an even level, that is to maintain a balanced demographic transition with equilibrium of births and deaths. Such nations will have to depend on immigration but this has its own problems. For example, Japan now has more people aged over 70 years than those aged under 10 years and this skewing of the population distribution is causing some worries. It is obvious that children are needed for national survival. When countries are developed and their health is good as in Japan, their age pyramid looks very much like a measuring cylinder. Most of the children survive to old age. In Nigeria, our age pyramid is triangular like a conical flask, wide at the bottom and tapering to a point at the top (Fig 1). The World Health Organization (WHO)\textsuperscript{4} has estimated that for the year 2002, only

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1}
\caption{Reproduced from \textit{My Name is Today} by Morley D, Lovel H. 1986 London: MacMillan Publishers.}
\end{figure}
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as in Japan, their age pyramid
cylinder. Most of the children
age pyramid is triangular like a
and tapering to a point at the top
WHO) 4 has estimated that

418% of the Nigerian population compared with 24% of the
Japanese lived for over 60 years and that life expectancy at birth in
Nigeria was 48.8 years compared with 81.9 years in Japan.
Nigeria’s population was estimated to be 120.9 million with 45%
or 54 million of it being children aged 15 years and below and
20% or 24 million being children aged under 5 years. This means
that 1 out of every 2 or 3 Nigerians is a child in his or her first 15
years of life. How can anyone doubt that such an enormous
proportion of the population is important?

Thirdly, children are important for economic reasons and I
am not referring to the child labour to which we unfortunately put
them. Poverty is the single most pernicious adverse influence on
the life and health of children and it is so prevalent in Nigeria.
There is a widening in equality of health, wealth and educational
attainment in the society. Poverty leads to difficulties in accessing
mainstream services, poor health, injuries and a host of other
medical and social problems.

Fourthly, children are important because of service related
reasons. Healthy children become healthy adults and many adult
diseases have their roots in childhood. Hypertension, stroke, heart
diseases, obesity are examples. The evidence linking childhood
social and economic disadvantage with poor child health and later,
poor adult health is now robust. Children, their health and well-
being are important.

IS IT WELL WITH THE HEALTH PROVISION,
PROMOTION AND SUPPORT RESOURCES FOR
CHILDREN?

The main determinants of the well-being or otherwise of
children are the statuses of the structures, agents, facilities and
other resources available to promote, provide or support health for
them. This has been well documented elsewhere 5. Since resources
include men, money and materials, let us start by considering the
status of mothers. You must have noticed the recognition given
by Elisha to the corporate health of the whole family, hence his
three pronged question “.......... Well with thee.........thy
husband.......the child”. Nigerian mothers are marginalized and
powerless. In addition, when compared with men, they are less educated. The United Nations system in Nigeria assessed that whilst adult literacy had declined from 57% in 1991 to 49% in 1999, gender gap remained wide with only 41% of adult females being literate in 1999 compared to 58% of males. Yet, it has been convincingly shown that the survival and health of children are directly related to the lack of or amount of education received by their mothers. Furthermore, Nigerian mothers are overworked. A woman’s duties are never finished nor are her day done. This fact has been aptly put by Okot p’Bitke, a poet from East Africa.


The next health promotive and support resource I want to consider is the home and environment complex of the Nigerian child. Between 70 and 80 percent of Nigerian children live with their parents in villages and other rural settings. These rural areas are isolated and difficult to reach with services. The villagers are themselves conservative. They are powerless and the strong, vocal and overemphasized urban sectors ensure that most of the resources (water, electricity, roads, schools, clinics etc.) are located with them such that Nigeria is an instruction in misallocation and maldistribution. Eighty percent of health facilities are located
compared with men, they are less literate. In Nigeria, it was estimated that fewer than 5% of adult females had received any education. Yet, it has been observed that while the survival and health of children are largely a result of the amount of education received by their mothers, this is not always the case. Nigerian mothers are often overworked. Their lives are her day done. This is an observation made by poet from East Africa.

Where once the African woman is seen as the primary caregiver, she is also a provider of goods and services. She takes care of the household, manages production, and is responsible for the entire family. Her role is not limited to cooking and cleaning; she is also involved in the production and sale of goods.

The village is often a reflection of the health system of the country. In Nigeria, the rural areas are often neglected, with little investment in infrastructure and health facilities. The provision of essential services such as clean water and sanitation is often inadequate. Health facilities are located far from the villages, making it difficult for people to access them. The situation is made worse by the lack of qualified medical personnel, who are oftendrawn to the cities for better pay and opportunities.

Let me now comment on the support received from health services delivery points. Kale in a paper delivered at the University of Ibadan and published by The Comet Newspaper on 12th February 2004 described our health system as “A Health Service in Decay.” Others have described it as a service which is a mere shadow of its former self. It seems to me that the service is more of a ghost of its former self, for as you visit the delivery points these days, you will be struck by the absence of service. The phrase “Not Available” abbreviated “N/A” is familiar with hospital and clinic staff. Some in this audience may know that newly qualified medical doctors may have to wait for a few years before they find a place for internship because the State and General Hospitals do not have consultants in the four main clinical disciplines of Medicine, Surgery, Paediatrics and Obstetrics.

Very often hospital beds are empty not because the people are healthy, but because, poor as the services are, they have been priced beyond the reach of most citizens. We in the medical profession of course have a blame in this. The medical Directors and Management of Teaching and Medical Centres have been de-motivated and even in some instances de-humanised as they try to generate funds or recover costs. Many times, they conveniently
forget the aspect of the doctors' oath they have taken which deal with not denying patients of their services because of financial considerations. To illustrate my point about service and usage, let us look at the Wesley Guild Hospital Illesa's admission and attendance data over a 25-year period. The hospital (Fig 2) serves a community with a long history of hospital consciousness and has staff who are traditionally geared and motivated to promote child health.

Figure 2 Showing the Entrance to Wesley Guild Hospital, Illesa
Table 1

Total Yearly General Paediatrics and Neonatal Admissions and Deaths 1978 – 2003 26yrs

<table>
<thead>
<tr>
<th>Year</th>
<th>Total General Paediatric and Neonatal Admissions</th>
<th>Total General Paediatric and Neonatal Deaths</th>
<th>% of Total gp and NN Deaths of Total Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>2087</td>
<td>262</td>
<td>12.6</td>
</tr>
<tr>
<td>1979</td>
<td>3309</td>
<td>402</td>
<td>12.1</td>
</tr>
<tr>
<td>1980</td>
<td>2822</td>
<td>399</td>
<td>14.1</td>
</tr>
<tr>
<td>1981</td>
<td>2515</td>
<td>328</td>
<td>13.0</td>
</tr>
<tr>
<td>1982</td>
<td>2654</td>
<td>268</td>
<td>10.1</td>
</tr>
<tr>
<td>1983</td>
<td>3084</td>
<td>315</td>
<td>10.2</td>
</tr>
<tr>
<td>1984</td>
<td>2135</td>
<td>244</td>
<td>11.4</td>
</tr>
<tr>
<td>1985</td>
<td>2823</td>
<td>318</td>
<td>11.3</td>
</tr>
<tr>
<td>1986</td>
<td>2333</td>
<td>266</td>
<td>11.4</td>
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<tr>
<td>1987</td>
<td>2436</td>
<td>294</td>
<td>12.1</td>
</tr>
<tr>
<td>1988</td>
<td>2652</td>
<td>299</td>
<td>11.3</td>
</tr>
<tr>
<td>1989</td>
<td>2547</td>
<td>292</td>
<td>11.5</td>
</tr>
<tr>
<td>1990</td>
<td>2742</td>
<td>252</td>
<td>9.2</td>
</tr>
<tr>
<td>1991</td>
<td>2568</td>
<td>163</td>
<td>6.3</td>
</tr>
<tr>
<td>1992</td>
<td>2450</td>
<td>232</td>
<td>9.5</td>
</tr>
<tr>
<td>1993</td>
<td>1725</td>
<td>122</td>
<td>7.1</td>
</tr>
<tr>
<td>1994</td>
<td>1675</td>
<td>158</td>
<td>9.4</td>
</tr>
<tr>
<td>1995</td>
<td>1988</td>
<td>162</td>
<td>8.1</td>
</tr>
<tr>
<td>1996</td>
<td>2004</td>
<td>170</td>
<td>8.5</td>
</tr>
<tr>
<td>1997</td>
<td>2045</td>
<td>180</td>
<td>8.8</td>
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<tr>
<td>1998</td>
<td>2079</td>
<td>175</td>
<td>8.4</td>
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<td>1999</td>
<td>1767</td>
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<td>8.4</td>
</tr>
<tr>
<td>2000</td>
<td>2263</td>
<td>183</td>
<td>8.1</td>
</tr>
<tr>
<td>2001</td>
<td>1719</td>
<td>159</td>
<td>9.2</td>
</tr>
<tr>
<td>2002</td>
<td>1654</td>
<td>146</td>
<td>8.8</td>
</tr>
<tr>
<td>2003</td>
<td>1895</td>
<td>148</td>
<td>7.8</td>
</tr>
</tbody>
</table>
Table 2

Paediatrics Non-Consultant General Outpatient Attendances ≈ Children’s Welfare Clinic

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MALES</th>
<th>FEMALES</th>
<th>MALES AND FEMALES ALTOGETHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEW</td>
<td>TOTAL</td>
<td>NEW</td>
</tr>
<tr>
<td>1978</td>
<td>17388</td>
<td>73362</td>
<td>24185</td>
</tr>
<tr>
<td>1979</td>
<td>18365</td>
<td>67408</td>
<td>20145</td>
</tr>
<tr>
<td>1980</td>
<td>17349</td>
<td>64183</td>
<td>16928</td>
</tr>
<tr>
<td>1981</td>
<td>10825</td>
<td>35334</td>
<td>13151</td>
</tr>
<tr>
<td>1982</td>
<td>5893</td>
<td>19561</td>
<td>5747</td>
</tr>
<tr>
<td>1983</td>
<td>6305</td>
<td>19407</td>
<td>5126</td>
</tr>
<tr>
<td>1984</td>
<td>6336</td>
<td>18079</td>
<td>5691</td>
</tr>
<tr>
<td>1985</td>
<td>5305</td>
<td>17537</td>
<td>4738</td>
</tr>
<tr>
<td>1986</td>
<td>5480</td>
<td>19358</td>
<td>4841</td>
</tr>
<tr>
<td>1987</td>
<td>4951</td>
<td>17919</td>
<td>4409</td>
</tr>
<tr>
<td>1988</td>
<td>4571</td>
<td>15662</td>
<td>3916</td>
</tr>
<tr>
<td>1989</td>
<td>3460</td>
<td>10004</td>
<td>3183</td>
</tr>
<tr>
<td>1990</td>
<td>3545</td>
<td>9339</td>
<td>3213</td>
</tr>
<tr>
<td>1991</td>
<td>4170</td>
<td>11070</td>
<td>3874</td>
</tr>
<tr>
<td>1992</td>
<td>3680</td>
<td>9375</td>
<td>3273</td>
</tr>
<tr>
<td>1993</td>
<td>3114</td>
<td>7573</td>
<td>2699</td>
</tr>
<tr>
<td>1994</td>
<td>2555</td>
<td>7085</td>
<td>2767</td>
</tr>
<tr>
<td>1995</td>
<td>1827</td>
<td>6131</td>
<td>2315</td>
</tr>
<tr>
<td>1996</td>
<td>2891</td>
<td>8214</td>
<td>3474</td>
</tr>
<tr>
<td>1997</td>
<td>2113</td>
<td>5968</td>
<td>2306</td>
</tr>
<tr>
<td>2000</td>
<td>2905</td>
<td>5928</td>
<td>2864</td>
</tr>
<tr>
<td>2001</td>
<td>2403</td>
<td>6374</td>
<td>2721</td>
</tr>
</tbody>
</table>

Table 1 shows a gradual fall of yearly children’s admissions from the range of 3009 and 2,450 between 1978 and 1992 to the figures of 2,263 and 1,654 between 1993 and 2003 i.e now. (2004 figures are not available yet). The trend is even more obvious in Table 2 which is more appropriate to the point. Ours should be a health
and not a disease service and child welfare (ambulatory services) clinics should best show how we are doing. Attendance (new and total) fell from the range of between 80,000 and 59,000 between 1978 and 1983 to between 35,000 and 12,000 between 1984 and the present time (2003). Our contemporary experience in the health services points to the worsening and not improvement of the health status of children as the reason for these falls in admissions and attendances.

The story is the same when you look at other data. The 2004 World Health report[10] has revealed that only 41.6% of child births in Nigeria were attended by skilled health personnel in the year 2000. Measles has been eliminated from Europe and America, but that possibility is not attainable in Nigeria because for the year 2001, only 40% of one year olds in Nigeria were immunized against measles. Some here know the sad story of Polio in spite of the brilliant efforts of Rotary International. The WHO's chance of eradicating polio lies precariously in the hands of Nigeria which now has the highest number of polio cases in the entire world and exports some of them to other countries. The acceptability of the vaccine has been a controversy in our country.

You will all agree with me that the status of the health providing, promoting, and supporting structures and resources in our country is unacceptably poor.

**WHAT DISEASES DO WE SEE IN CHILDREN?**

**WHY ARE THEY ADMITTED TO THE HOSPITAL?**

Table 3 shows the main diagnoses in 546 children, including neonates, hospitalized during a 3 month period in 1982 in the Wesley Guild Hospital Ilesa (WGH). The pattern has so far recorded no significant change. Table 4 shows only the post-neonatal childhood admissions over a one-year period in 1991/1992 and compares the pattern with that in a small Saudi Arabia 110 bedded General Hospital during the same year. Please note that for Nigeria, the post-neonatal conditions in Tables 3 and 4 are similar.
Table 3

Main Diagnoses in 546 Children Hospitalized in Ilesa During a 3 Month Period in 1982.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No of Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal jaundice</td>
<td>107</td>
<td>19.6</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>83</td>
<td>15.2</td>
</tr>
<tr>
<td>Gasoenteritis</td>
<td>78</td>
<td>14.3</td>
</tr>
<tr>
<td>Febrile convulsion</td>
<td>46</td>
<td>8.4</td>
</tr>
<tr>
<td>Malaria</td>
<td>43</td>
<td>7.9</td>
</tr>
<tr>
<td>Anaemia</td>
<td>24</td>
<td>4.3</td>
</tr>
<tr>
<td>Neonatal sepsis</td>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>Prematurity</td>
<td>12</td>
<td>2.2</td>
</tr>
<tr>
<td>Protein-energy malnutrition</td>
<td>30</td>
<td>5.5</td>
</tr>
<tr>
<td>Measles</td>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>Heart failure</td>
<td>19</td>
<td>3.5</td>
</tr>
<tr>
<td>Wheezy bronchitis</td>
<td>7</td>
<td>1.3</td>
</tr>
<tr>
<td>Sickle-cell crisis</td>
<td>4</td>
<td>0.7</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>14</td>
<td>2.6</td>
</tr>
<tr>
<td>Birth asphyxia</td>
<td>11</td>
<td>2.0</td>
</tr>
<tr>
<td>Others</td>
<td>145</td>
<td>26.6</td>
</tr>
</tbody>
</table>

There were many instances of multiple diagnosis.
Table 4

Main Diagnoses in a 12 month 1991/92 Post Neonatal Admissions in Saudi and Ilala

<table>
<thead>
<tr>
<th>No of Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>107</td>
<td>19.6</td>
</tr>
<tr>
<td>83</td>
<td>15.2</td>
</tr>
<tr>
<td>78</td>
<td>14.3</td>
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<tr>
<td>46</td>
<td>8.4</td>
</tr>
<tr>
<td>43</td>
<td>7.9</td>
</tr>
<tr>
<td>40</td>
<td>7.3</td>
</tr>
<tr>
<td>39</td>
<td>7.1</td>
</tr>
<tr>
<td>32</td>
<td>5.9</td>
</tr>
<tr>
<td>30</td>
<td>5.5</td>
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<tr>
<td>29</td>
<td>5.3</td>
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<tr>
<td>29</td>
<td>5.3</td>
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<tr>
<td>27</td>
<td>4.9</td>
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<tr>
<td>14</td>
<td>2.6</td>
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<tr>
<td>14</td>
<td>2.6</td>
</tr>
<tr>
<td>11</td>
<td>2.0</td>
</tr>
<tr>
<td>145</td>
<td>26.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No of Children</th>
<th>% of 964</th>
<th>No of Children</th>
<th>% of 2396</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Anaemia</td>
<td>4</td>
<td>0.4</td>
<td>552</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>258</td>
<td>26.8</td>
<td>277</td>
</tr>
<tr>
<td>Convulsions</td>
<td>46</td>
<td>4.8</td>
<td>260</td>
</tr>
<tr>
<td>Malaria</td>
<td>0</td>
<td>0</td>
<td>223</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>202</td>
<td>21</td>
<td>158</td>
</tr>
<tr>
<td>Measles</td>
<td>19</td>
<td>2.0</td>
<td>164</td>
</tr>
<tr>
<td>Protein Energy</td>
<td>0</td>
<td>0</td>
<td>149</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>0</td>
<td>0</td>
<td>81</td>
</tr>
<tr>
<td>Acute Bronchitis</td>
<td>105</td>
<td>10.9</td>
<td>0</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>4</td>
<td>0.4</td>
<td>81</td>
</tr>
<tr>
<td>Congestive Cardiac Failure</td>
<td>13</td>
<td>1.3</td>
<td>80</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>116</td>
<td>12.0</td>
<td>35</td>
</tr>
<tr>
<td>Burns and Scalds</td>
<td>0</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>0</td>
<td>0</td>
<td>61</td>
</tr>
<tr>
<td>Meningitis</td>
<td>5</td>
<td>0.5</td>
<td>43</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Fractures</td>
<td>0</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>Asthma and Asthmatic</td>
<td>105</td>
<td>10.9</td>
<td>34</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>257</td>
<td>26.7</td>
<td>658</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1134*</td>
<td></td>
<td>2868*</td>
</tr>
</tbody>
</table>

You will easily see that the conditions for which...
children are hospitalized in Nigeria are mainly infections and undernutrition. From both Tables, you can pick out pneumonia, gastroenteritis, malaria, neonatal sepsis, measles, upper respiratory tract infections, septicaemia and meningitis as infections. Note the presence of PROTEIN ENERGY MALNUTRITION (PEM) in both Tables. It is so important that I want to comment at some length on it. In the clinical setting, we encounter it in four forms namely, kwashiorkor, marasmus, marasmic kwashiorkor and underweight. Kwashiorkor and Marasmus are shown in Figures 3A and 3B below:

Our studies\textsuperscript{11} of 88 children hospitalized with severe protein energy malnutrition in Ilesa showed that the 6 to 18 month weaning age period was the most frequently affected whilst poverty, social disruption, unwholesome feeding practices, previous attacks of measles, recurrent and/or prolonged
are mainly infections, and you can pick out pneumonia, epigastric, measles, upper respiratory meningitis as infections. Note the MALNUTRITION (PEM) in that I want to comment at some g, we encounter it in four forms, marasmus kwashiorkor and... shown in Figures 3A

Fig 3 B

hospitalized with severe protein showed that the 6 to 18 month most frequently affected whilst unwholesome feeding practices, s, recurrent and/or prolonged gastroenteritis were the main predisposing factors.

In the community, PEM presents as stunting and wasting. According to the 2001 World Health Report,12 almost a third (30.7%) of Nigerian under 5 children were underweight for age in 1999. Protein energy malnutrition has been linked by research to 52% of all under five deaths in Nigeria. We have found in a study in Ilona13 that most of the infections found in children as shown in Tables 3 and 4 are closely associated with protein energy malnutrition. Thus either in the overt or covert form, protein energy malnutrition is the factor underlying many childhood diseases and deaths in Nigeria. It is a scourge whose casualties happen to be increasing everyday.

Between 1987 and 1990 children in a rural community aged from birth to 6 years were subjected by us to anthropometric measurements. This was a community where the same measurements had been taken on the same age group 30 years before. Our findings were shocking! The height and weight curves obtained fell behind corresponding growth curves in the same community three decades previously and the mid-upper arm circumference values obtained indicated moderate to severe malnutrition in 25.8% of the under fives children. The heights of 67.1% and weights of 59.7% of the children fell below the third percentile of a Nigerian equivalent of an international reference population standard (Figures 4 and 5).

The tragedy of PEM is not just that it causes childhood disease and death. Those who survive may become under achievers. Studies on children eating too little food have shown that they conserve energy for growth. More food leads to more activity and better intellectual development. Several other studies have shown the adverse effects of PEM on brain weight, ventricles, and biochemical composition. We have also found in Ilona that there are significant reductions in the head circumferences of malnourished children compared with those of their well-nourished age mates. (Figure 6A and B) Is collective brain poverty arising from generations of childhood malnutrition one of the causes of our nation's woes?
Figures 4 and 5 comparing 1987/90 Curve with International Standard Curve and Curve obtained 3 decades previously.

Figures 6A and B showing head circumference curves of malnourished Imesi boys and girls compared their well-nourished age mates and Tanner's International Curves.
Having discussed PEM at some length, let me add that nutritional rickets and the micronutrient Vitamin A deficiency called the blinding malnutrition are two other nutritional disorders of some importance seen among Nigerian children. One example of each of this disorder is shown by the illustration. Figure 7 shows rickets florid changes including enlargement of the wrists and knees and genu valgum. Figure 8 shows a child who has had measles with blindness due to vitamin A deficiency.
The stories of these nutritional disorders are tragic because an ounce of correct feeding can prevent tons of havoc done to life and health of children.

I now want to comment on some of the other disease conditions, which we see in children. Please remember that the nutritional disorders are in the background of many of them. According to the data collated by the United Nations system in Nigeria\textsuperscript{21}, the reported relative contributory causes of morbidity and mortality in Nigerian under five children were for morbidity, malaria – 41%, Diarrhoea 24%, Acute Respiratory infections 15%, Vaccine preventable diseases 15% and others 5%.

<table>
<thead>
<tr>
<th>DISEASE CONDITIONS</th>
<th>% Contributed to Total Under 5 Morbidity</th>
<th>% Contributed to Total Under 5 Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALARIA</td>
<td>41%</td>
<td>30%</td>
</tr>
<tr>
<td>DIARRHOEA</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>ACUTE RESPIRATORY INFECTIONS</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>VACCINE PREVENTABLE INFECTIONS</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td>OTHERS TYPHOID</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Information collated by the United Nations System in Nigeria – Reference 21**

For mortality, they were malaria – 30%, diarrhoea – 19%, acute respiratory infections – 16%, vaccine preventable diseases – 22%, typhoid – 3% and others – 10%. This means that the four
Disorders are tragic because some of the other diseases are preventable and the mortality and morbidity in children can be reduced. Please remember that the background of many of them is the United Nations system which assists in the prevention of diseases. The vaccine preventable diseases are responsible for 95% of the deaths in children under 5 years of age in Nigeria. The vaccine preventable diseases are responsible for 95% of the deaths in children under 5 years of age in Nigeria. The vaccine preventable diseases are responsible for 95% of the deaths in children under 5 years of age in Nigeria. The vaccine preventable diseases are responsible for 95% of the deaths in children under 5 years of age in Nigeria.

Under the Acute Respiratory Infections are pneumonia, bronchiolitis and upper respiratory tract infections.

### Pneumonia

We reviewed 2027 cases of pneumonia admitted over a 10 year period into the WCHF and found measles, aspiration and pertussis to be the predisposing conditions to some of the cases of pneumonia. Over 90% of the cases were bronchopneumonia and the remainder lobar pneumonia. Whilst the former tended to affect the first 2 years of life, the latter affected the over 2 year age group. In many cases malnutrition and anaemia coexisted whilst sepsicaemia, empyema thoracis and congestive cardiac failure were the complications seen. You can see the examples of their X-ray appearance in Figures 9 and 10.

<table>
<thead>
<tr>
<th>Disease</th>
<th>% Contributed to Total Under 5 Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lobar Pneumonia</td>
<td>30%</td>
</tr>
<tr>
<td>Bronchopneumonia</td>
<td>19%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>16%</td>
</tr>
<tr>
<td>Malaria</td>
<td>5%</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>5%</td>
</tr>
<tr>
<td>Others</td>
<td>3%</td>
</tr>
</tbody>
</table>

In many cases, malnutrition and anaemia coexisted whilst sepsicaemia, empyema thoracis and congestive cardiac failure were the complications seen. You can see the examples of their X-ray appearance in Figures 9 and 10.
Anaemia

The high prevalence of severe anaemia in our children is a matter of serious concern because of its economic and other serious effects. Hardly does a day pass in our practice when we do not give one or two blood transfusions to correct severe anaemia. The common causes are malaria, sickle cell disease and glucose 6 phosphate dehydrogenase deficiency (G6PD) associated haemolysis. Both G6PD deficiency and sickle cell disease are genetic diseases. Haemolysis in the former leads to passage of coca cola coloured urine when the sufferer comes across any of the offending drugs or materials.

Sickle Cell Disease is the most important genetic disease we encounter in Nigerian children. The sickle cell haemoglobin disorders and carrier states have incidences at birth in Nigeria of about 2% and 25% respectively. Whereas sickle cell disease has been shown to have adverse effects on the working lives, mental health, physical health, financial well being and marriages of the parents, the poor knowledge and perception of sickle cell disorders among the general population and especially among the parents of affected children is both abstruse and perplexing.
anaemia in our children is a serious economic and other serious health practice when we do not give due attention to severe anaemia. The common cause of anaemia is glucose 6 phosphate dehydrogenase (G6PD) deficiency, a genetic disease. Haemolysis in children results in a darkly coloured urine when the patient is being treated with drugs or materials.

One important genetic disease we encounter in Nigeria is sickle cell anaemia. The prevalence of sickle cell anaemia is about 2% and 25% of the population is a carrier. The disease has been shown to have serious health consequences, including mental health, physical health, and the health of the population. The poor knowledge of sickle cell anaemia among the general population makes it difficult for affected children to be diagnosed and treated early.

Malaria

This is the most important parasitic disease in the world. It is caused by a parasite, plasmodium falciparum, which is transmitted by the female anopheles mosquito. The parasite causes severe morbidity and mortality as a result of its serious complications on the lungs, kidneys, brain, and blood. Malaria has been estimated as causing 30% of childhood deaths.

Figure 11 showing a child hand-foot syndrome in sickle cell disease.

On the children themselves, the effects of the disease on their health, growth including sexual maturation and educational performance are deleterious. Figure 11 shows a patient presenting with painful swelling of hands and feet called hand-foot syndrome. Strenuous exercises, exposure to cold weather, anoxia, and infections commonly precipitate illness and crises episodes, which occurred at least biannually. As at the present time control by genetic counseling should be more seriously undertaken.

Malaria

This is the most important parasitic disease in the world and of the 4 parasites that cause the disease, the plasmodium falciparum is the dominant one here which causes severe morbidity and mortality as a result of its serious complications on the lungs, kidneys, brain, and blood. I have already referred to it as an important cause of anaemia. The parasite is transmitted by the female anopheles mosquito. Eradication has now been considered unfeasible; control itself is a serious problem. Malaria has been estimated as causing 30% of childhood deaths.
Diarrhoeal Diseases
Anyone who goes around our villages and city slums will appreciate why diarrhoea has to be such a serious problem with us; Faeces, fingers, flies, and food are its agents. I have already attributed 19% of childhood deaths to it.

Burkitt's Lymphoma
This is the commonest type of cancer we see in children. It is a predominantly a primary school age disease and it presents typically as a tumor in one or more of the 4 quadrants of the jaw, the abdomen, the nervous system, ovaries, testes, lymph nodes etc. The typical histological appearance is a starry sky of large pale histiocytes in a sky of dark lymphocytes. The tumour fortunately is sensitive to chemotherapy. Figure 12 shows a child with this tumour in the jaw.

Figure 12 showing a child with Burkitt’s lymphoma

Injuries
These account for 5.4% of childhood admissions and deaths respectively. The main injuries seen over a 15 year period
of childhood admissions and injuries seen over a 15 year period.

The table (Table 6) shows the main injuries recorded in 1229 patients seen over a 15 year period in Hesa. It highlights the following:

- **Fractures**: The most common injury, with 456 cases, accounting for 36.5% of total injuries.
- **Burns**: 292 cases, 23.4% of total injuries.
- **Poisoning**: 166 cases, 13.3% of total injuries.
- **Soft tissue injury**: 153 cases, 12.2% of total injuries.
- **Head injuries**: 132 cases, 10.6% of total injuries.
- **Bites and Stings**: 36 cases, 2.9% of total injuries.
- **Others**: 14 cases, 1.1% of total injuries.

Vehicular and fall accidents account for the majority of fractures, soft tissue and head injuries. There is a rising trend of injuries and deaths due to motor vehicle accidents noticed especially after the adoption of the motorcycle as commercial transport. It is a problem, which requires an appropriate intervention.

I have earlier commented on the unwholesome environment in our homes and communities. This is one reason why burns (Figure 13) and poisoning injuries are so many. If our homes, environment, roads and driving were safer and our care of children better, we would see fewer children killed while street trading or exploring an unsafe environment. Figures 14 and 15 show examples of such environment.
Figure 13 showing a child with burns

Figure 14 showing street trading
A STRONG SOCIAL FACTOR IN MANY OF THESE DISEASES

I wish to underscore the strong influence of social factors in many of the diseases and conditions I have spoken about. Our research has documented the higher morbidity of, and poorer maternal parenting received by hospitalized children of socially disadvantaged mothers compared with their non-disadvantaged mates. Also, among hospitalized children, it has been shown that pneumonia, gastroenteritis, febrile convulsions, malaria, protein energy malnutrition and measles are significantly commoner among the children of the lower than those of the higher social classes. The same has been shown with injuries (Tables 7 and 8).
Table 7
Frequency of Main Diagnoses According to Parental Social Classes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Social Class</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>Total</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal jaundice</td>
<td></td>
<td>1</td>
<td>9</td>
<td>23</td>
<td>32</td>
<td>42</td>
<td>107</td>
<td>&gt;0.5</td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>30</td>
<td>44</td>
<td>83</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td></td>
<td>0</td>
<td>3</td>
<td>11</td>
<td>22</td>
<td>42</td>
<td>78</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Febrile convulsion</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>20</td>
<td>23</td>
<td>46</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>18</td>
<td>19</td>
<td>43</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>17</td>
<td>14</td>
<td>40</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Neonatal sepsis</td>
<td></td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>39</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>Prematurity</td>
<td></td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>32</td>
<td>&gt;0.5</td>
</tr>
<tr>
<td>Protein energy malnutrition</td>
<td></td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>13</td>
<td>30</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>29</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

* Total no of subjects from higher social classes (I-III) = 191
* Total no of subjects from lower social classes (IV & V) = 355
** p = level of significance of differences between higher social classes (I-III) and lower social classes (IV & V)

Table 8
Social Classes of Patients with 730 Injuries

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>No of Injuries sustained by patients in the various social Classes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td>Fractures</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>Burns</td>
<td>16</td>
<td>38</td>
</tr>
<tr>
<td>Poisoning</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Soft tissue injury</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Head Injury</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Bites and Stings</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>93</td>
</tr>
</tbody>
</table>

The social classes are in Roman numerals
**The fathers' occupations were available for use in deriving social classes in 730 instances.
AND SO WHAT = THE GRIM FACTS

The health status of Nigerian children is poor. Our infant, under five and maternal mortality rates are high. We have made development goals and failed them. Ours was one of the signatory countries to the Alma Ata Declaration for Primary Health Care (PHC) in 1978 in Russia. It was hoped that it would usher in the much-needed improvement in health status. The National Health Policy was adopted in 1987 and it states,

“The National Health Policy aims to achieve health for all Nigerians based on the national philosophy of social justice and equity. A health system based on primary health care is adopted as the means of achieving the goal”.

However, today some 17 years after the policy and 26 years after the Alma Ata Declaration, the dream of the primary health care approach has gone wrong. This is principally because we have failed to seriously implement the programme and have abused the national health policy. Where are the equity and social justice of our National Health Policy with 80% if the resources located where 30% of the population lives and with the services of 45% of the entire population who are children being subordinated to the demands of the adults?

Among the reasons given for the poor implementation of the primary health care include ridiculous ones like that of the PHC is only relevant to poor developing countries that cannot afford modern medical care, that it is a second best programme fit for the rural poor and urban slum and that it is a stop gap awaiting better facilities or that it is separate from the main health system.

The people carrying about such fallacies have forgotten that the Western Europe health system did not come about through therapeutic advances, but environmental improvement in the last 3 centuries marked by 4 stages, Viz.
an improvement in nutrition, which commenced after 1700 made the
earliest and strongest impact.
(b) Hygiene measures—safe water, sewage and refuse disposal and
food hygiene reduced death rate by at least 20% between mid 19th
century and now.
(c) Immunisation and therapy came to be applied on a large scale in
the first 25 years of the 20th century.
(d) Declining birth rates—change in reproductive behaviour was first
noticed in the 19th century.
This was how European countries achieved their demographic
transition and present health status.
In our case, we want to arrive at the same status without
experiencing the discipline they went through.
The status of our health and PHC services is best assessed by
comparing where we are now with where we were a decade or
more ago and where our African neighbours are.
As for comparing our present status with the past, I have
already commented on the depth of morass into which the teaching
and other large hospitals and centers have sunk. When I qualified
as a doctor in 1969, I could never have imagined that the teaching
and patient care facilities in our hospitals and clinics can
experience so much deterioration in my life time. However, this
has happened largely due to serious under-funding and neglect by
successive governments and authorities coupled with the rigid and
unyielding nature of the Health Ministries and Management
Boards. Some of the authorities in the hospitals just misallocate the
little money that is voted on white elephant projects—diseases and
programmes which affect very small segments of the population to
the neglect of fundamental needs like water, electricity, laboratory
and clinical care consumables and locally endemic diseases.
I have already referred to the deterioration of previously
acquired nutritional status in the community. Thus we have
experienced a resurgence of Cancer of the oral cavity (NOMA). This is an
acute necrotizing ulcerative gingivo-stomatitis, which affects
malnourished children due to infection by Borellia
Vincenti and Fusiformis fusiformis—organisms which are found
ch commenced after 1700 made the
exter, sewage and refuse disposal and
by at least 20% between mid 19th
could be applied on a large scale in
the Netherlands was first
munities achieved their demographic
arrive at the same status without
they went through.
and PHC services is best assessed by
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neighbours are.
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serious under-funding and neglect by
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Health Ministries and Management
ies in the hospitals just misallocate the
white elephant projects – diseases and
ery small segments of the population to
needs like water, electricity, laborator
es and locally endemic diseases.
ated to the deterioration of previously
is in the community. Thus we have
of Cancer of the mouth (NOMA). This is an
ve gingivo- stomatitis which affects
children due to infection by Borrelia
isiformis – organisms which are found
as commensals in the healthy mouth. An example in a child is
shown in Figure 16.

Figure 16 showing a child with Cancer of the mouth.

As for where we are now compared with our neighbours, we can
use the data extracted from the WHO computed health indicators
published in 2004 World Health Report. You can see from Table 9
that we are much worse than Ghana and Cameroon.

THE WAY FORWARD

I said at the beginning of the lecture that my topic “Is it well
with the Nigerian child?” has been adopted from Elisha’s question
to the Shunammite woman and that she answered “It is well”.

Actually, it was not well. The child had died and the woman
was visiting the prophet to seek help. On knowing this, Elisha
instructed his servant Gehazi to go and perform a miracle to bring
back the child to life by laying his staff on the child’s face. As
recorded in II King 4: 26-37, the child was not revived. When
Elisha himself saw the dead child, he lay upon him and put his
mouth upon the child’s mouth and his eyes upon his eyes and
hands upon his hands etc. Then the child sneezed and his eyes
opened. Some among us medical people, believe that this is the
first authentic account of cardio-pulmonary resuscitation (CPR).
## The World Health Report 2004 Millennium Development Goals

**Selected Health indicators in who state 2000 unless specified computed by who to assure comparability. pages 148 – 155**

**whreport 2004**

<table>
<thead>
<tr>
<th>Member State</th>
<th>Children under 5 years of age underweight for age</th>
<th>Under 5 Mortality Rate Per 1000 live births</th>
<th>Infant Mortality Rate per 1000 live births</th>
<th>% one year olds immunized against Measles 2001</th>
<th>Maternal Mortality Rate per 100,000 live births</th>
<th>Malaria Mortality Rate per 100,000</th>
<th>Tuberculosis Prevalence Rate per 100,000</th>
<th>Population with Sustainable access to improved water source %</th>
<th>Population with access to improved sanitation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>22.2 1998</td>
<td>155</td>
<td>91</td>
<td>62</td>
<td>730</td>
<td>116</td>
<td>232</td>
<td>78 39</td>
<td>92 66</td>
</tr>
<tr>
<td>Ghana</td>
<td>24.9 1998-99</td>
<td>105</td>
<td>62</td>
<td>81</td>
<td>540</td>
<td>66</td>
<td>381</td>
<td>91 62</td>
<td>74 70</td>
</tr>
<tr>
<td>Nigeria</td>
<td>30.7 1999</td>
<td>183</td>
<td>103</td>
<td>40</td>
<td>800</td>
<td>209</td>
<td>491</td>
<td>78 49</td>
<td>66 45</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1.3 2001</td>
<td>7</td>
<td>6</td>
<td>85</td>
<td>11</td>
<td>0</td>
<td>12</td>
<td>100 100</td>
<td>100 100</td>
</tr>
</tbody>
</table>
Now, what is the CPR for the poor health status of the Nigerian child?

Reformation and Mobilization are the two processes we need to undergo now. We need to REFORM the health services. The government should undertake a realistic appraisal of its role in health care provision and make a sustained change to improve efficiency. We should also MOBILISE the stakeholders – the people of the country, the public and private sectors, the professionals and other partners like the religious and international bodies to health action. If health is to be for all, all must work towards health. There can be no real progress without intersectoral collaboration, community involvement and formal health structure support.

Which vehicle do we use to reach the destination of good health for our children? The answer is CHILD PUBLIC HEALTH.

What is child public health? It is not marked differently from primary health care. Indeed, it encompasses all its components and activities. Conventional definitions of child public health contain the elements of promoting health, preventing disease and prolonging life among children and young people through organized effort of society at policy, organization and local levels. However, these definitions omit ‘reducing health inequalities’.

Kohler defined child public health thus, “The organized efforts of society to develop healthy public health policies to promote children and young people’s health, to prevent disease in children and young people and to foster equity for children and young people within a framework of sustainable development”. Apart from the three elements of preventing disease, promoting health and fostering equity, there is a further important component of child public health if we are to succeed. This is advocacy and this, in its effective form is one crucial missing element in Nigeria. Children by definition are not enfranchised. They are born defenceless and vulnerable. Since every living thing is struggling for a full life, we must advocate for them.
Many workers in the services for children take pride in their dedication to their parents, clients and duties. Some have driven themselves to an early grave through their commitment to children. But dedication is not enough. Advocacy is also needed since success depends also on having the best facilities and resources for children. To this we have to speak effectively for the needs and rights of children and their families. Frankly, this means understanding and engaging in politics. Politics is the means of influencing change and policy is the engine for doing so.

Tackling health inequalities is fundamentally about addressing the wider determinants of health like poverty, education, housing, healthy environment etc. This cannot be done without the Redistribution of Resources. In much of Africa today, there is a paradox between the improvement in national income and the continuation of poor maternal and child health. This is also so in many South Asian countries. However, Sri Lanka has achieved the best health indicators in that region with Infant Mortality rate at 16 per 1000 live births, literacy rates at over 90% for both sexes and the population growing only at replacement level. The feat has been achieved through the promotion of social and gender equity, primary health care activities and focus on education. The equity and social justice included in our national health policy will do us much good if we can work for them.

The reason for which God blessed Nigeria with billions of Naira is not for the purpose of stealing and stashing it away in foreign banks, but for the use of Nigerians, and 45% of those aged below 15 years constitute such numerical proportions of our population, should we not have Ministers and Commissioners at Federal and State levels for children? We should overhaul our Ministries of Health and Health Management Boards such that we remove structures and
or children take pride in their
and duties. Some have driven
their commitment to children.

Locality is also needed since
est facilities and resources for
effectively for the needs and
ilies. Frankly, this means
ics. Politics is the means of
e for doing so,
s is fundamentally about
uts of health like poverty,
ent etc. This cannot be done
rees. In much of Africa today,
vement in national income
al and child health. This is also
es. However, Sri Lanka\textsuperscript{11} has
ors in that region with Infant
ths, literacy rates at over 90%.
 growing only at replacement
through the promotion of social
care activities and focus on
justice included in our national
if we can work for them.

blessed Nigeria with billions of
of stealing and stashing it away
of Nigerians; and 45\% of those
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CONCLUSION

Chairman Sir, Mr. Vice-Chancellor, distinguished ladies and
gentlemen, it is not yet well with the Nigerian child and it will not
be until in the words of the UNICEF, publisher of the Progress of
the Nations\textsuperscript{12}.

"The day will come when the progress of nations will be judged
not by their military or economic strength, nor by the splendor of
their capital cities and public buildings, but by the well-being of
their peoples; by their levels of health, nutrition and education, by
their opportunities to earn a fair reward for their labours, by their
ability to participate in the decisions that affect their lives; by the
respect that is shown for their civil and political liberties, by their
 provision that is made for those who are vulnerable and
disadvantaged and by the protection that is afforded to the growing
minds and bodies of their children.\textsuperscript{13}.

It now remains for me to give thanks to my Lord Jesus
Christ for the innumerable benefits he has bestowed on me, my
family and my work as children's physician cum advocate and on
my academic career in this University. I wish to acknowledge
the cooperation and help of all my colleagues in the Department of
Paediatrics and Child Health -both academic and non-academic. I
also thank the very many children and mothers who have given me
the opportunity to study them and learn from them.

I thank you all for listening and May the Lord bless you real
good.
References


