OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE, NIGERIA.

INAUGURAL LECTURE SERIES 363

THE PAINS OF WOMANHOOD, TOILS OF EARLY CHILDHOOD AND THE ETHOS OF STANDARDISED NURSING LANGUAGES:

A COMPENDIUM BY A MATERNAL AND CHILD HEALTH NURSE SPECIALIST

By

ADENIKE AYOBOLA OLAOGUN
Professor of Maternal and Child Health Nursing

OBAFEMI AWOLOWO UNIVERSITY PRESS, ILE-IFE, NIGERIA.

ADENIKE AYOBOLA OLAOGUN

Professor of Maternal and Child Health Nursing

THE PAINS OF WOMANHOOD, TOILS OF EARLY CHILDHOOD AND THE ETHOS OF STANDARDISED NURSING LANGUAGES: A COMPENDIUM BY A MATERNAL AND CHILD HEALTH NURSE SPECIALIST

An Inaugural Lecture Delivered at Oduduwa Hall,
Obafemi Awolowo University, Ile-Ife, Nigeria
On Tuesday, July 19, 2022

By

ADENIKE AYOBOLA OLAOGUN PhD RN RM RPHN RNT
Professor of Maternal and Child Health Nursing

Inaugural Lecture Series 363

ISSN 0189-7848

Printed by:
Obafemi Awolowo University Press Limited,
Ile-Ife, Nigeria.

…while still dark, at the early hours of a Wednesday, in a rural community, a young primary school teacher fell into labour. Without a doctor, midwife or traditional birth attendant, she delivered herself of a baby girl. Twelve years later, the same woman died from the complications of pregnancy on another fateful midnight in a maternity hospital… another statistics in the case of maternal mortality…

Preamble

Mr Vice Chancellor, Sir; distinguished ladies and gentlemen, I hereby express my deep appreciation to God, for giving me the privilege to deliver the 363rd inaugural lecture of this great university and fourth (4th) from the Department of Nursing Science, after Professors Jinadu, Fajemilehin and Irinoye. My presentation today addresses my contributions to research in Maternal and Child Health Nursing and in Standardized Nursing Languages, my life -long teaching experience in nursing and my community service.

I grew up, when the prevailing custom about female nurses was that they are 'women of low character', 'snatchers of married men' and 'wreckers of homes'. Sadly, my father thought this was true. He advocated against nursing for his daughters. Coincidentally, at a later stage in his life, he got married to a nurse. It was a big polygynous family with many children. Therefore, each child had to cater for his / her post-secondary education. To the glory of God, I finished secondary education with a very good grade. Thereafter, my elder sister (Mrs Moji Adeleye) who was working as a clerk decided to sponsor my post secondary education. I proceeded to the Higher School Certificate programme at the Queen's School, Ilorin with an aim of getting my A 'Levels; and, then, proceed to the university. However, a distant cousin (late Mrs. Dupe Akinuoyenu) who was a midwife, got information that the School of Nursing, Ilorin would be commencing; and had placed advertisement for admission. She got the application form, on my behalf. This was to pave way for Moji to proceed to the Advanced Teacher's College, Zaria. At the interview, the members of the panel asked why 'I wanted to study Nursing with such an

excellent school certificate result'. I had to make a choice; so in 1973 at age 17, my journey into Nursing, started without informing my father. When I received my first stipend, like every good child, I decided to send the money to him. He returned the money. My father's perspective notwithstanding, I believe that I had been divinely led into Nursing. This divine guidance has piloted my progress over the 49 years of being in the Nursing profession. In 1977, I completed my hospital- based Nursing programme and proceeded to the University of Ibadan, Ibadan in 1979 earning BSc Nursing Second Class Honours (Upper Division) in 1982. Later on, in 1985, I became one of the pioneer MSc Nursing students, at Obafemi Awolowo University, Ile Ife; and I obtained my PhD in Sociology and Anthropology at the same University, in 2005 with specialisation in Medical Sociology. My PhD thesis was titled; 'The contributions of spiritual birthing homes to reproductive health care in Osun State'. Four years later, for my post-doctoral fellowship, I went back to core nursing knowledge, at the Center for Nursing Classification and Clinical Effectiveness of the College of Nursing, University of Iowa, Iowa, USA. I studied the Standardized Nursing Languages. All these educational opportunities guided my focus, in my career.

Introduction

Mr Vice Chancellor, Sir, the anecdote about the woman who died from pregnancy complication which I presented at the beginning of this lecture is a true -life story that reflects a common experience among many Nigerian women; and projects the pains of womanhood. Womanhood includes the totality of experiences that comprise the life of a woman. These include the held expectations and beliefs about the woman's qualities, characteristics, and, her defined role in society. In Africa, the social construct of womanhood has two central defining elements which are, being a wife and being a mother (Schaan *et al*, 2015). Traditionally, as a wife, a woman is responsible for taking care of the home and family. As a mother, the woman's social standing and self- worth in the community is based on her ability to bear a child. In many parts of Nigeria, these long-held beliefs and expectations about

women are based on patriarchal ideologies that could seriously affect a woman's health. Ras –Work (2016), identified some of these beliefs as harmful traditional practices, namely: early and forced teenage marriages, female genital mutilation/ cutting, taboos or practices which prevent women from controlling their own fertility, nutritional taboos, son preference and; widowhood practices. As a nurse with a medical sociological background, some of my research emanated from the consequences of these harmful practices.

Child marriage is a formal or informal union in which one or both parties are below 18 years old (Liang *et al*, 2021). Nigeria is recorded as the 11th nation with the highest rate of child marriage, globally (UNICEF, 2020). The woman, at this stage, is biologically, economically and socially not prepared for child-bearing. Epidemiological reports from some northern part of the country have revealed that 93.7% of young women whose first marriage is at 14 years end up with obstructed labour while 83.8% end up with obstetrical fistula (Bello *et al*, 2020). In a retrospective study that we conducted on the complications and outcomes of pregnancy, at the Muritala Mohammed Hospital (MMH), Kano, as reflected in Table 1, in 1989, there were a total of 16,408 deliveries and 3,289 (20.04%) that ended with complications, while in 1990, there were 15,628 births, 3,222(20.6%) had complications; and a total of 596 cases of obstetrical fistula (Olaogun, *et al*, 1992). The major complications were antepartum haemorrhage, eclampsia and obstructed labour, due to delays in accessing care. Obstructed labour resulted in obstetrical fistula (OF) in the women; and foetal death, sometimes, necessitating embryotomy, or craniotomy, and maternal death. A ward and a surgical theater were assigned to OF patients, in MMH. The result of this study was my first publication, before joining academia (Olaogun *et al*, 1992).

Table 1: STATISTICS ON DELIVERIES & OBSTETRICAL FISTULA AT THE MURITALA MOHAMMED HOSPITAL, KANO 1989 AND 1990

	1989	1990
Total deliveries	16,408	15,628
Complicated deliveries	3,289 (20.04%)	3,222(20.6%)
Vescico Vaginal Fistula		596

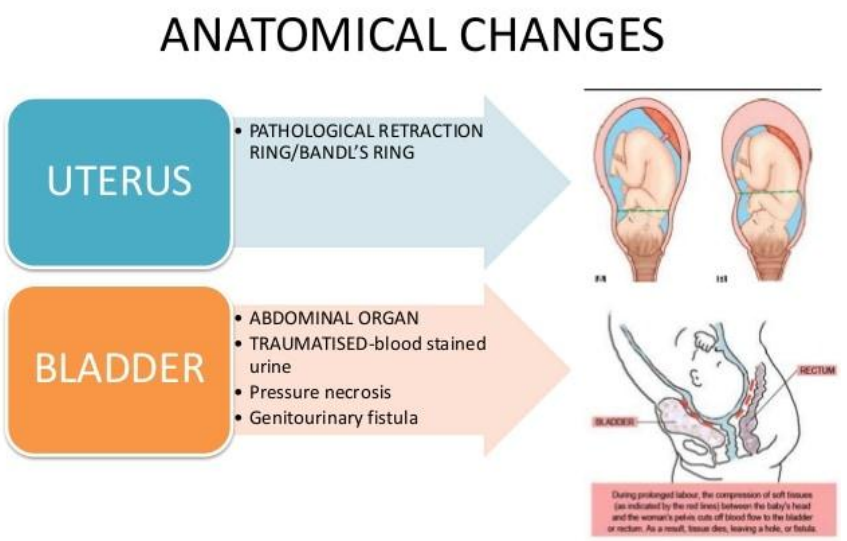


Figure 1: Process of Development of Obstetrical Fistula.
Source- https://pt.slideshare.net/obgymgmcri/obstructed-labour-65113434

Obstetrical fistula (OF) is a life altering condition that results in maternal morbidity. It is a social problem that has implications for public health. (Olaogun *et al*, 1992; Bello *et al*, 2020). During labour, because of an obstruction, the urinary bladder or the rectum is displaced upwards (Figure 1). With increased rub from the presenting part (foetal head), during contractions, there is reduced blood supply to the soft tissue of the bladder or the rectum. This

results in necrosis (localised death) of the tissue. After delivery, within the 3rd – 10th day, the necrosed tissue sloughs off, leaving a perforation, between the vagina and the base of the bladder or the rectum. This results in continuous leakage of urine or faeces from the vagina. The effects of the urinary or faecal incontinence on the women are enormous. The women become ostracised by their husbands and families. They often do not have income to live on; and are excluded from social life, because of the smell from the incontinence. Therefore, they suffer psychologically, socially and economically. For over three decades, global efforts have been targeted at eliminating OF. Thirty one years after our retrospective study, an ongoing project (Table 2) at the same hospital, have revealed an increase in the number of OF patients receiving care at MMH within the last five years; and on national level, the number of OF's centres have also increased from three in 1990 to nineteen (19) (Olaogun *et al*, 2022). May 23rd has been designated as the International Day to End Obstetrical Fistula (#EndFistula).

Table 2: Statistics on New and Old Cases of Obstetrical Fistula at the Muritala Mohammed Hospital, Kano from January 2017- December 2021

	2017	**2018**	**2019**	**2020**	**2021**
New Cases	721	694	464	464	426
Old Cases	551	505	820	313	340
	1,272	**1,199**	**1,284**	**777**	**766**

After taking appointment, at this University, in 1995, I discovered that OF rarely occurs. However, female genital mutilation/cutting (FGM/C) is a common practice. FGM/C is a traditional harmful practice. It is estimated that over 200 million girls and women worldwide have suffered the effects of this practice; and that approximately 4.1 million girls and women are at risk, each year (UNICEF, 2016; UN, 2020; WHO, 2020). The national prevalence of FGM/C in Nigeria has decreased from 25% in 2013 to 20% in 2018 (NPC, 2019). This ancient practice of FGM/C cuts across different ethnic and religious groups. FGM/C covers all the procedures that result in the partial or total cutting of the female external genitalia which could be for cultural or any other non-

therapeutic reasons (WHO, 2020). According to WHO, FGM/C are of four types (Figure 2).

Type 1- this is the partial or total removal of the clitoris and/ or the prepuce. It is called **clitoridectomy**

Type II- this is the partial or total removal of the clitoris and the labia minora with or without the removal of the labia majora. This is called **excision.**
Type III- the labia minora and or the labia majora is cut, and re-positioned. The flaps otherwise called the seal are stitched together leaving a small opening for the passage of urine and menstrual blood. This is called **infibulation**.

Type IV- this includes all other harmful procedures to the female genitalia, performed for non- medical purposes. It includes pricking, piercing, scrapping or cauterization.

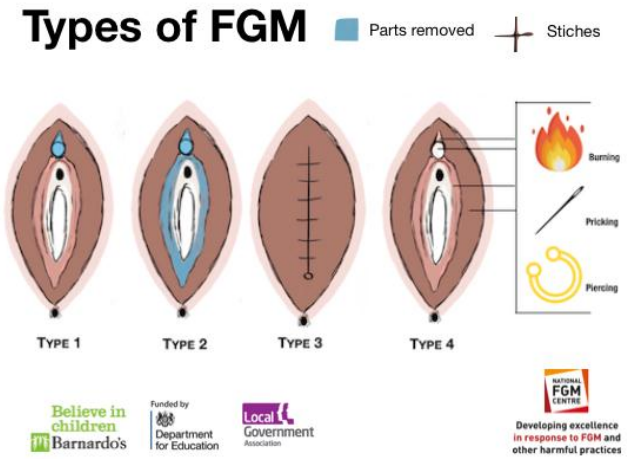


Figure 2: Types of Female Genital Mutilation. Sourced from national fgm centre.org.uk

Different reasons have been given for the practice of FGM/C. The most common reason is that it minimizes sexual desire and preserves virginity in girls/women. However, the complications of the practice include hemorrhage, septic shock, infections, reproductive/ sexual problems- sexual dysfunction, dyspareunia,

frigidity, depression, infertility, severe dysmenorrhoea, obstructed labour and obstetrical fistula (Bello *et al*, 2020). From the sexual rights perspective, FGM/C is a major indicator of gender inequality. The re- infibulation (re- stitching of the vulval scar) done after child birth in women with type III FGM is to ensure that the vulval opening is narrowed, to give the husband sexual satisfaction. ***What a world of pain for the woman, while the man gains pleasure from sex!*** The global community has set up various treaties and mobilized campaigns on the eradication of FGM/C. From 1996 to 1998, I contributed to the attempts targeted at its eradication. I got a fund from the John D and Catherine T Mac Arthur Foundation's Fund for Leadership Development. This grant was used to conduct a community- based project on the eradication of FGM/C, in five communities, in Osun State (Ibodi, Osu, Ifewara, Okebode and Kajola). At the pre- intervention phase, 93% of the adult women and 83% of the adolescents were already mutilated. Additionally, clinical examination of the genitals of female babies at the immunization clinics revealed that 80.7% of the babies were already mutilated. The respondents on the project revealed local circumcisers, traditional birth attendants and health workers as operators of the practice. The qualitative results revealed further that the people had heard of the campaign against FGM/C, but linked it with part of media activities. Sadly, with the misconception that FGM/C reduces promiscuity, a secondary school principal made a special plea –

"...any campaign that is aimed at female circumcision should also teach our girls how to delay getting sexually active and how to prevent pregnancies…these girls get pregnant; they commit abortions, and drop out of schools,…also look at the streets; they are there selling akara (bean cake), table water, pure water etc ." (comments of a principal at an in-depth interview).

Based on the results of the preliminary phase of this project, I formed a multidisciplinary team that comprised two nurses, a health educator, a drama artist and some secondary school teachers. The team developed an integrated educational

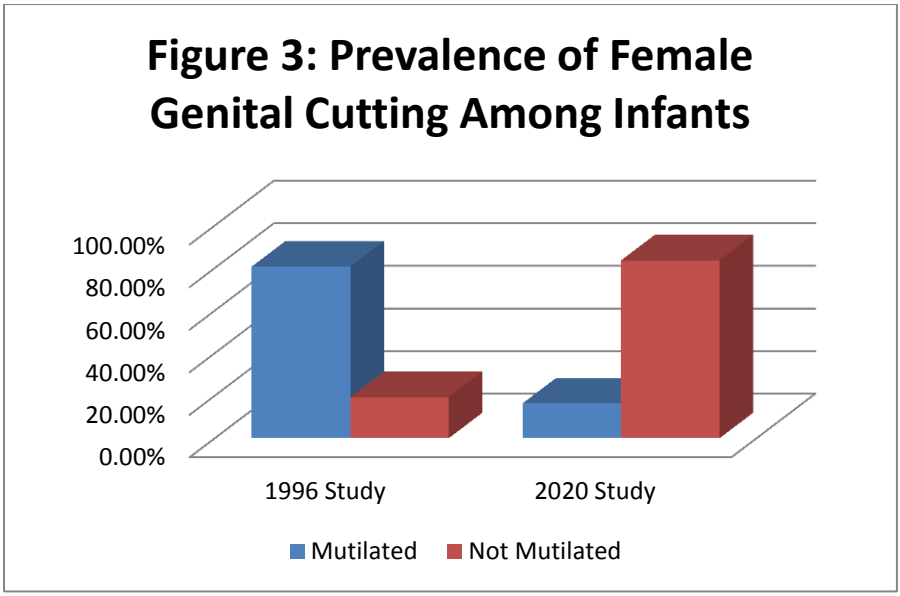
programme (IEP). The IEP had modules on 'anatomy and physiology of sex organs', 'reproductive health', 'traditional practices including FGM/C', 'safety', 'nutrition', 'how to study and career talks'.

Community Outreach at Ibodi with Professor Bolale Awe (Country Coordinator, MacArthur Foundation), and Research Advisers- Professor Modupe Onadeko (College of Medicine, University of Ibadan, Ibadan) and Professor Simi Afonja (Dept of Sociology & Anthropology, OAU, Ile Ife)

Facilitators At the WHO, FMOH Training of Trainer's Workshop on Pilot Testing FGM/C Modules into Nursing and Midwifery Curricula, Ibadan 2000.

The team produced a video titled "ATUMBOTAN"(The Consequence); and composed songs. We used these, to campaign against FGM/C, for over two years. The team held group sessions with students, teachers, parents and various sections of the communities. Over two decades, after our intervention project; and with continued effort from many international and local non-governmental organisations (NGOs), evidence is showing that the attitude to FGM/C is changing. A subsequent project by Olaogun and Siyanbade (2020) that assessed the practice of FGM/C among mothers with infants attending Primary Health Care centres, showed that, out of 244 female babies whose genitalia were

examined, only 40 (16.4%) were mutilated with either type1 or type II FGC. When compared with the 80.7% of the babies already mutilated as found in the 1996-1998 project (Figure 3), there is a reduction but a continuation of the practice.

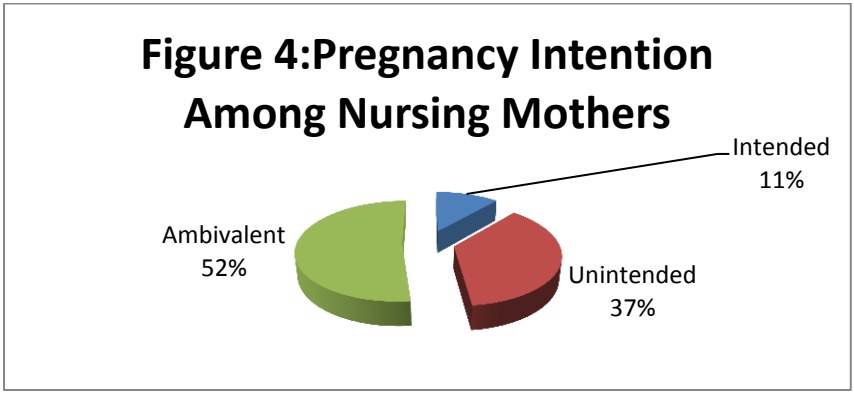


Unfortunately, a new issue is arising from the continuation of the practice. This is the ***medicalisation of the procedure;*** that is, the performance of the procedure, by health care providers. Medicalisation is reinforced by health care providers who are deeply entrenched in social/ cultural norms, and the economic gains motivated by the commercialization of FGM/C. To forestall such practice, in 2000, working with the Federal Ministry of Health and the World Health Organization, a 'Training of Trainers' workshop was conducted in Ibadan. Learning modules on how to integrate FGM/C into the Nursing and Midwifery Curricula was pilot-tested. The Nursing and Midwifery Council of Nigeria (N&MCN) has introduced FGM/C in its midwifery curriculum. Medicalisation of FGM/C is now a global issue. It has been reported, in some developed nations (Cohen *et al*, 2020, Hodes *et al*, 2021). For a better understanding of this problem, Olaogun *et al*

(2016) proposed a nursing diagnosis labelled 'Handicapping Beliefs', to the NANDAI Diagnostic Committee. In the eleventh edition of the NANDA-I text book, "Risk for Female Genital Mutilation" was included, as a new nursing diagnosis (Herdman & Kamitsuru, 2017). The UN general assembly has designated February 6th as the **International Day for Zero Tolerance for FGM/C;** and fixed 2030 as a global projection, for its full eradication.

Other factors causing pain in womanhood are cultural and religious practices that prevent women from controlling their own fertility. This could result in unintended pregnancies. The World Health Organization has reported that, globally, 74 million women living in low- and middle-income countries have unintended pregnancies, annually (WHO, 2019). In Nigeria, the total fertility rate is 5.3; but the wanted fertility rate is 4.8. This implies that 0.5% of pregnancy was unwanted (NPC, 2019). Globally, the major strategy to reduce unintended pregnancies is the use of contraceptives. Women may use contraceptives, to limit or space their children; or rather, to prevent pregnancies. The reported contraceptive prevalence rate (CPR) in Nigeria is 17% in married women. Unintended pregnancy is a pregnancy that is either unwanted, such as a pregnancy that occurs when no children or no more children are desired; or when the pregnancy is mistimed, such as occurring earlier than desired, at the time of conception (Afolabi *et al*, 2020a). The rate of unintended pregnancy in a nation is a central measure of reproductive health. It reveals the extent to which a woman and families can determine, freely, whether or when they want to have a child. When our team conducted a community-based mixed method research on the determinants of unintended pregnancies among nursing mothers, data showed (Figure 4) that **only 11.5% of the women reported that their index pregnancy was intended.** Sixty- seven percent (67%) were not using any contraception, at the time of the study. Significant risk factors for unintended pregnancy are parity, ethnicity and religion (Afolabi *et al*, 2020a&b). Islam and Catholicism discourage the use of modern contraceptives; and emphasise that every child is a gift from God

thus preventing women from controlling their fertility. It is interesting to note that some women desire to terminate such pregnancies. In a nation where abortion is not legalized, such abortions could be handled by quacks, thus exposing them to infections and death. Why would a woman be subjected to such pain? ***Every woman should have the right to be free from pain which includes the choice of when to get pregnant.***



To further compound the problem of unintended pregnancies is the issue of son- preference. Son -preference exists, in all cultures; and is tied to inheritance. We conducted a study of university undergraduates; 50% of them desired having a male child as first child. Of those who desired a male child, 89% wanted between three and six children (Olaogun *et al*, 2009). Preference for sons discourages women from using contraceptives; and such women have shorter birth interval. A potent strategy to reduce unintended pregnancy and its consequences of abortions and death rates among reproductive age women is to provide accurate information on reproductive physiology (anatomy of the female body, ovulation, and menstrual cycle), true risk of conception, pregnancy and other relevant health issues (Ayoola *et al*, 2016). This information must be provided as early as possible during teenage years; and continued, into adulthood. I joined a team from Calvin University, Grand Rapids, Michigan, USA, on an international/multisite (USA, Kenya and Nigeria) educational programme of two weeks' health camp that runs, annually, for

adolescent girls of ages 9-15. The girls are educated; and taught hands on skills on general health issues, leadership, reproductive anatomy and physiology, sex, contraception and the negative impact of smoking, alcohol, drug abuse etc. Currently, this project is being replicated locally in selected rural and urban secondary schools in Osun state through a grant from Bowen University, Iwo. The project is targeting boys and girls, parents and teachers. It is anticipated that these health camps will give (i) appropriate knowledge and decision-making skills to teenagers that will equip them to make right choices, (ii) enable parents and teachers to develop skills for communication on sexual issues with adolescents.

Girls at Bowen University, Iwo Computer Centre participating in the virtual Health Camp with teams from Calvin University, Grand Rapids, MI, USA and Daystar University, Nairobi, Kenya

Using the workbook and Computer during the Virtual Health Camp

The problems of womanhood are not only limited to cultural and traditional practices. There are pathological factors that can affect a woman based on her anatomy. A woman is characterized biologically by the breasts (mammary organs) and the uterus. There are breast cancer (BC) and cervical cancer (CC). BC is the world's most prevalent cancer and the fifth cause of death that

affects women in every country and at any age. It is not transmissible, like cervical cancer. There were approximately 2.26 million women with diagnosed BC and 685,000 deaths reported globally, in the year 2020 (Globocan, 2021; WHO, 2021). Nigerian statistics revealed a 5-year reported prevalence of 60,276 cases and 28,380 new cases in 2020 with 14,274 deaths (Globocon, 2021). WHO strategy; is to reduce global BC mortality, by 2.5% every year, by 2040. Prevention is better than cure. A very important strategy in the prevention of BC is to identify those that are at high risk. Our team (Adebayo *et al,* 2019) used the Gail mathematical model to estimate an individual's five-year absolute BC risk. The identified risks were attaining menarche between 9-14 years of age, having first child after age 30 years, nulliparity, history of never having breastfed, having had a breast biopsy and a history of BC in a first-degree relation -mothers or sisters. The Gail model, used for risk assessment, revealed that only 2.3% of the respondents were at high risk level of developing BC. Hence, majority of the respondents have a low risk of developing BC. The family history of BC increased, significantly, with the odds of having a higher risk of BC development. However, increase in average duration of breastfeeding reduced, significantly, the odds of having higher risk of BC. While the result of this study revealed that very few of the women, were at high risk, the American Cancer Society has advocated that the women at a high risk for BC should be accurately identified, so that appropriate prevention strategies can be offered- (i) control of specific modifiable risk factors and (ii) screening for BC which includes-regular clinical breast examination, mammography, ultrasound and/or MRI. The listed screening methods are expensive; and may not be accessible, in low resource settings such as Nigeria. Breast Self-Examination (BSE) is a screening method that can be performed by women themselves. It is inexpensive and convenient; and is, therefore, a good screening method that can be used on a regular basis and at any age. Furthermore, our team in another study discovered that among a segment of Obafemi Awolowo University (OAU) workers, 96 % had good knowledge of BC while 75% had good knowledge of BSE. In the area of practice, 69% indicated that they

practice BSE; 19% practice BSE, a week after menstruation; and only 6 % utilize the three patterns for searching for breast lump– vertical strip, wedge pattern and circular pattern in performing the BSE(Oginni *et al*, 2014). These results reveal that there may not be an early detection of BC by the few women that are at high risk. We recommended that intensive education be given to girls/ women, on BC and BSE. Based on this, cancer awareness was incorporated into the health education packages developed in our programme.

Cervical Cancer (CC) is the fourth most common cancer in women (WHO, 2022). About 90% of all new cases and deaths that are caused by CC occur in lower resource countries (WHO, 2022). In Sub-Saharan Africa, CC is the leading cause of cancer- related deaths in women. The incidence and mortality rates for CC in Sub-Saharan Africa are 34.8 and 22.5 per 100 000 respectively—the highest of any world region. The World Health Organization (WHO) has advocated a comprehensive approach to cervical cancer prevention and control. As reflected on the table 3 below, this includes:

TABLE 3: Comprehensive Approach to Cervical Cancer Prevention and Control

Primary Prevention	Secondary Prevention	Tertiary Prevention
Girls 9-14	Women 30 years old +	All women
HPV vaccination		

Our research team conducted an intervention project using two universities- the University of Ibadan, Ibadan as control and Obafemi Awolowo University, Ile Ife as the intervention group. We recruited sexually active female undergraduate students into the programme. We designed and disseminated an educational programme. Students in the intervention group were educated on what CC is, the risks factors, signs and symptoms and as well as prevention strategies. Also, the participants were given the opportunity to have Pap's smear done. During the intervention, 47% of the experimental group that had volunteered for the Pap smear had positive results and required cytology and further

investigation (Afolabi *et al*, 2013). The number of students who volunteered for Pap smear could be linked directly with the effect of the educational programme. The number of students with positive results from the test raised great concern. This supports the advocacy for primary prevention of CC. As a follow up to the 2013 study, we conducted a survey; and identified four major roles of nurses in CC prevention. These are health education, giving of HPV vaccines, CC screening and involvement in treatment services (Afolabi & Olaogun, 2020). The results of our study demonstrated that it is possible to implement a sustainable CC screening in Nigeria, using nurse midwives. In furtherance with our work on CC prevention, an intervention project tagged "cervifix project" utilised existing facilities and staff of State Hospital , Osogbo, State Hospital Ikirun, State Hospital, Ila, MicCom Cancer Foundation, Ada , and OAUTHC , Ile Ife, all in Osun state (Afolabi, 2019). The nurse- midwives and community health workers were trained on community awareness, sensitization and mobilization in order to promote uptake and utilization of CC screening services. Free screening services were provided to reproductive-age women. The outcome of the project showed an increase in the number of women screened and subsequent increase in the number of women who were screened positive and referred for treatment. The competency level of service providers increased from 54% to 86.3%. There was a strengthened link, between primary, secondary and tertiary health facilities and provision of instruments and supplies to facilities. At the end of the project, it was recommended that structural component in secondary health care facilities be updated; and standard guidelines for delivery should be developed and improved and spousal support in CC screening be encouraged.

The various sources of pain in womanhood are more compounded, with reports of mistreatment of the women by health-care providers during childbirth. This situation violates women's basic human rights, violates the fundamental obligation of the health system to provide support and healing in childbirth; and can cause lasting emotional trauma. Many interventions have been proposed

by international agencies to improve access to health care facilities. One of the interventions is 'Respectful Maternity Care' access to skilled birth attendants. Our team used a mixed method approach to evaluate the impact of a training programme organized by White Ribbon Alliance and Nursing and Midwifery Council of Nigeria on RMC (Adegbite, 2022). Our results revealed that there was a slight increase in knowledge and practice of Respectful Maternity Care (RMC) among trained nurse-midwives. Still, the clients reported that the RMC received was ***very poor***. Identified barriers to RMC were- lack of women's knowledge on human rights, inadequate staffing and infrastructure. It was recommended that there is the need for RMC policy formulation in health facilities. Behavioural change interventions must be targeted at nurse-midwives. The government agencies must increase staffing and quality of infrastructure, in order to ensure provision of standard RMC. Also, our team conducted a scoping literature search that critically analysed recent health workforce crises (Adeloye *et al*, 2017). The Nigerian health system is characterized by a number of health workforce crises, due to non- payment of salaries, poor welfare, lack of appropriate health facilities, emerging factions engaged in protracted supremacy challenge and massive brain drain. Consequently, these crises have prevented optimal healthcare delivery to the Nigerian population.

Ageing is another factor that has great influence on womanhood. There are biological changes and new role acquisition dictated by socio-cultural factors that could negatively affect the experiences of ageing women. (Oyibocha & Olaogun, 2016). Our team discovered that the women experience (i) vasomotor symptoms- profuse sweating during the day and hot flushes; (ii) psychosocial symptoms- poor memory, and feeling of being anxious or nervous; (iii) physical symptoms- decrease in stamina, difficulty in sleeping, weight gain; and (iv) sexual symptoms - changes in sexual desire, dryness of the vagina during intercourse, and trying to avoid intimacy (Oyibocha & Olaogun, 2016). Also, we discovered that common health conditions suffered by these women were hypertension, neoplasm, cerebro-vascular disease (CVD) and

gastrointestinal diseases. Role changes encountered were, widowhood due to loss of spouse, getting poorer because of retirement from active work and becoming care-givers to the elderly with chronic diseases (Oyibocha & Olaogun, 2016; Faronbi & Olaogun, 2017; Faronbi et al, 2019; Faronbi et al, 2019; Faronbi et al, 2020). In Yoruba culture, women are the main caregivers at the household level. They are believed to stay more with their sick loved ones because of their compassionate nature. Caregivers spend substantial numbers of hours in providing care, daily, for their sick elderly. They assist in activities of daily living; such as feeding, grooming, changing of position, giving of medication and running errands. Unfortunately, the caregivers' that were studied experienced degrees of burden, ranging from light (12.0%), moderate (28.9%), to severe (59.1%). This burden manifests in the lives of caregivers in various ways: poor health, financial difficulty, disruption of family processes, and social isolation. Nigeria is one of the African countries that lack working policy or provision for older adults. Therefore, the pains of these women are neither recognised nor attended to. As an outcome of our study, we recommended that domiciliary nursing services should be established in Nigeria, to provide basic nursing care to home-bound individuals. Governmental and non-governmental organizations should be actively involved in establishing and coordinating support groups for caregivers.

Toils of Early Childhood;

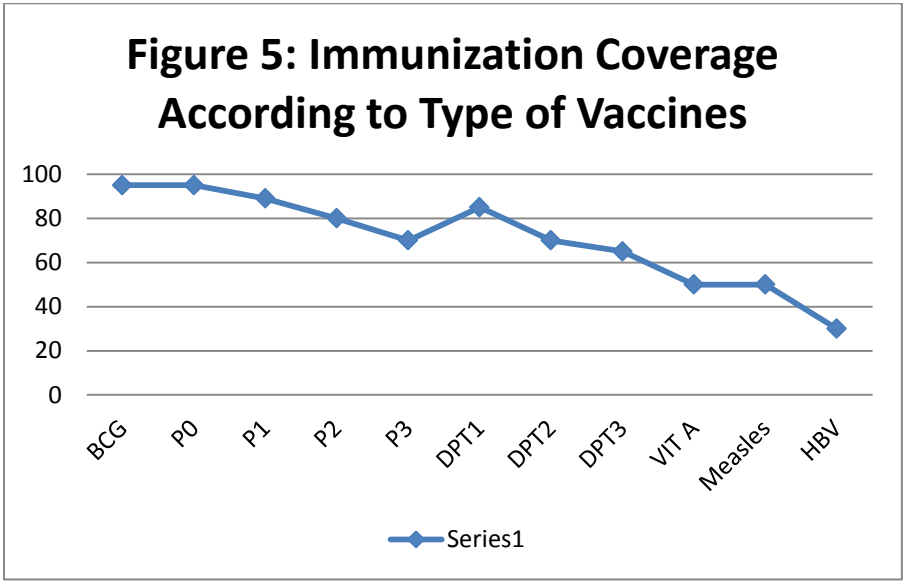
Mr Vice Chancellor, Sir, UNICEF defines a child as anyone below the age of 18 years while early childhood is defined as the period between birth and 8 years. The period of early childhood is marked with rapid growth, and high susceptibility to ill-health that could, sometimes, be linked with traditional food taboos, low socio economic-status of parents and inaccessibility to health facilities. Globally, 5.2 million under- five children died, in 2019. The rate of under-five mortality in low-income nations was 68 per 1,000 live births; and this is 14 times higher than in higher income nations with 5 deaths / 1000 live births. (WHO,2020). The Nigerian report was 132 deaths per 1,000 live births for the country (NPC, 2019).

The major causes of the deaths are preterm birth complications, birth asphyxia / trauma, pneumonia, congenital abnormalities, diarrhoea, and malaria (WHO, 2020). Other causes are measles, malnutrition, bacteraemia and respiratory conditions. Deaths from these diseases are preventable and can be managed with simple curative interventions. The Sustainable Development Goals (SDGs) has targeted that all nations end all preventable deaths of these children and reduce neonatal mortality to less than 12 per 1000 live births; and under-five mortality to less than 25 per 1000 live births respectively, by 2030. (United Nations, 2019). Nigeria is a tropical nation with an environment conducive for the breeding and survival of microbes and vectors that are implicated in the aetiology and transmission of many of the febrile illnesses. This explains the prevalence of febrile illnesses, especially malaria. Malaria is implicated in one out of every five childhood deaths in Africa. The best option in reduction of the high mortality rate is the prevention, through vector control, of these diseases. In the absence of vector control, seeking prompt care from an appropriate health care provider is an important step to have the correct assessment, accurate diagnosis and management of a child's illness. Most African cultures are built on a patriarchal system. Traditionally, men are the heads of households and decision makers in all issues of family life. Males are major critical decision makers in families. In some communities, they play the role of gatekeepers to health care. Our team researched into parental decision making in care of under-five sick children (Olaogun, *et al* , 2005; Olaogun *et al*, 2006a;Olaogun, et al, 2006b). Results revealed that both fathers and mothers concurred that illness was recognised first by the mothers; but there was evidence that the fathers and mothers may not have been working in partnership. Mothers had taken an action, before bringing the children to health facilities. The mothers' description of *iba* was for malaria, *ara gbigbona pelu osin* for upper respiratory tract infections, *aragbibona pelu igbeyiya* for diarrheal diseases. At home level, the mothers had combined the use of orthodox drugs with traditional herbs. The orthodox drugs used were paracetamol, aspirin products, chloroquine, septrin and cough mixtures. Most of these

drugs were purchased at the patent medicine stores (PMSs). The PMS has been found to be an alternative source of health care which, most of the time, is manned by people who are not health professionals and who supply non-prescribed drugs. Where there was disagreement on the choice of health facility to use in the care of the child, fathers favored the use of formal health care sector but mothers preferred the use of informal sector. Urban dwellers were better at taking similar decisions than rural dwellers, although, level of education influenced decision making. Family members play the role of caregivers. The results of our studies are very significant for the care of a sick child. Recommendations were made on the use of educational interventions to enhance spousal communication and fathers and mothers' joint participation in childhood illness management.

To reduce the effect of preventable causes of death in under-fives, childhood immunization is a key primary prevention strategy. It is one of the most cost- effective public health interventions. In 2018, WHO reported that about 19.4 million infants did not receive routine immunisation and about 60% of those that were not immunised were from ten countries including Nigeria. The SDG goal 3 is to ensure healthy lives and promote wellbeing for all at all ages while its target 2 emphasises that, by 2030, there must be an end to preventable deaths of new-born and children that are under five years of age, with achieving of more than 90% coverage of all basic vaccination among children aged 12-23 months. Our research team conducted a study on immunisation coverage (Olaogun et al, 2007; Obiajunwa and Olaogun, 2013). **Slightly over 26% of the children had been fully immunised**, 64.7% were partially immunised while 11.9% were not immunised at all. We discovered that complete coverage of immunisation increases with increased educational level of parents. Vaccination coverage dropped, as the child grew older (Figure 5). The vaccines received at birth – BCG and Zero Polio had the greatest coverage while the least received was measles and the HBV which were received at 9 months of age. The very poor completion of immunisation and drop in immunization as the child grows older, are very dangerous trends.

There is the tendency of occurrence of re-emerging diseases. Factors linked with poor coverage in our study were parents getting frustrated, when mothers go to clinic repeatedly due to lack of vaccines in clinics, illness of children and low economic status of parents. Intervention strategies should target parents' education on vaccines, its benefits, and list of centres that give immunisation. Motivations should also be given to parents for completion of child's vaccination.



***Information Fron Mothers Using Immunization Cards**

One of the most common adverse stimuli experienced by infants is pain. Pain experience in infants is stored in memory; and they, subsequently, influence reactions to pain, in future. The anatomical, physiological and biochemical prerequisites for pain perception are already present by the 22nd- 24th week of intrauterine life. New-born babies have a well -developed endocrine system that is able to release cortisol and catecholamine, in response to pain stresses. Therefore, even pre-term babies can perceive pain (Olaogun *et al,* 2008). Our team investigated mothers' knowledge and management of pain using mothers who brought their babies for routine growth monitoring, at well babies'

clinics. The mean age at which pain is experienced by infants according to majority of the mothers is 2 ½ months. They described pain experience in infants as 'distressing'; and behavioural response as irritable, incessant crying, tightening of eyes and assuming curled-up position. Malaria was the most reported cause of pain. On management strategies, over 50% of mothers used paracetamol bought at the patent medicine stores, while very few use breastfeeding, cuddling, application of compress and positioning (strapping baby on the back). When probed on role of breastfeeding in pain relief, many expressed that it serves as a pacifier and an analgesic. As a follow up to this, our team used an intervention approach to investigate pain relief strategies in infants receiving DPT1 immunization (Achema *et al*, 2011). The results (Table 4) revealed that 40% each of the infants in 'Breastfeeding' and 'Eutectic Mixture of Lidocaine' (EMLA -a local anaesthetic) groups and 25% of control group exhibited mild pain; but 50% of the control infants exhibited severe pain. We recommended that parents should be educated, at antenatal clinics, on pain perception in new born, effect of not giving prompt care to infants in pain and use of exclusive / breastfeeding in relieving pain in infants. EMLA cream should be adopted as a prophylactic strategy, at least 60 minutes prior to invasive procedures in infants

Table 4 INFLUENCE OF INTERVENTION STRATEGY ON INFANTS RESPONSE TO PAIN N= 60

Response to pain	Breastfeeding Group	EMLA Group	Control Group
Mild	8 (40%)	8 (40%)	5 (25%)
Moderate	12 (60%)	11 (55%)	5 (25%)
Severe	0.0	1 (5%)	10 (50%)
Total	20	20	20

While closing up my sections on maternal and child health, may I request that we rise up; and observe a minute silence for all the women and children that have been counted in the global statistics of maternal and child mortality.

The Ethos of Standardised Nursing Languages

Mr Vice Chancellor, Sir, the concluding part of my lecture is on the ethos of Standardised Nursing Languages (SNLs). In 2005, after my PhD programme, my then Head of Department, Dr (now Professor) R B Fajemilehin, assigned me to teach the post-graduate courses of NSC 603- Advanced Study of the Nursing Process to MSc students and NSC 701- Advanced Theory Development in Nursing to PhD students. I decided to search the literature for new advances in the Nursing Process. The concepts of SNLs- Nursing Intervention Classifications (NIC) and Nursing Outcome Classifications (NOC) came up. Thereafter, I checked for opportunities to learn from the developers of the terminologies. By the grace of God, this led me to my 2009 postdoctoral fellowship programme at the College of Nursing, University of Iowa, Iowa, USA. The fellowship was sponsored by a joint fund from International Network on Doctoral Education in Nursing (INDEN) and Sigma Theta Tau International (STTI), while Obafemi Awolowo University paid fully, for my travel expenses. It was great learning under the mentorship of Dr Sue Moorhead and the NIC and NOC teams.

As the first African nurse on the team, I contributed to the 7th edition of NIC and the 5th edition of NOC textbooks. Returning home, my Department at OAU gave full support and we organized the NANDA International – African chapter now – Association of Standardized Nursing Languages in Nigeria. These concepts of NIC and NOC have been introduced into my teaching of MSc students since 2009. In 2010, it was introduced nationally, at the first biennial conference of the NANDA-I African Network-Nigeria Chapter, in conjunction with the College of Nursing, University of Iowa and the NANDA International – a hybrid conference with our international partners joining through the virtual window ahead of Covid-19 era (Olaogun, *et al*, 2011; Adubi,*et al*, 2016). Recently, the Nursing and Midwifery

At the Board Room of Centre for Nursing Classification and Clinical Effectiveness, University of Iowa, College of Nursing with the NOC Team- From left- Dr Elizabeth Swanson, Dr Sue Moorhead, Dr Gloria Bulechek. From Right- Dr Marion Johnson, Dr Adenike Olaogun, Dr Meridean Mass.

Council of Nigeria (N&MCN) introduced the SNLs into all its educational curricula and the MCPDP modules. To intensify the introduction of the concepts, biennial conferences were held, in 2012 at OAU; at the University of Ibadan, Ibadan, in 2014; at the Women's International Centre in Abuja in 2016; and in 2018 at the University of Calabar, Calabar. Lagos would have been the venue for 2020, but for the Covid 19 lock down. Working with a team, training workshops were held in University College Hospital (UCH), Ibadan; University of Ilorin Teaching Hospital, (UITH) Ilorin; Ogun State University Teaching Hospital (OSUTH), Shagamu; University of Abuja Teaching Hospital, Abuja, Lagos State University Teaching Hospital, (LASUTH) Lagos, at MCPDP programmes in Ekiti and Osun states; OAUTH, Ile Ife and at the Nigeria Airforce Base, Kaduna.

NANDAI- African Network 2014 Biennial Conference, University of Ibadan, Ibadan. With Dr Sue Moorhead (NOC team leader/ Director of CNC, University of Iowa), Dr Marcel Chanes (Brazil representing NANDA-International) and Dr Howard Butcher (NIC Team Leader, CNC, University of Iowa)

With Chief of Airstaff at the February 2020 NAF worshop, Kaduna

Nurses at the NAF Workshop in Kaduna

The SNLs are the pathway for making the nursing process (NP) useable and visible. They are content standards that include terms which represent a focus on diagnoses, interventions and outcomes that are consistent with the scope of nursing practice. Planning of nursing care is an essential part of nursing practice; and it provides a framework for client care. The content of the nursing care plan must be according to the NP. When the terminologies for diagnosis, outcome and intervention are used to develop a pre - determined intervention for a particular patient group or nursing diagnosis, it becomes a Standardized Nursing Care Plan (SNCP) (Oluwatosin & Olaogun, 2016). The SNCP is a clinical guideline that is used in practice. SNCPs increase the ability of nurses to provide the same quality of care to all patients; reduces the time spent on documentation and minimise unnecessary documentation. It enables optimal information exchange and meaningful use of data in research and programme evaluation. SNCPs are the only way that nursing care plans can be incorporated into the electronic health system.

Our team started research in this area by using a client study to demonstrate the use of SNLs in a clinical setting (Adejumo and Olaogun, 2009; Olaogun *et al*, 2009). Lessons learnt were that, when these concepts are applied while caring for a client, documentation was presented in a better form. As part of a needs assessment, our team assessed nursing process booklets from the Medical, Surgical, Orthopaedic and Mental Health units of Obafemi Awolowo University Teaching Hospital, Ile Ife (Olaogun *et al*, 2011). About 87% of the booklets had a total of 154 nursing diagnoses (NDs). Sixty percent of the NDs were made within the first 48 hours. The most frequently used NDs were Acute Pain in the Surgical and Orthopaedic Wards, Anxiety in Medical Wards and Self Care Deficit in Mental Health Wards. Working with my post graduate students, we have validated three nursing diagnoses. According to Herdman and Kamitsuru (2017), a nursing diagnosis is defined as *"a professional judgment that is based on the application of clinical knowledge which determines potential or actual experiences and responses to health problems and life*

processes or a vulnerability to such response, from an individual, family, group, or community." The list of NANDA-I nursing diagnoses can be applied to individuals, families, or communities. This standardized language system presents nursing diagnostic label, along with its theoretical definition and defining characteristics (DCs) which are the observable or communicable signs and symptoms, related or risk factors (RF) and associated conditions (AC). Studies on nursing diagnosis validation are essential sources in searching for evidence and in the reduction of the probability of errors in the nurse's diagnostic process and decision-making process. The fact remains that, for nurses to provide care that is based on the clinical reasoning process, it is essential that nursing diagnosis (ND) be accurate. The Clinical and the Content Diagnosis Validation Models by Richard Ferhing (Ferhing, 1987) were used, in our studies which included:

a. Validation of "Acute Pain" -This study was conducted at the Federal Medical Centre, Owo. Ninety- three (93) nurses and 98 post-operative patients were selected for the study. In-depth interviews were held with seventeen nurses. (Abiodun *et al*, 2016).
b. Validation of "Impaired Mood Regulation"- the study was conducted at the Federal Neuropsychiatric Hospitals Aro, Abeokuta in Ogun State and Federal Neuropsychiatric Hospital Kware, in Sokoto State. Two hundred and thirty-eight (238) mental health nurses (120 at Aro and 118 at Sokoto) were recruited. They have been working, for at least 5 years, with mentally-ill patients. Eighty-seven (87) patients with mood disorder (Mania, Depression and Bipolar Affective Disorder) were recruited. The criteria for selection was the patients must be at least 18 years old with mental capacity to give informed consent, or when the patient was not capable of giving consent, the guardian gave consent. (Adebiyi, *et al*, 2020).
c. Validation of "Ineffective Infant Feeding Pattern"- the study was conducted in the neonatal intensive care units of Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC) in Ile Ife and Ilesa; Federal Medical

Centre, Owo, in Ondo State; and Massey Street Children's Hospital, Lagos. Eight nurse experts in the area of SNLs, 68 nurses that were working at the NICU for not less than two years, 30 babies with feeding difficulty and their mothers were recruited for the study. The babies were observed for the evidence of defining characteristics of the diagnosis. The results of the study showed that the prevalence rate of the nursing diagnosis—ineffective infant feeding pattern was 14.5%, among the NICU babies (Adeniyi, 2022).

Our team has worked further on developing Standardized Nursing Care Plans (SNCPs). We introduced for the first time into the country paper- based SNCPs (Plate 1, pg. 30) through a quasi-experimental study (Odutayo *et al*, 2013). The setting of the study was Ijebu Ode and Odogbolu Local Government Areas (LGAs). During the pre- intervention phase of this work, a needs assessment was done. It was discovered that the Public Health Nurses (PHNs) document the care given to their clients, in small booklets, using medical diagnoses. These booklets were studied; and frequently occurring health problems were identified, including malaria, malnutrition, gastroenteritis, teenage pregnancies, poor school attendance, drug abuse, and rape. Based on these identified health problems, the following nursing diagnoses (NDs) related to the commonly occurring health problems were identified: hyperthermia, imbalanced nutrition (less than body requirements), deficient fluid volume, anxiety, situational low self-esteem, rape–trauma syndrome, risk for violence, and impaired parenting. These NDs were used to develop paper form SNCPs. Also, an educational package was developed with the following modules;

-Module 1—Historical development of SNLs;
-Module 2—Introduction to the concepts of NANDA-I nursing diagnoses, NOC, and NIC (NNN);
-Module 3—Linkages within the NNN;
-Module 4—Documentation of care using NNN and the SNCPs; and
-Module 5—Advantages of using NNN in documentation.

A 5-day training workshop was held with the PHNs, in the intervention group, using one of the PHCs. During the workshop, the modules were used for teaching; and client studies were presented, at practical sessions. The SNCPs were introduced to the PHNs, and their use was monitored, in each of the PHCs, on a monthly basis. At the end of 12 weeks, the first post-test was conducted. One hundred SNCPs were selected randomly, from the PHCs; and were assessed, using the modified Muller-Staub et al. (2008) Q-DIO checklist. A second post-test was done, at the end of 12months (a year) of post -intervention to assess 100 randomly selected SNCPs from the experimental group. Results revealed that, at the pretest, most of the participants had theoretical training on the NP, during their schooling; but none of the participants have heard of the NOC and NIC. At post-test, there was a significant difference in the knowledge area of the experimental group, but no significant difference in the pre- and post-test mean scores of the control group. At post-test, the PHNs in the control group were still using notebooks; but the experimental group was using SNCPs. The PHNs in the experimental group were able to identify actual nursing diagnoses with the signs and symptoms and etiologies, while, in the risk diagnoses, they identified the nursing diagnoses with the related factors. Also they identified NIC activities that were specific to solving client problems and linked indicators of NOC, which were related to the identified diagnoses and interventions. This was the humble beginning of introducing SNCPs into the country.

As a follow up to this work on introducing SNCPs to the nation, our team developed; and introduced electronic nursing records tagged ‘Stenicare’(Plate 2, pg. 31) , at the University of Ilorin Teaching Hospital, Ilorin (Adereti and Olaogun, 2018). During the study, paper-based SNCPs were introduced to selected wards, while the SNCPs were incorporated into the Electronic Health Records of selected wards. Nurses in selected wards were given a planned educational programme. The package consists of four learning modules which are:
Module 1: An overview of the nursing process;

Module 2: Standardized Nursing Languages, Nursing Diagnoses (NANDA-I), Nursing Outcomes Classification (NOC), and Nursing Interventions Classification (NIC);
Module 3: Standardized Nursing Care Plans; and
Module 4: Benefits of EHRs and practical sessions on the use of electronic SNCPs.

The results revealed that many of the nurses were computer literate. There was an improvement in documentation quality in the selected wards, after introducing SNCPs; were higher quality scores in the electronic ward post-intervention. The SNLs educational intervention improved nurses' assessment and documentation skills. The SNCPs provided nurses with a guide to be used to enhance care planning and documentation.

Furthermore, we conducted evaluation studies in the three teaching hospitals that have benefited from our work on SNLs and SNCPs from 2015 – 2019 (Adubi *et al*, 2017; Ojo & Olaogun, 2022). These hospitals were Obafemi Awolowo University Teaching Hospital, Ile Ife (OAUTH); University College Hospital, Ibadan (UCH); and University of Ilorin Teaching Hospital, Ilorin (UITH). Results revealed that there was moderate utilization of SNLs (Figure 6, pg. 31) in the nurses' documentation of care. Over the 5 years' period, there were fluctuations in the overall quality of document. There was a significant difference in the quality of documentation between the three hospitals with OAUTH scoring a higher mean score, followed by UCH, amongst the group. The qualitative study revealed that the nurses' documentation was done manually, thus posing storage problems. Lack of mandate from educational system, inadequate staffing and non-motivation were major challenges to the use of SNLs in clinical practice. It is noteworthy to indicate, that based on this humble beginning, some universities have incorporated SNLs into their nursing research activities.

STANDARDISED NURSING CARE PLAN - Readiness for Enhanced Childbearing Process 00208

Definition- A pattern of preparing for and maintaining a healthy pregnancy, childbirth proces and care of the newborn for ensuring well-being which can be strengthened.

Client Name: Hospital number:

Name of Admitting Nurse: Date of Admission:

Defining Characteristics	Desired Outcomes	Nursing interventions
During pregnancy _Reports appropriate prenatal lifestyle (eg diet, elimination, sleep, exercise, personal hygiene) _reports appropriate physical preparations _reports managing unpleasant symptoms in pregnancy _Prepares necessary newborn care items _Seeks necessary knowledge (eg of labour, and delivery, newborn care) _ Has regular prenatal visits	Knowledge Pregnancy Definition: Extent of understanding conveyed about maternal health prior to conception to insure a healthy pregnancy (indicate rate _1 :_2 :_3 :_4 :_5) Indicators: -Importance of frequent prenatal care -Importance of prenatal education - Major fetal developmental milestones -Healthy nutritional practices - Safe sexual practices -Warning signs of pregnancy complications -Appropriate self-care for discomforts of pregnancy -Signs and symptoms of labour	Prenatal Care Definition-Provision of health car during the course of pregnancy Activities: -Discuss importance of participatin in prenatal care throughout entire pregnancy and encourage involvement of patient's partner or other family member -Monitor weight gain -Monitor for hypertensive disorder (e.g., blood pressure, edematous ankles, hands, and face, and proteinuria) -Monitor fetal heart tones -Measure fundal height and compare with gestational age -Discuss nutritional needs and concerns (e.g., balanced diet, folic acid, food safety, and supplements) -Assist patient in preparing for labor and delivery (i.e., discuss pain management options, review labor signs and symptoms) -Discuss sexuality

Plan initiated by:_____ Date_____

Plan/ outcome evaluated:_____Date_____

Plan / outcome evaluated :_____Date_____

Date Discharged Signature of Nurse

Plate 1: Standardised Nursing Care Plan for Nursing Diagnosis- Readiness for Enhanced Childbearing Process

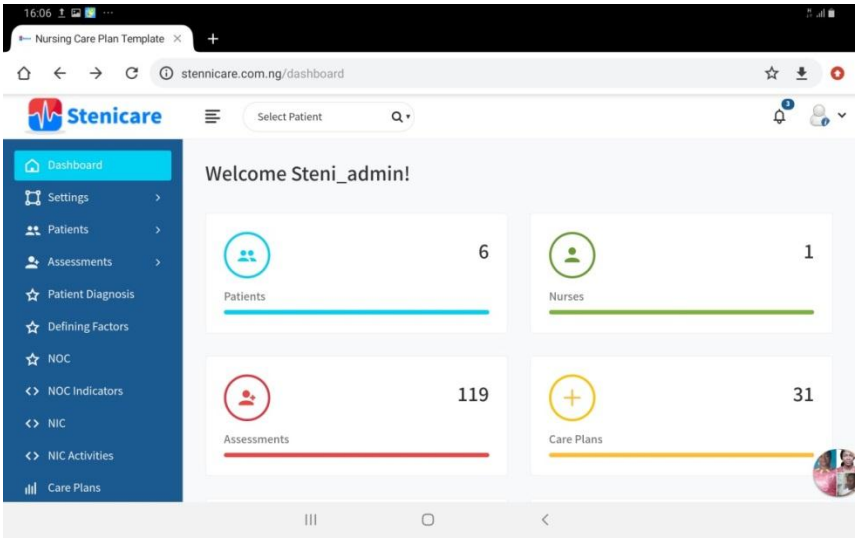
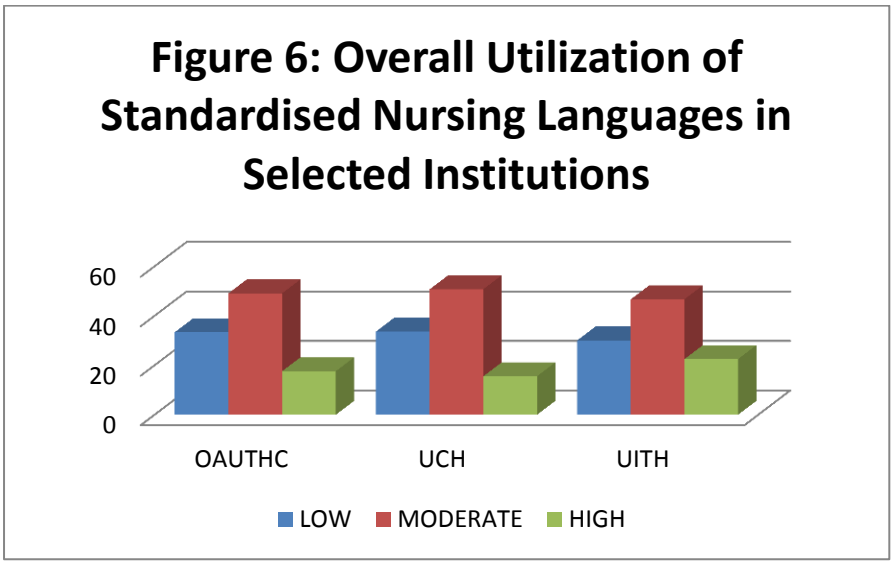


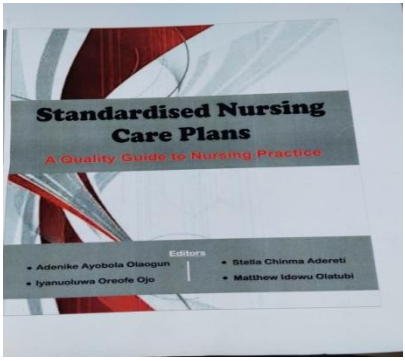
Plate 2: The Dashboard of Stenicare- Electronic Nursing Record



In recognition of my work in this area, I received the "Outstanding Service Award", for serving as national president, from 2009-2017. Sustaining the continuation of this work has been a

challenge. There is need for support from the nurses at all levels and from the management of hospitals / health facilities; and the involvement of university programmes for further research and implementation of these concepts in the country. In order to enhance nurses' access to the SNCPs, our team is producing a book titled- "Standardised Nursing Care Plans- A Quality Guide to Nursing Practice" (Olaogun *et al*, 2022)

The Award



The Book

Contribution to Teaching;

Mr Vice Chancellor, Sir, I got into nursing as a teenage student nurse, at a hospital -based School of Nursing, Ilorin in May 1973. As one of the pioneer students, I suffered because of the delay in the accreditation of the school; and spent 4 years before graduating. My journey as a registered nurse started in July, 1977. I have spent most of my life in the nursing educational setting. I, taught at schools of Nursing in Ilorin, Obangede and Kano, where I rose from Nurse Tutor in 1983, to Principal Nursing Tutor, before joining Obafemi Awolowo University, in 1995. Therefore, I have had the great opportunity of relating with students, from 1983 till date – from the Diploma to the PhD level. Over the years, I have, successfully supervised twenty- five (25) MSc and five (5) PhD students who finished their programme at record time. I have co-supervised PhD students in Clinical Psychology and Sociology who were working on researches related to my field; a Masters of Public Health (MPH) student from the University of Leeds, Leeds

in the United Kingdom whose research setting was based in Nigeria; and MPhil Nursing students at the School of Nursing, University of Ghana, Legon, Accra, Ghana. Two of my doctoral students benefited from the Consortium for Advanced Research Training in Africa (CARTA) fund. Subsequently, I received awards for the early completion of these doctoral students from CARTA. I was invited as a guest scholar on a PhD course 'International Health Systems and Research', at the School of Nursing, John Hopkins University, Baltimore, Maryland, USA in 2010 and this year- 2022, on the Public Health (PUBH 522) of the Calvin University, Grand Rapids, MI USA. As a guest scholar, the cultural appropriateness, field organization and challenges of my research work and publications were discussed; and reviewed by the lecturers and students. I have contributed to four textbooks and have published over fifty journal articles. My teaching courses have been on abnormal midwifery, research and concepts development. Based on my experiences with pains of womanhood, I have, emphasised to every group of students that I have taught, and; at every opportunity of giving induction lectures these words:

"To the girls, love is not blind; it has two eyes. Shine your eyes, before you choose a husband. Do not marry an abuser
To the boys, care for every woman, including your wife.
To all, do not have more than two children that you can care for, properly."

Contributions to University and Professional Development-

Obafemi Awolowo University has been a grooming and nurturing ground for me. I joined this university, as a Lecturer II, in October, 1995; and rose to the rank of a Professor, in October, 2013. At the department, I have had the opportunity of serving as the Post graduate coordinator, Coordinator for the Distance Learning programme and as acting Head of Department. Outside the university, I have served on the board of the Nursing and Midwifery Council of Nigeria (N&MCN), from 2013-2015. During that period, I chaired the Education Committee and the Research and Publication Committees. I worked with the teams to develop reforms in nursing education in Nigeria and in producing

the N&MCN journal. I want to deeply appreciate the current Registrar (Dr Faruk Umar Abubakar) and the board of the N&MCN, for implementing all our proposals. In 2019- 2021, I was privileged to serve on an adHoc Committee of the N&MCN that developed clinical-based Masters in Nursing Curricula for the nation.

With members of Education Committee of the Nursing and Midwifery Council Board 2013-2015

The Baptist Convention, Bowen University and the Board of The Bowen University Teaching Hospital.

By the grace of God, since November 1995 till date, I have had the opportunity to serve as an adviser to the Baptist Student Fellowship of this university. The missions' group has demonstrated great strides in combining their academic work with community outreaches where they preach the gospel of the Lord Jesus Christ, work with the communities to upgrade their lives through teaching and provision of health care. They have been involved with over 28 villages. This brought me into a relationship with the Nigerian Baptist Convention (NBC) and generations of students. Many of the students are graduates; and are living productively, all over the world. I was also instrumental to starting the BNSc programme of the Bowen University, Iwo. Currently, I

am serving on the Bowen University Teaching Hospital Board; and work directly with the Medical Board of the NBC in writing programmes related to health matters.

Contributions to the Community-

Widows' group- (November 1995- October 2015): I was introduced to a widows' group that met monthly, at the First Baptist Church, Ilare. This group is an outreach venture of the Love Fellowship. The fellowship was started by Professor L O Kehinde. We supported widows from very poor background; who were struggling with meddling relatives- in-laws and growing children, thus adding to their pains. We held Christian fellowship with them and paid occasional visits to them at home to understand their situations. The Love fellowship got funders who sponsored the tuition fees and one school meal for the widow's children at a private Christian school. Funders also sent money to set up businesses for these women. Working with late Mrs Iluyomade (a former Registrar), Late Mrs Fabunmi (a lawyer), Mrs R.O Olaniyi and Mrs Adebajo, we were able to attend to their needs. We have success stories of some of these children becoming graduates, starting families and making positive progress in their lives. Some are still struggling. We rejoice at the successes; but empathize with the struggling ones. My experience with this group influenced my life, especially my parenting style.

Recommendations-

Mr Vice Chancellor, Sir, as a maternal and child health nurse specialist, who have researched into consequences of cultural and traditional practices and other factors that negatively affect womanhood and early childhood, I have worked with teams to develop and test intervention programmes that are targeted at empowering the community into taking health-promoting decisions. I hereby proffer the following recommendations:

1. I propose a health sociological approach to the training of nurse midwives and provision of care for the populace, particularly women and children. The grassroot, that is, the community / families and individuals should be the focus of

care. Health sociology emphasises on health goals that are bound with the prevention of people from diseases by promoting their well-being and reducing mortality and morbidity in populations. In Nigeria, this will include improving the midwife's knowledge of those practices that affect womanhood and early childhood as well as supporting community level transformation of norms and practices that will positively enhance health.

2. There must be intensified mobilization and empowering of the community and individuals of all age groups as well as proffering of reasons for preventing factors that lead to maternal and child morbidity and mortality; this would empower the girls and women to exercise their rights and ownership of their bodies
3. The current strife amongst health workers should be appraised and addressed. Effective and sincere dialogue should be used to settle differences. Prolonged strike actions prevent people from utilizing health facilities, even when they have the knowledge and will to make a choice. Nigerians, particularly women and children, are suffering.
4. Universities and clinical facilities should form collaborations on research and integration of SNLs and SNCPs into nursing practice. This will facilitate quality nursing care to clients and Nigeria's contribution to global knowledge development in nursing.

Conclusion

Mr Vice Chancellor, Sir, I started my discourse today with an anecdote. The anecdote is the story of my humble beginning. My mother (Oluwafunmilayo) whom I, then, called "auntie mi" delivered me all by herself, in the early hours of 11th April, 1956, without the assistance of a skilled birth attendant. Did she even receive antenatal care? Coincidentally, **April 11th has been declared as the International Day for Maternal Health and Rights**. What a great coincidence! The same woman became one of the statistics of maternal mortality, twelve (12) years later, when she died, in another midnight, at a Maternity hospital with

complications of pregnancy. I salute her gallantry. At the face of death, her last words to me were 'Nipa ife Olugbala, ki yio si nkan" (By the love of God our Saviour, all will be well). Could her life have been the driving force, for my unconscious passion for the reduction of maternal and child mortality and morbidity and the title of this lecture? My daily prayer and focus are on raising a generation of nurse-midwives and other workers who will join in this warfare to achieve the SDGs' 2030 (-full eradication of FGM/C, decrease in MMR to less than 70/ 100,000 live births, reduction in neonatal mortality to 12/ 1,000 live births, reduction in underfive mortality to less than 25/ 1,000 live births, ending of all preventable deaths of new-born and children that are under five years of age, achieving of more than 90% coverage of all basic vaccination among children aged 12-23 months and; the production of additional 9 million nurse midwives to achieve universal health coverage).

Appreciation

Mr Vice Chancellor, Sir, as I wrap up this lecture, I express my appreciation to persons and establishments that have supported me: I appreciate my teachers, starting from my grandmother, Mama Bernice Arinola Onawola, who introduced me to early secular and spiritual education; and to those at the formal institutions: Mr Adeniyi my first nurse educator at the School of Nursing, Ilorin, he laid the foundation of what I am in Nursing. My lecturers at University of Ibadan, Ibadan, Late Professor Elfrida Adebo the first Professor of Nursing in Sub Sahara Africa and Dr Bola Ofi who has been a mentor, for years. At the Department of Nursing Science, OAU, the late Ms Olufemi Kujore modeled the professional nurse; my PhD supervisor, Prof Adetanwa Odebiyi formerly, of the Dept of Sociology and Anthropology, was always defending and protecting her PhD student. I adopted her supervisory model to supervise my students. With reflection, I acknowledge my students at all levels that spurred me to search for knowledge and became my beacon to new knowledge. They are my source of joy and hope that my labour has not been wasted. I became the security name that clocked one of them to work, every

day in the USA. I became a face to many that flaunt my name as their supervisor/ teacher, all over the world. I sincerely thank my colleagues at the various Schools of Nursing and the Departments of Nursing Science at OAU, University of Ghana, Legon-Accra, Ghana, University of Iowa, Iowa, USA, University of Jos, Jos and Bowen University, Iwo. Working as a team could be challenging and stressful. We have had days of not understanding each other but the outcome has been phenomenal.

I acknowledge the international and local agencies that funded my researches and international travels- John D and Catherine T MacArthur Foundation Fund for Leadership Development (FLD), under the leadership of Professor Bolanle Awe; USAID and Dreyfus Foundations, Welcome Trust, Carnegie Foundation, Sigma Theta Tau International, International Network of Doctoral Education in Nursing, Tetfund, Calvin University, Grand Rapids, MI, USA and Bowen University, Iwo.

I express my appreciation to this great university- Obafemi Awolowo University, Ile-Ife for providing the environment for my academic and professional growth. To the Nigeria Baptist Convention, Bowen University, Iwo and Bowen University Teaching Hospital, Ogbomoso, I say thank you for providing me with the opportunity to express my Christian faith and values in my professional practice.

To God be the glory, for giving me a wonderful family- the entire Onawola's family that provided support and relationship, at the early stage of my life. My mother in law, late Mrs Eunice Obayomi Olaogun, for her love and care of my daughters, when I was pursuing my higher education in nursing; and the Olaogun's too; to my extended families – Akorodas, Fasunons and Olaleyes who gave me the opportunity to have more children at my aging years. To the Olaniyis, Oluyemis and Sonaiyas,….*better is a friend that is near than a brother that is far.* My children – Olufunbi, Olufunke, Oloruntoba, Olatunji, Oghenetega, Mofehintolu and Taiwo were my experiments with toils of early infanthood and the

rewards of various intervention strategies. ‘Funbi and ‘Funke are continuing with my work on eradication of maternal and child mortality and women empowerment as a Public Health physician and as a Lawyer, respectively. My grandchildren- Inioluwa, Iretomiwa, Korede and Modesire are my joy and fountain of blessings. Giants on God’s wings. Grandma loves you. My husband, Professor Matthew Olatokunbo Bamidele Olaogun, I appreciate your nurture, over the years. You pushed me into academia; and allowed my wings to fly. You believe in women empowerment; and ensured that your daughters had Master’s degree, before leaving home. We will make it to heaven. I love you.

Finally, To Almighty God, my Father and Creator who destined my path in life, to You be all the glory, honour, praise and adoration. Amen.

Thank you all, for listening and God bless.

References

Abiodun, O.O., **Olaogun, A.A.E.**, Adereti, C.S., Ayeni, A. R (2016) Clinical validation of North American Nursing Diagnosis Association International "Acute Pain" diagnosis among post operative adult patients and nurses in Owo, Nigeria. *European Journal of Biology and Medical Research.* 4(3), 16-27

Achema, G., Oyeleye, B.A., and **Olaogun, AAE** (2011) Pain relief strategies for infants taking DPT immunization in Health centres. *African Journal of Midwifery and Women's Health.*5(3): 131-135

Adebayo, R.O., **Olaogun, A.A,.** Loto, O.M., Kolawole, A.A., Alabi, T,O., Ajao, O and Solarin , A.E., (2019) Assessment of breast risk factors among women of reproductive age group in Osogbo using Gail Model. International journal of Nursing and midwifery. 11(2); 7-17. Doi:10.5897/ijnm2018.0348

Adebiyi, M.O., **Olaogun, A.A.,** Mosaku, K.S., and Oyelade, O.O (2020). Clinical validation of the nursing diagnosis- impaired mood regulation among individuals with mood disorders. *Sigma Repository*. http://handle.net/10755/21275

Adegbite, T.A. (2022) Impact of respectful maternity care training workshop on nursing practice in selected maternity care facilities in Kwara State, Nigeria. MSc Thesis Submited to Obafemi Awolowo University, Ile Ife. (Unpublished Work)

Adejumo, P. O., and **Olaogun, A.A.** (2009). Nursing Process: A tool for holistic approach to nursing care. *West African Journal of Nursing.* **20:**34-39

Adeloye, D., David, R.A., **Olaogun, A.A.**, Auta, A., Adesokan, A., Gadanya, M., Opele, J.K., Owagbemi, O., and Iseolorunkanmi, A. (2017) Health Workforce and Governance: The Crisis in Nigeria. *Human Resources for Health* 15:32. doi: 10.1186/s12960-017-0205-4

Adereti, C.S., and **Olaogun, A.A** (2018) Use of electronic and paper-based standardized nursing care plans to improve nurses' documentation quality in a Nigerian teaching Hospital. *Int J Nurs Knowl* Dec 7.doi: 10.1111/2047-3095.12232.

Adubi, I.O., **Olaogun, A.A.,** and Adejumo, P.O. (2017) Effect of standardized nursing language continuing education programme on nurses' documentation of care at University College Hospital, Ibadan. Nursing Open doi: 10.1002/nop2.108

Afolabi E K , **Olaogun AA E,**Ajenifuja KO and Adereti SC (2013) Prevention of cervical cancer among female undergraduates in two south western universities, Nigeria. *Tropical Journal of Obstetrics and Gyneacology.* **30:** 103-108

Afolabi AO, **Olaogun A A,** Afolabi KA, Afolabi EK (2020a) . Determinants of unintended pregnancy among nursing mothers in southwest Nigeria. *African Journal of Midwifery and Women's Health.* 2020. https://doi.org/10.12968/ ajmw.2019.0010

Afolabi, A.O., **Olaogun, A.A.,** and Afolabi, K.A. (2020b) Contraceptive preference and associated factors: implications on pregnancy intentions among nursing mothers in southwest Nigeria. *World Health Bull*.2020; 7(4): pp17-30.

Ayoola, A.B., Zandee, G.L., and Adams, Y.J., (2016). Women's knowledge of ovulation, the menstrual cycle, and its associated reproductive changes. Birth. Sept 2016. 439(3):255-62. Doi.10.1111/birth.12237. Epub 2016.

Bello, O.O., Morhason- Bello, I., O and Ojengbede, O.A (2020) Nigeria, a high burden state of obstertric fistula: a contextual analysis of key drivers. The Pan African Medical Journal. 36(22) doi. 10,11604/pamj.2020.36.22.22204

Cohen, I. G., Bowie, N., Jones, M., & Adashi, E. Y. (2020, May 6) Preventing female genital mutilation in the United States: The legal threat to effective action (world) Editorial. American Public Health Association. https://doi.org/10.2105/AJPH.2020.305606

Globocan (2020). New global cancer data. https://www.uicc.org/news/globocan.2020

Faronbi, J.O., Ademuyiwa, I.Y and **Olaogun, A.A.** (2020) .Patterns of chronic illness among older patients attending a university hospital in Nigeria. *Ghana Med J*. 54(1) 42-47. Doi:http://dx.doi.org/10.4314/gmj.v54iI.7

Faronbi, J.O., Butcher, H,K., and **Olaogun, A, A** (2019) Burden and coping ability of individuals caring for chronically ill older adults in Nigeria : A mixed methods study. Journal of Gerontol Nurse Jan 1: 45(1), 39-46

Faronbi, J. O., Faronbi , G, O., Ayamolowo, S, J., and **Olaogun. A.A** (2019) Caring for the seniors with chronic illness: The lived experiences of caregivers of older adults. Arch Gerontol

Geriatrics May- Jun; 82: 8-14. Doi 10.1016/ j.archger. 2019.01.013. Epub 2019 Jan 25.

Faronbi, J.O., and **Olaogun, A.A.** (2017) The influence of caregivers' burden on the quality of life of older adults with chronic illness in Nigeria. *International Psycho geriatrics*. Mar 13:1-9. doi: 10.1017/S1041610216002295. [Epub ahead of print]

Fehring, R.J (1987) Methods to validate nursing diagnoses. Heart Lung Nov 16(6): 625-9

Hodes, D., O'Donnell, N.A., Pall, K., Leoni, M., Lok, W., Debelle, G., Armitage, A.L., Creighton, S.M,. Lynn, R.M (2021) Epidemiological surveillance study of female genital mutilation in the UK. Arch Dis Child. 106(4): 372-376. Doi:10.1136/archdischild-2020-319569

Herdman TH, Kamitsuru S, editors. (2017) NANDA International nursing diagnoses: definitions and classification, 2018– 2020. 11ed. Oxford: Thieme; 2017

Liang, M., Simelane, S., Chalasani,S., and SnowR(2021) New estimates of child marriage: Evidence from 98 low and middle income countries. Plos One. (16)10. Doi:10.1371/journal.pone.0258378.e collection.2021

Muller-Stuab, M., Lunney, M., Lavin, M.A., Needham,I., Odenbriet, M., and Van Achterberg,T. (2008). Testing the Q-DIO as an instrument to measure the documented quality of nursing diagnosis, interventions, and outcomes. International Journal of Nursing Knowledge. 19(1): 20-27

National Population Commission (NPC) (Nigeria) and ICF (2019). Nigerian Demographic and Health Survey, 2018, Abuja, Nigeria and Rockville, Maryland, USA: NPC and ICF

Obiajunwa, P. O, and **Olaogun, A.,** (2013) Childhood immunization coverage in southwest Nigeria. *Sudanese Journal of Public Health.* **8**: 94-98

Odebiyi, A. I., (1999). Social Factors in Health and Disease. Inaugural lecture Series 135. Obafemi Awolowo University Press Ltd. Ile Ife. Nigeria.

Odutayo P, **Olaogun AA**,. Oluwatosin OA and Ogunfowokan AA (2013) "Impact of an educational program on the use of standardized nursing languages for nursing documentation among public health nurses in Nigeria" *International Journal of Nursing Knowledge* **24:**108-112

Oginni, M.O., Popoola, E.O., Irinoye, O.O., and **Olaogun. A.** (2014) Assessment of the knowledge and practice of breast self -

examination among female cleaners at Obafemi Awolowo University, Ile Ife, Nigeria. *International Journal of Caring Science*, 7(1): 239-251

Ojo, I.O., and **Olaogun, A.A.**, (2022) utilization and challenges of standardised nursing languages in nursing process booklets of selected tertiary health institutions in Nigeria. *Submitted to Ghana Medical Journal.*

Olaogun, M. O. B., **Olaogun, A. A. E**., Awojulu, S. O. (1992). Incidence of vesico- vaginal fistula in an urban hospital in Nigeria-the need for physiotherapeutic intervention. *Journal of Nigeria Society of Physiotherapy,* **XII**: 32-36

Olaogun, A.A. E., Adebayo, A. A., Ayandiran, O. E., and Olasode, O.A. (2006). Effects of mothers' socio- economic status on the management of febrile conditions in their under -five children in a resource limited setting. *BMC International Health and Human Rights* (Online).

Olaogun, A., Adejumo, O., and Akinloye, T., (2009). A client study using nursing process format. *West African Journal of Nursing:* **20**:66- 72.

Olaogun, A. A. E., Ayandiran, E. O., Olasode, O. A., Adebayo, A. and Omokhodion, F. (2005). Home management of childhood febrile conditions in a rural community in Nigeria. *Australian Journal of Rural Health*. **13**: 97- 101

Olaogun, A., Ayandiran, O., Obianjuwa, P., Ayeni, A., and Adeyemo, F. (2007). Evaluation of maternal immunization in Ile-Ife, Nigeria. *African Journal of Midwifery and Women's Health.***l1**:46-49.

Olaogun, A., Ayandiran, O., Olalumade, O., Obianjuwa, P., and Adeyemo, F. (2008). Knowledge and management of Infants' pain by mothers in Ile Ife, Nigeria. *International Journal of Nursing Practice* .**14**:273-278

Olaogun, A., Ayoola, A., Ogunfowokan, A., and Ewere, V., (2009) Preference for the male child and desired family size in Nigeria. *African Journal of Midwifery and Women's Health.* **3**: 193-197.

Olaogun, A. A., Brieger, W. R., Ayoola, A. B., Obianjuwa, P. O., and Adebayo, S.O. (2005-2006). Mother-father concordance on treatment choices in the care of sick children under five years of age in Osun State, Nigeria. *Int Quaterly Community Health Education* .**25**:283-93.

Olaogun A. A., Ogini, M. O., Oyedeji, T. A., Nnahiwe, B., &Olatubi, I. (2011). Assessing the use of NANDA nursing diagnosis at

OAUTH, Ile-Ife, Nigeria. *International Journal of Nursing Terminologies and Classification, 22*(4), 157–161.

Olaogun, A., Oluwatosin, A., Edet, O., and Olowokere A (2016a) Proposing a new nursing diagnosis- handicapping beliefs. Paper presented at the 2016 Biennial Conference of NANDAI in Cancun, Mexico.

Olaogun , A.A,. and Siyanbade, T.T (2020) Perception and practice of female genital mutilation among mothers attending postnatal clinics in selected primary health centers In Ogbomoso, Oyo State.. (Research Report- Unpublished Work)

Olaogun, (Eds) (2022). Standardised Nursing Care Plans- A Quality Guide to Nursing Practice (In Print)

Olaogun, A,A., Oginni, M. O.**,** Afolabi, A,O., Adetoye, C., and Dalhatu, A., (2022). Comparative study on the prevalence of obstetrics fistula and treatment outcomes in two selected health facilities in Nigeria. Preliminary Research Report (Unpublished work)

Oluwatosin, O.A., and **Olaogun, A.A.** (2016) Standardised nursing care plan: A tool for effective practice. *Nursing and Midwifery Council of Nigeria Research Journal.* 1(4):6-8

Oyibocha, E.O and **Olaogun, A** (2016) Quality of Life of women in climacteric transistion in Delta State, Nigeria. Repository Home, Sigma theta tau international. http://hdl.handle.net/10755/616353

Ras-Work, B. (2006) The impact of harmful traditional practices on the girl child EGM/DVGC/2006/EP.4 https://www.un.org

Schaan, M.M., Taylor, M., Gungquisa, N and Marlink, R (2016). Personal views about womanhood among women living with HIV in Botswana. Culture, Health & Sexuality. (18)2: 173-185. doi: 10.1080/13691058.2015.1072247. Epub 2015 Aug 25.

UNICEF. (2016). Female Genital Mutilation/Cutting: A global concern. UNICEF DATA. https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern

United Nations (2019) World population ageing 2019 highlights. ST/ESA/SER.A/430

UNICEF (2017) Levels and Trends in Child Mortality 2017

UNICEF (2020). Child Marriage: Latest trends and future prospects [Internet]. 2018 [cited 2020 Jun 5]. Available

from:https://data.unicef.org/resources/child-marriage-latest-trends-and-future-prospects/
United Nations (2019) The sustainable development goals report 2019.
UN (2020) International day of zero tolerance for female genital mutilation . www.un.org.observances.female genital mutilation.
WHO (2018) Obstetric fistula. https://www.who.int/news-room/facts-in-pictures/detail/obstetric-fistula
WHO (2019) High Rates of Unintended Preganacies Linked with Gaps in Family Planning Services: New WHO Study. https://www.int/news-room/details/25-10-2019
WHO (2019) Maternal Mortality. https://www.who.int/news-room/fact-sheets/detail/maternalmortality
World Health Organization (2020) Maternal, newborn, child, and adolescent health and aging. https://www.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data
WHO (2020) Children: Improving survival and well-being. https://www.who.int/news-room/fact-sheets/children-reducing
WHO. (2020). Female Genital Mutilation: Fact sheet https://www.int/mediacentre/fact-sheets/googlescholar
WHO (2021) Breast Cancer. https://www.who.int/news-room/fact-sheets/breast-cancer