

We reap what we sow.

Kelsey A. Harrison MD, DSc. (London) FRCOG, FMCOG
Nigerian National Order of Merit Winner 1989
Nigeria Centenary Awards 2014
Emeritus Professor of Obstetrics and Gynecology and former Vice-Chancellor
University of Port Harcourt.
Email: kelseyharrison500@gmail.com

Presented in part at the University of Medical Sciences, Ondo on 15th June 2016.
Copyright permission granted by Prof Friday Okonofua, Vice-Chancellor, University of Medical Sciences, Ondo

Niger Delta Medical Journal 2017; 2(1): 2-12

SUMMARY

This is an account of the work of Kelsey Harrison given by the man himself (1933 -), a pioneer undergraduate at University College Ibadan (1951-55), an obstetrician and gynaecologist, a researcher, a teacher, a relief worker during the Nigerian civil war of 1967-1970, a sort of social activist, and a cricket fan. At University of Ibadan in the 1960s, his researches were focused largely on the elucidation of how severe anaemia affects the mother and her baby. The results of this work led to the world-wide adoption of the treatment of this life threatening condition by the use of rapidly acting diuretics combined with direct blood transfusion instead of by the more elaborate and costly exchange blood transfusion. At Ahmadu Bello University (ABU) Zaria, his work analyzing 22,774 consecutive deliveries from 1976-1979 at ABU Teaching Hospital and published as a supplement to the British Journal of Obstetrics and Gynaecology (BJOG) in 1985 turned out to be a major factor in the launching of the global safe motherhood movement. At University of Port Harcourt (1981 – 1998) where he became that university's vice chancellor, his powerful advocacy for better health for women was important and the ideas therefrom are still hugely relevant.

INTRODUCTION

Coming under the influence of many good people, as I did, I went into medicine, specialized in obstetrics and gynecology, and then took to practicing, teaching and researching. Fellow Nigerian colleagues and I were all pioneers, whose working life coincided with some great events in our country and in international maternal health. It is some of these events and my own contributions that I wish to share with you believing as I do that this sharing of experiences especially in a budding university community is important for various reasons, not least, the acquisition of knowledge for improvement of our society. We reasoned that the correct application of

information generated through our research in Nigeria, would lead to improvement in the health of our women. This then is an account of some research seeds, how we acquired the seeds, how they were planted, how they grew into fruition and who benefitted. We reckon that we led an interesting life. The events are told in two of my books. One is an autobiography (1), and the other is a compilation of some of my research publications from 1966 to 2010 (2).

MY MENTORS

I count myself fortunate in having many mentors in my career. Eight were outstanding.

Ethel Taylor of Abonnema was my mother. She told me in my early teens why she preferred hospital based maternity care available at Aba, in Abia State to local traditional birth attendants (TBA) at Abonnema in Rivers state. She died aged 91 years in 2001.

Chief Anthony Karibi Bob Manuel of Abonnema was my surrogate father, a top man in the administrative arm of the colonial civil service in the 1920s and 1930s. His archives drew my attention to the success of the Church Missionary Society in reducing maternal mortality in its area of influence in parts of Eastern Nigeria in the 1940s (3). He died in 1972 aged 92 years, heart broken by our bitterly fought civil war of 1967 - 1970.

William Simpson, an Englishman, was in charge of Umuahia Government College, where I received my secondary education from 1946 to 1951. He counselled me successfully to study medicine, not civil engineering, my preferred choice when I was a teenager. He went to great lengths to inculcate modesty and character building as the two previous mentors did. He died in 1959 at his home in UK aged 58.

Dr. Mason Thomas Dokubo Braide of Bakana qualified as a medical doctor in Glasgow University. He spent his entire career in various capacities in the Nigerian Civil Service. Touched by the awful state of women's health, he singlehandedly collected data on over 2000 women in Eastern Nigeria. Some were circumcised, the rest were not. He compiled his observations into a thesis and was awarded the Doctor of Medicine degree by his alma mater in 1956. He titled it "a study of female circumcision in Eastern Nigeria: its medical significance". In it, he identified female circumcision in these words: "*It is a custom that causes a lot of suffering and ill health in African women. It is a custom that is bound to affect the span of life of African women adversely, on*

account of the associated obstetrical and gynaecological complications. It has brought misery and unhappiness to many husbands and wives. When critically analyzed, the practice has nothing to support the claims by its protagonists to perpetuate it. It is a primitive and barbaric custom. I condemn it in its entirety." The world bodies he then appealed to act to banish the harmful custom did nothing until now over 50 years later. Incidentally, the first caesarean operation I saw performed was by him at Obubra General Hospital in rural Eastern Nigeria in 1953. It was for the relief of obstructed labour and was successful. He died in 1995 aged 82 years. John Bateman Lawson was the foundation professor of obstetrics and gynecology at University of Ibadan from 1953 to 1969. Later as Vice President of the Royal College of Obstetricians and Gynaecologists in London (RCOG), he was responsible for overseas affairs at the College. Generations of health care workers in and outside UK benefitted enormously from his work towards the betterment of women's health in developing countries. Women with vesico vaginal fistula (VVF) have cause to be grateful to him. He died aged 75 years in 1997.

William Charles Wallace Nixon was professor of obstetrics and gynecology in University of London at University College Hospital. A thoughtful and humane man, who, while I was a London undergraduate medical student, helped to groom me towards what I eventually became. More importantly, he personally taught trained and researched towards improving the welfare of women from all back grounds. He initiated and directed the 1958 National Perinatal Mortality Survey of England and Wales. It was the first of its kind and it led to many changes nationally and worldwide, in maternity care. He died aged 62 years in 1966.

Frank E. Hytten is an Australian, a qualified medical doctor, a pioneer and top researcher and writer in the field of Human Reproductive Physiology. He is judged to be the most influential editor of the BJOG. Now aged 92, he and I still keep in close touch.

Finally, there was Niilo Hallman, a Finn. He was Professor of Paediatrics at University of Helsinki in Finland. While serving in that capacity, he became the moving spirit in the modernization of the Finnish health system. In later years, his support for the creation of maternal and child health clinics in rural Africa became legendary, and in the case of Zaria, the support came always when it was most needed. He died in 2011 aged 94 years.

THE IBADAN YEARS 1960 – 1972

My time in Ibadan began with me as one of only three house officers in the 107 bedded department of obstetrics and gynecology at University College Hospital (UCH), and ended when I rose to the post of a professor in the same department, and left. The department handled about 3000 deliveries annually with a large proportion of complicated deliveries. Consultant staff strength was never more than six. The facilities provided were sufficient to allow us to cope, although we were occasionally stressed.

The subject of maternal deaths dominated much of the department's activity. We all realised that the death of a woman during pregnancy, labour and/or soon after her delivery, from largely preventable conditions, was awful. The medical causes were anaemia, complicated abortions, obstructed labour, eclampsia, infections, and hemorrhage or excessive bleeding. Severe anaemia was by far the commonest cause of maternal death. Lawson, our chief, encouraged a multidisciplinary approach to the study of the subject. These studies

revealed that poor nutrition especially folic acid deficiency, malaria and sickle cell disease were the principal causes. When anaemia became extreme, exchange blood transfusion, not straight blood transfusion, was needed to raise the low haemoglobin level quickly without killing the patients through overloading the failing anaemic heart. But exchange blood transfusion was too complicated and costly to set up and use in rural settings where the patients first reported for treatment. While I was still a house officer, I suggested that a group should be tasked with the responsibility of undertaking rigorous research to look for a simple method of transfusion to replace the complicated exchange transfusion. The small group made up of me and Mr. A. I. Kadiri, the senior laboratory technologist of the department, measured the major changes in the circulation severe anaemia produced (4) and in the end, devised the method of combining direct blood transfusion with a rapidly acting diuretic, ethacrynic acid. It worked as well as exchange transfusion (5) which it has since replaced worldwide. Frusemide is now preferred to ethacrynic acid.

Two years later, we showed for the first time that anaemia in the mother impaired the growth of her baby in the womb, and that the correction of the anaemia during pregnancy led to catch-up growth of the baby (6); an issue of enormous public health interest in and outside this country.

Meanwhile, collaborating with haematologists and morbid anatomists we observed, carefully documented, and reported the dangers of sickle cell disease during pregnancy, and how to treat them (7). An important offshoot of these endeavours was the establishment of a quality research laboratory for the department of obstetrics and gynecology in 1970. I believe it still thrives.

While we were still based in Ibadan, there were other fruitful activities. One was the care we took of poor village women in and around University of Ibadan in illustrating how to run a community based maternal health service properly. Another was the pioneering of the use of anti-cancer medicines in treating one particular rare cancer in women - malignant trophoblastic disease. Suffice it to say that these and other additional duties made heavy demands on our time, but we still managed to carry out our routine clinical and teaching duties without compromising ourselves.

It has to be said that in Ibadan living and working conditions in terms of availability of facilities, and supporting infrastructure and personnel were almost at par with what I experienced during my undergraduate medical training in London from 1955 to 1959. The basic elements needed to take care of ourselves and look after the patients were provided and they functioned properly. All in-patients were hospital fed and without charge. Nursing standards were high. The whole place was vibrant, racially mixed at work and in private, with blacks, whites and Asiatic. Rented accommodation provided by both the university and its teaching hospital was good. There were no mobile telephones in those days, nevertheless, communication was not too bad. Outside, other forms of support such as facilities for children's education and recreation were good and easily affordable. We even made out time to resume playing cricket for Nigeria and went on tours to Ghana, Sierra Leone and Gambia. Throughout, hospitality on and off the fields of play was lavish. We were full of joy.

THE ZARIA YEARS 1972 – 1981

In 1972 I received the invitation to come to Zaria to replace Professor Jocelyn Moore, an

elderly British lady in charge of the department of obstetrics and gynaecology. There, the acute shortages of everything and the sight of large number of women having their babies under intolerably bad conditions, with too many dying, were our constant worry. We vowed to bring about improvements based on the real needs of these women and their newborn babies. To this end, over 3 years, (1976-1979), my team and I obtained detailed information from all 22774 mothers who delivered at our hospital or were admitted there soon after delivery elsewhere. The mothers were from over 120 different ethnic groups, and half were Hausa - Fulani. The youngest was only 9, and the oldest was 50. The shortest was 1.16 metres in height, and the tallest was 1.93 metres. Some of the mothers had had over 24 previous deliveries. The singleton babies produced weighed 3.08 kg on the average. There were also twins, conjoined twins, triplets and quadruplets. There were 238 maternal deaths and 2718 perinatal deaths giving an overall maternal mortality ratio of 1050 maternal deaths per 100,000 deliveries, and a perinatal mortality rate of 116 perinatal deaths per 1000 babies born. The principal medical causes of death were the same as in Ibadan and elsewhere in Nigeria, only that the delay on the part of the women in reporting to hospital for effective treatment made things very much worse. I should add that unlike Ibadan, complicated abortion was very rare.

More importantly the survey revealed that non-medical factors contributed hugely to the very bad situation. These non-medical factors were those which acted in combination, and made it impossible for women to have decent medical and obstetric care when they needed them. They included poverty, lack of formal education, adverse cultural, ethnic, and religious influences, inadequate health and physical infrastructure, and poor logistics. Having

established these myriad of factors responsible for much of the huge loss of life among the mothers and their newborn babies in that society, and backed by the results of the analysis of these “unique and valuable data” obtained, we concluded that the real problem to be faced was not so much medical as sociological, and that universal formal education is *the* important key towards the needed solutions (8). Our findings were published as a special supplement to the October 1985 issue of the BJOG titled “Child-bearing, Health and Social Priorities: A survey of 22,774 Consecutive Hospital Births in Zaria, Northern Nigeria. Supplement 5.” (9) It ran into 119 pages in 14 chapters, with tables, figures, and appendices totaling 129. From conception to publication took 13 years. Besides, high maternal mortality, another worrying issue was the scale and severity of the horrific injuries some women sustained during unsupervised complicated deliveries at their homes. By far the worst of these injuries is VVF, a condition whose victims continuously leak urine through their vagina wetting their lower limbs from buttocks to toes, day and night. VVF carries with it, serious reproductive, social and economic consequences which the work of a dedicated sociologist in Zaria, the late Dr. (Mrs). Margaret Murphy, a Scot, helped to unravel in great detail (10, 11). VVF occurs all over Nigeria, but it is commonest in the North. The basic fault is that in the affected women the space in the bony birth canal through which the baby has to pass during labour is too narrow. In consequence labour becomes prolonged and difficult, with high risk of damage to the surrounding soft tissues in and around the vagina. But why is the space in the bony birth canal too narrow? The answer is that two basic entities are involved. The first is that the girls are not allowed to finish growing before childbearing starts. The second is that even

when maturity is reached in terms of age, bony growth is hampered by the harsh conditions under which people have to live: there is poor nutrition, bad housing, frequent infections, and excessive physical work. More will be said about VVF later.

An original discovery made was that of growth during pregnancy in early teenage girls who had not finished growing when they became pregnant. Malaria and anaemia prevention by the use of antimalarial drugs, and iron and folic acid tablets taken throughout pregnancy made these underage girls grow even faster, with some having growth spurts during pregnancy. We reasoned that if the growth enhancing effect of antimalarial and anti anaemia measures is confirmed, it can become a way of preventing VVF in this country.

One would not have thought that information on stillbirths would open up important insights into the consequences of socio-economic deprivation. But it did. In Zaria, initially, there was strong opposition to the weighing of dead babies for cultural reasons. Eventually we arrived at a compromise. We provided separate sets of baby weighing scales, one set for babies born alive, another set for babies born dead and with torso intact, and the last set for babies born dead and with mutilated torso. We discovered that among babies born after prolonged labour had resulted in VVF the stillbirths were on the average much heavier than the live births. In all other situations, the reverse was the case in that stillbirths were lighter than live births. This reversal of the pattern of birth weight distribution in VVF carries implications.

One of such is the long-term consequence of pelvic contraction. In the growth-stunted adult woman, pelvic contraction is permanent. When she gets pregnant, her baby at term will either be small or big. If small, easy passage through the contracted pelvis will result in the birth of a small baby.

If her baby is big, the result is different. In this case, labour will be difficult, it may become obstructed which if neglected, results in damage to both mother and baby. The danger can be averted by timely caesarean operation with the birth of that big live baby. If the obstruction is allowed to persist for whatever reason, it will result at the end, in the birth of a baby of good size that is either born dead or born alive but severely damaged.

It is well known that in general, heavier babies are superior to their lighter counterparts in terms of their potential for growth and physical and mental development. We therefore postulated that in a population where obstructed labour is common, the surviving babies might not be the best babies. Furthermore, because of the bad conditions in which those inferior babies are reared – bad housing, no prevention against infection, excessive physical work, and bad nutrition – these inferior babies in their adulthood become growth stunted, and give birth to more damaged babies. So the end result of pelvic contraction is damaged babies that grow up to be damaged adults who in turn produce the next generation of damaged babies. Obviously, emergency obstetric care cannot break this horrible cycle because it does not correct the underlying fault, which is pelvic contraction. Only fixing the politics and sustaining the needed social change, will. For as long as the cycle is allowed to persist, there is this dreadful thought that superior babies die, and inferior babies survive. This thinking is only a hypothesis, but in the prevailing circumstances in Nigeria, it sounds plausible.

The overall message from this Zaria Maternity Survey is that there are four key factors for banishing maternal mortality and morbidity. First, living conditions must improve to the point at which the vast majority of people are healthy. Second, all

pregnant women must receive basic but professional antenatal care. Thirdly, measures must be taken to ensure that pregnant women who develop life-threatening complications get effective treatment if necessary operative interventions, before it is too late. Fourthly, records must be kept for audit and other purposes.

BEYOND IBADAN AND ZARIA

Major events that affected the whole of Nigeria happened in the years I lived and worked in Ibadan, Zaria and Port Harcourt. These events impacted on our work and living conditions, and on the living conditions of the society at large. In the 1960s and 1970s, there was first the Nigerian civil war, and second, the great Sahel drought. In the 1980s, it was the effects of the adoption of structural adjustment programmes (or SAP for short). Our civil war did much damage throughout the Eastern Region. Before the war, there were impressive human and infrastructural investments. During the war, these developments were halted and some were completely wrecked. Afterwards, support was needed to start afresh as it were. I became a relief worker. In the process, though still on the payroll of Ibadan University, I voluntarily gave the needed expert assistance on the spot in Port Harcourt in rebuilding the maternity services that had been destroyed through military action. Furthermore, partly through our efforts, the government of the Rivers state established the Rivers State School of Nursing and Midwifery. Nigeria next lurched from a man-made disaster which the civil war was, to a natural disaster. There was severe drought in the entire Sahel region of West Africa including Nigeria. For the best part of 1970s, crops and livestock production failed, food

became scarce, and food prices being uncontrolled rose sharply (12).

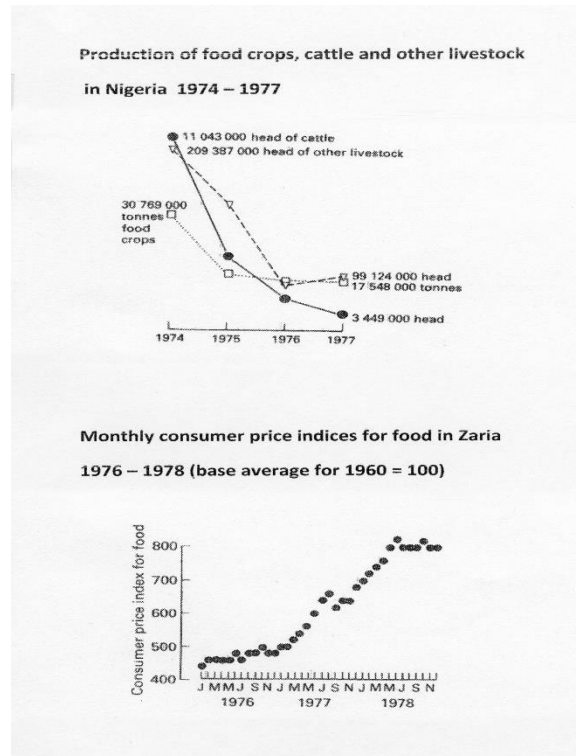


Figure 1 PRODUCTION OF FOODCROPS, CATTLE AND OTHER LIVE STOCK IN NIGERIA 1974 – 1977 AND MONTHLY CONSUMER PRICE INDICES FOR FOOD IN ZARIA 1976 - 1978 (BASE AVERAGE FOR 1960 = 100).

In fact, at the height of that period of extreme economic hardship - June to August 1977 - the price of staple foods suddenly doubled. For example, yam sold at 50 kobo per kg whereas before, it was 30 kobo per kg: cow meat was N3.3 per kg whereas before, it was N1.7 per kg. A similar pattern of price fluctuations was reported for beans, garri and to a lesser extent guinea corn. Looking at our Zaria data, we observed that the proportion of low birth weight babies being born also rose from around 23% to 40% for a subset of the population (12).

Table 1. RETAIL PRICES OF STAPLE FOODS AND FETAL BIRTH WEIGHT IN ZARIA. JANUARY 1976 TO DECEMBER 1977.

Staple Food Prices and Fetal Birth Weight in Zaria.
January 1976 - December 1977

	Jan 76 – June 77	Sep - Oct 77	Nov – Dec 77
Price of Yam in kobo Per kg	25	50	< 50
Price of Cow Meat in Naira per kg	1.6 – 1.9	3.3	<3.0
% Low Fetal Birth Weight	17 – 23	40	23

Data from Port Harcourt showed the same trend though less marked. If these data from these two centres represent what happened countrywide at that time - late 1970s - then one might argue that since the damage from acute food insecurity can be passed on to children of the future, Nigeria must have been in trouble from this cause (too many low birth weight babies) and its consequences for decades later. The consequences are well known: they are irreparable brain damage, with delayed motor and social development, and learning difficulties, among others. Above all, the whole thing warns us that action or inaction today has long term impact. So, of the three national disasters that befell us in 1960s to 1980s, I have discussed two, namely civil war and drought in the context of reproductive health. I now go on to the third, namely, SAP.

STRUCTURAL ADJUSTMENT PROGRAMMES

From the perspective of those of us who have to deal with maternity care in developing countries, the World Bank and International Monetary Fund promulgated Structural Adjustment Programmes (SAP) are not something we can ever forget. In the 1970s, like the rest of sub Saharan Africa,

Nigeria got itself into serious economic difficulties. The existing fiscal arrangements were no longer able “to balance the books”. So, beginning in the 1980s, SAP (13) was introduced for the stated purpose of halting poverty, and for paying the debts owed to our creditors, mainly powerful international banks abroad. But SAP policies were prejudiced against social welfare. Hence, their implementation helped to precipitate the sort of catastrophe in which virtually all social, educational, economic and public health gains made in the 1960s were wiped out. Weakening of government structures, reduction of state machinery, drastic reduction in the size of the public sector, worker retrenchment, increasing private sector involvement, devaluation of the naira, and charging of user fees for cost recovery in health care were all part of SAP. The consequences were damaging. Socioeconomic inequality widened, a tiny few got very rich, while the rest became very poor. The scale of impoverishment was huge and was of a magnitude never seen before by most adults. It became even more offensive as corruption levels soared. The results on maternal and child health and education in Nigeria were catastrophic, and till today, over 30 years later, full recovery is nowhere in sight. In terms of maternal mortality and morbidity, data from Zaria revealed what happened when user fees began to be charged (14). In 1983 when hospital treatment was free, the number of hospital deliveries was 7450, nearly 20 % were complicated labours, and there were 48 maternal deaths. In 1988 when user fees began to be charged in full, the number of hospital deliveries dropped to 2991, the proportion of complicated labours rose to 63 %, and the number of maternal deaths rose to 75. The experience in Port Harcourt where I was then based was even more terrible. The cost of an uncomplicated caesarean section was equivalent to nine

month’s average salary, and there were no proper records kept of the fate of those unable to afford the payment demanded by the hospital authorities. The truth was that women were dying in the hands of good doctors because they could not pay the user fees charged. Unclaimed corpses piled up in front of UPTH mortuary as impoverished relatives were not able to afford the fees charged to claim the corpses of their loved ones. Public education probably fared worse. All in all, it was a sorry sight, and one I would never wish on any institution or country.

PORT HARCOURT YEARS AND BEYOND 1981 –

The years we were based in University of Port Harcourt (1981-1998) were the most difficult. I was the university’s vice chancellor for 3 years only (1989-92). Throughout, provisions for staff and student accommodation and academic work were grossly inadequate, and the increasing activities of the secret cults meant more insecurity. Even so, we made out time for the promotion of advocacy for better maternal health in developing countries. With generous sponsorship from several donor agencies, we travelled widely within and outside Nigeria acting like town criers on this issue of how to make women’s lives better. Within Nigeria, the Nigerian National Task Force on VVF was formed in July 1990. It was initially led by Amina Sambo from Kano. I succeeded her as President in 1996. We were 15 members initially. The task force which later became National Foundation on VVF worked to increase advocacy and to building of the needed capacity to deal with thousands of women with VVF awaiting surgical repair and rehabilitation. Support came initially from Ford Foundation, joined later by the Federal

Ministry of Health, and other philanthropic groups. Since then, the WHO and other powerful international organisations and many donor agencies have taken over this concept and extended it to some African and Asian countries.

Next we facilitated an important UK Government sponsored joint project between Liverpool School of Tropical Medicine and University of Port Harcourt with Professor N.D. Briggs as its local coordinator. Based at K-Dere in Ogoniland, it was on the nature and pattern of non-fatal illnesses in women. Although the project ended nearly two decades ago, the University of Port Harcourt still benefits from it.

Then, there were the numerous invitations to write and publish. Among them, one gave me the greatest pleasure. It was an editorial for the African Journal of Reproductive Health on its debut in 1997 (15). It was titled "Maternal Mortality in Nigeria: the real issues". Since then, under the competent editorship of Friday Okonofua, the influence of this journal continues to grow, whereas some other Nigeria-based journals have packed up.

THE GREATEST SEEDS AND HARVESTS

World reacts to the results of the Zaria Survey. International health experts reacted very quickly to the results of the Zaria Survey. Within one month of the publication of these results, WHO summoned its first interregional meeting on the prevention of maternal mortality. The purpose was to raise world awareness of the problem and how to tackle it. I noticed that at the meeting which took place at the headquarters of WHO in Geneva, each of us 40 or so participants from over 25 countries received a free donation of the published Zaria Maternity Survey. And in February 1987, the World Safe Motherhood Initiative was formally

launched in Nairobi, Kenya. The aim of this initiative was to help reduce the existing high levels of maternal mortality and morbidity world - wide especially in developing countries. Empowering women, the setting up of efficient antenatal care, working referral systems, and emergency obstetric care, and an increased acceptance of family planning were seen as the corner stones for improving reproductive health. Its implementation gave fairly good results elsewhere but not in Sub Saharan Africa and most certainly not in Nigeria, where estimated maternal mortality ratio still exceeded 600 per 100,000 births. When progress became painfully slow, a rethink took place at the highest international level. Heads of UN agencies, development partners, research funders, and health foundations met and were confident that things could work better and that achievement through fresh goals was possible.

UN Millennium Development Goals 2000 replaced the safe motherhood initiative, but the truth was that we were stuck. There was not much to show for the combined efforts made by national and international bodies. By then I had left Nigeria for Finland on retirement but received regular information on the state of maternal health in Nigeria.

WE WERE STUCK

In faraway Finland, news kept reaching me that the poor state of maternal health at home had worsened. Trust in conventional maternity care was severely eroded. Good organization and proper communication between those concerned in maternity care had all but disappeared. In this tough situation, more and more of our women who could afford the cost travelled abroad to have their babies. Those who could not afford the cost remained at home but increasingly put their trust in TBAs,

Pentecostal churches, and even faith healers. I felt rage and anger for our expectant mothers.

Something had to be done. On Africa Day 23 March 2007 at the Royal College of Obstetricians and Gynaecologists in London I presented a very short paper titled “Thoughts on making safe motherhood work better”. In it, I expressed my concerns over the deteriorating situation in maternal health. All the efforts being made were coming to naught. I gave what I thought was the most important reason why: simply put, we are looking at and dealing with the wrong end of the problem of high maternal mortality and morbidity.

THE UNDERLYING DISEASE IN NIGERIA

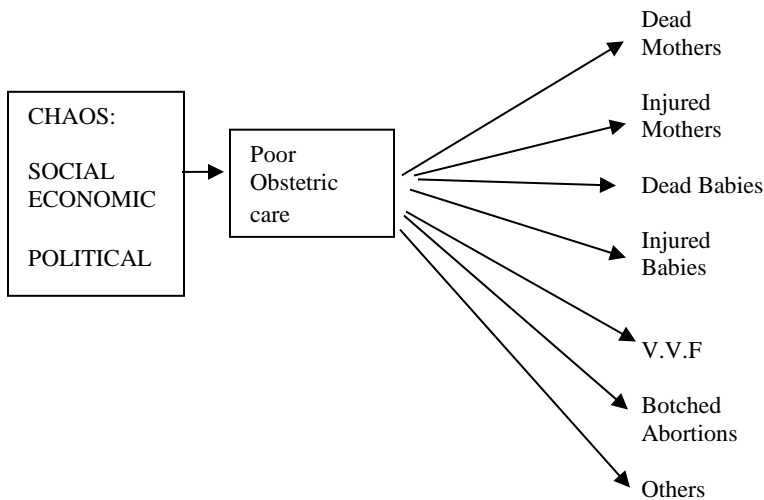


FIGURE 2. CHAOS: THE UNDERLYING DISEASE IN NIGERIA

Dead and damaged mothers and infants make up a cluster of conditions resulting from one thing, very poor obstetric care. Very poor obstetric care is, in turn one result of the chaotic health, socioeconomic and political systems, which is the major underlying disease. It is the disease, which has to be treated. Hence, the need is to turn things round to ensure that most things in

the public domain work to the general benefit of society.

During this lecture in London older top people present recognized that we in Nigeria were in the same situation as we were in 1979 when I spoke on the same subject at that same venue. It meant we had worked and published on this subject for nearly 30 years yet there was little on the ground in Nigeria to show for it, except perhaps unregulated private practice, which is part of the chaos, mentioned earlier.

It is clear than an individual no matter how energetic, no matter how dedicated, can succeed without support from like-minded followers. So my hope is in the coming generations. But things can change quickly, and they have in Ondo.

SUCCESS AT LAST: ONDO UNDER GOVERNOR MIMIKO’S LEADERSHIP

Dr. Olusegun Mimiko, a trained physician and politician became the governor of Ondo State in 2009. He then declared loudly and with absolute conviction that improving social welfare, including education, and reducing deaths of women and children would be among his priorities. The policies and strategies would be aimed at the removal of barriers to safe motherhood. Attention would be paid to the avoidance of delays encountered by pregnant women in seeking, reaching and receiving quality health care at both primary and secondary levels. He would provide skilled personnel for government health centres and hospitals, and ensure that through efficient administration of the resources provided, the results would improve. The promise was kept and the results exceeded my highest expectations in that maternal mortality ratio dropped from one that was above the average for Nigeria (600 per 100,000

deliveries) to around 100 per 100,000 deliveries. There is still a long way to go compared to the results elsewhere, for example, Finland, where the ratio is 5 maternal deaths per 100000 births. Nonetheless, a break-through has been achieved. Governor Mimiko's administration has transformed ideas into actual deeds. This ground breaking achievement is worth celebrating but at the same time we should also see it as having brought pressure on all sectors of health care in this country to do their job. So, henceforth, this can no longer be regarded as mission impossible.

CONCLUSION

Finally, permit me to end on a somewhat personal note. Please do not for one moment assume that there were no mistakes that were made along the path we carved out for ourselves. On the contrary, there were plenty, and indeed, some were inevitable. However, on this occasion, we ask you to join us in marking and celebrating the successes achieved. The overall point is this: individually or collectively, and in life, we reap what we sow.

ACKNOWLEDGEMENTS

I thank the following colleagues for their helpful suggestions and critical comments on the original draft of this lecture: Emeritus Professor N.D. Briggs and Professor R.S.Oruamabo, both of University of Port Harcourt and Professor T. C. Harry of Niger Delta University, Bayelsa State.

REFERENCES

1. Harrison K. A. (2006) An Autobiography. *An Arduous Climb: From the Creeks of the Niger Delta to a leading obstetrician and university vice chancellor*. Adonis and Abbey Publishers London ISBN 1-905068395 (PB) 1-905068-42-5 (HB)
2. Harrison K. A. (2010) *Sowing the seeds of safe motherhood in Sub-Saharan Africa*. Adonis and Abbey Publishers London ISBN: 9781906704780
3. Harrison K. A. (2003) Reproductive health struggles in Nigeria. *Lancet* 362, 582
4. Harrison K. A. (1969) Changes in blood volume produced by treatment of severe anaemia in pregnancy. *Clinical Science*, 36, 197 – 207.
5. Harrison K. A, Ajobor L.N, Lawson J.B.(1971) Ethacrynic acid and direct packed blood cell transfusion in treatment of severe anaemia in pregnancy. *Lancet* 297, 11-14.
6. Harrison K. A. Ibeziako P. A. (1973) Maternal anaemia and fetal birthweight. *Journal of Obstetrics and Gynaecology of the British Commonwealth*. 80, 778 – 804.
7. Hendrickse, J. P. de V, Harrison K. A, Watson-Williams E. J, Luzzatto L, Ajobor L.N.(1972) Pregnancy in homozygous sickle cell anaemia. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 79, 396 – 409
8. Harrison K. A. (1997) The importance of the educated healthy woman in Africa. *Lancet* 349, 644 – 647.
9. Harrison K. A. (1985) Child-bearing, health and social priorities: a survey of 22774 consecutive hospital births in Zaria, Northern Nigeria. *British Journal of Obstetrics and Gynaecology*, 92 supplement 5, 1-119.
10. Murphy M. (1981) Social consequences of vesico-vaginal fistula in Northern Nigeria. *Journal of Biosocial Science* 13; 139 - 150
11. Murphy M, Baba T, M (1981) Rural dwellers and health care in Northern

Nigeria. *Social Science and Medicine* 15A, 265 – 271.

12. Harrison K. A. (1978) Childbearing in Zaria. Public (Inaugural) lecture at Ahmadu Bello University. Zaria. Nigeria. Delivered on 20 March 1978.

13. Harrison K. A. (1996) Editorial. Macroeconomics and the African mother. *Journal of the Royal Society of Medicine*. 89, 361 – 362.

14. Ekwempu, C.C, Maine D , Olorukoba M.B, Essien E.S, Kisseka M.N.(1990) Structural adjustment and health in Africa. *Lancet* 336, 56-57.

15. Harrison K. A. (1997) Commentary. Maternal mortality in Nigeria: the real issues. *African Journal of Reproductive Health* 1, 7 – 13.