UNIVERSITY OF ILORIN

THE TWO HUNDRED AND FORTY-ONE (241ST)
INAUGURAL LECTURE

"MYRIADS AND HAZY QUALMS IN THE CHILD'S GLOBAL HEALTH AND THE BRAIN"

By

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FACULTY OF CLINICAL SCIENCES,
UNIVERSITY OF ILORIN, NIGERIA.

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The Vice-Chancellor

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The Vice-Chancellor,
The Deputy Vice-Chancellor (Academic),
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Professors and other members of Senate,
Chief Medical Director, University of Ilorin Teaching Hospital, Ilorin,
Head of Departments and Units,
Academic and Non-Teaching staff of the University,
My Lord Spiritual and Temporal,
Royal Fathers of the day,
Members of my family; nuclear, extended and In-laws,
Distinguished invited guests,
Gentlemen of the Press,
Great students of the University of Ilorin, especially ILUMSITES
Distinguished Ladies and Gentlemen.

Preamble:

In the name of Allah, the most Gracious, and the most Merciful! All thanks and adorations belong to Allah, the Lord of the worlds and Master of the day of judgment. He is the Source of life, Source of health and Source of knowledge. He taught man what man knoweth not. I appreciate my Creator for making today a reality.

Introduction

The idea of becoming a Medical Doctor dated back to 1987 and it was towards the end of my secondary school days when my father asked me what I intended to become after schooling. I told him I would like to be an Astronaut. He further asked, "Who are those and what do they do?" I told him "they are Scientists that explore the space", I added, "I might be among the first set of Scientists from Nigeria to land on the moon". He smiled and said "OK, that is quite ambitious, why don't you consider being a doctor? Being a doctor is good, doctors are very useful to the society, they are respected and not enough in number so, there is no fear of joblessness after completion of the course". Since it had never been in my character to say "no" to my parents, there and then, I promised him that by the grace of the Almighty God, I would work towards achieving that. Ten years later in 1997, I became Doctor and nine years after that in 2006, I became a Consultant Paediatrician and worked as a Hospital Consultant for nearly two years at Federal Medical Centre, Bida before proceeding to University of Ilorin in 2008, rising through the ranks from Lecturer 1 to becoming a Professor 11 years later 2019.***AlhamdulillahiRobil al Ameen.***

When my father and his two wives, who were my mothers were alive, (yes, my mothers because I didn't know who gave birth to me between them for a fairly long time) because they were very supportive, caring, watchful and prayerful over me**.** ***Alhaja Agba*** (as we fondly called her) would offer series of prayers on me, at times continuously for over 30 minutes and I always patiently knelt before her and chanted Amin, Amin, Amin. Prayers surely work. Today, three of them are back to their Creator, may Allah grant them all forgiveness and ease their paths more and more (Amen). For those of us that know it, please help me recite ***Suratul Ikhlas*** for them. Amin.

The Topic

The topic, "Myriads and Hazy Qualms in the Child's Global Health and the Brain" was well thought out to contain the summary of A to Z of my academic journeys. It tends to speak to the areas of my specialty –Paediatrics and Child Health, Neuro-Paediatrics and other areas where my academic and professional sojourn cover.

Chronology

The Vice-Chancellor Sir, it gives me great pleasure to give this 241st inaugural lecture in our "Better by Far" as well as "Better by Fact" University. This is the 52nd from the College of Health Sciences and the 8th from the Department of Paediatrics and Child Health. In my Department, the first inaugural lecture was delivered by the late Emeritus Professor Adeoye Adeniyi in 1980. Apparently, I was in primary school then. The title of his inaugural lecture was "Child Care in Nigeria: A Critical Appraisal of Some Modern and Traditional Concepts". In 2011, a rejuvenator par excellence, Prof. Ayodele Ojuawo presented his titled; "The Child's gut and its guts", It was laden with a lot of guts, not only from the children but also from the Lecturer. Thereafter the legendary Professor W.B.R. Johnson (2012) presented the third from the Department which was titled "Microbes and the bellows of young fellows: Towards proscribing a pernicious parley". This was loaded with a great display of oratory prowess, academic achievement and expression of hilarious talents from the master of all the acts. The fourth was that of an organiser personified in person of the former Dean, Clinicals and Former Provost, College of Health Sciences, Professor O.T. Adedoyin, (2012). It was titled; "Chronic Kidney Diseases in Children: The myths, the politics and the facts". The eloquent multitasking global citizen, Professor O.A. Mokuolu (2012) presented the fifth in the Department and titled his, "Saving the innocent from unsolicited encounters: The worm as a sharp threshing instrument". After this was that of the wisdom waves exponent, Professor S.K. Ernest (2017) who presented"…And the child died, Oh! No! Not

again: Adventures in Childhood Morbidity Prevention and Mortality Reduction". The 7th in the series which was presented in December 2022 by our Amazon, Professor Aishatu Gobir was titled "Child survival: obstacles and opportunities through the eyes of a Paediatrician in Practice and Research". These predecessors contributed significantly to the field of their interest and I learnt greatly from their submissions. Now that the baton has been passed unto me, I hope I won't disappoint any of them and also hope that I won't hold it for too long before passing it unto the next person.

My Academic Journey

Vice-Chancellor Sir, my academic journey started during my training as a Junior Resident Doctor when I made an observation that many of the childhood mortalities happened during the first 24 hours of admission. This was discussed with one of my Mentors, Professor Ayodele Ojuawo and he encouraged me to ensure I document the observation and the findings. Data to confirm or disprove this were gathered and analyzed. The outcome confirmed the assertion and was subsequently published. (**Adeboye**, Ojuawo, et al., 2011).

We looked at the infant who were below five and those beyond five years and we observed that death within the first 24 hours of admission was nearly 60% of the total number of the deaths recorded and that among the under-fives, mortality was much higher than among the older children. We also observed that the risk of such death was much reduced with early presentation in the health facility. This clearly shows that in the face of effective emergency services, childhood mortality could be reduced by more than half. Another important information from this study is that if we are able to significantly reduce deaths within 24 hours, we would be on course to a significant reduction of childhood mortality. Also, if ill children present early to the hospital, their chances of death are significantly reduced.

Table I: Distribution of Deaths by Age Group

Age Group	Number of Cases	Total Mortality	Mortality (%)
29 days – 1 year	184	18	10(35.7)
>1 year – 4 years	212	14	9(39.1)
5 yrs and above	210	19	10(34.5)
Total	**606**	**51**	**29(100.0)**

Source: Adeboye, Ojuawo, et al., 2011

Table II: Duration of Illness in Relation to Mortality

Duration of Illness (days)	No. of Patients	Death within 24 hours	Death after 24 hours	Contribution to Total Mortality by deaths within 24 hours
<1	97	1	–	1
1 – 7	239	11	7	4.6
8 – 28	197	12	11	6.1
>28	73	5	4	6.9
Total	**606**	**29**	**22**	**4.8**

Source: Adeboye, Ojuawo, et al., 2011

Table III: Mortality in Relation to Duration of Admission

Hours	No. of Death	Cumulative %	% Contribution to Overall Mortality
0 – 6	11	37.9	21.6
7 – 12	10	72.4	41.2
13 – 18	4	86.2	49.0
19 – 24	4	100.0	56.9

Source: Adeboye, Ojuawo, et al., 2011

Leading Causes of Childhood Mortality in Nigerian Tertiary Hospitals

Vice-Chancellor Sir, Maternal and Child Mortality Rates are important indices of the level of development of countries.

Due to socioeconomic instability and poor health systems among other factors, Africa is reputed to have one of the worst maternal and child health indices in the world (UNICEF, 2022). Of the approximately 10.8 million global child deaths annually, 41% occur in Africa, South of Sahara. Among African countries with little or no change in these indices, Nigeria features prominently. Nearly 1 million of 5.9 million babies born in Nigeria every year die before their fifth birthday. While newborns die from various conditions associated with the delivery, older children die from common and preventable infectious diseases such as acute respiratory infections (ARI), malaria, diarrhea, vaccine-preventable diseases, and Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). (Abdulkarim…..**Adeboye** et al., 2009) Malnutrition is an underlying predisposing and aggravating factor in over half of these deaths.

We set out to estimate the leading causes of child deaths in Nigeria from 2005 to 2009 in the six geopolitical zones of Nigeria and also identify any zonal-specific factors that may be associated with death rate (Smith, …. **Adeboye,** et al., 2016). The leading cause of mortality from this survey was neonatal sepsis, asphyxia, preterm complications, and acute respiratory illness. The other causes included severe hyperbilirubinemia with suspected kernicterus as the cause of death among the cases with jaundice, congenital abnormalities, non-communicable diseases (NCD), and pneumonia among others(Smith, ….. **Adeboye,** et al., 2016).

We concluded that Childhood mortality is mostly caused in our setting by preventable conditions such as neonatal sepsis, birth asphyxia, prematurity/low birth weight, and respiratory tract infections as previously reported (Smith, … **Adeboye,** et al., 2016).

Childhood Mortality in Selected Communities

Looking beyond the hospital settings, we conducted studies with the aim of identifying the causes of childhood deaths in selected communities in Northern Nigeria covering

Borno, Kwara, Plateau, and Sokoto States. The leading causes of under-five mortality in our community study of these four states representing three geopolitical zones in Nigeria were diarrhoea, asphyxia and respiratory tract infection. All these are either treatable or preventable by practicing good hygiene or adequate vaccination. This suggests some similarities between the killer diseases in the hospitals as well as the communities (Smith, **Adeboye** et al., 2018).

Helping Babies Survive Series

To stem the tide of these killer diseases in the newborn, the Federal Ministry of Health assembled some Medical Resources to brainstorm, and come up with a package that can assist in reducing neonatal mortality rate through a low technologically driven adaptable solution. This led to the production of Helping the Babies to Survive Series. For babies to be healthy, they need to survive first. This is because babies that have difficulty with their first breath of life often may not survive and if they do, they may have a neurologic disorder.

In conjunction with the National team assembled by the Federal Ministry of Health, we have produced four different manuals on Facilitator's Guide on Essential Newborn Care Course, (Module 1) Helping babies breathe (Module 2), Essential Care for Every Baby (Module 3) and Essential Care for Small Babies (Module 4). Each of the modules have Providers' Guide, Facilitators' Guide, Flip Chart and Action Plan. As part of the foreword to the Module 1 of this package, the former Minister for Health, Prof. Isaac F. Adewole wrote: "The development of the Essential Newborn Care Course (ENCC) package is a major breakthrough in our collective effort to reduce ***preventable Newborn deaths in Nigeria***. The process commenced in 2008 with the adoption and adaptation of the 2006 World Health Organization package which was later blended with the first edition of the "Helping Babies Survive" series of the American Academy of Pediatrics in 2011. This harmonization which spanned between 2014 and 2015 was achieved through intense stakeholder consultations. This guide

represents the output of these intense efforts. The invaluable effort of all our partners in supporting this process is much appreciated." I am glad to be one of those involved in this exercise from scratch till completion.

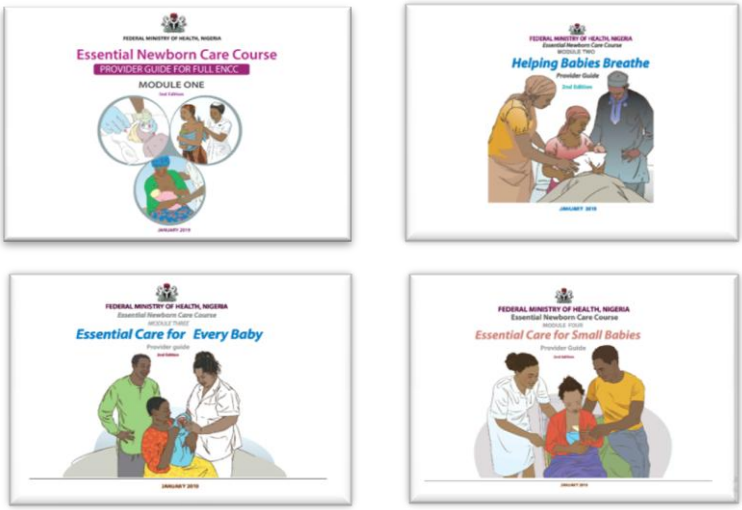


Figure 1: Modules 1 to 4 of ENCC

Module one is essentially about general precautions, communications and hygiene practices such as hand hygiene and the general principles of how to take care mother and child. (James, … **Adeboye et al.,**2016).

Module two is on ensuring babies breathe within their first minute of life either spontaneously or with the aid of intervention. One minute is a very long time if we are not able to breathe for that duration (Ezeaka, **Adeboye et al**., 2018).

Module three is on the care needed by every baby irrespective of their places of birth, danger signs and referral. It also deals with situations where referral is not possible (Bello, **Adeboye et al**., 2018).

Module four is on essential care for small babies the nucleus of which is Kangaroo Mother Care, feeding of a small baby with feeding problem. (Adeniran, **Adeboye et al**., 2018).

Congenital anomalies

Vice-Chancellor Sir, during my stay in Federal Medical Centre, Bida (FMCB) as Hospital Consultant Paediatrician, lots of congenital anomalies were seen. A case of an unusual syndrome was observed and this prompted a literature search for the condition. A deep and thorough search culminated in the publication on the condition. (**Adeboye** & Eze, 2008). In view of the rarity of this condition, there was an attempt to name the condition ***Adeboye Syndrome*** but the lack of genetic and other molecular investigations made that impossible. The baby was about a 72-hour old term male baby delivered at home and admitted with fast breathing, abnormally small tongue and multiple digits on both hands and legs. The mother was said to have drained liquor for three days prior to delivery. The baby was active, crying barely audibly, had a rudimentary multi-lobulated tongue, irregular gum, high arched palate, fleshy outgrowth in both nostrils and low set ears, receded chin, six digits each on the hands and seven each on the foot.

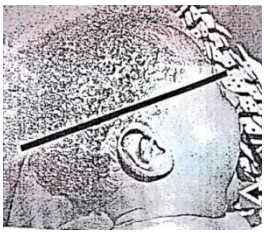


Figure 2: Low set ear and micrognatia

Figure 3: Rudimentary Tongue

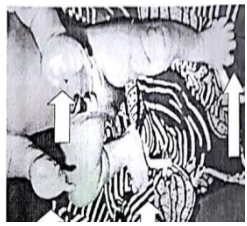


Figure 4: Polydactyly on all the limbs

Source: (**Adeboye** & Eze, 2008)

He had micropenis, normal findings in cardio-vascular, central nervous systems. He was successfully managed for the acute illness-sepsis, and was well enough to be discharged after six days. A major concern of the caregivers was the tongue of

this baby and they wanted to know if another tongue would grow or could be provided for the baby. There was also significant financial constraint as the few investigations carried out on the baby were financed by the department. He defaulted from follow up and the residential address of the family was traced just to discover that the baby was said to have died at home at the age of three months.

Familial Ectrodactyly Syndrome

This is another congenital anomaly of interest. Ectrodactyly, also known as Split-Hand/Split-Foot Malformation (SHFM) is a rare genetic condition characterised by defects of the central elements of the autopod. A baby was observed to have malformation of the two hands and the two feet at birth which are replica of the father's malformation. This condition is said to be relatively common in few Central African communities with possible common progenitor. Viljoen et al. have found three families of affected individuals among these tribes (Viljoen et al., 1985).

We reported the first case on this subject in Nigeria. Could there be a common ancestral origin for this family and those other African countries? Further robust genetic studies could answer this question. This is a case that is most likely inherited as autosomal pattern with high penetrance. This baby had two siblings who were late. (Durowaye, **Adeboye** et al., 2011)**.**

A patient with isolated Ectrodactyly can live near normal life if well managed, just as the father of this infant who was a commercial driver, but superstitious beliefs and social stigma constitute challenges to survival of such patients. Despite counseling, this child was not brought for follow up, and unfortunately, the managing unit was only told of his sudden death at two weeks of life when the team made a follow-up call. The outcome of this infant is not different from many cases of major congenital malformation in developing countries, where parents' initial enthusiasm to seek medical help become dashed when they soon realized that the much-anticipated cure may not exist.

Some parents and relatives readily think infanticide (i.e killing the baby) may be a way of coping with the associated social stigma. Illiteracy, poverty and declining primary healthcare negatively impact the health seeking behavior of parents.

Figure 5: Hand of the child

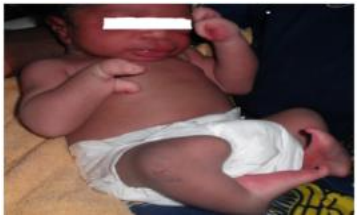


Figure 6: Hands and Feet of the child

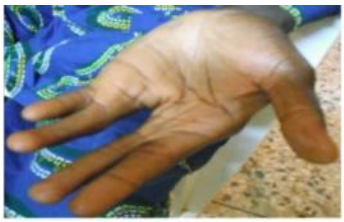


Figure 7: Father's left hand

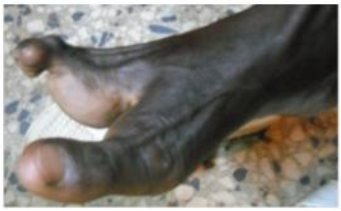


Figure 8: Father's right foot

Source: (Durowaye, **Adeboye** et al., 2011)

Before I leave the area of congenital anomalies, permit me to speak briefly on the array of congenital anomalies reported in Bida, Niger State **(Adeboye** *et al.*, 2017). The identified risk factors for congenital anomalies include consanguinity, with all being first cousins. This reflects the practice of consanguineous marriages amongst the some ethnic group. (Nadel, 1954) Advanced maternal age was another identified risk factor especially in relation to chromosomal disorders many of which have concomitant congenital malformation as part of their manifestation. (Azimi & Lotfi, 2012). Maternal age greater than 35 years is associated with increased risk of chromosomal disorders, such as Down syndrome. (Sadler, 2004; Wynshaw-Boris & Biesecker, 2007) and Cigarette smoking in the mother

or the father. This is in support of the negative campaign against cigarette smoking. Smoking is truly dangerous to health; it can even make babies malformed.

Vice-Chancellor Sir, care givers in most instances mean good for their children or wards. At times, the intervention may be dependent of variables such as their ethnic group or socio-economic status. A common example is the use of Amulets, Bands and Other Traditional Applications among Babies and Children for varying purposes. With this, I speak briefly on some of our experience in this regard. In a study by **(Adeboye** et al., 2011), We reported11.4%of children with at least one form of traditional application or the other.

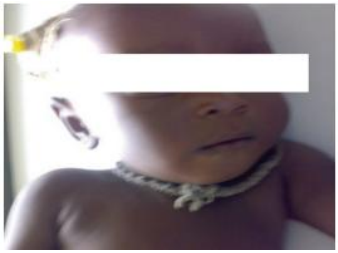


Figure 9: Tight Neck Band

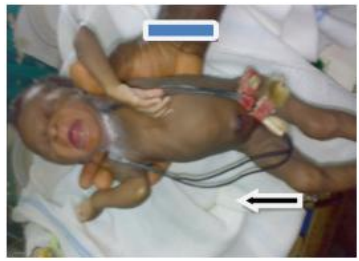


Figure 10: Loose Neck Band

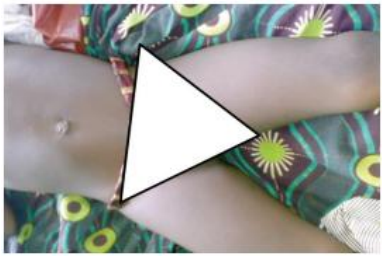


Figure 11: Waist Band

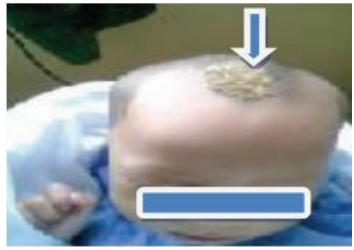


Figure 12: Head Paste

Source: (Adeboye et al., 2011)

I am sure many of us in this gathering wore some of these applications at one time or the other!

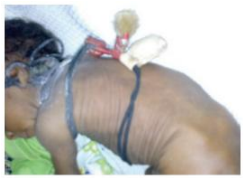
Table IV: Functions of the Traditional Applications According to the Care Givers

Function	Frequency	Percentage
Prevention of childhood illnesses	11	17.1
Closure of sutures	10	15.6
Ward off evil spirit	8	12.5
Treatment of sunken fontanelle	8	12.5
Treatment of skin rashes	7	10.9
Treatment of "teething problems"	6	9.4
Growth Enhancement	5	7.8
Enhancement of Intelligence	2	3.1
Treatment of Excessive Crying	2	3.1
Unspecified	5	7.8
Total	**64**	**100**

Source: (Adeboye et al., 2011)

Some parents were not willing to comment on the applications and they were not forced to, however, some others did. The consequences of such beliefs include delayed presentation for conventional medical care and increased morbidity and mortality. Hence, we advocated for continuous health education and sensitising public awareness to reduce the level of ignorance about the courses and causes of common childhood diseases so as to reduce the risks from such non-therapeutic practices.

Strangulation! A danger of twisted loose neck band



Source: (Adeboye et al., 2011)

We also studied Home interventions, Ethnicity and Socio-Economic Status of Children with Febrile Convulsions in Ilorin (**Adeboye** et al., 2012)**.**

Febrile convulsion is a condition in which children with fever between the ages of 6 months to 5 years convulse in the absence of intracranial or other defined causes. It is a frightening experience to most mothers; hence it usually evokes some interventions prior to presentation to the hospital. Over 60% of the care givers applied one or more home intervention. Other interventions are as shown in the Table V below.

Table V: Home Remedies Applied for the Control of Febrile Convulsions Before Presentation in the Hospital

Home Remedy	**Frequency n = 101 (%)**
Pouring of water on Convulsing child	61 (60.4)
Insertion of spoon in between Child's teeth	53 (52.5)
Application of balm on child's body	13 (12.9)
Rubbing of onion on child's face	10 (9.9)
Administration of cow's urine concoction	11 (10.9)
Administration of available syrup on the child	3 (3.0)
Administration of palm oil concoction	5(5.0)
Scarification on the child	6 (5.9)

NB: some had more than one intervention

Source: (**Adeboye** et al., 2012)

While the administration of Cow's Urine Concoction (***Agbo Ile Tutu***) is popular in the South West, palm kernel oil concoction (***adin***), use of scarifications (***gbere***) and application of hot fomentations are common in some other ethnic groups. Application of water on a convulsing child was found to be universal. Also, scarification and administration of Cow's Urine Concoction were predominantly seen among the families with lower socio-economic status.

Vice-Chancellor Sir, in view of the fact that Febrile Convulsion and Sickle Cell Disease are very common in tropical countries and both are associated with significant morbidity and mortality. Also, worldwide, Nigeria has the highest prevalence of Sickle Cell Disease. We set out to explore the pattern of haemoglobin electrophoresis in patients with febrile convulsions. We established the rarity of febrile convulsion in children with haemoglobin SS because severe anaemia is always an accompanying derangement in them. Whereas, packed cell volume is nearly normal in children with normal haemoglobin genotype with febrile convulsions. **(Adeboye** et al., 2015**).**

Innate resilience of innocent babies

Vice-Chancellor Sir, permit to start this section with a short video clip from India. This was not acted, this was a real situation of a global happening. Some babies are, however, blessed with innate resilience. What a resilient Child. ***Iwo ki yio ku iku kiku kan, afi yiye!!!***

I am proud to also talk about the resilience of some newborn epitomised in a paper titled: "Successful outcome of an abandoned baby infested with maggots" (Adesiyun, **Adeboye** *et al.*,**2010**) where we described the resilience of a nearly 4-day old term female neonate found in a polythene bag already infested with maggots with decaying placenta. The baby was successfully managed and discharged to the Ministry of Social Welfare. This baby was discovered by residents of the street and brought to our then Amilegbe Neonatal Intensive Care Unit. This baby was dirty, maggot infested and smelly. With aggressive antisepsis and adequate medical care, this baby was managed and successfully discharged to the Social Welfare team after about two weeks of hospital admission. This happened long before the access to ease of recording gadgets as typified by the Indian clip above. Surely, the baby is somewhere doing well as we talk. It is usually a thing of joy when our **Creator** uses us to restore life and hope to the helpless and hopeless.

Alhamdulillahi Robil al Ameen.

A number of unsolicited encounters have caused morbidity and mortality in newborns. Worthy of mention in this regard is the fact that some encounters are solicited by the care givers on account of poverty, ignorance and intention to cut corners. One of such "solicited" encounter for circumcision was from a quack that nearly resulted in permanent damage of the child's male reproductive organs if not for the quick intervention of our team. **(**Adesiyun**, Adeboye** *et al*, 2010**).** The baby was a 21-day old term male neonate who developed scrotal swelling subsequently followed by extensive gangrene of the scrotal sac following an illegal and unhygienic circumcision using a generally safe means (plastibel). Wound swab microscopy yielded mixed growth. We managed the baby with aggressive antisepsis guidelines and the immediate outcome of the child was favourable. We recommended that simple as male circumcision is, it should be done by qualified individuals maintaining the highest standard of hygiene and professionalism, and that care givers should avoid cutting corners. The Paediatric Surgical Team of the University as well as the Teaching Hospital are now on top of this.

Vaccine Preventable Diseases

The Vice-Chancellor, a number of childhood infections are vaccine preventable. Many of them can damage the baby's brain or spinal cord. For some of the vaccines to be included into routine immunization schedule, works of Epidemiologists, Immunologists and Clinicians contribute to studies and research works that form the basis for their development and deployment. The current immunisation time table is:

Current EPI Schedule in Nigeria

Minimum Target Age of Child	Type of Vaccine	Dosage	Route of administration	Site
At birth	BCG	0.05ml	Intra dermal	Left Upper Arm
	*OPV0	2 drops	Oral	Mouth
	**Hep B birth	0.5ml	Intra muscular	Antero-lateral aspect of Right thigh
6 weeks	Pentavalent (DPT, Hep B and Hib) 1	0.5ml	Intra muscular	Antero- lateral aspect of left thigh
	Pnemococcal Conjugate Vaccine 1	0.5ml	Intra muscular	Antero- lateral aspect of Right thigh
	OPV1	2 drops	Oral	Mouth
	Rota 1	1ml	Oral	Mouth
10 weeks	Pentavalent (DPT, Hep B and Hib) 2	0.5ml	Intra muscular	Antero-lateral aspect of left thigh
	Pnemococcal Conjugate Vaccine 2	0.5ml	Intra muscular	Antero- lateral aspect of Right thigh
	OPV2	2 drops	Oral	Mouth
	Rota 2	1ml	Oral	Mouth
14 weeks	Pentavalent 3 (DPT, Hep B and Hib)	0.5ml	Intramuscular	Antero-lateral aspect of left thigh
	Pnemococcal Conjugate Vaccine 3	0.5ml	intra muscular	Antero- lateral aspect of Right thigh
	OPV3	2 drops	Oral	Mouth
	IPV	0.5ml	Intramuscular	Antero- lateral aspect of Right thigh (2.5cm apart from PCV)
6 months	Vitamin A 1st dose	100,000 IU	Oral	Mouth
9months	Measles 1st dose	0.5ml	Subcutaneous	Left upper arm
	Yellow Fever	0.5ml	Subcutaneous	Right upper arm
	Meningitis Vaccine	0.5ml	Intramuscular	Antero- lateral aspect of Left thigh
15 months	Vitamin A 2nd dose	200,000 IU	Oral	Mouth
	Measles 2 dose (MCV2)	0.5ml	Subcutaneous	Left upper arm

Figure 13: Current EPI Schedule in Nigeria

Source: https://www.publichealth.com.ng/

Haemophilus influenza type b:

A time was when vaccination against *Haemophilus influenza* type b, an organism with potential of damaging the brain or killing children was not part of our routine immunization. (**Adeboye** *et al*, 2010) was one of the studies that called for the introduction of Hib vaccine into our routine immunization. Part of the recommendation from this work was the need for continuous high index of suspicion for *Haemophilus influenza type b* meningitis in the newborn as well as inclusion of the *Haemophilus influenza type b*, (Hib) vaccine into our routine immunisation schedule.

Measles

Measles is a highly infectious immunisable disease with potential for eradication but is still responsible for high mortality among children particularly in developing nations like Nigeria. Currently, Nigeria is one of the 47 countries in the world where the burden of measles is highest and where it is still responsible for the highest number of vaccine preventable death.

We reported that 8.0% of children aged 6 months to 6 years had measles. Majority of the children without measles vaccination did not receive any other vaccines meant for routine childhood immunization in the Nigerian NPI schedule. An overwhelming majority (80.7%) of the parents or guardians felt immunisation was bad for various reasons hence they refused to allow their children or ward to be vaccinated. Their reasons are as shown in Figure below. (**Adeboye,** et al., 2011**).**

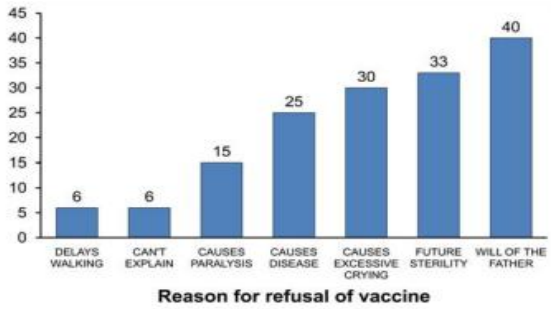


Figure 14: Reasons for refusal of vaccination in Bida

Source: (**Adeboye,** et al., 2011**)**

It is important to bring to our notice that all the measles associated mortality occurred among the children without measles vaccination. Lack of immunization and negative parental disposition are the major risks of death among children afflicted by measles. (**Adeboye,** et al., 2011**)**.

Tetanus

Tetanus is another vaccine preventable killer disease that doesn't occur in epidemics. It kills 'quietly' and causes significant morbidity. As far back as 1989, the World Health Assembly adopted a resolution to eliminate neonatal tetanus by 1995 through the increased availability of tetanus toxoid, clean deliveries and increased surveillance. This implies that any case of tetanus should be an embarrassment to the health service delivery in the country since a safe, cheap and effective vaccine has been available for ages. (Adegboye, **Adeboye** et al., 2012).

Viral hepatitis

The Vice-Chancellor, Health workers must not be harbinger of ill health. Infections with Hepatitis B virus (HBV) and Hepatitis C viruses (HCV) are global public health problems reaching endemic proportions in sub-Saharan Africa.

In Nigeria, prevalence for HBV is in the range of 10% – 40% while for HCV, it ranges from 4.7% - 20%. Infected health workers are risk factors to children generally, thus, we set out to conduct a study on four main categories of health care workers; Doctors, Nurses, Allied health workers (AHWs) and Admin Staffs. Overall Awareness of the various types of hepatitis was high, (70.6%), though could be higher (Amiwero, ……. **Adeboye** et al., 2017).

Preventing Missed opportunities for Vaccination/Immunisation

Missed opportunities for immunisation (MOI) occur when a child who is eligible for immunization visits a health service facility and does not receive all the recommended vaccines despite the absence of any contraindication to the vaccine.

The common reasons for missed opportunity for immunization/vaccination visits were ill child (26.8%), ignorance about routine vaccine but received vaccine during polio vaccine booster campaign, and mother travelled, and ill mother, and religious belief. (Ibraheem……**Adeboye** et al., 2016), It was glaring that inaccurate information about some symptoms in the child was identified in the study as another source of missed opportunities.

We strongly recommended in the study that health care providers should enquire about the vaccination status of children at all contact. There is also a need to increase awareness on illnesses that are not contraindications to vaccination, and routine vaccine status should be checked during supplementary immunisation activities (Ibraheem……**Adeboye** et al., 2016).

Pain in Children

Pain is one of the most common symptoms experienced the world over. It has always received the needed attention and care in the adult but not until recently among children. Pain is both a sensory and an emotional experience. In older children, the character, location, quality, duration, frequency, and intensity of their pain can be assessed. Behavior and physiologic signs are useful, but can be misleading. A child who is experiencing significant chronic pain may play "normally" as a way to distract attention from pain. This coping behavior is sometimes misinterpreted as evidence of the child "faking" pain at other times.

The theories, pathways, transmission, regulations, classifications, assessment scales and the treatment of Paediatric pain and practical issues that arise from the use of pharmacologic analgesic in the children were also reviewed and highlighted. (**Adeboye** et al., 2012).

Myths about pain in children

1. Infants cannot feel pain because their nervous system is immature. The true situation is that there is considerable maturation by 26 weeks of gestation; nociceptive pathways to the central nervous system are myelinated by about gestation 30 weeks. Descending inhibitory pathways develop later than afferent excitatory pathways. Extremely pre-term infants can localize and withdraw from noxious stimuli. Neonates exhibit behavioral, physiological and hormonal responses to pain.
2. An active or sleeping child is not in pain. The true situation is that pain may result in "exhausted" sleep. Children may read, play or watch TV to distract

themselves from the pain. Children are particularly good at using distraction as coping mechanism.

3. Children always tell the truth about pain. This may not be true because children are scared of injections. Younger children may feel that pain is a punishment for doing something wrong. Onset of pain may be gradual so the child does not realize they have pain until it has been alleviated.
4. Children cannot describe and locate their pain. McGrath reports children as young as 18 months being able to report their pain verbally and localize it. Children as young as three years old have used self- report tools to describe and locate their pain. Children can demonstrate on an outline of the body where they hurt without knowing the names of the body parts.

Epilepsy

Vice-Chancellor Sir, Epilepsy is a common medical and social disorder or group of disorders with unique characteristics which is usually defined as a tendency to recurrent seizures. It affects about 50 million people globally, out of which about 40 million live in the developing countries and over 60% of cases has its onset in childhood. It is a chronic disorder marked by intermittent, often unpredictable seizures which may be embarrassing and disruptive to the normal activity of daily living. It cuts across age groups and may have a limiting effect on the quality of life of the sufferer.

According to the International League Against Epilepsy (ILAE), (Fisher et al, 2017, p 522) epilepsy is a disease of the brain manifesting in the following ways: (1) At least two seizures, both unprovoked, occurring greater than 24 h apart; (2) one unprovoked seizure and a probability of more seizures similar to the general recurrence risk of individuals who have had two unprovoked seizures, occurring over the next 10 years; (3) diagnosis of an epilepsy syndrome.

There are different types of Epilepsies with different levels of prognosis and associated quality of life. We have managed a

lot of cases with some completely resolved and some not. An Audit of Childhood Epilepsy in a Tertiary Hospital in Ilorin, North-Central Nigeria (**Adeboye** et al., 2020) found a male predominance among the patients, that most children have localization related (partial) epilepsy which were secondarily generalized, then a generalized epilepsy syndrome. Most of the patients were more than one year on follow up and this is in accordance with the chronic nature of the condition. Majority of children presented for follow up between twice and six times in a year. As basic as Electroencephalogram (EEG) is, over 40 percent of children on treatment for epilepsy did not have an EEG done on them mostly on account of financial difficulty of the parents / care givers. Paediatric epilepsy in our Paediatric Neurology out-patient clinic demonstrated male predominance. The main Anti-Epileptic Drugs (AEDs) in use are the first generation AEDs with carbamazepine being the mostly used. The rate of loss to follow-up was also found to increase after 5 years. A major issue we are facing now is the availability of anticonvulsant drugs as many of the Pharmaceutical companies are currently struggling to remain in business or meet the demand. This has led to some recent breakthrough seizures in a number of those that have hitherto being well controlled.

Any Need for Routine Folate Supplementation in Childhood Epileptics?

In view of the fact that children suffering from epilepsy are chronically maintained on antiepileptic drugs (AED) to guarantee a reasonable quality of life, the side effects of these AEDs have been shown to include disturbance in folate metabolism and related/unrelated hematologic derangements since folate is among the cofactors for Purine and Thymidine synthesis. It has been suggested that epileptics on AED receive routine supplemental folic acid to prevent these side effects. It has also been reported that routine supplementation with folic acid might not necessarily be beneficial. The need to clarify the true situation has been explored (Omefe…**Adeboye** et al., 2022) and the finding revealed that children with epilepsy had lower

mean serum folate levels compared with age-and-sex-matched controls. Serum folate level in subjects on AED was, however, comparable with that in AED naïve subjects. The serum folate level was also comparable among subjects on carbamazepine, phenobarbitone, and valproate as monotherapy. There was no correlation between the duration of AED use and serum folate level. It is, therefore, recommended that only epileptic children with demonstrable low folate values receive folate supplementation. Routine administration of folic acid to epileptic children on AED may not be justified.

Mentorship in Paediatric Neurology especially Epilepsy

As a foundation member of Child Neurology Society of Nigeria and African Child Neurology Association, I have had a number of exposures to training on Electroencephalography (EEG) in Egypt, South Africa, India and Nigeria. Outside my place of primary assignment where Professor Ayodele Ojuawo mentored me excellently, I also received encouragements and guidance from Professors Gabriel Ofovwe, IkeOluwa Lagunju and Dr. M.A. Salisu to give more priority to Child Neurology when I had divided interest in Newborn Care, Neurology and Pulmonology. I have also observed that Medical students and Junior Residents were too "scared" of Neurological Examinations and basic investigations especially Electro encephalogram tracing. I decided to develop an introductory module to EEG for them about five years ago with objective of demystifying EEG tracing and the feedback has been encouraging till date. Usually after the training session on these, a number of them felt confident of basic interpretation of EEG tracings. With this, I believe a number of them will consider Paediatric Neurology as their future career pathways. Also, in conjunction with the Department of Radiology, we have developed a Virtual Academy where we look at Paediatric Neuro-Radiological issues from both ends. Kudos to Professor O.I Oyinloye and his team on this. It will surely get better.

Duchenne Muscular Dystrophy

Vice-Chancellor Sir, above is called Gower sign which is a manipulation by a patient with a condition called Duchenne Muscular Dystrophy (or its likes). The condition hits differently, but it is only most painful to the afflicted families. Typical history is usually that of a normal delivery and normal development of a baby boy up until the age of 2 to 3 years before difficulty in bearing weight of the body starts to manifest with the child supporting the hip girdle with both hands with obvious lumbar lordosis. Soon, the child finds it difficult to stand from lying position then learn to manipulate himself as above. The disease progresses and soon, the child would not be able to move on his own. The more painful issue is that it affects all the male children in the family and the management is mainly supportive. This condition is the commonest genetic neuromuscular disorder and we lack the capacity to confirm the diagnosis at molecular level. Serum Creatine Kinase is a useful biomarker in the condition but it is hardly available in most laboratories. The most painful of this is that I have families with this condition in their numbers; two, three and four affected in their families respectively. We know what is lacking, Dystrophin; we know the genetic basis, X-linked recessive, we know the course of the condition, we know the way forward; Genetic Engineering interventions, yet we remain handicapped in the care!!!. ‘

Congenital Hypothyroidism in Multiple Gestation

Vice-Chancellor Sir, hypothyroidism during the neonatal period can lead to severe mental retardation later in life. It is actually one of the most common causes of preventable mental retardation globally. Early diagnosis is critical in preventing the devastating consequences of the disease. Let’s imagine a family blessed with a set of triplets and the three grew old to develop mental retardation! That could have been a great demoralizer and probably a negative game changer for such a family.

I’m glad to share the report of how we prevented a set of triplets from becoming mentally retarded in a family. (Abdulkadir…… **Adeboye** et al., 2016)A set of triplets delivered to a 38-year old then para 3+0 (4 alive) woman via spontaneous vertex delivery were reviewed within 6 hours of their birth. The

pregnancy was planned and booked and she had not received any fertility medications. The mother had not been diagnosed with any chronic illness (Hypertension, Diabetes or Hyperthyroidism) and was not on any medications asides routine medications during pregnancy.

They were delivered in a private hospital and referred and got to us within six hours of delivery. On examination at admission all three neonates were profoundly lethargic with generalized hypotonia and poor cortical responses. They had a weak cry and depressed primitive reflexes (rooting, sucking, Moro). They were in respiratory distress and had tachycardia. An initial diagnosis of severe perinatal asphyxia with a risk for sepsis and managed as such. Respiratory distress resolved within 24hours of admission but they remained floppy and by the third day they were commenced on feeds via orogastric tube. With other treatment, Thyroid Function Tests were requested and the results confirmed it as shown below:

Before the commencement of thyroxine

Parameter	**Reference Ranges**	**Triplet I**	**Triplet II**	**Triplet III**
Free serum T3 (pmol/L)	3.7-8.6	2.8	2.9	2.2
Free serum T4 (pmol/L)	12–33	11.8	10.1	10.3
Serum TSH (mIU/L)	1.7–9.1	2.55	2.6	1.83

Four weeks after commencement of thyroxine

Parameter	**Reference Ranges**	**Triplet I**	**Triplet II**	**Triplet III**
Free serum T3 (pmol/L)	3.7-8.6	3.9	4.5	4.2
Free serum T4 (pmol/L)	12–33	14.2	15.6	15.5
Serum TSH (mIU/L)	1.7–9.1	2.8	2.7	3.4

Source: (Abdulkadir…… **Adeboye** et al., 2016)

Their activities and tone were subsequently noticed to have improved and they were subsequently followed up at the Endocrinology Clinic. As at today, I am glad to inform you that they have developed very well neurologically.

Neurological Impairment and Intelligence Quotient

There is ability in disability and this is a true statement confirmed in one of our studies where we evaluated the Intelligence Quotient of Neurologically Impaired Children Attending Neurology Clinic (**Adeboye** et al., 2018).Their clinical conditions were Epilepsy, Cerebral Palsy, ADHD, Down Syndrome, Speech/Hearing impairment, Hypothyroidism. Their ages ranged from 4 years to 16 years. Their IQ distribution were Normal (5.3%), Borderline (16.0%), Mild Mental Retardation (21.3%), Moderate Mental Retardation (25.3%), Severe and Profound Mental Retardation (32.0%).

Cerebral Palsy

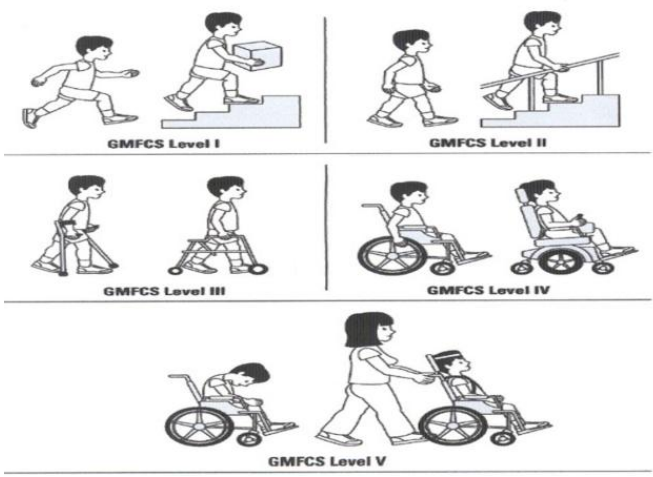


Figure 15: Cerebral Palsy Gross Motor Function Classification System (GMFCS) I to V

Source: www.canchild.ca

Cerebral palsy is a non-progressive disorder of posture and movement. Children with difficulty in transition from intra-uterine to extra-uterine life stand a risk of later developing cerebral palsy. Often the event that led to CP can also affect the eyes. This was further buttressed by my team when we evaluated for ocular abnormalities in children with CP. This ocular abnormalities can further aggravate learning in them. (Bodunde, ……**Adeboye** et al., 2015). Cortical Visual Impairment, refractive errors and strabismus are the most common ocular findings in children with Cerebral Palsy in Nigeria. We advocate early detection and early intervention to achieve best developmental and educational attainment. Multidisciplinary approach involving Neurologists, Ophthalmologists, and Physiotherapist is paramount in managing these children from the time of diagnosis.

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is a significant public health disorder and has been established to be associated with learning disabilities leading to school failure; as much as 33% of those with the condition are said to be kept back a grade before reaching high school. Other recognised problems with children with ADHD include poor peer relationship, sleep disorders, increased risk of road traffic injuries and depression and anxiety disorders. It places the child at risk for juvenile delinquency, criminality, substance abuse, and sexual promiscuity with HIV/AIDS and teenage pregnancies as possible consequences. These are problems that are better nipped in the bud. Children with ADHD are also at risk of being misunderstood, thus are prone to be physically abused at times in the name of corrective measures.

Our study on the risk of ADHD in selected public and private primary schools and recorded a prevalence of 15.8% in Ilorin metropolis. There were more pupils with ADHD risks in public schools than in private schools. It was thus recommended that school entry screening for ADHD should be instituted to enhance early recognition and prompt intervention. Nationwide

epidemiologic studies to determine the national prevalence of ADHD risk and ADHD across various age groups. (**Adeboye** et al., 2018) was advocated.

Advocating against Child Abuse

Vice–Chancellor Sir, Child Abuse is a big issue in the society and indeed the world over. It occurs when a parent or caregiver, whether through action or failing to act, causes injury, death, or risk of serious harm to a child. There are many forms of child maltreatment, including neglect, physical abuse, sexual abuse, exploitation, and emotional abuse. It is a common phenomenon that can be easily missed by the health workers. Thus it has a potential of becoming perpetuated. Some are characterised by tell-tale signs that give the diagnosis away very easily while some are not. It is generally acceptable in several African cultural settings for a parent or caregiver to "discipline" his or her child or ward by spanking or by any other physical measures than 'spare the rod and spoil the child'.

We suspected Child Abuse of an Infant to the point of death by the Father and called for Enforcement of Protection Acts for Nigerian Children. (**Adeboye** et al., 2017).

The father was angry, he acted before thinking and the resultant events led to the demise of the child. Anger is indeed madness. ***The Holy Qur'an advises: "Hence, if it should happen that a prompting from Satan stirs thee up (to blind anger), seek refuge with Allah: Behold, He alone is All-Hearing, All-Knowing. (Suratul Fussilat, Quran 41:36).*** The Holy Prophet advised that if you become angry while standing, then sit down, and if you are sitting down, then lie down.(some other narratives added that if you were talking, keep quiet!) How too practical are these beautiful advises.

The story is pathetic!, but the summary is that a diagnosis of Child Abuse with severe head injury was made. The child died shortly thereafter despite emergency resuscitation and intervention. The post mortem examination revealed a well-fed child, severely pale, with two subcutaneous haematomata measuring 1.5-2cm each in the frontal region of the head and

2.5cm in the left occipital region. The calvarium was opened to reveal a bulging dura with massive collection of blood in the brain (subdural hematoma). About 700mls of fresh blood was evacuated. The brain weighed 1.1kg. The anatomical diagnosis was subdural haematoma. The management of the father's institution was officially communicated about the incident but there was no feedback from the institution and the case was not followed up.

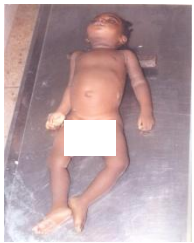


Figure 1: Remains of the well-fed child

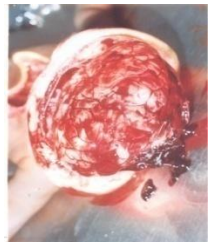


Figure 2: Massive sub duralhaematoma

Source: (**Adeboye** et al., 2017)

COVID -19 and Health of Children

The Vice-Chancellor, global health of children as well as that of all human race was globally threatened not too long ago with the pandemic of COVID-19. It came with its peculiar problems, politics, power play, potentials for appraisal and re-ordering of priorities especially as it relates to the health of the citizenry at country level. As the then Chairman, Medical and Dental Consultants' Association of Nigeria, UITH and Unilorin Chapter, part of the contribution of my colleagues, Nurses and I in conjunction with the UITH Management was a successful social sensitisation in form of production of a well circulated and a well applauded video clip on COVID-19.

As part of being a member of University of Ilorin COVID-19 team, we among many things sensitized the University community as well as the surrounding settlements, encouraged an improved hand hygiene practice among them. It may interest

you to note that when I became the Director of the SPS, some of the inhabitants recognized me as one of those that came to talk to them during COVID-19 sensitisation.

Also, to promote the culture of good hand hygiene as well as curtail spread of COVID-19, public hand wash stations were constructed across the University campuses. These were complemented with alcohol-based sanitizers produced in-house and dispensed through touch-less sensor-based units and 100 mL aliquots across the University campuses.

We at the committee then capped it all with an international publication (Durotoye et al., 2020).

Still on COVID-19, the infection was not as common in children as in adults but the effect was worse on the children because they are largely dependent on adults whose health and social interactions were grossly and directly compromised by the virus.

A warning and challenge was thrown to African leaders in view of COVID-19 in a paper titled: Double Sides of COVID-19 Pandemic: African Countries should Break Grounds or be Permanently Broken (Adegboye, **Adeboye** et al., 2020). In this publication, we noted**:** "That the current pandemic will be resolved is not a bone of contention at any level, the focus of divergent opinions is what happens especially to Africa after the pandemic. Should the continent remain naturally rich, humanly endowed but economically submissive, then she would remain broke permanently. The other option is for the continent to harness her potential and move out of the "potential" to "actualize" zone so that she can remain positively relevant in the scheme of events. This calls for discipline, transparent and purposeful leadership and followership, adequate funding for health and education, massive investment in trade, job creation, citizen vital data bank and security. Every life must be valued."It was hoped that the event would set the governance of the continent right so that the governments would effectively ensure a stronger and more economically vibrant nations emerge after the pandemic. On this very matter, have we shown that we have

learnt enough lesson as a nation or as a continent? I leave that for each person to answer.

Sleep Hygiene and Health

Vice-Chancellor Sir, Sleep hygiene is defined as the conditions and practices that promote circadian rhythm-appropriate, continuous, and effective sleep. The dictum "early to bed, early to rise makes a man healthy, wealthy and wise" actually gave an insight into sleep hygiene. It involves the establishment of a regular bedtime and wake time; adequate time in bed for sustained and adequate sleep; restriction of alcohol and caffeinated beverages before bedtime; and proper use of exercise, nutrition, and environmental factors that enhance restful sleep. Sleep hygiene practices includes behavioural and environmental factors that promote sleep and maintain sleep. These include regular exercise, regular bed times and arising times among others.

Ineffective sleep during childhood is an invisible phenomenon that does not receive attention from primary care providers until it interferes with the child's behavior, mood, or performance.(Showunmi, **Adeboye** et al., 2021) carried out a study is to describe the sleep hygiene practices among children presenting to General Out-Patient Department of our institution. Specific objectives include description of socio-demographic factors that are associated with identified sleep hygiene practices.

Examination of the Sleep hygiene practices of respondents showed that nearly 40% had a TV/computer in the bedroom, while over 60% used the TV/video too close to bedtime and about 40% used the computer/internet/cell phone too close to bedtime.

We concluded in that study that inadequate sleep hygiene practices were present in children and adolescents seen at UITH and this include routine room sharing with parents/guardian/ sibling, presence in bedroom and use of media devices around bedtime, use of caffeinated beverages, and engaging in vigorous exercise close to bedtime.

Brain Drain

Vice-Chancellor Sir, this is arguably, the most topical issue in the Medical workforce in this country at the moment and it is another qualm in the health of both children and adult in this country. I have chaired and a directed a number of discussions and I have been involved with a number of publications on the subject. In one of such, (Yarhere &**Adeboye,** 2022) we observed that the health workforce of a nation is crucial to its economic productivity and development. In Nigeria, the emigration of healthcare professionals from the country has become alarming and is fueled by various factors. The push and pull factors encouraging the emigration of medical consultants from Nigeria as well as their perceptions of what can be done to retain Nigeria's health workforce in the country was studied. Top Push factors promoting the emigration of doctors identified in this study include the need to improve professional skills (82.4%), inadequacy of job opportunities (69.7%), poor remuneration (69.7%) as well occurrence of armed conflict / insecurity (66.0%).

Some top Pull factors supporting the emigration of the doctors include better remuneration (87.4%), improved security (85.3%), better prospects for and their children (84.9%), availability of incentives (82.4%) and better prospects for their professional practice (65.1%).

We concluded by stating that the problem of doctors' emigration from Nigeria persists and is fueled by various factors that need to be addressed urgently for improving the retention of the country's health workforce. It is recommended that a holistic approach confronting issues of training, availability of an enabling environment as well as the professional progression of doctors be adopted in tackling this emigration problem.

This phenomenon is deep. As regards to brain drain, there are different levels which have been attributed to meanings such as "***Ja***", "***Japa***", "***Japada***" and the final desired endpoint, "***Japadawa***".

"Ja" means to escape albeit, on temporary basis, even though without knowing what next. *"Japa"* means to flee with

an intention of never to return. "*Japada*" means to return out of frustration from where one has hitherto escaped to. "*Japadawa*" is to deliberately return after a well planned and well executed migration so as to cultivate, nurture and develop the system at the home country.

In a recent lecture titled ***JAPA syndrome:*** *The Issues, the Challenges and the way forward* which I delivered at the instance of NMA Kwara State Chapter, I talked about the 10 R's of the way forward to come out of this **JAPA** qualm. These I identified as Recognise, Readiness, Reappraise, Re-invest, Reflect, Repair, Request, Regulate, Reward, Relish**.** ***JAPADAWA*** isa term I believe will be popular in use during our life time.

My Role as a Medical Teacher

` My love for teaching dated back to my secondary school days when I would set questions in Mathematics and Sciences for my younger siblings and their friends according to their classes. I often gave token as prizes for the best or whoever scored certain marks. When I became a Medical Doctor, even as an Intern, I was always teaching Medical students the little I knew. So, it is not surprising that a number of my publications are also in form of question setting (**Adeboye,** 2008; Adegboye &**Adeboye**, 2018; Adesiyun &**Adeboye**, 2019).As a Resident Doctor, I usually set questions for medical students and junior colleagues and usually this prepared them better for their exams and improved their practice. This hobby has earned me the Role of Quiz Master in many Quiz Competitions. Till date, I have mentored countless number of students and colleagues; I have supervised ten dissertations and I have been part of success stories of many more. I am proud to state that some of my mentees have also become Professors and Readers in a number of Nigerian and foreign Universities. Some are Directors in Federal and some State ministries, some are well celebrated Politicians of repute, some are well accomplished businessmen and women, some are Super-Specialists in some world-class Centres in developed countries and they look forward to giving back to the system whenever the opportunity comes. Recently,

ILUMSA floated **Professor M.A.N. Adeboye** Cerebral Tussle, an Annual Febrile Academia Quiz event in a bid to resuscitate and sustain the competition. I have authored over 70 scholarly publications in local, national and international outlets.

Community Services

The Vice-Chancellor, I have had the privilege to serve the University community in the following capacities: Departmental Examination Coordinator, Departmental PG Coordinator, Chairman, Faculty of Clinical Sciences Bulletin Committee, Co-ordinator, Medical Education Resources Unit and Director, School of Preliminary Studies, University of Ilorin, Fufu campus. One thing I can say about each of these places of assignment is that to the glory of the Almighty, I left each of them better than how I met them. Today, I am the Head of Department, Paediatrics and Child Health, University of Ilorin and I also pray to leave the Department better than I met it. Amen. I have been Chief Invigilator and Examination Coordinator for Part III MBBS of the Faculty of Clinical Sciences examinations a couple of times. I have been a member of University final year screening committee for students in the Faculty of Clinical Sciences and I have been External Examiner to a number of medical schools including University of Ibadan, Bayero University, Kano; Afe Babalola University, Ado Ekiti and Ladoke Akintola University of Technology.

I have also been part of Medical Outreach to various communities in Kwara State and beyond. In a recent one held in Lagos in conjunction with Outreach Hospital, Lekki, we were stretched to full limits as we started 8am and closed daily by 7 or 8pm instead of the advertised 8am-4pm daily, attending to children with various Neurological conditions. I have also endowed a Prize for the best student in Sciences in the University of Ilorin Secondary School, an event that has been on for Ten years still counting.

For the Sister Institution, University of Ilorin Teaching Hospital, I have had the opportunity of being “Servant” Chief Resident who took the call duties of some of the junior ones

when there was a need to do so. I have been the Chairman of the Departmental Annual Award Committee since 2010.I was a member of Therapeutic Care Committee that produced the drug formulary that is still operational in UITH till today. I was a member of Infection Control Committee that carried out some TETFund and Senate Research Grant assisted Studies on Methicillin-Resistant Staphylococcus aureus Carriage Among Health Care Providers. (Fadeyi, **Adeboye** et al., 2011), (Fadeyi,… **Adeboye** et al., 2010). I was a member of Open-Heart Surgery Committee as the link person between UITH and Apollo Hospital, Chennai, India and developed a relationship that led to the only open-heart surgeries carried out in UITH till date. This success was also documented in a publication by my team. (Adeoye, ….. **Adeboye** et al., 2017) I was a member of Research Ethics Committee, Medical Audit Committee and Chairman, Medical and Dental Consultants' Association of Nigeria (MDCAN, UITH Chapter).

As Chairman, MDCAN, UITH (2019-2021), I led an Executive that commenced and completed the building of a block of six shops (MDCAN OFFICE AND SHOPPING COMPLEX) without borrowing a kobo or imposing any special levy on members. We thought out of the box and the building is still standing strong and solid.

At the National Postgraduate Medical College of Nigeria, I have had the privilege of being an Examiner since 2012 till date. I am a Member of Performance and Cognitive Skills Examination (PACSE) Committee of the Faculty of Paediatrics,

NPMCN. I was a member, Computerisation Committee of the National Postgraduate Medical College of Nigeria (NPMCN) between the year 2016 and 2017. I am currently member, Faculty Board of Paediatrics 2019 to 2023 and the Secretary-Elect, Faculty of Paediatrics, NPMCN, Member of Accreditation Team to a number of a number of Teaching Hospitals nationwide.

Which of the Favour of my Lord can I deny? Absolutely none!

In my home town, Oke -Ola, Oro, I am a member of Oke Ola, Oro Think Tank Committee as well as Oke-Ola Oro Professionals and I have been contributing to the growth and development of my town to the best of my ability. Also, for Oro as a whole, I have been contributing my quota to the development. I am also a member of the Muslim Community in the University of Ilorin and University of Ilorin Teaching Hospital. In the latter, I have held the position of Chairman Welfare Committee since the year 2018.

Recommendations

In view of the above and other experiences I have gathered over the past 26 years in health care provision and 15 years in core acacdemics, I want to make the following recommendations.

To the Government

1. **Adequate funding of health system must be taken as a priority**: The WHO recommended budgetary allocation to Health is 15%. The highest so far in the country is 5.75% in the year 2023. The framework for health systems consist of these "building blocks": (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, (vi) leadership/ governance. Poverty promotes late presentations that result in increased morbidity and mortality. Adequate funding of health would improve the general well being and survival of our children.

2. **Regional centres for genetic studies and dysmorphology should be established and supported**
   This will not only ease the management of children with congenital malformations. It will also enhance quality research that can generate data for adequate intervention, mapping and meaningful engagement of such children and their families.
3. **National Newborn Screening programme should be established**
   Newborn screening programme should be established and made to be a standard as lots of potentials are lost due to late presentation or late diagnosis. The impact of congenital hypothyroidism on newborn can surely be negative and lifelong if not identified and intervention instituted early in life.
4. **Poverty eradication or reduction should be seriously actualised**
   Enough of lip service to the issue of poverty eradication/alleviation as the real situation on ground is poverty regeneration. Take home of any government worker can't take them home even though they are supposed to be bread winners, cost of bread is daring. A well-fed child is less likely to die of the common causes of morbidity and mortality.
5. **Vaccine production and protection should be prioritised**
   Vaccine production was one of those experience of the good old days and when COVID-19 threatened us, we scratched the surface. It will be nice for Government to sustain effort on this as prevention is not only better, it is also cheaper than cure.
6. **Deliberate effort to attract and retain Medical and other Lecturers**
   To reduce the rate of migration of manpower in the medical and educational sector, government should pay more attention to the push factors which have been highlighted over and over. True, the grass is greener here but the

landmines, traps, difficulties should be removed to enable access to the greener grass here.

7. **Child abuse should be criminalised**
   Offenders should be prosecuted according to the laws of the land irrespective of their status.

To the University

1. The Management should continue the good work

Parents and Care giver

1. Early presentation of a child with a medical complaint saves life, at times, saves from a life-time complication.
2. Immunization is harmless. There is more "good" associated with it than "bad". Encourage it.
3. Appropriate feeding which means exclusive breast feeding for the first six months of life, complementary feeding thereafter can prepare a child to be a true future leader.
4. Congenital anomalies do occur, not all are death sentence, seek medical attention rather than hide the child, show them love and affection.
5. Avoid anger that can make you beat a child violently, you may kill the child physically or psychologically
6. Encourage good sleep hygiene in your children and wards, it is healthier for them.

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My Creator

All glory, honour, adorations and thanks are due to Allah alone for His blessings, guidance and support before the day I was born till this day and beyond. May His perpetual blessings continue to be on the noble soul of our Holy Prophet Muhammad (SAW), his household, his companion and all the generality of the believers all over the world. Amen.

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I acknowledge my late father Alhaji Abdulkareem Olaniyan Aremu Adeboye, he taught me wisdom, hardwork, and determination. I acknowledge his two wives, my mothers, Alhaja

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