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Women's health in Nigeria: past, present and prospects for the next millennium

The Ninth Paul Hendrickse Memorial Lecture

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The Provost, College of Medicine, Professor Temitayo Shokunbi, The Chief Medical Director, UCH, Professor Dare Olatawura, Deans of Facuilties, College Secretary, Mrs Abimbola Bolodeoku, Distinguished Colleagues, Distinguished Ladies and Gentlemen.

It is, indeed, an honour and a privilege to have been invited to give the 9th Paul Hendricks Memorial Lecture. I understand that the last lecture (the 8th in the series) was delivered over 9 years ago by our distinguished colleague and former Head of our Department of Obstetrics and Gynecology, Professor Vincent Aimakhu. Today's lecture has therefore, had a rather prolonged gestation of over 9 years! I hope, however that its delivery will be uncomplicated, smooth and straightforward!! This memorial lecture was established by the University during the tenure of Professor Vincent Aimakhu as Head of the Department of Obstetric & Gynaccology. I note that Professor Aimakhu, in his lecture 9 years ago, paid tribute to me for the role I played in the establishment of the lecture during my tenure as Dean of the then faculty of Medicine. I wish to say quite clearly that Professor Aimakhu has a lot of credit in this respect, and everyone who knows the dynamism and zeal with which he ran the department during the period he was Head of Department, will know that he got whatever he sets his mind on and, in this regard, he deserves the greatest credit.

It is now more than 23 years since our great teacher, educator, medical scientist and distinguished obstetrican & gynecologist, Professor Paul Hendrickse passed on to the great beyond. The history of the Ibadan Medical School would not be complete without reference to the various distinguished contributions made by Professor Hendrickse. He worked tirelessly, both in the hospital and in the lecture rooms, to put Ibadan on the academic map. He was dedicated and committed clinician, an acknowledged and keen researcher and an articulate teacher. We will always remember him for his humane approach to students, patients and staff. May his soul continue to rest in perfect peace.

All the previous lectures have addressed issues, which are of great importance to women's health in the country. And today, I have chosen as the tittle o f my lecture. *Women's Health in Nigeria: past present and prospects for the next millennium.* I hope to reflect on the past, ponder on the present and gaze throught the crystal glass to what the future holds for the health of Nigerian women in the next millennium.

**This memorial lecture was delivered at the College Auditorium, College of Medicine, University College Hospital, Ibadan, Nigeria on November 22, 1999.*

In reflecting on the past, I wish to highlight some of the contributions made by Professor Hendrickse and his colleagues in promoting women's health in Nigeria. His contribution in this field is enormou, but due to the constraints of time, I will limit myself to only two areas, notably:

(i) Trophoblastic disease: and
(ii) Haemoglobinopathies

Malignant trophoblastic disease

Hendrickse and his associates were the first to document the varied radiogical manifestations of malignant trophoblsatic disease. They showed that the radiologist can play an important part in the early recognition of this disease, as patients may frequently present a medical rather than a gynecological problem.

In a series of elegant publications, Hendrickse and his associates showed the limitations and dangers of histologic diagnosis and the advantages of correlating the quantitative tests of human chorionic gonadotrophin (HCG) execration and the findings on pelvic arteriograpy in determining the presence of malignant trophoblastic disease.

The showed that the tradition means of diagnosis of malignant trophoblastic disease possesses many disadvantages. The established methods are based on histologic examination of tissue obtained from the uterus or from metastases, and the presence of an increased excretion of HCG in the serum or urine.

In Nigeria, many of the patients with malignant trophoblastic disease present with profound anemia (sometimes with hemoglobin as low as 2 gm per 100ml) and sepsis may be severe. A considerable delay may be inevitable before an anaemic patient is fit for surgery and when the disease is extensive, this may never be achieved. Moreover, uterine curettage may provoke severe hemorrhage that can only be controlled by hysterectomy. This procedure, apart from the inherent dangers in patients, who are so ill, is undesirable, since most of the patients are young and the disease often having developed after their first pregnancy. To render such a young woman sterile is disastrous in many ways. If the ovaries have also been removed, apart form mental trauma, menopausal symptoms will be severe.

By preserving the uterus, Hendrickse and colleagues permitted several patients treated with chemotherapy to deliver live infants. A report of three of such cases was made in their publication in the New England Journal of Medicine in October 1964.

They concluded that the standard procedure used in the diagnosis of malignant trophoblastic disease are unsatisfactory in that can be both dangerous and misleading and result in delay in the institution of specific chemotherapy. In their experience of this disease, hysterectomy is seldom indicated.

In another publication in the British Journal of Radiology in March 1965, Hendrickse and his associates reviewed the findings in the chest radiographs of 66 patients suffering from malignant trophoblastic disease. They showed that in many cases, lung manifestations occurred in the absence of pelvic disease, presumably because the initial primary deposits have regressed. They again emphasized the dangers of diagnostic curettage and operations in this condition. Accordingly, curettage in suspected cases of M.T.D. was avoided in Ibadan and quantitative human chorionic gonadotrophin estimation and pelvic arteriograph are carried out of confirm the diagnosis.

Between 1957 and 1963, Hendrickse and his associates observed 25 cases of acute dyspnoea complicating malignant trophoblastic disease at the University College Hospital here in Ibadan. Twenty-two cases occurred amongst 92 patients with malignant trophoblastic disease seen during the period,whilst 3 were seen in 72 patients with benign hydatidiform mole. In some cases, acute dyspnoea was the presenting symptom but in others it occurred after a trophopblastic tumour had already been diagnosed. The causes of the dyspnoea included pulmonary embolism in 11 cases; pulmonary embolism with pulmonary hypertension in 4 cases; rapid accumulation of pleural fluid in 5 cases; and severe anaemia in 5 cases (Table 1).

Table 1 : Causes of acute dyspnoea with trophostic tumours

	No.
Pulmonary embolism	11
Pulmonary embolism with pulmonary hypertension	4
Rapid accumulation of pleural fluid	5
Anaemia	5
TOTAL	25

They concluded that malignant trophpblastic diseases should always be considered in young women with acute dyspnoea, since early diagnosis is essential if therapy is to be effective.

Notable among Professor Hendrickse's associates in his work in the area of malignant trophoblastic disease are: C.J. Barton; Peter Cockshott; K.T.Evans; and and A.J.P. Willis.

Haemoglobinpathies

Another great interest of Professor Hendrickse is the influence of haemoglobinopathies on pregnancy. He and his colleagues worked tirelessly to study various aspects of the clinical manifestations of these conditions as they affect the course of pregnancy. They mapped out the clinical presentations and produced "best practices" in their management.

In a publication in the Journal of Obstetrics and Gynecology of the British Commonwealth in May 1972, Hendrickse and his associates reviewed the cases of 38 patients with homozygous sickle-cell anaemia (HB SS disease) studied during the course of 61 pregnancies over a 12year period (1958-69). They showed that maternal prognosis was poor, with 7 deaths. The causes of mortality and morbidity were severe anaemia, acute sequestration, bacterial infections, bone pain crisis and bone marrow embolism. They demonstrated the lifesaving effect of heparinization and blood transfusion when bone pain crises occurred during late pregnancy, labour and in the early pueperium.

They showed that fertility is reduced in sickle cell anaemia (Hb SS disease) but not in sickle cell haemoglobin C disease. However, both these conditions cause profound morbidity and mortality in pregnancy. They also showed that embolism is preceded by a definite syndrome which they referred to as "pseudo toxaemia". In this condition, systolic hypertension and albuminoidal develop during a bone pain crisis. The patient soon becomes increasingly dyspnoeic and anxious-looking and death from bone marrow embolism may soon follow. Such cases should be actively managed with heparinization which is life-saving. Finally they showed that acute sequestration of red cells to the liver and spleen, which sometimes occurs in bone pain crises should be treated with exchange blood transfusion with haemoglobin AA blood as a lifesaving measure.

There can be no doubt at all that Professor Hendrickse contributed enormously to Women's Health in Nigeria through these painstaking studies and their publications.

Notable among Professor Hendricks's associates in his work in the area of Heamoglobinopthies are: N.C. Allan; P.M. Barnes; A.F. Fleming; Kelsey Harrison; Lucio Luzatto; and E.J.Watson-Williams.

The Present

In addressing Women's Health in Nigeria at the present time, I wish to highlight the fact that it is indeed a pity that the health of women in Nigeria today is worse than it was two decades ago!!! There are several reasons for this, including poor resource allocation to the health sector which has led to the degradation of the health care infrastructure; the Structural Adjustment Programme (SAP) and the consequent devaluation of the Naria as well as the cost recovery system introduced in health care provision which has made health care unaffordable to a vast number of the Nigerian population.

Moreover, women's health is intimately linked to their status in the society. Where they have a low status and are not respected, their needs are not taken into consideration, and they are not able to take part in making decisions. It is more difficult for women to be healthy, or to help their children to be healthy, if they have no money or if they are exhausted from working too hard. It is even worse if their husband is violent and uncaring. The effect of the social and economic side of the life of a woman on her health is far more important than the medical services she uses (although these are important too).

Women who are not allowed to make decisions cannot make use of health education messages. In societies, where women are more respected, they are more likely to have some control over decision, which affect their own and their children's helath.

Some of the areas of Women's Health in Nigeria of current concern which I wish to address today are:
Matenal Mortality and Morbidity
Sexually transmitted diseases including HIV/AIDS;
Infertility;
Family planning;
and female gentle mutilation.

Maternal mortality

It is indeed alarming and a national tragedy that maternal mortality in Nigeria is amongst the highest in the whole world! Nigeria currently accounts for over 10% of the world's matenal mortality estimates.

Various hospital studies report rates of between 800 and 1,500 deaths per 100,000 births, but these figures may be on the low side since most deliveries still occur outside hospitals. Indeed, recent WHO/UNICEF estimates put the figure for Nigeria as 1,500 per 100,000. In contrast, material mortally has been significantly reduced in developed countries.

Harrison (1997) conceptualized the root cause of maternal mortality as the three fundamental issues of poverty with inequity, unbooked emergencies and illiteracy. In his opinion, the high material mortality in the country is a manifestation of gross underdevelopment. Indeed, according to the World Health Organization (WHO) and UNICEF, maternal mortality is a measure of human and social development (1996).

Maternal mortality is global tragedy. Every year 600,000 women die of pregnancy related complications, 99% of them in developing countries. And according to current estimates, at least 60,000 women die in Nigeria each year from pregnancy related causes. This is the equivalent of 3 jumbo jots packed with passengers who are all pregnant, crashing every week, in this country alone with the loss of all on board!!

According to WHO/UNICEF estimates, 7 Nigerian women die from pregnancy related causes every hour. This means that by the time this one hour lecture ends, 7 Nigerian women would have died from pregnancy related causes, virtually all of which are preventable!!!

The life time risk of drying from pregnancy and childbirth in developing countries is 1 in 48, whilst in developed countries it is 1 in 1,800. In Nigeria, the figure is an appalling 1 in 15 compared to 1 in 8,700 in Switzerland.

What makes this more depressing is the fact that services and technologies to prevent deaths, disability and illness are known and affordable. Moreover, maternal mortally is only the tip of an iceberg. Since for every woman that dies, at least 20 others have complications, which are serious and debilitating such as vesico-vaginal fistulae (VVF), recto-vaginal fistulae (RVF), obstetric neuropraxita, severe anaemia, pelvic sepsis which untreated or poorly treated may lead to chronic pelvic inflammatory disease (PID) and even infertility etc.

The cause of maternal deaths worldwide are well known and these include severe bleeding which constitute 25% of the deaths, infection 15%, eclampsia 13%, unsafe abortion 13% obstructed labour 7% other direct causes 8%, whilst indirect causes account for 19% of cases, In Nigeria, however, Okonofua and his associates, found that unsafe abortion was responsible for 40% all maternal deaths!.

Since most of the life-threatening complications occur during labour and delivery, and these cannot all be predicated. It is important to ensure that every pregnant woman has access to facilities and capabilities to provide emergency obstetric care (EOC). Neither effective antenatal care nor identifying risks will help women if emergency obstetric care is not available, not accessible, or not utilized . Recently some operations research on the prevention of material mortality was conducted, with assistance of the Columbia University , USA and the Carnegie Corporation in some West African countries, including Nigeria. Ghana and Sierra Leone. The studies identified barriers to timely and appropriate emergency obstetric care and highlighted 3 points at which delay in emergency obstetric care can occur.

1. Delay in deciding to seek care
2. Delay in reaching a first referral level facility; and
3. Delay in actually receiving care after arriving at the facility
4. It was found that delay in actually receiving care after arriving at the facility is the most critical.

The long road to maternal death

Dr. Fathalla, former Director of the WHO Special Programme of Research, Development and Research Training in Human Reproduction (HRP) described the events leading to maternal death in a most graphic way. According to him, the "*maternity road to death is a long one*" and the woman starts the journey probably at conception. The context of the economic development milieu in which she grows up may also lead her to maternal mortality. That road can be blocked by raising the status of women and if that is not done, she moves down the road through excessive fertility, by starting very early. With appropriate family planning services, they could be helped off the road. But if she is denied, she moves further down the road with high-risk pregnancy, a major factor in maternal mortality. Then she develops life-threatening complications. She could have been very quickly taken off the road by being given blood transfusion to deal with haemorrhage and caesarian section to deal with obstructed labour. Unfortunately, for many of these women, the side road that will take them out of the mortality road is blocked!.

The road is easily accessible at a number of points along its treacherous course, starting with poor socioeconomic development, excessive fertility, high risk pregnancy and finally the well-known life-threatening complications.

Its exits on safety turnings start with better status for women (including nutrition, education and gainful employment), then family planning information and services, community based maternity services and first-level obstetric services.

In developed countries, the number of women who step on the road are few, they usually join nearer the end of the road and will soon find an exit out. On the other hand, in developing countries, the numbers are enormous, women usually join nearer the beginning of the road and continue moving on and a way out is not readily available.

Reducing maternal mortality is a matter of social justice

Pregnancy and children are special events in women's lives and indeed, in the lives of their families. This can be a time of great hope and joyful anticipation. It can also be a time of fear, suffering and even death. Although pregnancy is not a disease but a normal physiological process, it is associated with certain risks to health and survival both for the woman and for the infant she bears.

These risks are present in every society and in every setting. In developed countries, they have been largely overcome because every pregnant woman has access to special care during pregnancy and childbirth. Such is not the case in many developing countries, especially here in Nigeria where each pregnancy represents a journey into the unknown from which all too many women never return!!.

This situation cannot be allowed to continue. The interventions that make motherhood safe are known and the resources needed are obtainable. The necessary services are neither sophisticated nor very expensive, and reducing maternal mortality is one of the most cost-effective strategies available in the area of public health. It must be recognized that the reduction of maternal mortality is not only a matter of effective health care but also one of social justice. The risks that women face in bringing life into the world are not more misfortunes or unavoidable natural disadvantages but injustices that societies have a duty to remedy through their political, health and legal systems.

According to Dr. Fathalla, the question that scientists, and our political leaders, must answer is, how much is the life of a mother worth?

Sexually transmitted diseases including HIV/AIDS

Nigeria, like many other developing countries, also has high rates of sexually transmitted diseases, including HIV/AIDS. In spite of the mounting reproductive health problems in Nigeria, there are very few programmes that provide comprehensive reproductive health care in the country. Most programmes, especially those that relate to family planning and the prevention of STD/AIDS, are donor-driven and hardly meet the need of men and women in rural areas.

Worldwide, sexually transmitted diseases (STDs) are on the increase, and their repercussions on women's health are serious, causing pelvic infection, infertility, ectopic pregnancies, cervical cancer and now AIDS.

In some parts of Africa, AIDS has overtaken malaria as the greatest cause of death. Fortunately, the situation in Nigeria is not that bad yet. But we cannot afford to be complacent in view of the fact that there are indications from recent studies that the incidence of HIV infection is rising in the country.

Peter Hain, Britain's Foreign and Commonwealth Office Minister of State in an article published in the New Statesman of 11 October 1999 stated that ***"AIDS is killing more Africans than war. Every day, around 5,500 Africans die of the disease and thirty million in all are likely to die within the next five years".*** This very gloomy picture was also confirmed by the Executive Director of UNICEF, Ms Carol Bellamy, in a recent address to the Eleventh International Conference on AIDS and STDs in Africa. She called the HIV/AIDS pandemic *"the world's most terrible undeclared war"* saying that it had turned sub-Saharan Africa into Africa into a killing field. "Some 200,000 people, most of them children and women, died in 1988 as a result of armed conflict on the African continent and yet 2 million Africans were killed by AIDS in that same year". How many of these deaths took place in Nigeria is difficult to ascertain due to lack of relevant data. What is clear is that the incidence of HIV/AIDS is increasing at an alarming rate in the country and yet there is little awareness campaign or preventive measures being undertaken. In a recent address by Professor Olikoye Ransome Kuti, former Federal Minister of Health, he lamented that very little is being done to ascertain the rapidly exploding epidemic in the country. This should be our "wake-up call" to rouse us from sleep so as to take urgent and necessary steps for forestall imminent disaster.

Although, the exact prevalence of HIV/AIDS in Nigeria is not known, Obisesan of our department and his associates showed in their studies an increasing prevalence of HIV-1 and HIV-2 infections in Nigeria. They studied 314 pregnant women aged 15-40 years of age (median age 26 years) who attended the antenatal clinic of Adeoyo Hospital; Ibadan during the period June-August 1995. Their study showed the incidence of HIV-1 to be 6.7% (95% confidence interval 4.3-10.2) whilst the incidence of HIV-2 was 1.6% (95% confidence interval 0.6-3.9). The prevalence of both HIV-1 and HIV-2 in this study (8.3%) is higher that the 1.2% reported 4 years earlier for pregnant women in Nigeria in the sentinel site surveillance system. Moreover, an earlier study by Shokunbi *et al.* reported HIV prevalence 0.84% in blood donors, 1.23% in international travelers and 1.48% in hospital patients for the period 1987-1988; whilst Olaleye *et al.* (1993) found a prevalence of 2.1% for HIV-1 and 1.3% for HIV-2 in a study group consisting of female commercial sex workers, blood donors, hospital patients with tuberculosis or sexually transmitted disease (STD) and hospital health care workers. It should be borne in mid that pregnant women are often considered a low risk group for HIV infection when compared to other groups like commercial sex workers, blood donors and patients with STDs.

These studies suggest that the prevalence of HIV infection in the Nigerian population is rising. Indeed, concern about the rising prevalence of HIV infection in Nigeria is receiving media attention outside the country as shown by a publication in a recent newspaper in Uganda with the headline *"5.6 million Nigerians have HIV"* The figures includes 3.1. million men, 1.5 million women and done million children showing a gender imbalance tilted toward men!!.

It is estimated that about 700 young Nigerians between the ages of 10 and 24 are getting infected with HIV everyday. This gives a frightening figure of 30 persons every hour!!!

Mother to child transmission of HIV is the leading cause of infection among young children in Africa. Because of this, it is essential to put in place measures which would enable all pregnant women to learn of their HIV status and to support preventive measure, including the use of the short-course anti-retroviral drug regimens along with suitable advise on infant feeding options. An initial study in Uganda of a simple and relatively inexpensive anti-retroviral drug.

Nevirapine, by Ugandan scientists in collaboration with the US National Institutes of Health, showed that the drug can reduce HIV transmission by 50 percent with a single dose to the mother and infant at a per-treatment cost of about US$4. Further studies are required to assess this promising drug, which is relatively cheap and affordable for use in developing country settings.

Family planning

Contraceptive use in Nigeria is very low. It is estimated that only 6-7% of women are using any from of contraception (modern and traditional methods). As a result, the total fertility rate of 6.1 per 1,000 women is I one of the highest in the world. Recent demographic and health surveys indicate that the prevalence of modern contraceptives in the country is low, at around 3.5 percent.

The world's population at the beginning of this millennium stood at less than 2 billion. This figure was trebled at the end of the millennium as the world's population reached the 6 billion mark on Tuesday, October 12, this year (1999). The population of Nigeria has followed the same trend. It was 55 million at independence in 1960, and today it is about 120 million. At the current growth rate of 3.13 percent per annum, the population of Nigeria is expected to reach 162 million by the year 2010 and 255 million by the year 2025!! According to a recent report in the Guardian newspaper, the Health Minister, Dr. Tim Menakaya, "worried about the disturbing trend in population growth of the country has solicited assistance from international agencies to implement population reduction and poverty alleviation strategies estimated to cost US$300 million per annum"

Although, Nigeria has more than 33,000 family planning service sites, the availability of services varies widely from state to state and the selection of methods offered is limited. According to the 1992 Nigeria Family Planning Fertility Census, population coverage ranges from 11 sites per 100,000 populations in Jigawa State to almost 70 per 100,000 in Osun State. Chemist shops and patent medicine stores are the most common providers of family planning services (56%), followed by clinics (11%), health centers, hospitals and maternity homes each make up about 7% of providers. Of the 33,366 sites offering family planning services, 86% provides condoms, 72% the pill, 45% spermicidal foaming tablets, 26% the injectable and 14% the IUD; whilst 4% report providing sterilization.

Emergency contraception

Emergency contraception, otherwise known as "post coital contraception" or the morning after pill" has been called the "best kept secret of family planning' due to the fact that knowledge of this effective method has been limited and little effort has been made until fairly recently to promote its widespread use.

Knowledge of emergency contraception is crucial to its use as women must known that it is possible to prevent pregnancy after intercourse before they can seek treatment. Recent studies in Nigeria by Arowojolu and Adekunle, both of our department of Obstetrics and Gynecology here in Ibadan, showed that 87.6% of the respondents were aware of emergency contraception, although only 15% knew the correct timing of emergency contraceptive. However, the use of emergency contraception was low among the respondents as only 15.7% had used emergency contraceptive pills.

Bako (1997) conducted a study to assess the knowledge and use of emergency contraception among female students at the Institute of Administation, Ahmadu Bello University, Zaria. The study showed that about 64% of the students were aware of the existence of emergency contraception but only 18% knew the correct time limit. The study also reported that 4% of the respondents had experienced termination of pregnancy. All these women said they would have used emergency contraception if they had known about it. The low rate of abortion in this study could be due to the fact abortion is illegal in Nigeria, thus most women would not disclose it.

There can be no doubt that family planning can signifi cantly improve women's reproductive health – especially of underprivileged women in Nigeria, where pregnancy complications account for more than a third of all deaths in the reproductive age group; and where, for each such death, the health of women is seriously impaired from pregnancy related illnesses.

The ability to control their fertility is the most important event in the history of womankind. Women now have the choice of whether to have children, when to have them and how many. Freedom from excessive fertility has been described as the fifth freedom, after freedom of speech and worship and freedom from want and fear. In order to exercise this freedom, women and men need access to family planning services that are effective and safe.

Unfortunately, not all women in Nigeria have the power to exercise that choice. Availability of contraceptives will certainly be a first long stride towards that freedom. It will ultimately give women in Nigeria and other developing countries the opportunity for health, education, gainful employment and self-realization.

Infertility

Fertility is important to all societies. The inability to have children has traditionally been a source of pain, anxiety, and shame. The more important children are to the fabric of a given culture, the more important it is for couples to be fertile, and the worse the consequences if a couple is infertile. Couples who are unable to bear as many children as they wish may feel anguish or emotional pain. Several reports have focused on the causes, prevention, and treatment of infertility in Africa. In Nigeria, ability to have children is an important sign of an individual's worth. Failure to have children can and often leads to social disgrace and divorce. According to a Yourba saying: " Children are the cloth of the body. Without children you are naked."

Studies undertaken by WHO involving 10,000 infertile couples in 33 centres in 25 countries, including ibadan Nigeria, showed the important role of infection in the aetiology of infertility. Worldwide, one third of cases of infertility resulted from pelvic infection, but in Africa tubal factors from infection accounted for two thirds of female infertility. The WHO studies showed serological evidence of chlamydia in 76% of infertile woman with tubal disease as compared to 29% in those with no tubal disease and 10-16% in non pregnant fertile women.

Spectacular progress has been made in the last two

decades in the management of infertility through assisted reproduction. In Nigeria, some successes have been reported from centres in Lagos, Abuja and more recently Owerri, and the number of "test-tube" babies produced in the country continues to increase. However, due to high costs, such procedures are virtually inaccessible to the majority of infertile couples in Nigeria and other developing countries.

It is, therefore, important to concentrate efforts on measures that prevent tubal blockage. These include prevention of unsafe abortion, puerperal and post-abortal infection as well as sexually transmitted diseases (STDs). WHO, in collaboration with the Centre for Disease Control (CDC) in Atlanta, USA, is currently exploring the development of a chlamydia vaccine, which, if successful, will be a major advance in prevention against tubal blockage from chlamydia infection.

Female Genital Mutilation (FGM): Is it Crime or Culture?

According to the definition provided by WHO and now universally adopted, Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the female external genitalia and /or injury to the female genital organs for cultural or any other non-therapeutic reasons. WHO estimates that over 130 million girls and women have undergone female genital mutilation. It is further estimated that 2 million girls are at risk of undergoing some form of the procedure every year. Studies undertaken in Nigeria show an overall prevalence rate of 50% in which case 30.6 million Nigerians have been subjected to the procedure.

Although, the adverse effects of female genital mutilation have been documented for years, serious attention to this practice by governments and bilateral development agencies is more recent.

FGM not only compromises the immediate physical and mental health of women and girls but also increases the risk of adverse and long-term health consequences. In view of the serious health risks and consequences of FGM, the health system should work with the community and others to safeguard the health, integrity and well-being of girls by ending the practice. Medicalization of this procedure is unacceptable. Impressed by the arguments presented by WHO to the 4th International Conference on Population and Development (ICPD) held in Cairo in 1994, the Programme of Action of ICPD urges that 'Governments and communities should urgently take steps to stop the practice of female genital mutilation and protect women and girls from all such similar unnecessary and dangerous practices".

The debate about female genital mutilation, like other traditional practices, is highly charged. Some Africans, indignant at the way Western critics denounce the tradition as barbaric and primitive, defend it in the name of culture and tradition. After all, they say, it is mostly women and not men who carry out and defend the practice.

The best way to bring about change may be to avoid cultural judgment and concentrate on the health consequences, as well as the rights of children and women.

Women's health in the next millennium: prospects and challenges.

As we gradually move into the next millennium, it is permissible to crystal-gaze as to what the future holds for women' s health in Nigeria.

Whilst doing this, we will have to take into account the vagaries of political and economic factors. The last two decades of the current millennium have witnessed a rapid gain for women world wide in the areas of gender equity and a recognition of the importance of the reproductive health of women in particular. These gains have not made visible impact on the health of women in Nigeria as shown by the current dismal reproductive health indices, which I have addressed earlier. However, the climate has changed and the next millennium holds a bright future for women's health in the country.

Maternal mortality and morbidity

One of the greatest challenges for Women's Health in Nigeria in the next millennium is to significantly reduce the level of maternal mortality and morbidity to the low levels prevailing in the developed world. The will require political will backed by adequate resource allocation to the health sector. In this regard, I call on all the governments in the country to provide free medical services to all pregnant women and all children.

Family planning

In the next millennium, Nigerian women should enjoy the freedom from excessive fertility and avoidance of unintended pregnancies through access to safe and effective methods of family planning. This should include knowledge, widespread availability and access to emergency contraceptives such as levonorgestrel and mifepristone. Widespread use of emergency contraceptives could prevent most unintended pregnancies and thus prevent the need for induced abortion and the aftermath of unsafe induced abortions, a great contributor to maternal mortality in Nigeria.

Infertility

In respect of infertility, the challenges for the next millennium include measures that will prevent tubal damage, as well as increasing acess to medically assisted reproductive technologies, including new technologies of infertility caused by the male factor.

Sexually transmitted diseases including HIV/AIDS

In the next millennium, , efforts should be directed to reducing the numbers of STDs through appropriate public health measures, greater awareness of preventive measures of HIV acquisition as well as reduction in mother to child vertical transmission of HIV. It is also anticipated that an HIV vaccine will be developed in the next millennium.

Female genital mutilation (FGM)

In respect of female genital mutilation (FGM), the challenges for the next millennium include increasing acceptance by the Nigerian community of the harmful nature of the practice and a reduction, and even a total eradication, of FGM.

I am optimistic that change will occur in the next millennium, and it will be fast. The world is now a global

village, no longer separated by distances; people can transit through time zones in a matter of hour rather than days and months. Communications are rapid. Telephones, facsimile, E-mail transmission systems, and even the Internet is widely available everywhere. Radio news and audiovisual images of global events transmitted though satellite television reach even the remotest regions of the world instantaneously. There is a much greater awareness of how the other side of the world lives.

Recent reports from Italy, U.K. and USA have shown that older women, who have attained menopause, can still conceive by embryo or oocyte donation and fulfill their desire to attain motherhood. However, Medically Assisted Reproductive Technologies (MARTs) are expensive, not widely available and their success rates are reduced in older women.

One of the most astonishing breakthroughs in the last few years of the current millennium is the birth of "Dolly" the sheep through cloning. Scientists used to think that it would be difficult to clone an animal as complex as a mammal, but Dolly the sheep certainly demolished that theory. If you can clone a sheep, a human is not much tougher. Whether it is ethical to do so is another matter, and in fact human cloning has been outlawed in a number of countries. However, illegal or not, this event may have an impact on the way the human race is reproduced in the future! If so, what will be the future role of men and women in human reproduction in the next millennium?

Women's health cannot be improved and maternal morbidity and mortality cannot be significantly reduced without overall development of the women, including adequate education and employment opportunities. The status of women in the society reflects the status of the nation. Women are important change agents for development.

There is an urgent need for increase the awareness, knowledge and perception of the people, and the women in particular, about the important role women can play in family life, performing domestic responsibilities, making economic contributions and as effective change agents for various social developments. For progress, women's development is of utmost importance and for all-round development, women's participation is vital. Women should be motivated and helped to organise themselves as demand groups. There is an urgent need to arouse society's concern and for total social mobilization and action.

Mr. Chairman, Ladies and Gentlemen, Professor Paul Hendrickse did a lot to promote women's right to good reproductive health through his work in this citadel of learning. He devoted his life to the selfless service of Nigerian women and died in active service. A former distinguished Dean of this Medical School and now Professor Emeritus of the University (Professor O.O. Akinkugbe), once titled his address to the 1974 graduating class "Gold or Garbage" He concluded that erudite address by saying: ***"Deans will come and Deans will go – it is history that determines whether the currency of their contribution is in gold or in garbage"***

Similarly, the medical staff of this College will come and go, and it is history that determines whether the currency of their contribution is in gold or garbage. Ladies and Gentlemen, it is now 23years that our dear colleague, teacher and renowned clinician. Professor Hendrickse left for the great beyond. I am sure that his legacy and contribution to this Medical School and to women's health in Nigeria and the world over are certainly worth their weight in gold. Thank you.

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