

# KevinMD.com

## **The death of a child is an abomination**

OLUBUNMI ODE, MD / PHYSICIAN | JUNE 23, 2016

When, aged thirteen, my best friend died of complications from sickle cell disease, her parents could not attend her funeral, or find out where she was buried. My mom explained to me that in the Yoruba culture, because parents are not expected to survive their children, it is considered an abomination for a parent to know where their child is buried. So, the young adults in the extended family attended the burial, and the older people stayed at home with the parents to console them. My grieving eleven-year-old mind interpreted the custom to mean "the death of a child is an abomination."

That thought resounded in my mind as I mourned my friend. It echoed when I was thirteen, and a classmate died in a car accident on the newly commissioned Third Mainland Bridge in Lagos; and again when at fifteen, I lost another friend to cerebral malaria. At seventeen years old, in my first year of university, one morning, a friend was found dead in his hostel bed without apparent cause. The only revelation at autopsy were the fragments of his last meal seen lodged within his airway. His parents were poor and lived far

away from their extended family, so it fell to us his friends to be at his burial. At the funeral, as clods of earth fell on his coffin, the thought came to me again: The death of a child is an abomination.

The thought stayed with me throughout my time in medical school and internship in Lagos where we lost several children to illnesses even as we worked hard to save the lives of many. It stayed through my pediatrics residency in Brooklyn, and pediatric critical care medicine fellowship in Boston as I learned to use every available knowledge, skill, and technology to prevent most deaths while caring for critically ill children in intensive care units. The belief that the death of a child is an abomination motivated me through long hours at patients' bedsides during my years working as an attending pediatric intensive care physician in Camden. There, children came in with untold injuries and severe illnesses. Eventually, in the fall of 2014, I moved home to Lagos to be with family, and to join the efforts of people working to stem the tide of childhood deaths in Nigeria.

Every hour in Nigeria, a hundred children die before their fifth birthday. Second only to India in the number of our dying children, one of every eight under-five children who die in the world today is Nigerian. These children mostly die of treatable, vaccine-preventable illnesses which are [complicated by malnutrition](#). There are no accounts of the vast numbers of children who die between the age of five and adulthood. There are no pediatric intensive

care units in Nigeria, and there are no pediatric ICU training programs or fellowships either. When I went around the hospitals introducing myself and describing my qualifications, no one knew of any other pediatric intensivists in the country. In a nation where more than 60 percent of citizens live on less than a dollar a day and most healthcare expenditure is [out of pocket](#), few families could afford to pay for pediatric intensive care services if their children needed it.

When I first met Ibrahim, he was two years old. Scrawny and undernourished, he looked half his age. He was born with Tetralogy of Fallot and had just undergone corrective open-heart surgery. He was one of seven children operated on during a pediatric cardiac surgery mission in Abuja. The surgeries were organized by an American-based nonprofit healthcare organization. Unlike the other children in the group, he was having a rough course. I was in Lagos when, on his seventh post-operative day, I got a call from a surgeon asking if I could help. The child was sedated, and mechanically ventilated. He was in hypoxemic respiratory failure, and had right ventricular dysfunction with low cardiac output syndrome. He was recovering from acute kidney injury with oliguria, and had suffered an extended period of atrial fibrillation. From his physical exam, he seemed to have developed a right-sided stroke. I started managing the patient on the phone, then flew to Abuja to join the team at his bedside. He did well and was eventually discharged home.

Every year, an estimated 85,000 children are born with congenital heart defects in Nigeria, all are currently referred out of the country for surgeries to [fix their hearts](#). Nigeria does not train doctors in cardiac surgery or routinely do cardiac surgeries. Pediatric cardiac surgery in Nigeria happens sporadically, most often done by international teams volunteering on medical missions. Children whose families cannot afford the immense cost of cardiac surgery abroad either die early in childhood, or struggle with poor health, unable to live to their full potential. In 2015, I estimate that fewer than sixty children with congenital heart disease had their surgeries done at different hospitals within the country — it doesn't come close to meeting the need.

Working with the same nonprofit organization, in one year, we have completed thirty-three pediatric cardiac surgeries, recording a 94 percent success rate similar to some of the best cardiac centers in the world. We bring together a mostly volunteer international team in short missions and work with the local staff in Nigerian hospitals. We emphasize staff training, skills transfer, and facilities development. It has been very rewarding work. Parents bring back their children to visit, and they send us pictures. A few months after we discharged Ibrahim, he ran up to me in the hospital hallway and hugged my knees. Like a different child, I could barely recognize him. Another child, Jeremiah, who at five months had survived days of profuse bleeding and massive transfusion syndrome in the ICU following a repair of Tetralogy of Fallot, came

back with his parents to visit us. I was filled with emotion as I watched him – chubby, bouncing and playing in his father’s arms. For many of the children, I remembered pulmonary hypertension, heart failure, pneumothoraces, or other post-operative complications we helped them through in order to get them well and home.

Beyond the joys of the individual lives changed, I feel the satisfaction of working to develop a system that serves Nigerian children. In the 1950s, when pediatric ICUs first started in North America and Europe, they happened as consequences of [advances in pediatric surgery](#). These units evolved to meet a need to provide appropriate post-operative care and monitoring for children who underwent complex surgeries like cardiac and neurosurgery. In today’s PICUs, dedicated staff work around the clock to monitor and care for children suffering an array of severe illness. Over time, I see our team getting better and our system becoming stronger. It fills me with the hope that our work will yield training, systems, and resources to continue to improve the care critically-ill Nigerian children receive, and to reduce the occurrence of childhood death and its abomination.

Adslot's refresh function:

```
googletag.pubads().refresh([gptadslots[1]])
```

*Olubunmi Ode is a pediatric intensive care physician and clinical director, pediatric intensive care operations [Hospitals for Humanity](#).*

*Image credit: [Shutterstock.com](https://www.shutterstock.com)*