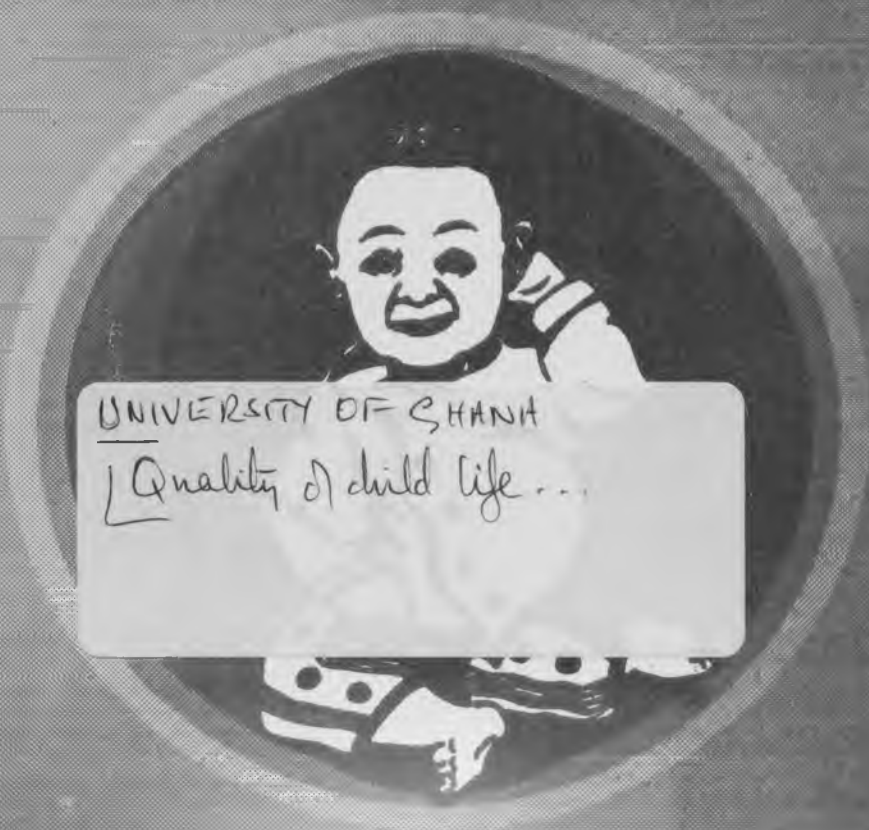


# THE QUALITY OF CHILD LIFE AND HEALTH

AN INDICTMENT AGAINST SOCIETY



F K Nkrumah

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***Child Life and Health***

**THE QUALITY OF CHILD LIFE AND HEALTH  
AN INDICTMENT AGAINST SOCIETY?**



**F. K. Nkrumah**

*Professor of Child Health, University of Ghana Medical  
School, Accra, Ghana*

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## Introduction

First of all I would like to express my appreciation to the University for giving me the opportunity, in the form of an inaugural lecture, to address myself to a subject which, I think, is of concern not only to those of us so-called health workers or health professionals but also one that ought to be equally of paramount concern to the community at large.

As such the choice of an appropriate title, which on this traditional occasion was left entirely to me, was not a difficult one, at least in so far as the first part of the title was concerned. I could have left it at that. However, since on such occasions, one is at unaccustomed liberty to talk not only on any appropriate subject but also without the usual sense of some discomfort at facing a barrage of questions and challenges thereafter, I decided to add a second, rather provocative, part to the title in the form of a question. This I did with full intention partly to arouse a certain uneasy awareness in all of us who together form the larger community or society, and partly as an attempt to relate and project the content of the first part of the title into its appropriate social context. If even in the smallest measure I am able to achieve these objectives in this inaugural lecture, then the inclusion of the second part of the title would seem justified, however provocative it may sound.

## Criteria for Determining Health and Quality of Child Life

*Health* has been very simply and unambiguously defined as "the absence of disease, and a sense of wellbeing" by the World Health Organization. *Child life*, for our purposes, implies the period from birth, when the fetus assumes an extra uterine existence, up through the various stages of a continuous, dynamic and ever changing process (known to many of us simply as growth and development) until maturity is reached. This period takes us through infancy, early childhood, (pre-school years) late childhood (school years) and adolescence (the

period of transition to full adulthood). This development and maturation process of child life, which takes up about 25 percent or more of the human life span, is probably the most critical in the entire human life — viewed both from its biological and social perspectives. At the end of this period of growth and development, the human individual is then expected to be maximally equipped, as far as his individual innate potential allows, for an independent life useful not only to himself, but also to the the society into which he is born. The achievement of this end state which expresses to the fullest *the quality of child life* should be the rightful expectation of all children irrespective of the type of social milieu or organization into which they may happen to be born and live.

Ideally, the fullest expression of health and quality of child life within any social context is measured principally in terms of three characteristics:

1. *Normal Physical Growth* — which is achieved through proper and adequate nutrition, physical conditioning through games and exercises, prevention of disease, and the occasional restoration of health when illness supervenes;
2. *Normal Emotional Maturation* — which again is achieved through a process of adaptation and relation of the child to his environment and prevention or removal of abnormal environmental factors that could readily lead to emotional instability and a disturbed relation to his social environment; and
3. *Normal Intellectual Growth* — leading to acquisition of the various skills — both cognitive and manipulative — that are necessary for an independent life and function within a social order.

These then are the three major components, or if you like, the essential ingredients, of normal child life and health wished for by parents, and one hopes also by society. They should be

seen to be universally accepted as nothing less, but the right of every child, irrespective of social standing or other social stigmata. I shall have to emphasize that in dealing with the quality of child life and health, we have to be constantly aware and appreciate that the developing child is not an autonomous individual: he is dependent on the social environment, the family and the wider social circle, which together strongly interact with him, in both positive and negative ways that may affect his physical or mental wellbeing and as such his developmental process. Child life and health thus constitute a collective responsibility of both the individual family and the larger society into which children are born.

With this statement of the criteria for determining the health and quality of life of a child, we have now set the stage to enable us examine, a little more closely and within our own social context, some of the stated components which together are essential for an acceptable quality of child life and health. The overall picture does not appear to be an encouraging or illustrious one from whatever angle one may wish to look at it. In actual fact, it is a rather depressing and alarming one, particularly in regard to those aspects of child life that directly affect his physical wellbeing and health and which, for obvious reasons, are of immediate concern. The only consolation, if indeed it is one, is that we share an overall poor quality of child life and health in unevitable company with many other developing or Third World Countries. The characteristic health statistics of such countries, Ghana included, are that of high birth rates, high perinatal and infant mortality rates and low general life expectancy.

### Indices of Health

Since most of the generally accepted indices of health of nations relate directly to the quality of life for the child, we may briefly wish to reflect on some of them, bearing in mind that the facts that we call health statistics are all too often incomplete and fragmentary for most of our populations. Nevertheless, health statistics provide the necessary evaluable



and focusing points which should prod us into recognition and appreciation of the problems and hopefully thereby provide us with the basis for more meaningful approaches. Let us briefly examine one such health statistic — the *Perinatal Mortality*. This, as a concept, expresses the number of newborns (including stillbirths) that die within the first week of life per thousand births. It reflects, to a large measure, the quality of care available to the pregnant mother and the newborn within a community. The perinatal mortality rate is probably one of the finest indicators of both the social and economic level of development and particularly the degree of access to, and sophistication of, health services in any given country. It is estimated that in West Africa, the perinatal mortality rate may be as high as between 80–100/1000 births. In other words, 1 out of the every 10 or 12 infants born in our countries does not survive beyond the end of their first week of life. As it were, these infants never even had the chance to get on their marks for the race of life. In the so called developed countries, the comparable perinatal mortality rate is approximately six times less. The major causes of such high fetal wastage in our environment are mainly related to problems associated with pregnancy and delivery; examples are: birth trauma or injuries of all types to the newborn in the course of delivery, premature delivery, low birth weight, and early neonatal infections.

If we examine another important child health indicator, the *infant mortality rate*, the statistics are equally, if not more so, disheartening. The infant mortality rate simply expresses the number of children that die within the first year of life per 1000 live births. This statistic in recent years has assumed significant importance as a comparative and reference yardstick for both health planners and developmental economists alike, because of its readily recognizable close correlation with the level of economic development of nations. For most of our West African countries, Ghana included, the estimated infant mortality rate is between 130–160 per 1000 live births. To put it in real and harsh terms, out of every 1000 infants born alive as many as 130–160 do not live to celebrate their first birthday. This figure is again about six to eight times higher than

that given for most developed countries. If we proceed a little further on the ladder of life and inquire how many of our children born do not survive beyond the fifth year — the usual school going age — the answer is simply that at least a quarter of them do not: that is, one out of every four children born does not survive beyond the pre-school age. This gloomy statistic most likely represents a conservative estimate and may be assumed to be much worse for children in our rural communities, where often even the most rudimentary health care services are unavailable or non-existent. In actual fact, and however staggering this may sound, it has been estimated that globally over 95 percent of all deaths below the age of 5 years takes place in the less developed countries. Infancy and early childhood constitute, therefore, the most critical and vulnerable years for the majority of children in our environment.

So far, I have used death, a finite end point, as an indicator of child health within our society without much reference to the quality of life that the surviving have to suffer, or endure. Yet these basic statistics bear grim witness to the precariousness of survival itself and by inference, also to the quality of life and health of the majority of children within our society. It is probably needless to emphasize that many children escaping death in infancy and early childhood may forever carry the “scars of battle” as it were, for the rest of their lives. Crippling deformities from poliomyelitis, blindness from measles, possible restriction of mental performance from early malnutrition and chronic debility from various parasitic and infectious diseases acquired in early childhood, readily come to mind as examples of such “battle scars” that not only infringe on the quality of child life but also on the individual and his social potential.

### Some Major Causes of Ill-health Among Children

What then are some of the major causes of early childhood ill-health that manage to sap the energies and, literally, the lives of such a large proportion of our children? And what are the identifiable factors which interplay to maintain such a state of ill-

health for such large segments of our childhood experience? A comprehensive answer to the first question is probably beyond the scope of this lecture. It may just suffice to mention that major childhood diseases such as measles, diarrhoea, malaria, anaemia, whooping cough, malnutrition, and pneumonia probably together claim well over 70 percent of all early childhood deaths. Malnutrition and infections, frequently presenting themselves in an interlocking and deadly manner, probably constitute the greatest threat to the pre-school child in our environment. These are principally diseases of poverty, ignorance, and under-development. As such, answers to the second question, i.e. identification of the factors that relate to such child ill-health, and by implication, the quality of child life, may have more relevance in the setting of this lecture.

### Factors Affecting the Quality of Child Life

The quality of child life and child health in any society are dependent on an interplay of environmental factors and human responsibilities. Positive factors would tend to promote healthy child development and a higher quality of child life, whereas negative factors would accomplish the opposite. Unfortunately, within our Third World context, the scales are weighed rather heavily in favour of adverse environmental factors on the growing child.

#### *Economic Factors*

First and foremost are factors that relate to the economic realities existing in our third world countries. It is not an accident of fate that the infant mortality rate in almost every country that one cares to look at, closely parallels the Gross National Product (GNP) or the Average per Capita Income. Indeed, as stated earlier, the infant mortality rate is now one of the internationally accepted indicators for socio-economic development of countries. Countries with the highest GNPs and highest per Capita Incomes exhibit the lowest infant and childhood morta-

lity rates and, vice versa, those with the lowest GNPs and low per Capita Incomes exhibit the highest infant and childhood mortality rates. National and personal economic exigencies therefore constitute one of the important determinants of the quality of life for most children. The saying that "when things get tight, children are first 'to go'" holds true of every social order, and vividly underscores the close relationship between the state of national economies and quality of child life and health. Presently in Ghana, things are tight and the obvious implications of the above saying are already evident from the increasing numbers of exceptionally ill and malnourished children we see these days and from the changing patterns of their illnesses for the worse.

### *Environmental Factors*

The rather harsh and hostile environment into which the majority of our children are born is another factor that readily predisposes many to disease acquisition at alarmingly tender ages. Low standards of personal hygiene and environmental sanitation, lack of adequate clean water for the majority of the population, inadequate waste disposal systems, poor and overcrowded living conditions particularly in our rural and ever expanding peri-urban slum areas (where incidentally over 70 percent of our population lives) contribute in no small measure to the prevalent high childhood morbidity and mortality. Diseases such as gastroenteritis, typhoid fever, pneumonia, tuberculosis, bilharzia, malaria, and a host of other parasitic and infectious diseases are directly cause-related to the environmental conditions into which most of our children are born and are expected to live and grow. The old dictum that the child is the product of his environment could not be truer as seen from the health perspective of the child. At no other time in the lifespan of the individual is the quality of his health and life so interrelatedly dependent on his total environment, as in childhood.

## *Educational Factors*

Parental ignorance (directly related to the prevalent high illiteracy rate) traditionally rooted misconceptions on child care, and adverse socio-cultural attitudes and practices are other pertinent factors that contribute significantly to the poor quality of life of children in our environment. Again, it is no accident of nature that the children of the literate minority in our society not only appear to, but in actual fact do, have better protection against many of the adverse environmental factors mentioned earlier. It is often surprising how a minimum level of education or literacy can in parallel modify and positively reinforce parental attitudes to child care practices.

## *High Birth Rates and Short Birth Intervals*

Other factors that adversely affect survival and quality of child life in our environment are the prevalent high birth rates and short birth intervals. These two factors in concert, have created within our societies a rapidly expanding population with a disproportional high number of children who have to be taken care of and supported by a relatively small number of productive adults. Presently in Ghana children constitute the broad base of the population pyramid. It is estimated that approximately 50% or half of our entire population is made up of children under 15 years of age and furthermore 20% of the population is made up entirely of children under 5 years. Unfortunately, allocation of health resources does not seem to reflect these demographic facts.

So far, I have limited myself mainly to the physical needs of children and have dwelt less on their emotional needs which, in complement to the former, form the basis of the quality of child life and health. This is in no way meant to belittle the emotional or adaptive needs of children, but mainly reinforces the brutal reality of the precariousness of sheer physical survival for most children, particularly for the pre-school child in our environment. Fortunately, the emotional needs of most chil-

dren in our environment are readily and adequately met within the framework of our extended family system, and also within the context of the nuclear family. Possibly, this is because our nuclear families still exist under the protective umbrella of the extended family. However, recent rapid urbanization and attendant dislocations in the traditional family structure, coupled with disturbing changes in attitude to traditional social values, have begun to create problems. An increasing number of children in the ever expanding urban and peri-urban areas of our cities and towns is being subjected to many adverse emotional and adaptive stresses which could easily disturb their social development and maturation. Liberalized moral attitudes, particularly in our urban and peri-urban areas are creating an ever enlarging pool of unplanned for, unwanted and under-cared-for children who are often denied adequate emotional support necessary for healthy social development.

Equally so, I may have appeared to remain silent on the special needs of the handicapped child — the mentally retarded, the crippled child, the blind or deaf child within our society. Their special needs are real and must be recognized, but in my view, they cannot assume greater concern than the overwhelming numbers of normal children for whom physical survival remains their greatest challenge. Moreover, many of these childhood disabilities are acquired rather than inherited or born with, and could have been averted had the primary diseases that led to their causation been prevented in the first place.

### **The Need for an Effective Collective Responsibility**

Earlier in this paper I asserted that the quality of child life in any society is determined by an interplay of environmental factors, and human responsibilities. The extent of the latter is again determined by the degree of individual and collective responsibility for the children born into that society. If individual or what we may also term parental responsibility is an instinctive one, then collective responsibility must be regarded

as a natural extension of that instinct. Not even those who advocate total individual liberty would deny society's responsibility for the welfare of its children. Within our own Third World context, the translation of individual responsibility into better quality care of the child is often restricted by social and economic circumstances often, but not always, beyond the control of the individual. Thus, without an effective collective responsibility, a majority of children in third world countries, Ghana included, run the high risk of being denied a right to better child life and health.

How effectively or seriously then have we, as a nation, taken this collective responsibility for our children? The still prevailing high and unacceptable infant and early childhood morbidity and mortality rates bear distressing testimony to our efforts. The full impact of the fact that one out of every four children born does not live to see his/her fifth birthday must somehow weigh heavily on our collective conscience. Any society that allows a quarter of its new entrants into the society to perish within the first year or so of life, has a collective, answerable responsibility to our Maker. We can no longer claim ignorance of the fact. It would appear that, thirty three years after Independence, we have not been able to bring about much meaningful or significant changes in the quality of life and health for the majority of children in our society. The *Year of the Child* proclaimed by the World Health Organization with great fanfare in 1979 to draw global attention to the plight and quality of life of children, particularly in Third World countries, has to a large extent remained an empty dream, mere rhetoric, and political slogan shouting. And although we are rapidly advancing close to the 21st century, we still maintain infant mortality rates comparable to what existed in Western Europe in the mid 19th century. And this despite the fact that we have had at our disposal for some time now, and fortunately for us through the learning experience of others, adequate know-how to have been able to effect significant changes in the quality of life for at least our present generation of children.

The major diseases associated with high infant and early childhood morbidity and mortality rates are still **very much**

with us in the face of the tremendous advances in medical science and technology that are related to improvements in child health. If we have failed the unspoken and unsung expectations of the majority of our children it is, in my view, mainly through a lack of seriousness of approach to the problems that affect their wellbeing and health. Though inadequate resources, high birth rates, rapid and unplanned urbanization etc., constitute real problems in terms of constraints to provision of adequate child care, still they are very unconvincing excuses for lack of motivated action and lukewarm attitudes to child care problems. Just looking at the Health Services alone, it will be a shock to many of us to learn that presently about 70 percent of children, mostly those residing in the rural areas where the need is greatest, still receive absolutely no medical care at all, for the simple reason that health care facilities, even in their very basic and rudimentary forms, are non-existent in the rural communities they are born into. Even in our more urbanized areas where we seem, ill-advisedly, to have concentrated our restorative health efforts, most of the facilities are designed primarily for adults, and provision for the child is made grudgingly or only as an afterthought.

In spite of the fact that children under 15 years constitute up to 50 percent of our entire population, their interests are mostly under-represented in the planning and management of our health care and other relevant social services. Even our urbanized and, supposedly, planned residential areas are all devoid of any recreational and play-ground facilities for children. Visit any hospital in Ghana and you will notice that facilities for taking care of sick children (who constitute over 60 percent of daily attendances) are mere appendages to other sections of the hospital. Furthermore, our health and social planners seem to have become fossilized in their mistaken conception that children are just miniaturized adults without specific and special needs. Consequently, child health promoting programmes such as protective immunizations, health education, nutritional support, counselling to parents particularly on family planning and child spacing, supervision of the environment of the child, recreation facilities for the child, etc.



have not been taken with the degree of seriousness and urgency they demand. The resources necessary for implementing such programmes should not be grossly beyond our collective capacity to pay for or beyond our administrative capacity to plan for. The present ill-suited system of our emphasis on restorative or curative aspects of health care, with its high cost and its limited accessibility to the more urbanized areas where only a minority of our population lives, deprives a large segment of our total community of resources for health promoting and preventive programmes which particularly bear on child life and health. This is by no means meant to belittle the definite and appropriate role of the curative services and their relation to child health.

Health preventive and health promotive measures when even applied judiciously and with absolute and even collective enthusiasm, take time to register their desired effect on child health statistics. In the meantime, it becomes imperative that we provide the necessary care and comfort to literally the thousands of sick children who flock to our over-burdened and ill equipped health service centres crying out for help. To deny them the restorative care they need or to ignore their silent pleading will be equally irresponsible. A health system has to evolve which, not only is responsive to the immediate health needs of the large numbers of ill children already threatened with physical extinction but also, more important, firmly lays the foundation for disease prevention and health promotion for better quality child life and health.

Society as a whole bears a collective moral responsibility to its young ones, if only for the simple reason that children cannot articulate their needs in any effective manner. It is society that must share the collective responsibility of speaking for and acting on their behalf and interest. Can we, as a society, with good conscience, attest that we have discharged or are discharging this responsibility to the best of our intentions and ability? The facts, as I have tried to lay before you, and as I see them, must deny us an affirmative answer. We seem not to have quite grasped the biological and social fact that the future of a nation is built on the foundation of its children. If we, the

society, are willing to recognize and concede this, then those of us, in particular, whom our struggling societies have elevated to more enlightened positions and who therefore cannot claim ignorance, must insist that those responsible for the planning and administration of our health and social services take due note of the special needs of all our children at every stage of their development. These, in the main, should include the provision of the essential elements of primary health care to all of our communities, particularly to our rural and grassroot communities where the need is greatest and most urgent.

Active promotion of child health through immunizations, communicable disease control, environmental sanitation, family planning, health education and the promotion of individual and community participation in child health and social programmes must be seen to be the bedrock of any future programmes aimed at improving the quality of child life and health. Many of the causes of common child health problems derive from parts of society itself and as such, a strict health sectorial approach will not be totally effective. Other actions outside the field of health such as improvements in food production, expansion of adult education, provision of good drinking water, adequate housing and better waste disposal systems are necessary to augment any strictly health intervention programmes. The bleak economic outlook predicted for many developing countries implies that improvements in the quality of child life and health will also demand a political commitment to apply and redeploy resources where the need is greatest.

Our leaders, our governments, and we ourselves have a moral obligation to define and implement those policies whose basic guidelines will allow our children to accede to that physical, emotional and social wellbeing, which is their right. The effort required may be great, but the best way to improve a nation's health, in the long run, is through the care of its young ones.



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