
Obstetric and Gynaecological Status of African Women With Plight of Girls: experience and interest

Although the above article is comprehensive enough, yet I feel that I should add a few more points relevant to African culture, concerning the women folk and the girls.

Way back while working in Nigeria, as the consultant Gynaecologists/Obstetrician to the wives of Armed Forces and Police personnel of that country, for 6 years, starting from 1962 onwards, I encountered the following scenarios worth mentioning here.

Some of the Nigerians had double marriages e.g. one according to Christianity and the other, even after years, according to Church of Africa. Furthermore, Nigerians being polygamous, the men of the forces, mostly of lower ranks had multiple wives, but they were allowed free treatment for only 4 of them (The educated officers however invariably had single wife). Thus while conducting antenatal clinics I had to entertain to the tune of 300 to 360 women every alternate day. Of course being the only doctor I could only manage these numbers in a meaningful manner, with the help of four British qualified competent nursing sisters. This goes to show that many of these women were aware of the benefits of appropriate antenatal care. All of these women however did not deliver at the Military Hospital Yaba, Lagos, where I was working, as majority of them preferred to deliver in the 'Primitive Settings'. Regarding Primitive Births, I was told by some women that in some tribes the baby is kept connected to the placenta, until the latter comes out. Thereafter the placenta is placed on a hot iron plate to drive all the goodness in it to the baby, before the cord is cut. Moreover at times when

placental expulsion is delayed a woman would stand on the abdomen of the parturient to expel the placenta and so on.

It was therefore the educated ones (often the wives of senior officers) those otherwise aware of benefits of hospital delivery or those with complications (screened out at antenatal clinic), along with some emergencies that came to us. Deliveries were either normal, instrumental or by Caesarean sections for various indications including cephalo pelvic disproportion or antepartum haemorrhage with blood flowing out from the floor like in a non antenatal case of ours who was fortunately saved along with her baby girl - who was named after me by the parents, the Nigerians being full of gratitude, as patients.

Another feature was bravery of these women - once having delivered a woman by forceps I went to wash my hands and lo and behold I saw her walking in the veranda!

Furthermore, many Armed Forces individuals with children up to 13 to 14, in number when offered 'Tubal Ligation' on their wives would say I wish they (doctors) told me this before, I would then have had lesser children.

Every child born to parents of some Tribes, like elsewhere in Africa, would have a 'song' dedicated to it for life.

But strangely enough, if any wife of these young soldiers ever required hysterectomy for reasons like multiple fibroids with complications (fibroids being common in

that country), the husband would say “I can put her to grave, but not have her without a womb”! This is where and why I had to perform many Myomectomies according to Victor Bonney’s Minute of Myomectomy.

Post-delivery vesico-vaginal fistulas were also encountered in wives, of some soldiers, who delivered in remote areas. On them I performed Fistula Repair according to what I had learnt directly from Prof. Col. Sami - The Pioneer of Fistula Repair in Pakistan - at his visits to Ganga Ram Hospital, Lahore, during the years of my training from 1957-1959.

Another situation that I encountered in Lagos, Nigeria was of Female Circumcision/Cutting or better called Female Genital Mutilation (FGM). Some young girls of 10-13 were brought to me with gross sepsis of mutilated genital areas or with profuse bleeding from there, in moribund condition. Thanks to the well-equipped hospital, I was working in, that I could manage these situations - but alas I could not abate physical scars at that time, nor the psychological trauma these young girls had and would continue to suffer from.

Way back home in Pakistan in early 70s at Holy Family Hospital, Rawalpindi I encountered a Sudanese woman, well placed and full term, who wanted me to deliver her through a small hole left at the perineal site, after FGM done on her during her childhood— I wondered how she had conceived. I had to tell her that I can just not deliver her from below, to which she replied Oh doctor, I have had 2 prior deliveries from below, at home in Sudan. To this I replied please go home and get delivered there. She returned after 3 months, having had a baby from below after wide bilateral posterior perineal incisions extending from both sides of the hole, and was OK about it all!

In addition to my personal experience, there are certain core issues of African culture, which deserve further special mention here

Female Genital Mutilation

Having started around 4000 years ago in Egypt (horn of Africa)¹, FGM became wide spread in Africa (and some middle Eastern Countries). It was meant to appease the ego of patriarchal men, to reduce promiscuity of girls, and/ or to maintain their virginity till the time that a man so called gets them at marriage. If uncut they are secluded, thus getting married could be a problem for them etc. etc.

People of spectrum of faiths follow the practice of FGM, like Christians, Muslims or those who believed in Church of Africa.²

Its Types — They may be minor to major, including genital pricking, piercing, cutting parts of clitoris and labia and suturing remaining labial folds together, leaving a small hole for urine and menstrual blood flow, or even complete amputation of the external genitalia of girls. Some girls have FGM twice. Invariably the girls were swept away in the backwoods or some room and cut under unhygienic conditions, held tight by a number of women.

The tragedy is that this practice has no advantages, but innumerable health hazards for the victimized girls. Immediate and late consequences include sepsis, haemorrhage, problems with urination, cyst formations inside and over the perineum, even infertility and difficulty at delivery if at all possible from below. Above all there is great psychological trauma, for life.¹

This menace not only affects the girls living in Africa, but also those of African origin settled with their parents abroad like in USA and UK, from where too the parents send these girls back to their ancestral lands during vacations for genital cutting, at times called “Vacation Cutting”.² According to WHO 125 million living women in the world have had FGM of some sort,¹ with huge numbers residing in the countries to where they have migrated. By virtue of stringent Laws, Bans and

Advocacy agencies, the tradition has reduced in recent times, yet it exists in the tune of 98% in Somalia, 96% in Guinea, 93% in Djibouti and 89% in Mali and so on, although many African countries are now free of it.²

A USA directed report suggests that most probably the families seek to carry out these mutilations, in a culturally sensitive manner, being aware of the long history of this practice.² Various goals have therefore been set for the Support groups working to end this practice which include, dispelling the false hood that it is an Islamic tradition, gently educating the families about the health hazards and teaching and training the doctors to look after the victims at the time of mutilation, later for repair or reconstruction of their genitalia if possible and still later at the time of delivery and so on.

It is painful to read the song of a mutilated girl

“I had my female cut from me, my sensations stolen and discarded replaced with numbness and pain. My say in the matter? Negligible and disregarded.

I was told it was to cleanse me, purify me, ensure my chastity till the day my husband took me at sunrise.

So they mutilated me, without second thought or anesthetics, they cut me with razor sharp non-sterilized blades, they sliced me. They took it!”²

Rape

Of late this hideous animalistic crime has attained a high level of misery in Africa, for the young girls and women, like in many other countries of the world. Worst part of it is that in the warring zones the soldiers do not leave even the pregnant women! Laws against it if at all existent have significant impunity, serving the lust of the men, with submissive attitude of affected girls and women. It is only of late that some of the victims are becoming outspoken and exposing the culprits.

Activists and organizations are working to get rid of these ills and as mentioned earlier Laws and Bans too are being enforced. Yet lot more work and efforts have to be put in for eradicating these inhuman acts.

Some of the current activists and other outstanding women of the past from African Continent will be described in the ensuing issue(s) of JSOGP.

References

1. Douglas Martin. The International New York Times, Oct 30th, 2014:2.
2. Julie Turkewitz. The International New York Times, June 12th, 2014:5.

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