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Characteristics of childbirth in women who have suffered female genital mutilation at the maternity ward of the Ignace Deen National Hospital Conakry University Hospital

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Abstract
Introduction: FGM is any procedure involving the partial or total removal of the external female genitalia or injury to these organs for cultural or other non-therapeutic reasons. The objective was to contribute to the study of the characteristics of childbirth in women who have undergone female genital mutilation at the Obstetrics and Gynecology Department of the Ignace Deen National Hospital.
Methodology: This was a prospective descriptive study lasting 6 months from July 1 to December 31, 2024, carried out in the gynecology-obstetrics department of the Ignace Deen National Hospital in Conakry, involving women in labor who had undergone female genital mutilation and were admitted to the department who had given birth vaginally, and their newborns.
Results: The frequency of delivery in parturients who had undergone female genital mutilation was 75.69% with 39.92% type I and 60.08% type II. These were mainly patients aged 21-25 (38.54%), married (80.0%) and primiparous (56.91%). Instrumental extraction was 38.93% and episiotomy was performed in 34% of cases with 6.08% early neonatal death.
Conclusion: This study shows that the frequency of female genital mutilation remains high among parturients received in the department and type II remains the most frequent. The abandonment of female genital mutilation could contribute to the reduction of maternal and neonatal morbidity.

Keywords: Childbirth, female genital mutilation, Ignace Deen, Conakry

1. Introduction
Female genital mutilation (FGM) means all procedures involving the partial or total removal of the external female genital organs or damage to these organs for cultural or other non-therapeutic reasons [1]. The damage caused is irreversible and can be responsible for serious complications, of which obstetric complications are particularly to be feared [2]. The age at which these interventions are performed varies according to ethnic groups and countries. They are most often carried out before adolescence, on girls aged 4 to 10 years [3]. They are rarely carried out at birth, in adolescence, at the time of marriage, or even after the first childbirth [4]. Approximately 60% of women in developing countries are victims of female genital mutilation [5]. It is common in several countries, mainly in Africa, and the WHO estimates that more than 100 million little girls and women have undergone some form of sexual mutilation [1]. The geographical origin of this practice is believed to be the Upper Nile region, where it was already practiced in the Pharaonic era [6]. They are practiced mainly in Africa, in the south of the Arabian Peninsula and along the Persian Gulf. Due to migratory flows, FGM is also increasingly found among immigrant populations in Europe, Australia, Canada and the United States of America [7]. Epidemiological data on FGM vary from one country to another. It is particularly common in the Horn of Africa region (Djibouti, Somalia and northern Sudan) but also in Egypt, Ethiopia, northern Kenya, Mali and Nigeria [8]. In Guinea, female genital mutilation is practiced in all regions. According to data from the latest Demographic Health Survey (2016), nearly 97% of women aged 15 to 49 years surveyed reported having undergone at least one form of female genital mutilation [9]. Childbirth among women who have undergone FGM is complicated by expulsion dystocia with frequent vulvo-perineal lesions and acute fetal distress [10].
Thus, female genital mutilation constitutes, due to its high frequency and its complications, a

real public health problem, and the absence of previous study on this subject in the department motivated the realization of this work whose objective was to contribute to the study of the characteristics of childbirth in excised women in the obstetrics and gynecology department of the Ignace Deen national hospital.

2. Methodology

2.1 Type and duration of study: this was a prospective descriptive study lasting 6 months from July 1 to December 31, 2024, carried out in the gynecology-obstetrics department of the Ignace Deen national hospital in Conakry, involving parturients who had undergone female genital mutilation and were admitted to the department who had given birth vaginally and their newborns who were alive or died during childbirth and who agreed to participate in the study.

2.2. Sampling: We carried out an exhaustive recruitment of parturients meeting the selection criteria defined above during the study period.

The variables were:

- **Quantitative:** Maternal age, parity, number of CPNs, gestational age, duration of labor and duration of expulsion
- **Qualitative:** Occupation, educational level, marital status, types of female genital mutilation, mode of delivery, instrumental extraction, maternal morbidity and mortality, neonatal morbidity and mortality.

2.3 Data entry and analysis: Data were entered using Excel software from the Office 2016 package and analyzed using SPSS.26.0 software.

2.4 Ethical considerations: Informed consent was obtained from participants, confidentiality and anonymity were maintained. The results obtained will be used solely for scientific purposes.

3. Results

3.1 Frequency

We recorded 1012 deliveries of women who had undergone female genital mutilation out of a total of 1337 deliveries, i.e. a frequency of 75.69%. Type I concerned 404 parturients, i.e. 39.92%, compared to 608 type II, i.e. 60.08%.

Table 1: Sociodemographic characteristics of women who have given birth and are victims of female genital mutilation

Settings	Staff	Percentage
Age (years)		
≤ 20	236	23.32
21-25	390	38.54
26-30	260	25.69
31-35	82	8.10
36-40	34	3.36
> 41	10	0.99
Average age: 24.5±5.7 years	Extreme ages: 14 years and 44 years	100
Occupation		
Liberal	354	34.98
Student	252	24.90
Housewife	250	24.70
Employee	156	15.42
Marital status		
Bride	850	84.00
Bachelor	162	16.00
Educational level		
Not in school	468	46.25
Primary	94	9.29
Secondary	234	23.12
Superior	216	21.34

Table 2: Distribution of women giving birth who were victims of FGM according to parity

Settings	Staff	Percentage
Parity		
Primiparous	576	56.91
Pauciparous	324	32.02
Multiparous	90	8.89
Large Multiparous	22	2.17
CPN number		
1	84	8.30
2	228	22.53
3	308	30.43
4	340	33.60
> 4	42	4.15
None	10	0.99
Term of pregnancy		
Pre -term	26	2.56
Term	962	95.05
Post term	24	2.37

Working hours		
< 12h (primipara)	189	18.68
< 10h (multiparous)	355	35.08
>12h (primipara)	206	20.36
>10h (multiparous)	262	25.88
Duration of expulsion		
≤ 30 min	634	62.64
> 30 mins	378	37.35
Release mode		
Spontaneous	618	61.07
Instrumental	394	38.93
Episiotomy		
Yes	344	34.00
No	668	66.00
Perineal tear		
Yes	217	21.44
No	795	78.56
Types of perineal tears		
First degree	120	55.30
Second degree	80	36.87
Third degree	17	7.83

Table 3: Distribution of women who have given birth and are victims of female genital mutilation and their newborns according to their prognosis

Settings	Staff	Percentage
Maternal prognosis		
Immediate HPP		
Yes	246	24.30
No	766	75.69
Neonatal prognosis		
Apgar s greater than 7/10 at the 1st minute		
Yes	634	62.65
No	378	37.35
Results of neonatal resuscitation		
Newborn successfully resuscitated	355	93.92
Newborn resuscitated in vain	23	6.08

Discussion

The frequency of childbirth among circumcised women in this study was 75.69%. This frequency is significantly lower than that found in EDS V Guinea in 2018 (95%) [11] but comparable to the 76% of circumcised women reported by EDS IV Mali in 2006 [12], and higher than the 72.86% reported by Millogo Traoré *et al*. in 2007 in Burkina Faso [13]. This finding could be explained by the fact that religion and sociocultural factors appear as a factor of exposure to the practice of excision which is anchored in social norms, particularly at the level of initiation rites (the passage from childhood to adolescence and adulthood of girls or the preparation of the young girl to enter working life in certain communities). The age group of 20 to 25 years was the most represented in our series, i.e. 38.54%. A proportion of 34% was recorded in the WHO multicenter study carried out in six (6) African countries in 2006 [1]. This could be explained by the fact that this age group is sexually active. It emerges from this series that 34.98% of women who gave birth and underwent female genital mutilation were self-employed, this rate is double that reported by Sidibé D *et al*. in 2019 in a level II hospital in southern Guinea, i.e. 15.31% [14]. Married women were the most represented in our sample, i.e. 84%. This proportion is significantly higher than those reported by Sidibé D *et al*., i.e. 62.24% [14]. In our society, marriage constitutes the situation allowing children to be born due to the weight of culture and religion, because in our society, it is not admissible to have children outside of marriage. In the majority of cases, those who gave birth were not in school. This result corroborates that of the EDS Guinea V of 2018 [11], i.e. 69% of women having no level of education.

The study population was dominated by primiparas. An identical observation was reported in the study of Millogo Traoré F *et al*. in their series in 2007 at the maternity ward of the Yalgado Ouédraogo University Hospital in Ouagadougou with a frequency of 46.70% of primiparas [13].

Regarding prenatal consultation, the majority of parturients had at least 3 consultations during pregnancy. A lower number of prenatal consultations than ours was recorded in the study of Sidibé D, i.e. 43.88% of parturients having benefited from two prenatal consultations [14]. Female genital mutilation types II and I were the most frequently recorded in our series. Labor was prolonged in 46% of parturients. In the literature, some authors note a prolongation of the second phase of labor in circumcised women, particularly in type III FGM [15-17]. Some authors believe that the lengthening of the duration of labor is not related to the perineal scar [18, 2, 15]. Indeed, the duration of labor is related to uterine dynamics and the state of the cervix. The perineum will only be used during the expulsion phase. In our sample, 3 out of 10 parturients (37.35%) had an expulsion duration greater than 30 minutes. For Dolo A *et al*. the risk of a prolonged expulsion of the fetus was 2 times higher in circumcised women and was correlated with the extent of genital mutilation [19]. This is linked to the resistance caused by fibrosis of the scar tissue of the perineum [15, 19, 20].

We recorded 38.93% instrumental extraction. This result is twice that found by Théra T *et al*. in 2013 in Mali, i.e. 17.8% instrumental extraction [21].

This could be explained by the high frequency of the expulsion

phase with the high risk of acute fetal distress and the mastery of instrumental extraction by the providers in the delivery room.

This work shows that a third of parturients had benefited from episiotomy (34%). This rate is identical to that of Millogo Traoré *et al*. who reported in their study a frequency of 34.56% [13]. Episiotomy is an act aimed at preventing perineal tears in women in the event of difficulty related to expulsion.

Perineal tears were common in this series. They were dominated by those of the 2nd and 3rd degree. Frequencies lower than ours have been reported by some African authors [13, 14].

During the study, we recorded 37% of newborns with an Apgar score below 7/10 in the first minute who received neonatal resuscitation, of which 94% were successfully resuscitated versus 6% resuscitated in vain. The prolongation of the expulsion phase and maternal exhaustion and Our finding is comparable to that of Sidibé D who reported 48.99% of newborns resuscitated [14].

For Akotionga *et al*., fetal suffering is related to expulsion dystocia in circumcised women, which is accompanied by neonatal suffering and even death per partum [20].

We recorded 227 cases of neonatal evacuations to the Institute of Nutrition and Child Health, or 22.43%. These are mainly newborns who were resuscitated whose Apgar score was less than 10/10 at the fifth minute, some of whom presented respiratory distress.

Conclusion

This study shows that the frequency of female genital mutilation remains high among women in labor received in the department and type II remains the most frequent.

FGM resulted in a very high use of instrumental extraction in our series and episiotomy. Perineal tears, immediate postpartum hemorrhage and fetal distress were the main complications. The abandonment of female genital mutilation could contribute to the reduction of maternal and neonatal morbidity.

Conflicts of interest: The authors declare no conflicts of interest related to this work.

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