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Case Report

A Maternal Near-Miss: A Case Report of Prolonged Labour Due to Female Genital Mutilation at the Bole District Hospital, Ghana

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Abstract

Introduction: Ghana continues to grapple with the complex issue of female genital mutilation/cutting (FGM/C), a practice marked by notable regional disparities. Driven by multifaceted motivations, including deeply ingrained cultural values, perceived benefits for the girl child, and efforts to curb sexual promiscuity, FGM/C poses significant health risks. This article presents a near-miss case of a 19-year-old woman who experienced prolonged labour and postpartum haemorrhage (PPH) due to complications arising from FGM/C. Case Presentation: A 19-year-old woman with a history of FGM/C presented with prolonged labour and PPH. Physical examination revealed Type 3 FGM/C (infibulation) complicated by multiple perineal and vaginal tears. A vaginal delivery was facilitated by bilateral episiotomy, and the episiotomies and lacerations were subsequently repaired. Due to significant blood loss from PPH, the patient received 2 units of whole blood. Fortunately, the mother recovered physically well, with normal urinary and faecal continence, and the baby pair is doing well. However, true recovery in this case will require an enabling environment and supportive care to address her psychosocial needs. Conclusion: We strongly recommend a comprehensive approach to eradicate FGM/C, including awareness creation, strengthening anti-FGM/C laws, and providing a supportive environment that promotes the physical, psychological, and social well-being of victims. Collective efforts by all stakeholders are crucial to achieving this goal and ensuring that women and girls are protected from the harmful effects of FGM/C.

Keywords

Maternal Near-Miss, Female Genital Mutilation or Cutting, Prolonged Labour, Savannah Region, Ghana

1. Introduction

Female Genital Mutilation / Cutting (FGM/C) is a harmful cultural practice that involves the partial or total removal of the external female genitalia for non-medical reasons [1]. FGM/C is a violation of the human rights of girls, adolescents, and women [1]. According to the World Health Organization (WHO), FGM/C is a global public health issue, practised in at least 30 countries, and over 200 million girls and women have undergone FGM worldwide [1]. FGM/C is most commonly

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practised in Africa, the Middle East, and Asia, but it also occurs in other regions, including Europe, North America, and Australia, due to migration and globalisation [2]. The highest prevalence is found in Somalia (98%), Guinea (97%), and Djibouti (93%) [2]. Other countries with high prevalence rates include Sierra Leone, Mali, Egypt, and Sudan [2].

The prevalence of FGM/C in Ghana is estimated to be less than 12% of women of reproductive age with marked regional disparities [3-7]. In Ghana, FGM is a criminal offence punishable by law under the Criminal Code (Amendment) Act 1994 (484). Perpetrators could be sentenced to 5 – 10 years imprisonment if found guilty [8]. Over the years, the government of Ghana has implemented many programmes to raise awareness about the devastating effects of FGM/C and to educate the citizens about the law. These and other global efforts led to a drastic reduction in the practice of FGM/C in Ghana but not abandonment, from 97% in 1994 to among the Kasenas [9] to about 24% in 2021 [7]. The practice of FGM/C is still ongoing in some remote parts of the country, especially in the 5 northern regions with disparities in the prevalence [7, 10, 11]. In the Northern region, the prevalence of FGM/C is 7.5%; 24.0% in the Upper East; and 50.5% in the Upper West Region [7].

The commonly cited reasons for the practice of FGM/C include traditional and cultural beliefs, religious beliefs, a rite of passage into womanhood, suppression of sexuality, promiscuity, ethnic identity, and inclusivity [1, 11-13]. The predictors and factors associated with the practice of FGM/C in Ghana and other parts of the world include age, place of residence, ethnicity, educational level, economic status, marital status, employment status, religion, and maternal FGM status [7, 14, 15].

The obstetric complications of FGM/C include prolonged and obstructed labour, increased risk of maternal and neonatal mortality, vaginal and perineal lacerations, obstetric fistula, infection and sepsis, foetal distress and stillbirth [1, 5, 16-18]. Again, women who have undergone FGM/C are more likely to experience emotional trauma, anxiety, and depression during childbirth, which can further exacerbate these physical complications [19, 20]. In this paper, we report on a maternal near-miss case of a 19-year-old nulliparous woman with prolonged labour due to complications of FGM/C. We complemented the case report with existing literature to highlight the ongoing FGM/C pandemic and its devastating impacts on women's health, well-being, and lives.

2. Case Presentation

A 19-year-old nulliparous woman was referred to the Bole District Hospital in the Savannah region of Ghana after 18 hours in labour, including 12 hours at home and 6 hours at a CHPS Compound, due to failure to progress. On arrival, she was in severe pain but had stable vital signs. Obstetric and pelvic examination revealed the Symphysio-fundal height (SFH) to be 32cm, lie longitudinal, cephalic presentation descent 0/5th, Contractions: 4/10 minutes, 50secs duration, and foetal heart rate was 170 bpm. The external genitalia had no clitoris, no labia minora and some parts of the labia majora. (This was carried out during her childhood) Parts of the labia majora were fused with an old scar between them (Type 3 FGM with narrowed vaginal introitus). There was massive caput succedaneum and very tight vaginal introitus, with perineal lacerations.

Vaginal delivery was achieved with the aid of bilateral episiotomy. The patient sustained multiple perineal and vaginal lacerations with resultant primary postpartum haemorrhage. The total estimated blood loss was about 1100mls.

The baby delivered weighed 2.6 kg, had low APGAR scores (4/10, 6/10) and was admitted to the neonatal intensive care unit for 7 days due to birth asphyxia before discharge.

Following the challenging delivery, her episiotomies, vaginal, and perineal tears were repaired. To prevent infection, she was prescribed a 7-day course of antibiotics (Amoxicillin-clavulanic acid and Metronidazole). Additionally, she received a blood transfusion of 2 units to address anaemia caused by postpartum haemorrhage (PPH) due to the perineal and vaginal lacerations. The haemoglobin before transfusion was 6.1g/dl and post-transfusion haemoglobin was 9.0g/dl. Pain management was effectively achieved with diclofenac suppositories. A urethral catheter was placed for 10 days as a precautionary measure to prevent obstetric fistula formation, ensuring a thorough and safe recovery. She was prescribed tab fesolate 200mg daily x 30 days.

The patient was discharged after 14 days, she has come for postnatal services and the mother-baby pair is doing well. The mother is continent of both urine and faeces.

This case report was conducted in accordance with the principles outlined in the Declaration of Helsinki. Written informed consent was obtained from the patient for publication of the clinical details and accompanying images for academic purposes. The patient was fully informed that the images might be published in medical journals, and consent was obtained after ensuring anonymity by removing any identifying information.

3. Discussion

The case presented in this paper originates from the Savannah region of Ghana, a region with one of the highest prevalence rates of female genital mutilation (FGM/C) in the country [7, 8, 10]. The patient in this case had type 3 FGM/C, which resulted in a narrowed vaginal introitus [1, 6, 21]. This traumatic practice, experienced in childhood as part of a sociocultural tradition, has led to severe consequences, including prolonged and obstructed labour, as well as other obstetric complications. By examining this case, we aim to highlight the critical role of environmental factors surrounding the patient in perpetuating such adverse outcomes.

FGM/C causes complications throughout a woman's lifespan, broadly categorised into urogynaecological, obstetric, and psychological complications [19]. Research has shown a

direct association between type 3 FGM/C and obstetric complications, including prolonged or obstructed labour [5, 17, 18, 22-24]. Studies have reported increased risks of postpartum haemorrhage, perineal trauma, caesarean section, and neonatal complications [17, 18, 25]. However, some studies have found no association between obstructed labour and FGM/C [26, 27]. In FGM/C cases like the one described, prolonged or obstructed labour occurs due to excessive scarring preventing normal stretching of the perineum and vaginal outlet during labour, leading to severe maternal morbidity and mortality [28, 29].

Figure 1. *Type 3 FGM/C causing perineal and vaginal tears.*

The management of FGM/C cases requires skilled birth attendants trained to perform procedures like episiotomy, which was necessary in this case to aid delivery. However, FGM/C stigma deters women from seeking skilled delivery [30]. Our patient exemplifies the consequences of delayed medical care, having laboured for approximately 12 hours under the care of a traditional birth attendant in a home setting, likely due to perceived stigma associated with formal medical facilities, a concern particularly relevant among nulliparous women. This case highlights how cultural beliefs and stigma can contribute to both the perpetuation of FGM/C and delayed access to skilled medical care. We use this case to illustrate the complex interplay between cultural factors and healthcare-seeking behaviours, emphasising the need for targeted interventions to address these barriers.

Figure 2. *Repaired episiotomies, vaginal and perineal lacerations.*

Despite Ghana outlawing FGM/C in 1994, this case report underscores the persistence of this practice as a significant public health concern. FGM/C continues due to inadequate collaboration among key stakeholders, including opinion leaders, state institutions, and human rights groups [31]. Predictors of FGM/C in Northern Ghana include residence region, ethnicity, educational level, and economic status [10], with cross-border activities potentially contributing to its prevalence in border towns due to legislative gaps [8, 10]. Addressing FGM/C requires a coordinated effort among stakeholders, including government modification of laws to include cross-border FGM/C, development of preventive protocols by the Ministry of Health, awareness creation by healthcare providers, public denunciation by community leaders, media reporting, and integration of FGM/C education into school curricula.

Notably, this case report highlights the direct causal link between a harmful environment and tragic health damage, underscoring that FGM/C is a broader societal issue determining women's health. Our ethical responsibility extends beyond treating individual patients to transforming the social environment perpetuating FGM/C. A comprehensive approach addressing the root causes of FGM/C and promoting a supportive environment for women's health and well-being is essential.

4. Conclusion

While this case achieved physical recovery through timely and appropriate medical intervention, it marks only the beginning of a long journey toward true recovery. Victims of FGM/C often face lifelong challenges, including psychological trauma, reduced quality of life, and ongoing health complications. Comprehensive support, encompassing not only physical post-treatment care but also psychological counsel-

ling and community-based interventions, is essential for holistic recovery. This case underscores the urgent need to eradicate FGM/C as a harmful environmental factor and create a supportive environment that protects the physical, mental, and social well-being of survivors. By doing so, we can work toward a future where women and girls are free from the physical and psychological harm caused by this practice.

Abbreviations

FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation / Cutting
PPH	Postpartum Haemorrhage
SFH	Symphio-Fundal Height
WHO	World Health Organisation

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Author Contributions

Jonathan Wadeyir Abesig: Conceptualization, Validation, Writing – original draft, Writing – review & editing

Ernest Tei Maya: Supervision, Validation, Writing – review & editing

John Kuumuori Ganle: Supervision, Validation, Writing – review & editing

Conflicts of Interest

The authors of this case report declare that they have no competing interests.

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