

Original Research Article

Management of deliveries at the University Gynecology & Obstetrics Department of the Institute of Social Hygiene Hospital in Dakar

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Abstract: Introduction: The current strategy to combat maternal and infant mortality is essentially based on three pillars which are family planning, childbirth assisted by qualified personnel (midwife, nurse, doctor) and emergency obstetric and newborn Care (EmONC). **Objective:** Evaluate the care of parturients in the gynecology and obstetrics department of the Institute of Social Hygiene in Dakar. **Patients and Methods:** We conducted a retrospective and descriptive study conducted over a period of six months from January 1st to June 30th, 2019 on the management of births in the Gynecology and Obstetrics department of the Hospital Institute of Social Hygiene in Dakar. We studied the epidemiological, clinical parameters of parturients and the prognosis of childbirth. **Results:** We collected 689 birth records, representing 8.2% of the overall activities of the service and 69% of emergency activities. The epidemiological profile of our parturients was that of a young primipare (41%) with an average age of 27.4 years, married (96%) with a history of cesarean section (14.6%), who had completed at least 4 prenatal consultations (58.1%) and carried a pregnancy to term (72%). The evacuees represented (43.7%) parturients and came mainly from outside the southern health district (61.8%). More than half of the parturients had given birth vaginally (55.3%). The cesarean section and instrumental extractions accounted for 44.6% and 0.1%, respectively. We recorded 706 births, 98% of which were alive. The stillbirth (20) was distributed as follows: 9 fresh stillbirths and 5 macerated stillbirths. **Conclusion:** The current strategy to combat maternal and infant mortality must be strengthened on the ground by properly filling out birth records, promoting and using partograms and recording fetal heart rate.

Keywords: Institute of Social Hygiene, Primiparous, Caesarean, Stillbirth, Fetal Heart Rate Recording.

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INTRODUCTION

According to estimates by the World Health Organization (WHO), 529 000 women die each year worldwide due to complications during pregnancy, childbirth and post-partum conditions, nearly half of which occur in sub-Saharan Africa [1]. Other United Nations sources confirm that about 287 000 women die from pregnancy-related causes and more than half a million women die every year worldwide as a result of pregnancies or difficult deliveries [2-4]. The results of the evaluation survey on the availability, use and quality of Emergency Obstetric and Neonatal Care in Senegal during the period 2012-2013 reveal that Senegal is far from achieving Millennium Development Goals 4 and 5 [5, 6], and this despite a decrease in the maternal

mortality rate between 1990 and 2010, from 510 to 392 maternal deaths per 100,000 live births [7]. The current strategy to combat maternal and infant mortality is essentially based on three pillars which are family planning, childbirth assisted by qualified personnel (midwife, nurse, doctor) and emergency obstetric and newborn care (EmONC). Our work was conducted with the aim of evaluating the management of parturient women in the gynecology and obstetrics department of the Institute of Social Hygiene in Dakar.

PATIENTS AND METHOD

We conducted a retrospective and descriptive study conducted over a period of six months from January 1st to June 30th, 2019 on the management of

births in the Gynecology - Obstetrics department of the Institute of Social Hygiene Hospital in Dakar. Were included in our study all patients admitted for the management of their childbirth with more than 22 weeks of amenorrhea regardless of the mode of admission (evacuated or coming from their home) and regardless of the mode of delivery (vaginal delivery or caesarean section).

RESULTS

During the study period, we collected 689 birth records, representing 8.2% of the department's overall activities and 69% of emergency activities. The average age of the patients was 27.4 years with extremes of 14 and 45 years. The most represented age group was that of 20 to 29 years (50.94%) followed by that of 30-39 years. The vast majority of patients (96%) were married. The average gestity was 2.5 with extremes of 1 and 12. Paucigests (38.9%) were more represented followed by primigests (37.7%) and multigests (23.4%). The average parity was 2.36 with extremes of 1 and 12. Primiparous were more represented (41%) followed by pauciparous (40%) and multiparous (19%). Most parturients (59%) resided outside the Southern District. Abortion was the most common obstetrical antecedent (17%) followed by caesarean section (14.6%). More than half of the parturients (58.1%) had received at least 4 prenatal visits. Pathological pregnancy was found in 89 patients (12.9%). The most common pathologies were diabetes (3.4%), arterial hypertension (2.6%) and hepatitis B virus infection (2.5%). Parturients were mostly admitted between midnight and 8 a.m. (37.9%) followed by 8-4 pm. in 32.7%. Evacuees accounted for 43.7% of parturients. They came mainly from outside the southern health district (61.8%). The majority of parturients were

carriers of a full-term pregnancy (72%). Prematurity and the exceeded term were found in 11% and 18%, respectively. Almost all patients were carriers of a single pregnancy (97%). We recorded 3% of twin pregnancies. The measurement of uterine height was normal in just over half of the parturients (59%). Excessive uterine height was found in 17% of patients. On admission, the fetal heart rate was normal in 95.5% of parturients. The abnormalities found were tachycardia (2.3%), bradycardia (1%) or fetal heart rate irregularity (1.2%). The examination at admission found ruptured membranes in 34.5% with an amniotic fluid that was most often clear (23.5%). The presentation of the summit was the most found (96%) followed by that of the headquarters (4%). In our series, 19% of the parturients had a moderately narrowed pelvis and 2% a surgical pelvis. At admission, 56.6% of parturients were in the latency phase of labor, 2.9% were not in labor and 19.4% were in the active phase. However 3.8% had expelled. We noted peculiarities in the workflow in 46% of the patients. These were 130 labor tests (18.87%), 67 uterine tests (9.7%), 76 work directions (11%) and 45 labor triggers (6.5%). More than half or 55.4% of patients benefited from work monitoring using the cardiotocograph and complicated work was found in 25.5% of patients. These were mainly cases of non-reassuring fetal state in 71.8% of the cases. Nearly two thirds of our parturients, or 74.3%, had a working time between 1 and 8 hours. More than half of the parturients had given birth vaginally, i.e. 55.3%. The cesarean section and instrumental extractions accounted for 44.6% and 0.1%, respectively. Among the patients who had a vaginal birth, 32.7% underwent an episiotomy and we recorded 8.4% of tears. Cesarean section was performed most often for patients in groups 1 (31.3%) and 5 (21.7%) of the Robson classification.

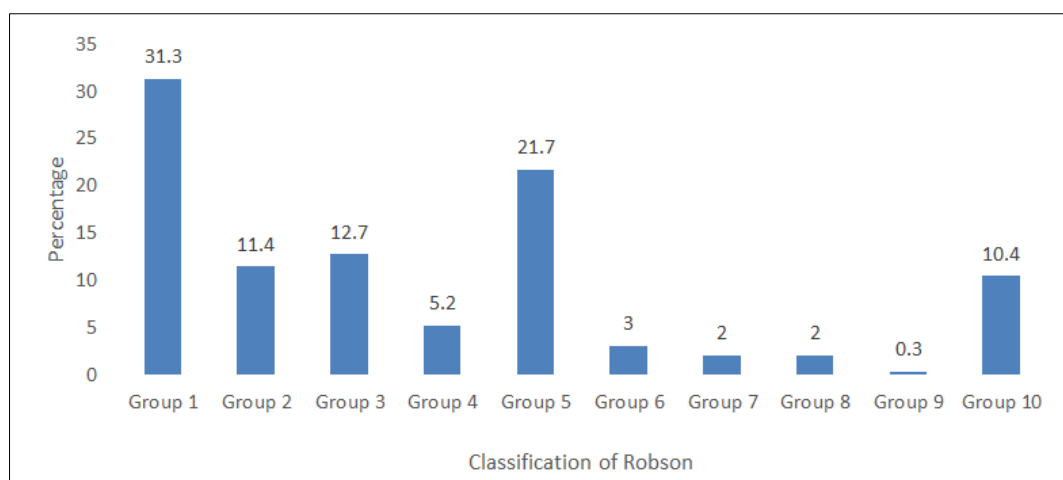


Figure 1: Distribution of patients who had a cesarean delivery according to the Robson classification at Institute of Social Hygiene between January 1st and June 30th, 2019 (N=307)

In our series 87.4% of newborns had an Agar score of 7 and 12.6% <7 at the 1st minute, at the 5th minute 70.4% had an Apgar score < 10 and 29.6% at 10. More than half or 52% of newborns were female and

48% male. We recorded 13.3% of hypotrophic newborns, 82% of eutrophic newborns, and 4.7% of macrosomal newborns. More than two thirds, or 69%, of newborns were admitted to neonatology. The main

reason for transfer was the non-reassuring fetal state in 59.4% followed by prematurity in 18.9% and low birth weight in 11.6%. Among newborns transferred to neonatology, 17.39% died during hospitalization. We recorded 706 births, 98% of which were alive. The stillbirth (20) was distributed as follows: 9 fresh-born deaths in a context of retroplacental hematoma and uterine rupture which respectively represented 4% and 0.6% of complications and 5 deaths macerated on maternal diabetes field (3.4%).

DISCUSSION

During the study period, we collected 689 birth records, representing 8.2% of the service's overall activities and 69% of emergency activities. The gynecology-obstetrics department is a reference in maternal and neonatal care. There were an average of 5000 deliveries per year. During the year 2016, the department recorded 8495 consultations including 1326 prenatal consultations (15.6%). The profile of the parturient was that of a young primiparous (41%) with an average age of 27.4 years, married (96%) with a history of cesarean delivery (14.6%) and having completed at least 4 prenatal visits (58.1%) and carriers of a full-term pregnancy (72%). This profile corresponds to that of the maximum fertility period in Senegal, which is between 20 and 29 years [8]. The average age of our patients is approaching that found in the series of Lankoandé [9], Andrianmady [10], and Bokossa [11]. In a study done by Belinga in Cameroon, the average age was 24.7 6.9 years and multiparous were the majority and lived in a common-law relationship (47.1%) [11]. Childbirth on scar uterus in our series represented 14.65%. This rate is higher than that found in the series of Cyr Espérance Koulimaya-Gombet with 9.6% [12]. More than half of the parturients (58.1%) had at least 4 prenatal visits, which corresponds to WHO recommendations [7-15]. Our parturients had performed more prenatal consultations than those who had given birth in Mali in district VI of the commune of Bamako where the parturients who had performed at least four prenatal consultations accounted for 33.7% [16]. During our study period, most parturients were admitted between midnight and 08 hours in the morning (37.9%). This is consistent with the study by Dr. Peter Martin which shows that spontaneous deliveries are more likely to occur at night and at dawn. He evokes an ancestral hypothesis [17]. This theory applies without any complications with our rate of patients coming on their own of 56.3%. Patients admitted during our study were transferred from other structures in 43.7% of cases. This value is significantly higher than that reported by Mbaye (10.8%) [18]. The Institute of Social Hygiene is a reference health structure in the Southern Health District. The majority of evacuations come more from areas outside the District (61.8%). This gives an idea of the workload and especially of the emergency activity. At admission 56.6% of parturients were in the latency phase of labor. The majority of our patients were in labor at admission (79.8%) with a predominance of the work

latency phase (56.6%). This rate is comparable to that found in the RCL Andrianmady study where the vast majority of women (71%) were admitted while they were already in work, including 9.4% in the expulsion phase [19]. In our series, noted peculiarities in the course of work in 46% of patients. These were 130 labor tests, 67 uterine tests, 76 labor directions and 45 labor triggers. The induction of labor is defined as an obstetric intervention intended to artificially induce uterine contractions allowing the dilation of the cervix and the descent of the fetal presentation in order to achieve birth. It is a common practice in obstetrics that deserves to be known and reassessed in order to ensure quality care for the patients concerned [20]. In our study, the induction of labor was done in 6.53% of parturients, which complies with the recommendations of the World Health Organization of 1985. The direction of the work is essentially done with the help of Syntocinon® marketed in the form of 1 ml ampoules that contain 5 international units (IU) of synthetic oxytocin. The administration of Syntocinon® is carried out intravenously (IV) or intramuscularly (IM). It is often preceded by an amniotomy. Its onset of action is rapid and less than 1 minute for the IV route and 2 to 4 minutes for the IM route. In developed countries, particularly in France, according to the 2010 perinatal survey, 58% of patients with spontaneous labor received synthetic oxytocin during labour. (primiparas and multiparas combined) [21]. This value is significantly higher than that of our study where only 11.03% of parturients benefited from a work direction. The labor test is a commitment test of the presentation of the summit of limited duration (2 to 3 hours) under conditions acceptable for the fetus and the mother and is done in case of moderate narrowing of the maternal pelvis. The labor test had been performed on parturients who had a moderately narrowed pelvis (18%) without any other pathology requiring a caesarean section from the outset. According to a study conducted by Cissé [22], the labor test did not induce a significantly greater risk than that related to prophylactic caesarean. Despite the constraints of obstetrical practice in Black Africa, the test of labor in moderately constricted basins must be the rule whenever possible even with exclusively clinical labor monitoring [23]. The uterine test, which is the attempt at vaginal delivery on a scar uterus, was performed in 9.7% of our parturients. In front of a woman with a scarred uterus, the information provided should present the attempt at vaginal delivery and the iterative caesarean section. The decision on the delivery route should be made with the obstetrician's agreement no later than the eighth month, taking into account individual risk factors for uterine test failure and uterine rupture. The uterine test is the preferred option for patients who do not have multiple risk factors. It is recommended that an obstetrician be on site when the obstetrical context suggests a higher risk of failure of the uterine test or uterine rupture [24]. More than half or 55.4% of patients benefited from work monitoring using the cardiotocograph. In our structure, we note an acceptable rate of use of monitoring in the workplace

compared to other reference structures in the country but which remains low despite its considerable expansion in daily obstetric practice. In 2002, in the US, 85% of fetuses were monitored by electronic monitoring [25, 26]. In France, this rate was 99% [27].

During our study period, more than half of the parturients had delivered vaginally (55.3%). The cesarean section and instrumental extractions accounted for 44.6% and 0.1%, respectively. Our cesarean section rate of 44.6% is very high with reference to the recommendations of the World Health Organization which recommends a cesarean section rate between 10 and 15% of deliveries [28, 29]. Other African series report lower rates almost half of our study: Cissé [30], Mbaye [31], and Ouédraogo [32] with 25.2%, 21% and 21.6% respectively. Robson's classification, classification into 10 groups, is a method of assessing and comparing the factors that contribute to cesarean rates and their effects. It also allows for comparisons to be made between institutions, regions and countries that use such a system [33, 34]. We found that group 1 (Nullipare, single pregnancy, cephalic presentation, term 37 weeks of amenorrhea, spontaneous labor) and group 5 (history of caesarean section, single pregnancy, cephalic presentation, term 37 weeks of amenorrhea) recorded the highest rates respectively 31.3% and 21.7%. This same observation was made in the series of Robson [35], and Mbaye [36]. The reason for the greater contribution of group 1 to the cesarean rate is the significant share of nulliparous in our study 41%, hence the importance of a good evaluation of the pelvis of parenting. Group 10 (single pregnancy, term < 37 weeks of amenorrhea) occupied an important place in our study with 10.4%. Le Ray, in his series, also reported that group 10 contributed enormously to the rate of caesareans in type 3 maternity hospitals [37]. We recorded 706 births of which 98% were alive, 87.4% of the newborns had an Apgar score of 7 and 12.6% had an Apgar score of < 7 at the 1st minute, at the 5th minute. 70.4% had an Apgar score of < 10 and 29.6% = 10. Female sex predominated (52%). The majority, 82% of newborns had a normal weight, 13.3% were born with low weight. This rate of low birth weight is comparable to that found in a study conducted in Senegal (10.7%) [38]. In our series, 69 newborns were admitted to neonatology. The main reason for transfer was the non-reassuring fetal state in 59.4% followed by prematurity in 18.9% and low birth weight in 11.6%. Neonatal mortality remains a concern in our environment and several factors, including those related to the organization of the transfer of newborns at the level of care structures contribute to it. In a study conducted in the Congo, the transfer rate in neonatology was 12.9% with prematurity as the main reason for transfer [39]. In a study conducted in Dakar between 2013 and 2014, the main reasons for transfer were sepsis (35.4%), respiratory distress (33.8%) and low birth weight (33.1%). Mortality among the newborns transferred was 22.3% [40]. The stillbirth (20) was distributed as follows:

9 fresh-born deaths in a context of retroplacental hematoma and uterine rupture which respectively represented 4% and 0.6% of complications and 5 deaths macerated on maternal diabetes field (3.4%). Fetal death in-utero is a public health problem of varying incidence worldwide with 5 births in developed countries and 10 to 50 in developing countries, which is consistent with our stillbirth rate (20) [41].

CONCLUSION

The current strategy to combat maternal and infant mortality must be reinforced on the ground by properly filling out birth records, promoting and using partograms and recording fetal heart rate.

BIBLIOGRAPHY

1. WORLD HEALTH ORGANISATION. Mortalité Maternelle en Afrique Subsaharienne. American Journal of Obstetrics and Gynecology, 2004 ; 192:342-349.
2. FONDS DES NATIONS UNIES POUR LA POPULATION(UNFPA). Lancement de la Campagne d'accélération de la réduction de la mortalité maternelle en Afrique (Niamey). Disponible sur le site : <http://www.niger.unfpa.org/docs/Rapport> en décembre 2011 consulté le 27 février 2017.
3. ORGANISATION MONDIALE DE LA SANTE. Tendances de la mortalité maternelle 1990-2015. Genève. Disponible en Décembre 2015 sur le site: www.who.int/reproductivehealth/publications/monitoring/maternalmortality.../fr consulté le 10 novembre 2016.
4. WORLD HEALTH ORGANISATION (WHO). Maternal mortality in 2000 estimates developpees by WHO.1993. Disponible sur le site : www.who.int/maternal_child_adolescent/document s/. Consulté le 23 mars 2017.
5. MINISTERE DE LA SANTE ET L'ACTION SOCIALE DU SENEGAL. Résultats de l'Enquête d'Evaluation de la Disponibilité, de l'Utilisation et de la Qualité des Soins Obstétricaux et Néonataux d'Urgence au Sénégal (SONU), 2012-2013. Direction générale de la santé, MSAS, UNFPA, OMS, UNICEF, CEFOPREP, Dakar, Décembre 2014.
6. ORGANISATION DES NATIONS UNIES. La Déclaration du Millénaire pour le Développement. New York, Septembre 2000.
7. ORGANISATION MONDIALE DE LA SANTE. Trends in maternal mortality : 1990 to 2013. WHO, UNICEF, UNFPA, Mai 2014 :25-28.
8. AGENCE NATIONALE DE LA STATISTIQUE ET DE LA DEMOGRAPHIE (SENEGAL). Enquête Démographique et de Santé à Indicateurs multiples au Sénégal (EDS-MICS), 2010-2011. Calverton, Maryland, USA : ANDS et ICF International.

9. LANKOANDÉ N. Analyse des indications de césarienne au Centre de Santé Nabil Choucair du 1er Juillet 2010 au 30 Juin 2011. Mémoire, Médecine UCAD Dakar 2011.
10. ANDRIANMADY C, ANDRIANARIVONY M, RANJALHY R. Indications et pronostic de l'opération césarienne à la maternité de Befelatanana- CHU Antananarivo : A propos de 529 cas durant l'année 1998. *Gynecol Obstet Fertil* 2001 ; 29 : 900-4.
11. BOKOSSA M, NGUESSAN K, DOUMBIA Y, KAKOU C, BONI S. Césarienne prophylactique et d'urgence : A propos de 394 cas au CHU de Cocody. *Med Afr Noire* 2008; 55(11) : 594-601.
12. BELINGA E, ESSIBEN F, NDOUA CCN, YAYA FA, TOMPEEN I, FOUMANE P. Aspects Épidémiologiques, Cliniques et Thérapeutiques du Travail D'accouchement à la Maternité de l'Hôpital Régional de Bertoua, Cameroun. *HEALTH SCIENCES AND DISEASE*, 2019 : 21(1).
13. KOULIMAYA-GOMBET CE, DIOUF AA, DIALLO M, DIA A, SENE C, MOREAU JC, DIOUF A. Grossesse et accouchement des patientes ayant un antécédent de césarienne à Dakar : aspects épidémiocliniques thérapeutiques et pronostiques. *Pan African Medical Journal*, 2017 : 27(1).
14. FLORIS L, MERMILLOD B, CHASTONAY P. Traduction et validation en langue française d'une échelle multidimensionnelle évaluant le degré de satisfaction, lors de l'accouchement. *Revue d'épidémiologie et de Santé Publique* 2010 ; 58 : 13–22.
15. ORGANISATION MONDIALE DE LA SANTE. Prise en charge des complications de la grossesse et de l'accouchement : guide pratique. Le partogramme. Partie IV : Principes de recherche opérationnelle. Genève, 1994 ; 32 : 27-31.
16. ORGANISATION MONDIALE DE LA SANTE. Les soins liés à un accouchement normal : guide pratique WHO/FRH/MSM/96.24 : 61.
17. KASSAMBARA M. Evaluation d'un centre de santé maternelle et infantile en milieu urbain appliqué à la commune VI du District de Bamako. Thèse Méd, Bamako, 1989, N°15 : 179
18. PETER MARTIN, MARIO CORTINA-BORJA, MARY NEWBURN, GILL HARPER, ROD GIBSON, MIRANDA DODWELL, NIRUPA DATTANI, ALISON MACFARLANE. Timing of singleton births by onset of labour and mode of birth in NHS maternity units in England, 2005–2014 : A study of linked birth registration, birth notification and hospital episode data.
19. MBAYE M, SÈNE N, MOREAU J. Audit des indications de césariennes au Centre de Santé Philippe Maguilen Senghor. Mémoire Médecine, Dakar, Université Cheich Anta Diop. 2014 ; 947.
20. ANDRIAMADY RCL, RASOARINAVALLONA AR, RANJALAHY RJ. Prise en charge des grossesses multiples à la Maternité de Befelatanana Centre Hospitalier Universitaire d'Antananarivo (Madagascar) : à propos de 143 cas. *Arch Inst Pasteur Madagascar*, 1999 ; 65(2), 103-106.
21. MERIEUX, MAÏEUTIQUE LYON SUD CHARLES. Le déclenchement du travail sur col perméable, double-Ballonnet versus Prostaglandines : comparaison de deux méthodes de déclenchement du travail à terme.
22. LOSCUL C. Utilisation du Syntocinon® au cours du travail spontané : évaluation des pratiques professionnelles à la maternité de Port-Royal. Mémoire pour obtenir le diplôme de Sage-femme. Paris Descartes, 2013.
23. CISSE CT, KOKAINA C, NDIAYE O, MOREAU JC. Epreuve du travail dans les dystocies osseuses modérées au CHU de Dakar. *Journal de gynécologie obstétrique et biologie de la reproduction*, 2004 ; 33(4), 312-318.
24. JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION, 2012 ; 41(8) : 824-830
25. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG). Intrapartum fetal heart rate monitoring : nomenclature interpretation and general management principles. *Obstet Gynecol* 2009 ; 114 :192-02.
26. MARTIN A. Rythme cardiaque fœtal pendant le travail : définitions et interprétation. *J Gynecol Obstet Biol Reprod* 2008 ; 37 : S34-S45.
27. ANAES. Intérêt et indications des modes de surveillance du rythme cardiaque fœtal au cours de l'accouchement normal. *J Gynecol Obstet Biol Reprod* 2002 ; 32 :183-86.
28. ORGANISATION MONDIALE DE LA SANTE. Déclaration sur les taux de césarienne 2014. Disponible sur le site www.who.int/reproductivehealth Page consultée le 12/11/2016.
29. DESSOLE L, DARAI E. Evolutions techniques de la césarienne. *Encyclopédie Médico-chirurgicale Gynécologie-Obstétrique* 2005 :110-24.
30. Cissé C, NGOM P, GUISSÉ A, FAYE E, MOREAU J. Réflexions sur l'évolution des taux de césarienne en milieu africain exemple du CHU de Dakar entre 1992 et 2001. *Gynecol Obstet Fertil* 2004 ; 32 :210-7.
31. MBAYE M, GUEYE SMK, GUEYE M, Cissé M, DIADHIOU M, FAYE DIÉMÉ M. Les soins obstétricaux et néonataux d'urgence au Centre de Santé niveau II de Rufisque : Impact du redéploiement du personnel de la Maternité du CHU Le Dantec. *Journal de la SAGO* 2006 ; 7(1) : 5-10.
32. OUEDRAGO C, ZOUNGRANA T, DAO B, DUJARDIN B, OUEDRAGO A, THIÉBA B. Césarienne de qualité au Centre Hospitalier Yalgado Ouedrigo de Ouagadougou. Analyse des déterminants à propos de 478 cas colligés dans le service de Gynécologie- obstétrique. *Med Afr Noire* 2001 ; 48 : 443-45.

33. BRENNAN D, ROBSON M, MURPHY M, O'HERLIHY C. Comparative analysis of international cesarean delivery rates using 10 group classification in spontaneous labor. *Am J Obstet Gynecol* 2009 ; 201: 308[e1- e8].
34. DELBAERE I, CAMMU H, MARTINS E, TENCY I, MARTENS G, TEMMERMAN M. Limiting the cesarean section rate (in low risk pregnancies is key to lowering the trend of increased abdominal delivery. An observational Study *BMC pregnancy Childbirth* 2012 ; 12:3.
35. ROBSON M, MURPHY M, BYRNE F. Quality assurance : the 10 group classification system (Robson classification). Induction of labor and caesarean delivery. In *Journal Gynecol and Obstet* 2015 ; 131 : S23- S27.
36. MBAYE M, GUEYE M, NDIAYE GUEYE M, SENE NIANG N, MOREAU J. Analysis of caesarean section rate according to Robson's classification in an urban health center in Senegal. *Int J Reprod Contracept Obstet Gynecol* 2015 ; 4(4): 1100- 1102.
37. LE RAY C, PRUNET C, DENEUX-THARAUX C, GOFFINET F, BLONDEL B. Classification de Robson : un outil d'évaluation des pratiques de césarienne en France. *Revue sage-Femme* 2015 ; 14 :199-207.
38. SARR M, HANNE K, THIAM C, DIOUF L, SOW D, FALL M. Les faibles poids de naissance : fréquence et facteurs de risque dans le district de Guediawaye (Banlieue de Dakar-Sénégal). *Médecine d'Afrique Noire*, 1996 ; 43(5).
39. KATAMEA T, MUKUKU O, KAMONA L, MUKELENGE K, MBULA O, BALEDI L, LUBOYA ON. Facteurs de risque de mortalité chez les nouveau-nés transférés au service de néonatalogie de l'Hôpital Jason Sendwe de Lubumbashi, République Démocratique du Congo. *The Pan African Medical Journal*, 2014 ; 19.
40. FAYE PM, DIENG YJ, DIAGNE-GUEY NR, GUEYE M, BA A, SECK MA, FALL AL. Problématique des transferts néonataux dans la région de Dakar (Sénégal). *Revue de médecine périnatale*, 2016 ; 8(2) : 94-102.
41. GERARDIN P, HEISERT M. Incidence, causes et facteurs de risque de la mort fœtale in utero dans le sud de la Réunion. *Encycl Med Chir* 2004.

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