



Royal College of
Obstetricians &
Gynaecologists

Female Genital Mutilation and its Management

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Female Genital Mutilation and its Management

This is the second edition of this guideline, which was previously published under the same title in 2009. Prior to this, an RCOG statement with the same title was published in 2003.

Executive summary of recommendations

Complications of female genital mutilation (FGM)

Clinicians should be aware of the short- and long-term complications of FGM.



The legal and regulatory responsibilities of health professionals

FGM and UK law

All health professionals must be aware of the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland. Both Acts provide that:



- 1. FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age:**
 - (a) which is necessary for her physical or mental health; or**
 - (b) she is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.**
- 2. It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM.**
- 3. It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.**
- 4. If FGM is confirmed in a girl under 18 years of age (either on examination or because the patient or parent says it has been done), reporting to the police is mandatory and this must be within 1 month of confirmation. [New 2015]**

Female genital cosmetic surgery (FGCS) may be prohibited unless it is necessary for the patient's physical or mental health. All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Acts. [New 2015]



Re-infibulation is illegal; there is no clinical justification for re-infibulation and it should not be undertaken under any circumstances. [New 2015]



What are the legal and regulatory responsibilities of health professionals in their evaluation of women with FGM?

When a woman with FGM is identified:

The health professional must explain the UK law on FGM. [New 2015]



The health professional must understand the difference between recording (documenting FGM in the medical records for data collection) and reporting (making a referral to police and/or social services) and their responsibilities with regards to these (Appendix I). [New 2015]



The health professional must be familiar with the requirements of the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication. [New 2015]



The health professional should be aware that it is not mandatory to report all pregnant women to social services or the police. An individual risk assessment should be made by a member of the clinical team (midwife or obstetrician) using an FGM safeguarding risk assessment tool (an example of such a tool can be found at <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>). If the unborn child, or any related child, is considered at risk then a report should be made. [New 2015]



What are the principles of FGM management in obstetric and gynaecological practice?

All acute trusts/health boards should have a designated consultant and midwife responsible for the care of women with FGM (Appendix II).



All gynaecologists, obstetricians and midwives should receive mandatory training on FGM and its management, including the technique of de-infibulation. They should complete the programme of FGM e-modules developed by Health Education England. [New 2015]



Specialist multidisciplinary FGM services should be led by a consultant obstetrician and/or gynaecologist and be accessible through self-referral. These services should offer: information and advice about FGM; child safeguarding risk assessment; gynaecological assessment; de-infibulation; and access to other services.



Health professionals should ensure that, in consultations with women affected by FGM, the consultation and examination environment is safe and private, their approach is sensitive and nonjudgemental and professional interpreters are used where necessary. Family members should not be used as interpreters.



How should recent FGM be managed?

Healthcare professionals should be vigilant and aware of the clinical signs and symptoms of recent FGM, which include pain, haemorrhage, infection and urinary retention. [New 2015]



Examination findings should be accurately recorded in the clinical records. Some type 4 FGM, where a small incision or cut is made adjacent to or on the clitoris, can leave few, if any, visible signs when healed. Consideration should be given to photographic documentation of the findings at acute presentation. [New 2015]



Legal and regulatory procedures must be followed (Appendix I); all women and girls with acute or recent FGM require police and social services referral. [New 2015]



How should FGM be managed in gynaecological practice?

What should the referral pathway be for women with FGM?

Women may be referred by their general practitioner (GP) to a hospital gynaecology clinic. The referral should be directed to FGM services, if available, or to the designated consultant obstetrician and/or gynaecologist responsible for the care of women and girls with FGM.



Women should be able to self-refer. [New 2015]



All children with FGM or suspected FGM should be seen within child safeguarding services. [New 2015]



How should women with FGM be assessed in gynaecological practice?

Women with FGM may present with symptoms directly attributable to their FGM or with co-existing gynaecological morbidity. Gynaecologists should ask all women from communities that traditionally practise FGM whether they have had the procedure. [New 2015]



Clinicians should be aware that psychological sequelae and impaired sexual function can occur with all types of FGM.



Examination should include inspection of the vulva to determine the type of FGM and whether de-infibulation is indicated, as well as to identify any other FGM-related morbidities, e.g. epidermoid inclusion cysts. [New 2015]



All women should be offered referral for psychological assessment and treatment, testing for HIV, hepatitis B and C and sexual health screening. Where appropriate, women should be referred to gynaecological subspecialties, e.g. psychosexual services, urogynaecology, infertility. [New 2015]



Gynaecologists should be aware that narrowing of the vagina due to type 3 FGM can preclude vaginal examination for cervical smears and genital infection screens. De-infibulation may be required prior to gynaecological procedures such as surgical management of miscarriage (SMM) or termination of pregnancy (TOP).



What is the role of de-infibulation in gynaecological practice?

Women who are likely to benefit from de-infibulation should be counselled and offered the procedure before pregnancy, ideally before first sexual intercourse.



Women offered de-infibulation should have the option of having the procedure performed under local anaesthetic in the clinic setting in a suitable outpatient procedures room (Appendix III).



What is the role of clitoral reconstruction?

Clitoral reconstruction should not be performed because current evidence suggests unacceptable complication rates without conclusive evidence of benefit. [New 2015]



How should FGM be managed in pregnancy?

What level of care do women with FGM require?

Women with FGM are more likely to have obstetric complications and consultant-led care is generally recommended. However, some women with previous uncomplicated vaginal deliveries may be suitable for midwifery-led care in labour.



How should women with FGM be identified in pregnancy?

All women, irrespective of country of origin, should be asked for a history of FGM at their booking antenatal visit so that FGM can be identified early in the pregnancy. This should be documented in the maternity record. [New 2015]



Women identified as having FGM should be referred to the designated consultant obstetrician or midwife with responsibility for FGM patients. Local protocols will determine which elements of care should be undertaken by these individuals and which may be undertaken by other appropriately trained midwives or obstetricians (Appendix IV).



What antenatal documentation is required to demonstrate that legal and regulatory processes have been adhered to?

The midwife or obstetrician should ensure that all relevant information is documented in the clinical records (Appendix I). [New 2015]



How should antenatal care be managed?

Referral for psychological assessment and treatment should be offered.



The vulva should be inspected to determine the type of FGM and whether de-infibulation is indicated. If the introitus is sufficiently open to permit vaginal examination and if the urethral meatus is visible, then de-infibulation is unlikely to be necessary.



Screening for hepatitis C should be offered in addition to the other routine antenatal screening tests (hepatitis B, HIV and syphilis). [New 2015]



De-infibulation may be performed antenatally, in the first stage of labour or at the time of delivery and can usually be performed under local anaesthetic in a delivery suite room. It can also be performed perioperatively after caesarean section (Appendix III).



The midwife or obstetrician should discuss, agree and record a plan of care (see Appendix IV). This may be documented in a preformatted sheet.



Women should be informed that re-infibulation will not be undertaken under any circumstances. [New 2015]



How should intrapartum care be managed?

If a woman requires intrapartum de-infibulation, the midwife and obstetrician caring for her should have completed training in de-infibulation or should be supervised appropriately.



If de-infibulation planned for the time of delivery is not undertaken because of recourse to caesarean section, then the option of perioperative de-infibulation (i.e. just after caesarean section) should be considered and discussed with the woman. [New 2015]



Labial tears in women with FGM should be managed in the same manner as in women without FGM. Repairs should be performed where clinically indicated, after discussion with the woman and using appropriate materials and techniques.



How should intrapartum care be managed for women identified as having FGM in pregnancy for whom there has been no agreed documented plan of care?

The impact of FGM on labour and delivery should be sensitively discussed and a plan of care agreed. [New 2015]



How should postnatal care be managed?

A woman whose planned de-infibulation was not performed because of delivery by caesarean section should have follow-up in a gynaecology outpatient or FGM clinic so that de-infibulation can be offered before a subsequent pregnancy. [New 2015]



The discharging midwife should ensure that all legal and regulatory processes have been adhered to prior to discharge (Appendix I). [New 2015]



1. Purpose and scope

The purpose of this guideline is to provide evidence-based guidance on the management of women with female genital mutilation (FGM) and those who are considered to be at risk. It covers the clinical care of women before, during and after pregnancy, including the legal and regulatory responsibilities of health professionals. The focus of this guideline is on practice in the UK. Although much of the content is applicable to all four constituent countries, the regulatory framework in Scotland and Northern Ireland differs to that described here; further information is available elsewhere.^{1,2}

For a global perspective on FGM, further information is available from other sources.^{3,4}

2. Introduction and background epidemiology

2.1 Definition and classification

Female genital mutilation, also known as ‘female genital cutting’, ‘female genital mutilation/cutting’ or ‘cutting’, refers to ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’.^{3,5} The widely accepted classification of FGM developed by the World Health Organization (WHO) in 1995 and updated in 2007 is shown in Table 1. FGM is practised for a variety of complex reasons, usually in the belief that it is beneficial for the girl.⁴ It has no health benefits and harms girls and women in many ways. FGM is a human rights violation and a form of child abuse, breaching the United Nations Convention on the Rights of the Child,⁴ and is a severe form of violence against women and girls.⁶

Table 1. WHO FGM classification³

Type 1:	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type 2:	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type 3:	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type 4:	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

2.2 Global epidemiology

UNICEF estimates that worldwide over 125 million women and girls have undergone FGM.⁴ It is a traditional cultural practice in 29 African countries. FGM prevalence by country is shown in Figure 1. Outside Africa, FGM is also practised in Yemen, Iraqi Kurdistan and parts of Indonesia and Malaysia. Far smaller numbers have been recorded in India, Pakistan, Sri Lanka, the United Arab Emirates, Oman, Peru and Colombia.

The type of FGM varies between countries. FGM type 3 (infibulation) is practised almost exclusively in Africa, with the highest prevalence in northeastern Africa, including Somalia, Sudan, Ethiopia, Eritrea and Djibouti. FGM prevalence also varies within countries, where it may be associated with particular ethnic groups. FGM is almost always carried out on girls between infancy and the age of 15, but the age at which girls are mutilated varies considerably between countries. It is estimated that in over half of countries practising FGM, girls are cut under the age of 5 years. In some communities adult women may undergo re-infibulation following childbirth.

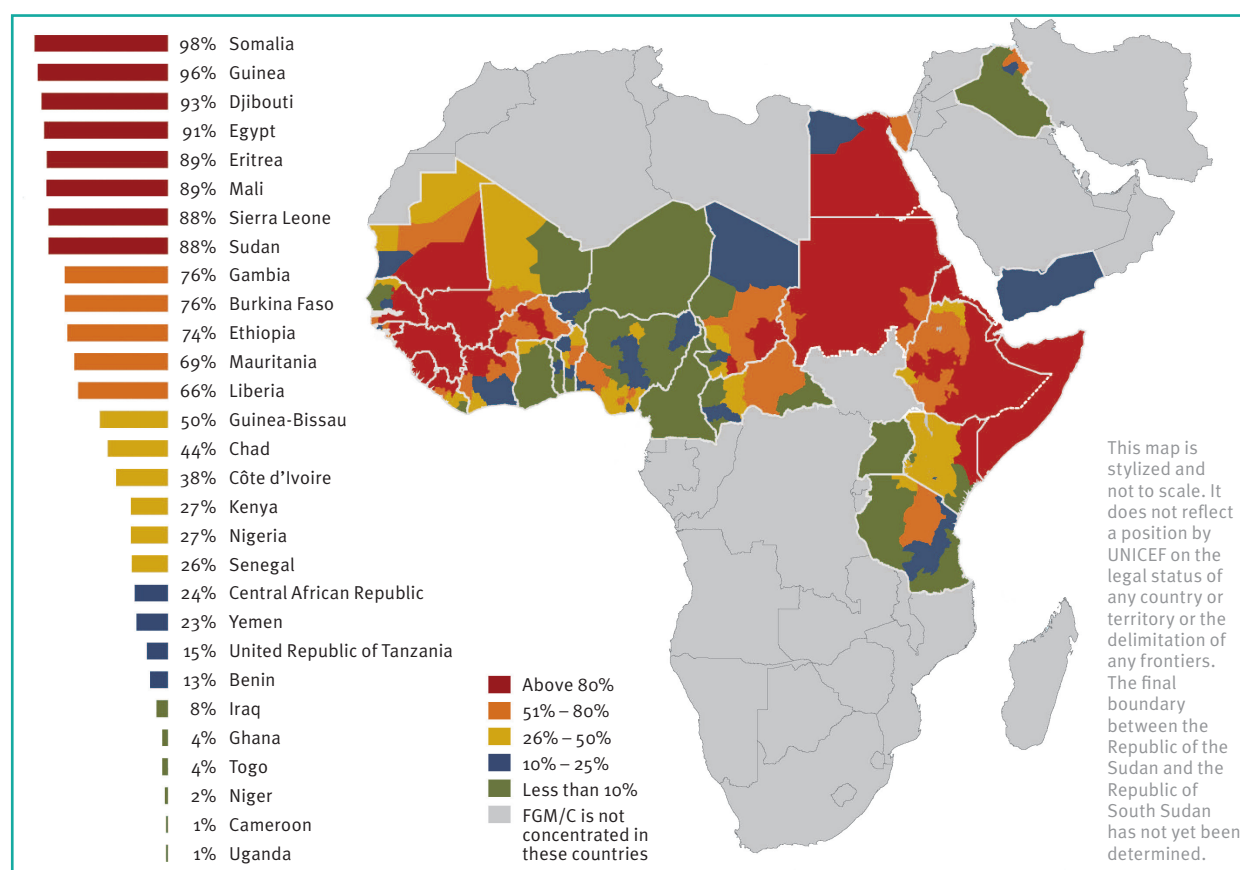
Those performing FGM are usually traditional practitioners with no formal medical training, who practise without anaesthetics using crude instruments such as knives, scissors or razor blades. However, in some countries health professionals undertake a substantial number of FGM procedures. These include Egypt, where doctors undertake the majority of FGM procedures, Sudan and Kenya. Globally, the trend towards medicalisation of FGM is increasing.⁴

As a result of migration, there has been a substantial increase in the number of girls and women with FGM living in North America, Australia, New Zealand and Europe.⁴

2.3 UK epidemiology

It has been estimated that 137 000 women and girls in England and Wales, born in countries where FGM is traditionally practised, have undergone FGM, including 10 000 girls aged under 15 years. These provisional interim estimates were derived by combining published data on FGM prevalence in FGM-practising countries with census and birth registration data in England and Wales.⁷ There are

Figure 1. Prevalence of FGM. Percentage of girls and women aged 15–49 who have undergone FGM, by region/ country. Source: UNICEF⁴



FGM/C female genital mutilation/cutting

no published studies on the prevalence of FGM in Scotland or Northern Ireland. There is anecdotal evidence that girls are taken from the UK to their country of origin to undergo FGM and that FGM also takes place in the UK.⁸

In order to capture data about numbers of women with FGM receiving care from the National Health Service in England, the Department of Health implemented an FGM data set in 2014. In April 2015, an enhanced data set was introduced, requiring all acute trusts, general practices and mental health trusts to record FGM data and return patient-identifiable data to the Health and Social Care Information Centre (HSCIC). Information can be found on the HSCIC website: <http://www.hscic.gov.uk/fgm>.

3. Identification and assessment of evidence

This guideline was developed in accordance with standard methodology for producing RCOG Green-top Guidelines. MEDLINE, EMBASE and the Cochrane Library were searched. The search was restricted to articles published between 2007 and January 2014 and limited to humans and the English language. A top-up literature search was performed in April 2015. The databases were searched using the relevant Medical Subject Headings (MeSH) terms, including all subheadings, and this was combined with a keyword search. Search terms included 'FGM', 'female genital cutting', 'female genital mutilation', 'circumcision', 'infibulation', 'deinfibulation', 'de-infibulation', 'clitoridectomy' and 'defibulation'. The National Guideline Clearinghouse, National Institute for Health and Care Excellence (NICE) Evidence Search, Trip, Guidelines International Network and the Geneva Foundation for Medical Education and Research website were also searched for relevant guidelines. The websites of the WHO, UNICEF, United Nations Population Fund (UNFPA), the Population Council, the Population Reference Bureau, FORWARD

(Foundation for Women's Health Research and Development), Rainbo and the UK Government were searched for relevant reports. Where possible, recommendations are based on available evidence. Areas lacking evidence are highlighted and annotated as 'good practice points'.

4. Complications of FGM

Clinicians should be aware of the short- and long-term complications of FGM.



4.1 Short-term complications

A systematic review by Berg⁹ found that the most common immediate complications from FGM were haemorrhage (5–62%), urinary retention (8–53%) and genital swelling (2–27%), although there were additional studies reporting infection and fever, and three deaths directly attributed to FGM. The methodological quality of these studies was generally poor.

Evidence
level 2+

There is concern that some type 4 FGM procedures, where a small cut is made adjacent to the clitoris, may now be performed more frequently.⁴ This may leave little in the way of long-term scarring and so contemporaneous recording of all findings is crucial.

4.2 Long-term complications

Reported long-term complications of FGM are listed below. The systematic review by Berg⁹ demonstrated an association of FGM with urinary tract infection, dyspareunia and bacterial vaginosis. Cohort studies and case reports have also found associations with other sequelae. Most studies are of poor methodological quality.

Genital scarring

Genital scarring after FGM can be unsightly and painful. Keloid scarring has been reported in up to 3% of women. Epidermoid inclusion cysts and sebaceous cysts may need surgical excision.¹⁰ Neuroma of the clitoris causing pain has been described.^{11–13}

Evidence
level 4

Urinary tract complications

Lower urinary tract symptoms are more common in women with FGM, particularly those with type 2 or type 3 FGM.¹⁴ Poor urinary flow beneath the infibulation scar may result in symptoms of urinary obstruction, and stasis of urine may lead to recurrent urinary tract infection (relative risk [RR] 3.01, CI 1.42–6.38)⁹ and to urinary or vaginal calculi.¹⁵ The recommended treatment is de-infibulation.

Evidence
level 2+

Damage to the urethra during FGM of any type may result in a urinary stricture or fistulae. These require assessment by a urologist or urogynaecologist.

There is no evidence that FGM directly increases the long-term risk of genital prolapse or incontinence.¹⁶ However, vaginal narrowing may hamper urodynamic investigation.

Evidence
level 3

Dyspareunia, apareunia and impaired sexual function

Dyspareunia may occur as a result of vaginal narrowing and painful scar tissue (RR 1.53, 95% CI 1.20–1.97). Apareunia and vulvovaginal lacerations during sexual intercourse have also been reported.⁹

Evidence
level 2+

The removal of sexually sensitive tissue such as the clitoris and labia minora may reduce sexual sensation, while scarring over the clitoris may be painful. Numerous reports exist of

various sexual consequences of FGM, including a reduction in desire and arousal, reduced frequency of orgasm or anorgasmia, decreased lubrication and poorer sexual satisfaction.¹⁷⁻¹⁹

Evidence
level 2+

Psychological sequelae

It is accepted that FGM has psychological effects, and flashbacks, anxiety²⁰ and post-traumatic stress disorder have been reported.²¹ FGM has been linked to an increased incidence of domestic violence in Africa^{22,23} but there are no European or UK data on this.

Evidence
level 3

Menstrual difficulties

Haematocolpos due to FGM has been reported. Dysmenorrhoea has also been reported among women with FGM, although the underlying mechanisms are unclear.¹³

Evidence
level 3

Genital infection and pelvic inflammatory disease

FGM has been associated with an increased risk of bacterial vaginosis⁹ and herpes simplex virus type 2.²⁴ However, currently there is no conclusive epidemiological evidence to support an increased risk of pelvic inflammatory disease as a consequence of FGM. One case-control study from Sudan showed similar rates of chlamydia, gonorrhoea and syphilis in women with and without FGM.²⁵

Evidence
level 2+

Infertility

At present, there are no well-planned studies that confirm whether or not FGM leads to infertility. Potential factors could include lack of sexual intercourse (apareunia, dyspareunia, impaired sexual function) and ascending infections caused by the FGM procedure. One case-control study showed an association between primary infertility and FGM.²⁶

Evidence
level 2-

HIV and hepatitis B infection

Many FGM-practising countries are hepatitis B endemic²⁷ and some have a high prevalence of HIV.²⁸ Although mechanisms by which FGM may increase the risk of transmission of hepatitis B, hepatitis C and HIV have been proposed (i.e. sharing of non-sterile instruments and cutting in groups), there is currently no conclusive epidemiological evidence to support this.

Obstetric complications

Research into the obstetric complications of FGM has been hampered by patchy methodology and the fact that in Africa, where FGM is typically practised, maternal and perinatal mortality and morbidity are already high due to other factors. Obstetric complications have been described with all types of FGM. However, the risks are greater with greater tissue damage.

Maternal complications associated with FGM have been described in Africa, North America and Europe. One large prospective study by the WHO investigated both maternal and perinatal outcomes in 28 000 women in six African countries.²⁹ A meta-analysis by Berg et al.³⁰ reviewed maternal outcomes and included some studies from Western countries (USA and Europe), although the majority were from Africa. The meta-analysis reported an increased risk of prolonged labour, postpartum haemorrhage and perineal trauma. The WHO study also found an increased risk of caesarean section and demonstrated an increased need for neonatal resuscitation and risk of stillbirth and early neonatal death.

Evidence
level 2-

There are no good quality European or UK studies investigating FGM and perinatal outcomes. However, evidence from epidemiological studies of non-European migrants in Europe has

shown a higher incidence of stillbirth^{31,32} and neonatal death,³¹ so women in the UK from FGM-practising countries may be at higher risk.

Evidence
level 2–

Although fistulae have been associated with FGM, studies have not demonstrated that a history of FGM increases the risk of subsequent obstetric fistulae due to obstructed labour.³³

Evidence
level 4

Other obstetric consequences that have been described include fear of childbirth, difficulty in intrapartum monitoring (including application of fetal scalp electrodes and fetal blood sampling), difficulty in catheterisation during labour, wound infection and retention of lochia.²⁹

Evidence
level 2+

5. The legal and regulatory responsibilities of health professionals

5.1 FGM and UK law

All health professionals must be aware of the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland. Both Acts provide that:

D

1. FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age:
 - (a) which is necessary for her physical or mental health; or
 - (b) she is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.
2. It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM.
3. It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.
4. If FGM is confirmed in a girl under 18 years of age (either on examination or because the patient or parent says it has been done), reporting to the police is mandatory and this must be within 1 month of confirmation.

Female genital cosmetic surgery (FGCS) may be prohibited unless it is necessary for the patient's physical or mental health. All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Acts.

D

Re-infibulation is illegal; there is no clinical justification for re-infibulation and it should not be undertaken under any circumstances.

D

Health professionals must have a clear understanding of the law on FGM so that they can explain it to their patients and so that they understand the basis for reporting concerns to the police and/or social care.³⁴

Evidence
level 4

FGM is illegal in England, Wales and Northern Ireland under the Female Genital Mutilation Act 2003 and in Scotland under the Prohibition of Female Genital Mutilation (Scotland) Act 2005. Both Acts make it an offence for any person:

- (a) to excise, infibulate or otherwise mutilate the whole or any part of a person's labia majora, labia minora or clitoris; or
- (b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body, or
- (c) to aid, abet, counsel or procure a person to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.

Both Acts also make it a criminal offence to carry out FGM abroad, and to aid, abet, counsel or procure the carrying out of FGM abroad, including in countries where the practice is legal. Both Acts permit

surgical procedures that may fall within these categories (carried out by an appropriately registered practitioner) if necessary for the physical or mental health of the woman or if performed during labour or immediately postpartum 'for purposes connected with the labour or birth'. It should be noted that the FGM Acts apply to adult women as well as children.

The Serious Crime Act 2015 reinforced existing FGM legislation and introduced mandatory reporting of FGM in girls under 18 years by healthcare workers, teachers and social workers to the police.³⁵

All health professionals should be aware of the Department of Health's guidance on FGM risk assessment and safeguarding.⁵

FGCS refers to non-medically indicated cosmetic surgical procedures, which change the structure and appearance of the healthy external genitalia of women (or internally in the case of vaginal tightening). UK guidance on FGCS is available and this includes the recommendation that FGCS should not normally be carried out on those under 18.³⁶ The legal status of some FGCS procedures has been called into question and it is likely to be illegal unless necessary to safeguard the patient's physical or mental health (the section 1(2)(a) exemption).

Evidence
level 4

Re-infibulation refers to the resuturing (usually after childbirth) of the incised scar tissue in a woman with FGM type 2 or 3. Previously there was uncertainty as to whether re-infibulation was covered by the FGM Acts.⁶ However, it is now accepted that re-infibulation is illegal and should not be performed in any circumstances.

5.2 *What are the legal and regulatory responsibilities of health professionals in their evaluation of women with FGM?*

When a woman with FGM is identified:

The health professional must explain the UK law on FGM.

D

The health professional must understand the difference between recording (documenting FGM in the medical records for data collection) and reporting (making a referral to police and/or social services) and their responsibilities with regards to these (Appendix I).

D

The health professional must be familiar with the requirements of the HSCIC FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication.

D

The health professional should be aware that it is not mandatory to report all pregnant women to social services or the police. An individual risk assessment should be made by a member of the clinical team (midwife or obstetrician) using an FGM safeguarding risk assessment tool (an example of such a tool can be found at <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>). If the unborn child, or any related child, is considered at risk then a report should be made.



To assist health professionals in explaining the law on FGM to their patients, women should be referred to information provided in the Health Passport.³⁸ This document is available in a range of languages.³⁹

The legal and regulatory responsibilities of health professionals are summarised in Appendix I.

Recording (see Appendix I)

Recording must be in accordance with the requirements of the HSCIC FGM Enhanced Dataset, which was implemented primarily to improve services for those with FGM. It requires all acute trusts, general practices and mental health trusts to record demographic, clinical and family information for all women with FGM and for these data to be submitted, without anonymisation, to the HSCIC. This should be explained to the woman. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication. According to Department of Health guidance (<http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/2903740%20DH%20FGM%20Leaflet%20Accessible%20-%20English.pdf>), women who object to use of their data in this way should go to <http://www.hscic.gov.uk/patientconf> for more details.

In accordance with the Enhanced Dataset, when a patient with FGM is identified, the fact that they have had FGM must be documented in the medical records regardless of whether FGM is the reason for presentation. A clinical examination may be indicated to determine the type of FGM and clinicians are required to use the WHO FGM classification (Table 1). For this reason genital piercings must be included as type 4 FGM. The woman should be informed that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will not be anonymised. Some services, such as sexual health services, are likely to be exempt from returning identifiable FGM data on adult women due to their specific legal obligations regarding confidentiality.

Reporting (see Appendix I)

Reporting means making a referral to the police or social services and guidance from the Department of Health is available.⁵

The requirement to report depends on whether an adult or a child is affected. FGM is child abuse and any child with confirmed or suspected FGM, or a child considered to be at risk of FGM, must be reported, if necessary without the consent of the parents. Information should also be shared with the general practitioner (GP) and health visitor. This is in accordance with section 47 of the Children Act 1989.

Local Safeguarding Children Boards (LSCBs) have responsibility for developing inter-agency protocols and procedures for safeguarding. If in any doubt, health professionals must contact their named lead for safeguarding who will advise. The urgency of the referral will vary depending on the type of risk.

There is no requirement to report a nonpregnant adult woman aged 18 or over to the police or social services unless a related child is at risk. The patient's right to confidentiality must be respected if they do not wish any action to be taken. No reports to social care or the police should be made in these cases.^{5,34}

It is not mandatory to report every pregnant woman identified as having had FGM to social services or the police. An individual risk assessment must be made by a member of the clinical team caring for the woman during her pregnancy. If the unborn child, or any related child, is considered to be at risk of FGM, then a report must be made to children's social care or the police.

Healthcare professionals must record identified FGM in antenatal notes, screening returns and immunisation notes. Notes should also include whether the woman has been de-infibulated and, where appropriate, referred to further specialist care. A list of specialist FGM clinics is available (please note that this list only covers England).⁴⁰

Following birth, relevant information about the mother's FGM should be recorded in the maternity discharge documentation so that GPs and health visitors are aware of the mother's history. The family history of FGM should also be recorded in the baby's personal child health record ('Red Book').⁴¹

Where appropriate, healthcare professionals should educate women on how FGM is illegal in the UK and how the practice has serious long-term physical, psychological and emotional consequences.⁴

Evidence
level 4

6. What are the principles of FGM management in obstetric and gynaecological practice?

All acute trusts/health boards should have a designated consultant and midwife responsible for the care of women with FGM (Appendix II).



All gynaecologists, obstetricians and midwives should receive mandatory training on FGM and its management, including the technique of de-infibulation. They should complete the programme of FGM e-modules developed by Health Education England.



Specialist multidisciplinary FGM services should be led by a consultant obstetrician and/or gynaecologist and be accessible through self-referral. These services should offer: information and advice about FGM; child safeguarding risk assessment; gynaecological assessment; de-infibulation; and access to other services.



Health professionals should ensure that, in consultations with women affected by FGM, the consultation and examination environment is safe and private, their approach is sensitive and nonjudgemental and professional interpreters are used where necessary. Family members should not be used as interpreters.



Each trust/health board should have a designated obstetrician and/or gynaecologist responsible for FGM care. These individuals should be aware of local and/or regional specialist multidisciplinary FGM services. They should remain competent and up to date in all aspects of FGM (including child safeguarding protocols).

The programme of FGM e-modules developed by Health Education England is available free to all healthcare professionals (<http://www.e-lfh.org.uk/programmes/female-genital-mutilation>). Use of a de-infibulation bench-top trainer as an aid to learning may be considered.

Most UK specialist FGM services are in major cities and may be located in a hospital or community clinic (e.g. GP surgery or sexual health clinic). All FGM specialist services should offer information and advice regarding FGM as well as gynaecological assessment and access to de-infibulation. Some may also offer antenatal care. Specialist FGM services should offer access to psychological assessment and treatment, sexual health screening and treatment and gynaecological subspecialties such as urogynaecology, psychosexual services and infertility. They should work collaboratively with other healthcare providers, including GPs and acute trusts, voluntary sector organisations, the police, social services and schools. Currently referral pathways, clinic hours and service provision vary and there is a need to develop national minimum quality assurance standards for establishing and operating these services.⁴²

Evidence
level 4

Guidance about the professional approach to take when women with FGM attend for consultation is available.³⁴ Health professionals should be nonjudgemental, pointing out the illegality and health risks of the practice without appearing to blame the woman. Appropriate language should be used. Although the term 'FGM' may be understood and accepted by some, referring to being 'cut', 'closed' or 'circumcised' may be more acceptable to many women.³⁴ A list of local/traditional terms for FGM is available in the Department of Health *Female Genital Mutilation Risk and Safeguarding* guidance.⁵

7. How should recent FGM be managed?

Healthcare professionals should be vigilant and aware of the clinical signs and symptoms of recent FGM, which include pain, haemorrhage, infection and urinary retention.



Examination findings should be accurately recorded in the clinical records. Some type 4 FGM, where a small incision or cut is made adjacent to or on the clitoris, can leave few, if any, visible signs when healed. Consideration should be given to photographic documentation of the findings at acute presentation.



Legal and regulatory procedures must be followed (Appendix I); all women and girls with acute or recent FGM require police and social services referral.



Healthcare professionals should be aware of the clinical signs and symptoms of FGM and record their examination findings accurately in the clinical records. The legal and regulatory procedures are outlined in Appendix I.

8. How should FGM be managed in gynaecological practice?

8.1 What should the referral pathway be for women with FGM?

Women may be referred by their GP to a hospital gynaecology clinic. The referral should be directed to FGM services, if available, or to the designated consultant obstetrician and/or gynaecologist responsible for the care of women and girls with FGM.



Women should be able to self-refer.



All children with FGM or suspected FGM should be seen within child safeguarding services.



All hospitals are expected to identify women with FGM and assess appropriately. In areas of low prevalence there must be clear pathways for referral to FGM services, including self-referral.

8.2 How should women with FGM be assessed in gynaecological practice?

Women with FGM may present with symptoms directly attributable to their FGM or with co-existing gynaecological morbidity. Gynaecologists should ask all women from communities that traditionally practise FGM whether they have had the procedure.



Clinicians should be aware that psychological sequelae and impaired sexual function can occur with all types of FGM.



Examination should include inspection of the vulva to determine the type of FGM and whether de-infibulation is indicated, as well as to identify any other FGM-related morbidities, e.g. epidermoid inclusion cysts.



All women should be offered referral for psychological assessment and treatment, testing for HIV, hepatitis B and C and sexual health screening. Where appropriate, women should be referred to gynaecological subspecialties, e.g. psychosexual services, urogynaecology, infertility.



Gynaecologists should be aware that narrowing of the vagina due to type 3 FGM can preclude vaginal examination for cervical smears and genital infection screens. De-infibulation may be required prior to gynaecological procedures such as surgical management of miscarriage (SMM) or termination of pregnancy (TOP).



The clinical management of women with FGM in gynaecological practice is summarised in Appendix II.

8.3 What is the role of de-infibulation in gynaecological practice?

Women who are likely to benefit from de-infibulation should be counselled and offered the procedure before pregnancy, ideally before first sexual intercourse.



Women offered de-infibulation should have the option of having the procedure performed under local anaesthetic in the clinic setting in a suitable outpatient procedures room (Appendix III).



De-infibulation is a minor surgical procedure to divide the scar tissue sealing the vaginal introitus in type 3 FGM. The need for de-infibulation can be determined on inspection of the external genitals by an experienced health professional. De-infibulation is sometimes termed a 'reversal' of FGM; however, this is incorrect as it does not replace genital tissue or restore normal genital anatomy and function.

De-infibulation is recommended if the introitus is not sufficiently open to permit normal urinary and menstrual flow, vaginal examination, comfortable sexual intercourse and safe vaginal delivery. It may also be necessary to permit cervical smears, sexual health screens and gynaecological surgery (e.g. SMM, TOP). In practice it will be required for most women with type 3 FGM, as the vaginal introitus will be narrowed.

De-infibulation can usually be performed under local anaesthetic in an appropriately equipped room for minor procedures or in a delivery suite room. Occasionally a spinal or general anaesthetic is required. One recommended method of de-infibulation is shown in Appendix III.

8.4 What is the role of clitoral reconstruction?

Clitoral reconstruction should not be performed because current evidence suggests unacceptable complication rates without conclusive evidence of benefit.



Several publications, including a large retrospective study,⁴³ claim that reconstructive clitoral surgery can restore clitoral function. However, surgery cannot replace clitoral tissue removed at FGM and it is also possible that surgical exploration of the clitoral area may result in further damage to the clitoral nerves and vasculature and loss of sensation. It is debatable that these procedures improve clitoral sensation, although improving the genital appearance may have benefits for some women. Existing studies are retrospective with poor follow-up and they lack standardised assessment of sexual function. In the study by Foldès,⁴³ 2938 women underwent surgery but only 29% attended for follow-up and 4% required hospital readmission because of surgical complications. There is a need for well-designed clinical trials to investigate the safety and effectiveness of this procedure.

Evidence
level 3

9. How should FGM be managed in pregnancy?

9.1 What level of care do women with FGM require?

Women with FGM are more likely to have obstetric complications and consultant-led care is generally recommended. However, some women with previous uncomplicated vaginal deliveries may be suitable for midwifery-led care in labour.



Women with FGM are more likely to have obstetric complications and consultant-led care is generally recommended. However, some women who have previously had one or more uncomplicated pregnancies and have delivered vaginally may be considered low risk, provided that they have no history of post-delivery re-infibulation.

9.2 How should women with FGM be identified in pregnancy?

All women, irrespective of country of origin, should be asked for a history of FGM at their booking antenatal visit so that FGM can be identified early in the pregnancy. This should be documented in the maternity record.



Women identified as having FGM should be referred to the designated consultant obstetrician or midwife with responsibility for FGM patients. Local protocols will determine which elements of care should be undertaken by these individuals and which may be undertaken by other appropriately trained midwives or obstetricians (Appendix IV).



Pregnancy is a time when the majority of women engage with healthcare services. It presents a key opportunity to identify women with FGM, provide information and advice, address healthcare needs and assess the risk to the unborn child and to other female family members. In the UK, it is normal practice to defer vaginal examination of pregnant women until the onset of labour, unless there is a clinical indication. For this reason, early identification of FGM in pregnancy is best achieved by asking all women booking for antenatal care whether they have a history of FGM.⁴¹ It is good practice if possible to obtain such a clinical history from the patient in the absence of a partner or other family member. It might be important to consider that some women may not know if they have been exposed to FGM.

Evidence
level 4

The clinical management of pregnant women is summarised in Appendix II.

9.3 What antenatal documentation is required to demonstrate that legal and regulatory processes have been adhered to?

The midwife or obstetrician should ensure that all relevant information is documented in the clinical records (Appendix I).



The information in the clinical records should include documentation that FGM has been recorded in accordance with the HSCIC Enhanced Dataset, as well as other information as shown in Appendix I.

9.4 How should antenatal care be managed?

Referral for psychological assessment and treatment should be offered.



The vulva should be inspected to determine the type of FGM and whether de-infibulation is indicated. If the introitus is sufficiently open to permit vaginal examination and if the urethral meatus is visible, then de-infibulation is unlikely to be necessary.



Screening for hepatitis C should be offered in addition to the other routine antenatal screening tests (hepatitis B, HIV and syphilis).



De-infibulation may be performed antenatally, in the first stage of labour or at the time of delivery and can usually be performed under local anaesthetic in a delivery suite room. It can also be performed perioperatively after caesarean section (Appendix III).



The midwife or obstetrician should discuss, agree and record a plan of care (see Appendix IV). This may be documented in a preformatted sheet.



Women should be informed that re-infibulation will not be undertaken under any circumstances.



For women with type 3 FGM, where adequate vaginal assessment in labour is unlikely to be possible, de-infibulation should be recommended antenatally, usually in the second trimester, typically at around 20 weeks of gestation. Antenatal de-infibulation as an elective procedure ensures that the procedure is performed by an appropriately trained midwife or obstetrician. However, women may prefer de-infibulation during labour, as this is the usual practice in some countries where FGM is prevalent.

There have been no randomised trials conducted on measures that may improve outcomes for pregnant women with a history of FGM.⁴⁴ However de-infibulation (when the introitus is narrowed) and selective episiotomy (depending on assessment at the time of delivery) may improve clinical outcomes.

Women should be informed that re-infibulation will not be undertaken under any circumstances.³⁷ They should also be informed of the health consequences of re-infibulation and the benefits of not re-infibulating.

Evidence
level 4

9.5 How should intrapartum care be managed?

If a woman requires intrapartum de-infibulation, the midwife and obstetrician caring for her should have completed training in de-infibulation or should be supervised appropriately.



If de-infibulation planned for the time of delivery is not undertaken because of recourse to caesarean section, then the option of perioperative de-infibulation (i.e. just after caesarean section) should be considered and discussed with the woman.



Labial tears in women with FGM should be managed in the same manner as in women without FGM. Repairs should be performed where clinically indicated, after discussion with the woman and using appropriate materials and techniques.



Women with FGM should generally be delivered in units with immediate access to emergency obstetric care and should have intravenous access established in labour and blood taken for full blood count and group and save. However, in certain circumstances women with FGM may be considered low risk and midwifery-led care in labour may be appropriate (see section 9.1).

The technique of de-infibulation at delivery is similar in principle to de-infibulation performed at other times (see Appendix III). However, in contrast to de-infibulation prepregnancy, antenatally or in the first stage of labour, when either a scalpel or scissors may be used, at delivery the incision should be made with scissors (rather than a scalpel) just before crowning of the fetal head. Lidocaine without adrenaline (epinephrine) should be used. Once the procedure has been performed, the need for episiotomy should be assessed; this is commonly required (irrespective of FGM type) due to scarring and reduced skin elasticity of the introitus.

In women for whom intrapartum de-infibulation was planned to permit safe vaginal delivery, emergency caesarean section may result in the woman having an ongoing need for de-infibulation during a subsequent pregnancy. If feasible from the perspective of maternal and fetal wellbeing, the option of perioperative de-infibulation, after safe caesarean delivery of the baby, should be discussed with the woman prior to transfer to theatre. This scenario may be discussed with women antenatally.

Guidance for repair of perineal and genital trauma is available⁴⁵ and should be followed for women with FGM, for example, in the case of labial tears.

Evidence
level 4

9.6 How should intrapartum care be managed for women identified as having FGM in pregnancy for whom there has been no agreed documented plan of care?

The impact of FGM on labour and delivery should be sensitively discussed and a plan of care agreed.



If vaginal examination is not possible or intrapartum procedures and urinary catheterisation are not feasible, then de-infibulation in the first stage of labour should be recommended. An epidural should be offered to cover the procedure and for subsequent examinations and delivery. If vaginal access is adequate then de-infibulation can be performed at the time of delivery under local anaesthetic (see section 9.5).

9.7 How should postnatal care be managed?

A woman whose planned de-infibulation was not performed because of delivery by caesarean section should have follow-up in a gynaecology outpatient or FGM clinic so that de-infibulation can be offered before a subsequent pregnancy.



The discharging midwife should ensure that all legal and regulatory processes have been adhered to prior to discharge (Appendix I).



The designated consultant obstetrician or named specialist midwife may consider a postnatal debrief with the patient and her partner, regardless of whether intrapartum procedures were undertaken or not. This represents a further opportunity to educate the family on FGM. All the appropriate legal and regulatory processes should be documented as shown in Appendix I. The discharging midwife should ensure that the documentation is complete.

10. Recommendations for future research

- The rates of stillbirth and neonatal death in women with FGM.
- Interventional trials to assess the role of de-infibulation in improving pregnancy outcomes and the optimal timing of de-infibulation.
- Clinical trials to investigate the safety and effectiveness of clitoral reconstruction.
- The role of psychological assessment and treatment in the antenatal care of women with FGM.

11. Auditable topics

- The proportion of women asked about FGM at booking (100%).
- The proportion of healthcare professionals who are familiar with the HSCIC FGM Enhanced Dataset (100%).
- The proportion of healthcare workers (gynaecologists, obstetricians and midwives) who have received training on FGM and its management (100%).
- The proportion of pregnant women identified as having FGM who are referred to a designated consultant obstetrician or specialist midwife with responsibility for FGM patients (100%).
- The proportion of women identified as having FGM who are offered screening for hepatitis B, hepatitis C, HIV and syphilis (100%).
- The quality of documentation of FGM in the medical records, including ensuring information is transferred to the community.
- Number of referrals made to social services and/or police.

12. Useful links and support groups

- Department of Health. *Commissioning services to support women and girls with female genital mutilation*. London: DH; 2015 [<https://www.gov.uk/government/publications/services-for-women-and-girls-with-fgm>].
- Department of Health. *Female Genital Mutilation Risk and Safeguarding. Guidance for professionals*. London: DH; 2015 [<https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>].
- Patient information leaflets may be ordered from the Department of Health [https://www.orderline.dh.gov.uk/ecom_dh/public/saleproduct.jsf?catalogueCode=2903740].
- FORWARD (Foundation for Women's Health Research and Development) [<http://www.forwarduk.org.uk>].
- Multi-agency practice guidelines have been produced by the Home Office and the Department for Education to support front-line professionals to prevent FGM [<https://www.gov.uk/government/publications/female-genital-mutilation-guidelines>].
- NHS Choices. *Female genital mutilation*
 - For patients: [<http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx>].
 - For professionals: [<http://www.nhs.uk/nhsengland/aboutnhservices/sexual-health-services/pages/fgm-for-professionals.aspx>].
- Orchid Project (a charity dedicated to ending female genital cutting) [<http://orchidproject.org/>].

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Appendix I: Legal and regulatory responsibilities of health professionals

1. Data recording (<http://www.hscic.gov.uk/fgm>)
 - Data recording is mandatory for all women identified as having FGM.
 - Document FGM diagnosis in medical records (even if FGM is not the reason for presentation).
 - If genital examination is performed and type of FGM is identified, record FGM type (WHO classification).*
 - Document further details in accordance with the HSCIC FGM Enhanced Dataset.
 - Explain to the woman that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will not be anonymised.
2. Reporting to police and/or social services in the event of risk to a child (<https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>)
 - Children under 18:
 - If FGM is confirmed (on examination or if the patient or parent says it has been done), refer as a matter of urgency to the police and this should be done within 1 month of confirmation.
 - If FGM is suspected (but not confirmed) or the girl is at risk (but has not had FGM), refer to social services or the police. The urgency of the referral depends on the degree of risk.
 - Nonpregnant women with FGM: no requirement to report unless a related child is at risk.
 - Pregnant women:
 - A member of the clinical team (midwife or obstetrician) must make an individual risk assessment using an FGM safeguarding risk assessment tool and if the unborn child, or any other child in the family, is considered to be at risk of FGM then reporting to social services or the police must occur.
 - Document maternal history of FGM in the personal child health record ('Red Book') prior to postnatal discharge.
 - If delivery of a baby girl, notify the designated child protection midwife, who should inform the GP and health visitor.

*Genital piercings should be classified as type 4 FGM in accordance with the WHO FGM classification.

Appendix II: Clinical management of adult women with FGM in obstetric and gynaecological practice

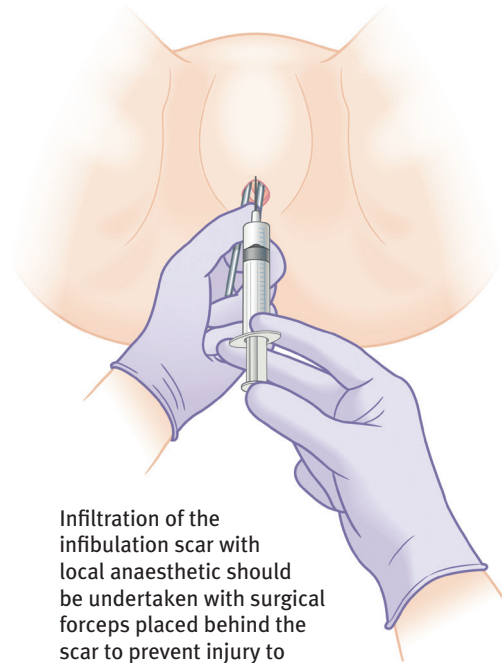
1. All acute trusts/health boards should have a designated consultant and midwife responsible for the care of women with FGM
2. All women in obstetric and gynaecological practice
 - Explain law on FGM, documenting the discussion and referring her to information provided in the Health Passport (<https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation>).
 - Provide interpreter if required (not a family member).
 - Offer referral for psychological assessment and treatment.
 - Offer specialist referral as appropriate, e.g. sexual health, urology.
 - Make a clinical assessment of FGM (symptoms, examination) and need for de-infibulation.
 - Record data in accordance with the HSCIC FGM Enhanced Dataset. These include age at FGM, country where FGM was performed, date of entry to UK (if applicable) and past history of de-infibulation and/or re-infibulation.
 - If de-infibulation is indicated, offer before pregnancy – it can usually be performed on an outpatient basis.
 - Reporting to social services or the police is only required if a related child is considered to be at risk.
3. Additional management in pregnant women
 - Refer to designated consultant obstetrician or specialist midwife with responsibility for women with FGM.
 - Local protocols will determine which elements of care (child safeguarding risk assessment, data recording, clinical management) should be undertaken by the designated midwife or obstetrician and which may be undertaken by other appropriately trained midwives or obstetricians.
 - Discuss and clearly document a plan of care – preformatted pro formas may be used.
 - Make an individual risk assessment using an FGM safeguarding risk assessment tool (an example of such a tool can be found at <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>). If the unborn child or any related child is considered to be at risk then reporting to social services or the police must occur.
 - Offer screening for hepatitis C in addition to routine screening for hepatitis B, HIV and syphilis.
 - If de-infibulation is indicated, discuss, agree and document the timing (antenatal or intrapartum). Inform the woman that re-infibulation after delivery will not be performed under any circumstances.
 - Manage as high obstetric risk (increased risk of haemorrhage, perineal trauma and caesarean section), except for women who have had previous pregnancies with uncomplicated vaginal deliveries and no history of post-delivery re-infibulation.
 - Document maternal history of FGM in the personal child health record ('Red Book') prior to postnatal discharge.
 - If delivery of a baby girl, notify the designated child protection midwife, who should inform the GP and health visitor.
 - Offer postnatal follow-up if de-infibulation performed intrapartum or if planned de-infibulation did not occur because of delivery by caesarean section.

Appendix III: One recommended method of performing de-infibulation

1) Type 3 FGM (infibulation)

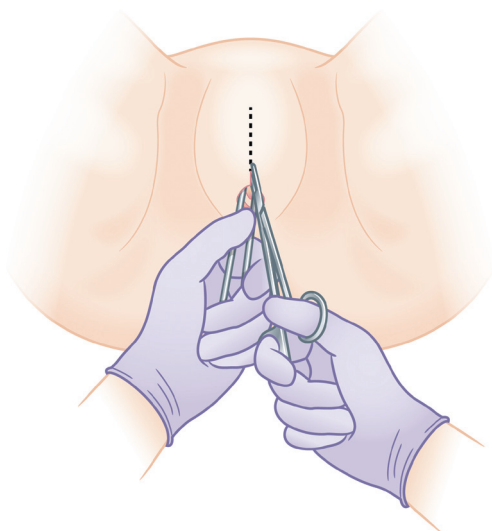


2) Infiltration of midline scar with local anaesthetic



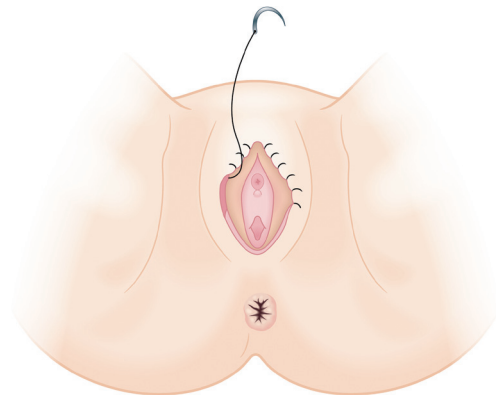
Infiltration of the infibulation scar with local anaesthetic should be undertaken with surgical forceps placed behind the scar to prevent injury to underlying tissues.

3) Incision of midline scar



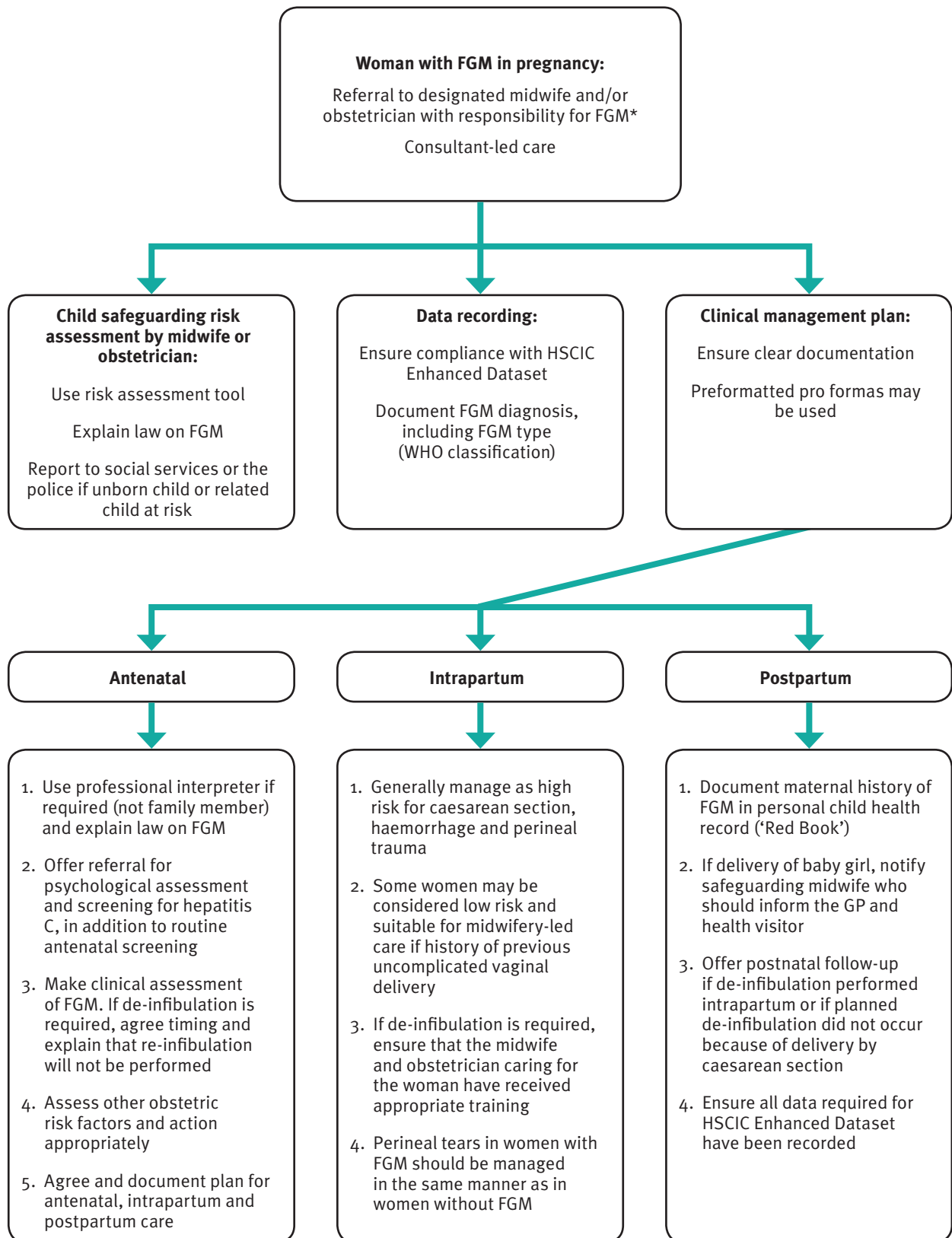
The incision should be made either with scissors or a knife and extended anteriorly until the external urethral meatus is visible.

4) Suturing of cut edges with absorbable suture



The cut edges may be oversewn with a fine absorbable suture and a paraffin gauze dressing applied.

Appendix IV: Plan of care for women with FGM in pregnancy




* Local protocols will determine which elements of care (child safeguarding risk assessment, data recording, clinical management plan) should be undertaken by the designated midwife or obstetrician responsible for women with FGM and which may be undertaken by other appropriately trained midwives or obstetricians

Appendix V: Explanation of guidelines and evidence levels

Clinical guidelines are: 'systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions'. Each guideline is systematically developed using a standardised methodology. Exact details of this process can be found in Clinical Governance Advice No. 1 *Development of RCOG Green-top Guidelines* (available on the RCOG website at <http://www.rcog.org.uk/green-top-development>). These recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Attention is drawn to areas of clinical uncertainty where further research may be indicated.

The evidence used in this guideline was graded using the scheme below and the recommendations formulated in a similar fashion with a standardised grading scheme.

Classification of evidence levels	Grades of recommendations
1++ High-quality meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a very low risk of bias	A At least one meta-analysis, systematic review or randomised controlled trial rated as 1++, and directly applicable to the target population; or A systematic review of randomised controlled trials or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results
1+ Well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias	B A body of evidence including studies rated as 2++ directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
1- Meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a high risk of bias	C A body of evidence including studies rated as 2+ directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
2++ High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal	D Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+
2+ Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal	Good practice point
2- Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal	 Recommended best practice based on the clinical experience of the guideline development group
3 Non-analytical studies, e.g. case reports, case series	
4 Expert opinion	

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All RCOG guidance developers are asked to declare any conflicts of interest. A statement summarising any conflicts of interest for this guideline is available from: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/>.

The final version is the responsibility of the Guidelines Committee of the RCOG.

The review process will commence in 2018, unless otherwise indicated.

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available.

This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.