CLINICAL PRACTICE GUIDELINE

TITLE

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

NATIONAL CLINICAL GUIDELINE

Management of Female Genital Mutilation (FGM)

Institute of Obstetricians and Gynaecologists,
Royal College of Physicians of Ireland
and the
Clinical Strategy and Programmes Division,
Health Service Executive

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Contents:

1. Revision History

Version No.	Date	Modified By	Description
1.0	7/2/19	Guideline Development Group	Version 1

2. Key Recommendations

1. It is an offence to undertake FGM on a child or woman in Ireland, and it is also an offence to bring a child or woman out of the country for the purpose of undertaking FGM. Consent of the woman or her parents to the procedure is not a defence, nor is it a defence to say it was required or permitted for customary or religious reasons.

2. Each hospital should have a designated consultant, senior midwife or nurse with a special interest in female genital mutilation (FGM) and experience in its management and appropriate referral pathways. This health care provider should be familiar the existing multidisciplinary services funded by the HSE, undertaken in the main by the Irish Family Planning Association (IFPA).

3. Obstetricians, gynaecologists, midwives, gynaecology nurses and GPs should receive formal training with regard to FGM, including clinical care pathways and the implications of the Criminal Justice (Female Genital Mutilation) Act 2012, and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. This training should be discipline appropriate and training should be updated regularly.

4. Women should be asked about FGM at their booking visit. This conversation should be supportive, patient focused & without value judgments. Translation should be used if required. Physical examination should be offered to ascertain the anatomical impact of FGM, and if indicated, de-infibulation explained and discussed.

5. Women identified as having undergone FGM at a booking visit, should be reviewed by a senior obstetrician or senior midwife. If FGM is identified in the index pregnancy but is not deemed to have a likely impact on delivery, then supported care may be an appropriate option. If however, the type of FGM may impact on delivery, at least one antenatal consultation with an obstetrician is required to plan for birth, bearing in mind the woman's preferences. Assisted or specialised care may be more appropriate in this scenario. Women who have previously delivered vaginally, with a history of FGM, should be offered supported care unless they have additional risk factors or prefer assisted/specialised care.

   National consensus recommends that deinfibulation should be offered to women intrapartum, however it may be undertaken in the late second or third trimester if preferred. Deinfibulation may be offered perioperatively, or post caesarean delivery if appropriate, or women may be referred for deinfibulation postpartum.

6. Although postpartum reinfibulation is not a specifically listed as an offence in Irish legislation, it is never clinically indicated and, consistent with best international practice, must never be carried out. Reinfibulation has no benefits, clinical or otherwise, and it may seriously affect the reproductive health of women and increase her risks for future birth/s. Reinfibulation violates the woman's human rights and bodily integrity. However, where clinically indicated, perineal tears must be sutured to achieve haemostasis using routine perineal repair techniques.

7. The type of FGM should be documented in the maternal healthcare record, and the midwifery discharge team, public health nurse and GP made aware. Be aware that FGM will not always fit into the defined subtypes, the anatomical impact should be clearly described.

8. Any concern with regard to female children of the woman and the risk of FGM should be assessed by a senior midwife or obstetrician – a referral to TUSLA should be made if appropriate as per Children First legislation. If there is no concern, this also must be documented in the maternal health record.

9. Deinfibulation should be offered to women who present to gynaecology services seeking same. HIPE data should be appropriately annotated on discharge.

10. Clitoral reconstruction is not currently recommended, and should be undertaken only as part of a research trial as there is insufficient evidence for its efficacy. To our knowledge, it is not currently offered in Ireland.

3. Purpose and Scope

The purpose of this guideline is to improve the management of women presenting with female genital mutilation (FGM) and to ensure that clinicians working in the area offer evidenced based care in a manner that is culturally sensitive. It aims to familiarise clinicians with the clinical care pathways and the relevant legal framework governing FGM in Ireland.

These guidelines are intended for healthcare professionals, working in HSE-funded obstetric and gynaecological services. They are designed to guide clinical judgment but not replace it. In individual cases a healthcare professional may, after careful consideration, decide not to follow a guideline if it is deemed to be in the best interests of the woman.

4. Background and Introduction

FGM comprises any procedure that either totally or partially removes, alters or injures the external female genitalia for non-medical reasons (WHO 2007). It is a significant global health problem, reportedly affecting between 125 to 200 million woman and girls worldwide, but predominates in sub-Saharan Africa (See appendix 1). FGM is recognised as an act of violence against women and children (UNICEF 2015). Recent trends in immigration have seen developed countries, such as Ireland, witness an increase in the overall prevalence of FGM (Goldberg et al 2016) in affected communities. There have also been reports of the practice being undertaken in diaspora communities (Irish Times 2016) within the country and in December 2019 a couple were found guilty of allowing the practice on their young daughter.

There are four different categories of FGM, although sometimes specific anatomic findings will not fit into a particular category (See appendix 2).
Type 1: the partial or total removal of the clitoris.

Type 2: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type 3: also known as infibulation; the almost complete closure and or part excision of the labia majora to leave a small aperture for the egress of urine and menses, with or without removal of the clitoris.
Type 4: includes all other harmful procedures to the female genitalia, for example, pricking, piercing, incising, scraping and cauterising.

The practice can take place at any age, but the most commonly occurs between two and ten years. It may be undertaken by local practitioners, but in some countries, there is an increasing trend towards the 'medicalisation' of FGM on the basis that it makes the practice safer (Van Rossem 2016, Mostafa 2006, Shell-Duncan 2001). Multiple international groups are campaigning against this medical model, underlining that there is no clinical circumstance where FGM is medically indicated.

The genesis of FGM is unknown, and it holds no formal basis in any religion; it is predominantly a cultural/traditional practice. Its prevalence traverses all social classes, and although protective, high educational attainment does not preclude its occurrence. Proponents cite traditional practice, social acceptance and marriageability on the basis of preserved virginity, aesthetic reasons and a cultural rite of passage to womanhood to justify the practice.

FGM has immediate and long-term complications – haemorrhage, urinary retention with associated urinary tract infection and sepsis, scarring and pain. Long-term genital scarring can cause a myriad of problems ranging from menstrual dysfunction, urological and sexual dysfunction, psychological problems including post-traumatic stress disorder. FGM is associated with an increase in obstetric complications, including the risk of prolonged labour, post-partum haemorrhage, perineal trauma and the development of fistula (Muteshi 2018). There is also an increased risk of caesarean section and of stillbirth and early neonatal death (Berg 2013), although the precise mechanism for same is unclear.

Overall, knowledge of FGM amongst GPs and obstetrician/gynaecologists in Ireland is poor. A 2013 survey of GPs revealed that almost 80% of the sample had no knowledge of FGM or its associated issues (Dhala, 2013). Of 81 respondents to a subsequent online survey presented at a national meeting of obstetrician/gynaecologists in Ireland, 49% stated that FGM had

never been addressed in their formal training or in CPD and only 12% were fully up to date with practice guidelines. 47% were not aware of any legislation in Ireland specific to FGM.

In general, clinicians will encounter FGM in three distinct presentations, and the suggested management of these presentations is separated for simplicity in this guideline:

1. The most common presentation is probably during the course of routine antenatal care. Women may disclose FGM, or may be asked by a midwife or obstetrician, either at their booking or subsequent visits.
2. Women may be referred or self-refer to the IFPA free service or be referred to a HSE funded gynaecological service seeking deinfibulation, or seeking treatment for complications of FGM. FGM may also be identified during attendance for cervical screening or when a person presents to a gynaecology clinic for apparently unrelated reasons (eg. infertility, pelvic pain or dyspareunia).
3. Women or girls may present with acute complications related to recently undergoing FGM, for example for the management of haemorrhage or infection.

5. Methodology

Medline, EMBASE and Cochrane Database of Systematic Reviews were searched using terms relating to 'female genital mutilation', 'female circumcision', 'cutting' and 'female genital surgeries'. Searches were limited to humans and restricted to the titles of English, French and Italian language articles published between 1951 and 2018. Relevant meta-analyses, systematic reviews, intervention and observational studies were reviewed.

Guidelines reviewed included the Royal College of Obstetricians and Gynaecologists, guideline 53 (2015), the Royal Australian and New Zealand College of of Obstetricians and Gynaecologists, guideline on FGM (2012).

The principal guideline developers were Dr. Maeve Eogan and Dr. Eibhlín Healy.
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Foundation) and members of the Executive Council of the Institute of Obstetricians and Gynaecologists.

6. Clinical Guidelines on FGM in the obstetric and midwifery setting

All women should be asked about FGM at their booking visit, using the assistance of a formal translation service where required. The use of partners or friends for the purposes of translation is not recommended. The booking midwife should enquire in a supportive and non-judgmental fashion with regard to FGM, and may need to use the relevant colloquial term ('cutting' or 'circumcision'). If the women self-identifies as having undergone FGM, or is identified via direct questioning, then a chaperoned physical examination should be offered to ascertain the type of FGM – type 3 FGM is the form which may require intervention during labour. If the urethral meatus can be easily identified and the urogenital hiatus is adequate, the woman can be reassured that, in the absence of other obstetric events, vaginal delivery without recourse to deinfibulation can be anticipated (see flow chart).

If the urethral meatus cannot be identified, with extensive iatrogenic fusion of the labia, then deinfibulation may be offered. The timing of deinfibulation should be discussed with the women. The RCOG recommends discussing both antepartum and intrapartum deinfibulation. A recent systematic review and metaanalysis (Okusanya 2017), found that antepartum deinfibulation conferred a reduced risk of caesarean section, postpartum haemorrhage and episiotomy, although the methodology did not specify whether formal intrapartum deinfibulation was offered in the included studies, and two of the four included studies had serious risk of bias. Clinical consensus based on enquiry (by a single clinician) from all 19 maternity units in Ireland was that intrapartum deinfibulation is generally preferred and offered over revision during the antenatal period but further research is required if one method is to be definitively endorsed over the other.

Most women who have undergone FGM will be suitable for the supported care pathway structure (National Maternity Strategy 2016-2026) unless they have other risk factors that may require the assisted or specialised care pathways. For women identified as having type 3 FGM, with significant labial fusion, assisted or specialised care may be recommended. If a woman with type 3 FGM woman has delivered vaginally in the past and prefers supported

care, this pathway may be appropriate after discussion with a senior midwife and/or obstetrician.

A discussion should be documented at booking and a plan made with regard to the woman's preference for either antepartum or intrapartum deinfibulation. Additional sociodemographic complications may exist, some women will be living in direct provision accommodation, others may be late bookers and/or may have risk factors for preterm delivery and review by a senior clinician for the articulation of an agreed birth plan is important.

The preferred method of anaesthesia for the purposes of deinfibulation depends on patient preference and the clinical scenario. In general, during pregnancy and intrapartum, local and regional anaesthesia is preferred over general anaesthetic. All obstetricians attending the labour ward should be familiar with intrapartum deinfibulation. Training should be offered and updated routinely. Relevant training and awareness raising should also be extended to midwifery and nursing staff and allied professionals (eg. medical social work) to ensure a broad understanding of FGM, among all staff providing a woman centred service. Deinfibulation falls within the remit of specialist midwifery care in some clinical sites. While postpartum reinfibulation is never clinically indicated, perineal tears must be sutured to achieve haemostasis in the usual manner, using routine perineal repair techniques.

It is important to reassure a woman who has undergone FGM that she herself is not guilty of an offence, but a conversation around the woman's beliefs regarding FGM and ensuring that none of her children, or future children, are at risk is important. Care should be taken not to offend or alienate women. It is, however, important that clinicians are aware of the relevant legislation, specifically The Criminal Justice (Female Genital Mutilation) Act 2012, and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. Broadly, it makes it an offence to undertake FGM on a child or women in Ireland, and it is also an offence to bring a child or women out of the country for the purpose of undertaking FGM. Consent of the woman or her parents to the procedure is not a defence, nor is it a defence to say it was required or permitted for customary or ritual reasons. Furthermore, the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 makes it an offence to withhold information from the Gardaí if you know or believe that an offence has been committed on a child.

A woman identified as having FGM that does not require deinfibulation should be offered psychological support if she wishes, and a social work referral may be appropriate. If midwifery or medical staff have any concerns with regard to the female infant born to a woman with FGM, or any of her other female children, a referral to Tusla should be made (Children First Act 2015). If no such concerns exist, this should be documented in the maternal health care record. Women who do not require deinfibulation, or who were deinfibulated in a previous pregnancy, can be offered midwifery led care.

Concerns with regard to an increased risk of HIV and Hepatitis C transmission are not substantiated by research; however the current international consensus is to include Hepatitis C screening in addition to routine serology in the booking bloods (RCOG, 2015).

If a woman planned for intrapartum deinfibulation undergoes caesarean section (CS), then deinfibulation may be offered after the CS (if elective), or if time allows in an emergency setting. If this is not possible, then arrangement should be made for elective postpartum deinfibulation (via postnatal or gynaecology clinic, with appointment being provided prior to postnatal discharge).

The type of FGM and any procedure on the perineum should be annotated in the discharge summary for the public health nurse and GP and should be coded appropriately for HIPE.

Although postpartum reinfibulation is not specifically listed as an offence in Irish legislation, it is never clinically indicated and, consistent with best international practice, must never be carried out. It has no benefits, clinical or otherwise, and it may seriously affect the reproductive health of women and increase her risks for future birth/s. Reinfibulation violates the woman's human rights and bodily integrity (Serour, 2010).

The authors of this Guideline recommend that the forthcoming new edition of the Irish Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* should include a section on FGM, expressly prohibiting the practice of reinfibulation. The authors have written to the Medical Council in this regard.

Care of the women presenting to gynaecological services

Women may self-refer to services directly related to FGM treatment (via the IFPA), or may seek specialist referral via their GP for deinfibulation. They may also present and be

diagnosed with FGM-associated complications at the gynaecology clinic, for example, during investigations for infertility, dyspareunia, apareunia, anorgasmia or urological complications. Ideally, women should be encouraged to undergo deinfibulation prior to first sexual intercourse and in order to facilitate cervical screening.

As per antenatal presentations, the legal framework should be sensitively outlined if indicated. Many women will already be fully aware of the legislation. Chaperoned examination should be undertaken to assess if surgical intervention is required. Dyspareunia may be improved by deinfibulation, however, currently there is not strong evidence to recommend clitoral reconstruction surgeries (Abdulcadir et al, 2015). Some work has been done demonstrating reduced dyspareunia and increased sexual satisfaction (Foldès et al, 2012), however, at present, to our knowledge in Ireland, this surgery is not being undertaken, and should only be undertaken as part of a research trial.

Screening for HIV, Hepatitis B and C are recommended by the RCOG, however at present, there is not robust evidence to insist on same. A mental health referral may be required.

Women and girls presenting with acute or immediate complications of FGM

This guideline does not directly address the presentation and management of FGM in children where a paediatrician should attend. There have been some reports in the media of FGM being undertaken in Ireland, and the first conviction in this country occurred at the end of 2019. Given the age profile at which FGM is generally undertaken (aged two to teenage years), it is likely that gynaecologists may not come into immediate contact with a child or young woman who has undergone FGM in Ireland; they may be called on to consult after the initial management. The basic tenants of resuscitation apply, and the patient may need surgical intervention to arrest bleeding if this has prompted the acute presentation.

A more likely scenario, perhaps, would be presentation of a child or young woman with complications related to FGM having been performed in another country. A high index of suspicion should be maintained when dealing with young women presenting with recurrent UTI, or frank perineal infection, or with new onset psychological disturbance, who come from an area or community of high prevalence. The clinical presentation should be managed in the acute setting and then appropriate referral made for follow up & support if indicated.

7. Implementation Strategy

- Distribution of guideline to all members of the Institute and to all maternity units.
- Distribution to the Directorate of the Acute Hospitals for dissemination through line management in all acute hospitals.
- Implementation through HSE Obstetrics and Gynaecology Programme local implementation boards.
- Distribution to other interested parties and professional bodies.

8. Qualifying Statement

These guidelines have been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. Clinical material offered in this guideline does not replace or remove clinical judgment or the professional care and duty necessary for each pregnant woman. Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise. This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible for:

- Discussing care with women in an environment that is appropriate and which enables respectful confidential discussion.
- Advising women of their choices and ensure informed consent is obtained.
- Meeting all legislative requirements and maintaining standards of professional conduct.
- Applying standard precautions and additional precautions, as necessary, when delivering care.
- Documenting all care in accordance with local and mandatory requirements.

9. Areas for further research, performance indicators and useful resources

Qualitative research is required into the timing of deinfibulation in affected women – the present recommendation is generated from expert opinion.

Review of number of deinfibulation procedures and the timing/location of same with audit of the medical notes to assess adherence to best practice.

Audit of the management of women with FGM in within the maternity services with respect to care pathways, documentation and discharge information.

Reliable epidemiological data are required to resource treatment modalities (surgical/psychological/social/educational).

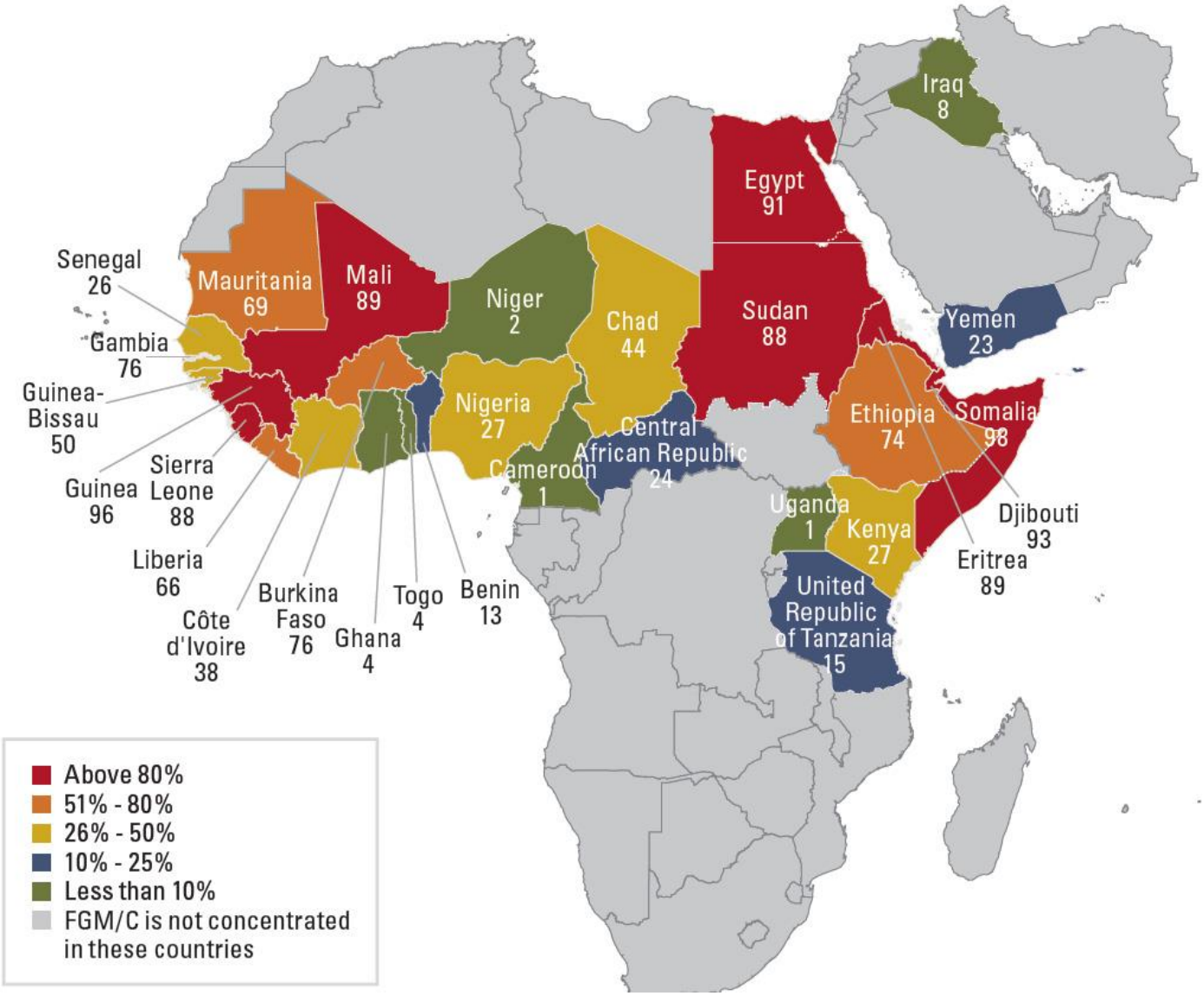
Akidwa (AkiDwA: African and Migrant Women's Network in Ireland www.akidwa.ie)

offers a free elearning module via https://uefgm.org/. Akidwa also publish *FGM: Information for Healthcare Professionals working in Ireland* online

RCOG Female Genital Mutilation and its Management, Green-top Guideline No.53, July 2015

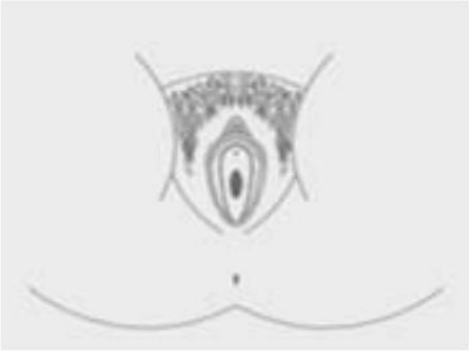
10. Appendix 1.

Proportion of Women and Girls (15-49 years) who have undergone FGM/C, by country. From Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. Unicef, New York. 2013.

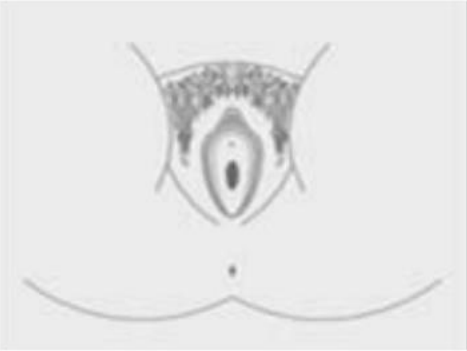


Appendix 2.

Adapted from Akidwa's Female Genital Mutilation, Information for Healthcare Professionals Working in Ireland, 2013.



FGM Type I
Refers to the partial or total removal of the clitoris and/or prepuce. It can also be know as clitoridectomy.



FGM Type II
Refers to the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

FGM Type III
This is the most severe form of FGM and involves narrowing of the vaginal ofifice with creation of a covering seal by cutting and positioning the labia minora and/or labia majora. This can be with or without excision of the clitoris. Commonly called infibulation.

FGM Type IV
Includes all other harmul procedures to the female genitalia for non-medical purposes e.g. pricking, piercing, incising, scraping and cauterisation.

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