If the mother is not immune and the infant is less than 4 weeks of age, and full term at birth, give varicella zoster immunoglobulin (VZIG) (if available).

If the infant is preterm, and regardless of maternal immunity, give VZIG.

Regardless of whether VZIG is given, monitor the baby for signs of infection to enable early treatment should infection occur.

Shingles is very rare in infants and, if present, suspect HIV infection.

**Doses of VZIG and aciclovir**

**In pregnancy**

**Aciclovir** is of no benefit if commenced more than 24 hours after the appearance of chickenpox vesicles.

- Oral route: 800mg five times daily for 7 days (mildly ill cases only).
- IV route: 10mg/Kg/dose every 8 hours for 7 days.

Side effects include nausea, vomiting, diarrhoea, headache and nephrotoxicity. Reduce the dose or dosage interval in patients with impaired renal function.

**Varicella zoster immunoglobulin (VZIG):** 1 gram IM.

Anaphylaxis is rare, but ensure that adrenaline is available.

**In the neonate**

**Aciclovir**

10–20 mg/kg IV every 8 hours for at least 7 days.

Side effects are as described above.

**Varicella zoster immunoglobulin (VZIG):** 250 mg by deep IM injection.

---

**2.9 Mental health problems associated with pregnancy and the postnatal period**

**BOX 2.9.1 Minimum standards**

- Screening tools for depression, such as the Edinburgh Postnatal Depression Scale (EPDS).
- Selective serotonin reuptake inhibitor (SSRI) antidepressant drugs.
- Ideally, an inpatient hospital facility for mothers and babies when the mother has puerperal psychosis.
- Antipsychotic drugs.

**BOX 2.9.2 Risk factors for development of maternal depression in low- and middle-income countries**

- Poverty and high levels of economic stress
- Low levels of social support
- Domestic violence
- Chronic maternal illness
- Maternal anaemia
- Lack of awareness among primary healthcare workers of depression as an illness
- Social stigma associated with a family member being diagnosed with a mental illness
- Families with four or more children, especially when the children are under 7 years of age
- Having a preterm infant or an infant with a low birth weight
- Having a child with a developmental disability
- Having an unplanned or unwanted infant
- Having a female child in a culture where there is a strong preference for male children
- Lack of participation in family financial decisions, control of resources and reproductive health

Adapted from Wachs, Black and Engle (2009).

**Introduction**

Childbirth poses a risk to a woman's mental health. This applies to all women and girls who become pregnant in all countries, irrespective of their social and cultural background. However, the background will influence how a mother presents and how quickly she receives appropriate care.

Much of the research about pregnancy-related mental illness and its effects on the new baby has been done in high-income countries where it has been possible to develop specialised services. However, there is evidence that mental health problems in mothers are as common in low- and middle-income countries. A number of risk factors that have been suggested as underlying maternal depression are listed in Box 2.9.2.

Perinatal psychiatric services have developed in many high-income countries, and involve liaison between psychiatric and obstetric services. The specialty covers women with pre-existing mental health problems who want to have a family, as well as mental illness that is first diagnosed antenatally and postnatally. Maintaining the mental health of a pregnant woman benefits the family, and in some cases can prevent problems from developing postnatally. The onset of depression and anxiety in pregnancy or postnatally can be especially worrying for a woman and her family because it is contrary to their expectations that this will be a happy time. The woman may not want to admit how she is feeling, being ashamed both of her inability to feel joy about her newborn baby and of her perceived inability to cope, and fearing that she will be judged harshly for these feelings. This is especially important in countries and cultures where women and girls are not valued and their main role is perceived to be the production of healthy babies.

Mild antenatal and postnatal depression can be managed with minimal resources and does not require medication. Recognition of the condition and practical help from family and friends can be enough to prevent depression affecting the care of the baby. Reassurance from...
Antepartum psychiatric disorders

There is evidence that psychiatric symptoms occur as frequently antenatally as postnatally, with an estimated prevalence of 10–15%. The symptoms are often of mild depression and anxiety. Careful enquiry may reveal that the symptoms were present before conception. The development of a serious psychiatric condition in the antenatal period is no more common than at other times, but if a diagnosis is made during pregnancy, the decision to start medication has to balance the severity of the mother’s illness against the adverse effects of medication on the fetus.

Women with mild symptoms usually present early in pregnancy, and may improve as the pregnancy progresses. Hyperemesis can make the first trimester miserable and lead women to express thoughts of rejecting the pregnancy. Sometimes this is mistaken for evidence of depression. The third trimester can be a time of anxiety about labour and the impending birth, especially for first-time mothers or those who have had previous complicated deliveries. The factors that make women and girls more vulnerable are listed in Box 2.9.3.

Supportive counselling is often sufficient to improve the mental health of most women, but if antidepressants are indicated, there needs to be a discussion about the risks and benefits before they are prescribed. The selective serotonin reuptake inhibitors (SSRIs) fluoxetine and sertraline seem to have the best safety profile, but new information is emerging as more women take antidepressants in pregnancy and clinicians continually evaluate the safety profile of this class of drugs. There is increasing evidence that the SSRIs antidepressants, especially paroxetine, are associated with an increased risk of cardiac abnormalities in the baby if taken during embryogenesis. However, the risk is still relatively low (4%), and has to be balanced against the risks to the pregnancy if the depression is left untreated. If SSRIs are not available, tricyclic antidepressants can be effective, but prescribers must be wary of patients with suicidal ideation, as the tricyclic antidepressants are more dangerous than SSRIs when taken in overdose.

A woman with an established diagnosis of bipolar disorder may be taking a mood stabiliser such as lithium, sodium valproate or carbamazepine, and these are associated with increased fetal malformations, so consideration needs to be given to stopping them prior to conception. In women in whom relapse has occurred when stopping lithium, the balance between risks and benefits is probably in favour of continuing the drug. This is less likely to be the case for sodium valproate or carbamazepine.

<table>
<thead>
<tr>
<th>BOX 2.9.3 Factors that increase the risk of antenatal depression and/or anxiety</th>
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<tbody>
<tr>
<td>Previous obstetric loss</td>
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<td>Previous fertility problems</td>
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<tr>
<td>Anxiety about the viability of the pregnancy</td>
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<tr>
<td>Social and interpersonal adversity</td>
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<tr>
<td>Feelings of ambivalence about the pregnancy</td>
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<tr>
<td>Previous depression and/or anxiety associated with pregnancy</td>
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</tbody>
</table>

Postpartum psychiatric disorders

Psychiatric disorders that present postnatally are traditionally classified into three types as shown in Box 2.9.4. Other conditions can also present at this time, and it has been suggested that the term postnatal common mental disorders is more useful for distinguishing the milder depressive, anxiety and obsessional disorders from the more severe depressive disorders and puerperal psychosis.

<table>
<thead>
<tr>
<th>BOX 2.9.4 Postpartum-onset psychiatric disorders</th>
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<tr>
<td>Maternity blues</td>
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<tr>
<td>Postnatal depression</td>
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<td>Puerperal psychosis</td>
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Maternity blues

This is generally a mild and self-limiting condition that affects over 50% of women, usually between day 3 and day 10 postnatally, but most commonly on day 5. A hormonal cause has been postulated for this transient condition, which is marked by variability of mood, feelings of confusion, irritability, insomnia and a feeling of not being able to cope. It is generally self-limiting, although if it is longer-lasting or more severe than usual, it can herald problems later in the postnatal period. Reassurance is usually sufficient to help the woman through this period, which usually last about 48 hours.

Postnatal depression

It is estimated that around 10% of woman develop symptoms of depression postnatally. The majority of these symptoms will be relatively mild and overlap with the process of adjusting to having a baby, particularly (although not exclusively) following the birth of a first child. In most cases a diagnosis will not be made until about 6 weeks after the onset of the depression.

Symptoms are not dissimilar to those that occur in non-puerperal depression, but sleep and appetite are...
often disrupted because of the baby’s presence, so different questions may need to be asked in order to elicit a diagnosis. The mother may not recognise that she is depressed and so does not show how she is feeling. The commonly experienced anhedonia (inability to feel pleasure) is particularly difficult at this time, when the mother (and those around her) feels that she should be happy. This can lead her to conclude that she is a poor mother. Meanwhile others, particularly in western cultures, may state that there is a problem with bonding, which can exacerbate her guilt and low mood. Obsessional symptoms and irritability are also often reported.

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool (see Appendix) which has been translated into a number of languages and used across diverse cultural settings. It requires no psychiatric training to administer, and so can be used by healthcare workers to identify mothers who may be depressed.

Two recent studies in Ethiopia showed the EPDS to be less effective in rural areas than in urban ones. For rural Ethiopia the self-reporting questionnaire (SRQ) was considered to be superior in urban areas the Kessler Psychological Distress Scale (which is used to assess psychological distress in various situations) and the EPDS were reported to be equally effective screening tools, but it was suggested that the Kessler Psychological Distress Scale may be more effective in detecting postnatal mental health disorders in this setting.

When the depression is mild, relatively simple interventions can be very effective, including listening to the mother’s concerns, reassuring her that her feelings do not mean she is a bad mother, and giving practical help with the baby, allowing her to rest as much as possible. Antidepressants are not usually indicated in mild depression.

In cases of moderate depression with persistent low mood, reduced sleep and appetite, poor concentration, feelings of not being able to cope, and lack of improvement when practical help and support are given, antidepressants are likely to be needed. If available, sertraline or paroxetine are the SSRIs with the lowest relative infant dose (i.e. the amount passing to the infant through breast milk), so are the safest ones for breastfeeding mothers.

- **Sertraline**: starting dose is 50 mg, with a maximum dose of 200 mg daily.
- **Paroxetine**: starting dose is 20 mg, with a maximum dose of 60 mg daily.

The most commonly reported side effect for both of these drugs is nausea, which wears off after 2 to 3 weeks – the same time that it takes for the therapeutic effects to begin to appear – so the mother needs to be warned about this. Imipramine and amitriptyline also appear to be safe in breastfeeding mothers.

- **Imipramine**: starting dose is 25 mg three times daily, increasing to a maximum total daily dose of 200 mg.
- **Amitriptyline**: starting dose is 25 to 100 mg total daily dose, given in three doses during the day or (usually more acceptably, because of its sedative effects) once at night. The maintenance dose is a total daily dose of 75 to 150 mg/day. Rarely a total daily dose of up to 300 mg may be used.

Side effects include sedation, postural hypotension, dry mouth, blurred vision, constipation, urinary retention and increased body temperature. In overdose imipramine and amitriptyline are cardiotoxic, and this has to be considered when prescribing for a mother who may be experiencing suicidal thoughts. However, if these are the only drugs available, this risk needs to be weighed against the ongoing suicide risk if the mother is not given antidepressants.

Severe postnatal depression affects about 3% of women and can merge with puerperal psychosis. It tends to occur early postnataally, and it is likely to be obvious that the mother is unwell. Sleep is evasive, even when the baby sleeps well through the night. Appetite will be markedly reduced, with marked weight loss. Most mothers, even when very depressed, will use all their energies on the baby and neglect themselves. Depressive delusions can develop, with the mother believing that the baby would be better off without her, and this leads to a significant suicide risk. The risk of the mother taking the baby with her in a suicide attempt, although rare, has to be considered, though again this should be managed by closely monitoring the mother while keeping her baby with her. Separating the mother from the baby can increase the woman’s sense of desperation and feelings of failure as a mother.

Admission of the mother and baby to a suitable hospital setting (if available) is the ideal way to manage a woman with severe delusional postnatal depression. Electroconvulsive treatment (ECT), but only if given under general anaesthesia and safely, is indicated, often fairly early after the onset of symptoms, as this can treat the mother quickly and reduce the amount of time she is unwell. Antidepressants should be given (see above for doses; the SSRI group is likely to be the best and safest option if available), and also antipsychotics if these are needed.

Once improved, the mother is likely to benefit from the supportive measures described for milder types of postnatal depression. It is not only possible but desirable to continue breastfeeding, whether or not the mother is being treated with antidepressants. If antipsychotics are also required, breastfeeding can continue. Adequate sleep for the mother can be achieved by her expressing breast milk and other family members giving this to the baby from a cup and spoon whenever the baby wakes during the night.

**Puerperal psychosis**

This is the most severe postpartum mood disorder, and symptoms can appear rapidly. The usual incidence is 1 in 500 deliveries. It is a great shock to the mother and her family when it develops with no prior warning. However, a previous diagnosis of bipolar disorder or puerperal psychosis increases the risk to as much as 1 in 2. This presents the clinician with an opportunity to identify women at risk antenatally, consider the options for prevention, and develop a plan of management for the puerperium should the mother become unwell.

Characteristically, the woman may have been mentally healthy during her pregnancy, which may have given her and her family hope that all would be well in the puerperium. Typically there is a sudden onset of symptoms, most commonly in the first 2 weeks following childbirth. Sometimes the symptoms appear to come on overnight. The symptoms vary, but tend to progress rapidly over the first few days, and characteristically include the following:

- perplexity and confusion
- overactivity
● insomnia
● marked behavioural changes.

These common presenting features are often accompanied by a fear that something will happen to the mother or the baby, or sometimes a belief that the baby is not her own. The woman is usually easily distracted, with grossly impaired concentration, and is unable to finish one task before trying to start another, in a markedly disorganised way. This significantly interferes with her ability to look after her baby. Pointing this out often causes her even more distress. This can reinforce delusional beliefs that the baby is not her own, or that others are going to take her baby away, especially if she is separated from the baby because of her illness. A strong affective component is often present, usually hypomania or labile emotions, although this can develop into a more typically depressive picture.

During the acute phase there is a risk of harm to the mother or child, mainly due to the mother’s chaotic behaviour which may unintentionally lead to neglect of the infant, rather than to any deliberately harmful actions on her part. Rarely, a mother may describe delusional beliefs involving the baby that could lead to direct harm, but this is very unusual. Although these risks to the child obviously have to be borne in mind, it is important to note that most mothers do not want to harm their babies. This risk should be managed wherever possible by keeping the mother and baby together and supervising them very closely. Even when the mother is very unwell and unable to manage much of the baby’s care herself, both mother and baby benefit from being in close proximity. The mother can then be encouraged to take over more of the baby’s care as her mental state improves, re-establishing the mother–child bond.

Women or girls with puerperal psychosis will frequently need medication, and the type of drug will depend on the predominant symptoms. In settings where the choice of medication is limited, the older antipsychotics can be just as effective as more modern drugs, and, with monitoring, breastfeeding can be continued, although it should be remembered that the disorganised behaviour of the mother can make breastfeeding difficult. It is therefore very important to supervise this.

Chlorpromazine is an inexpensive and generally widely available ‘typical’ antipsychotic drug which is very effective but tends to have been superseded in well-resourced countries by the ‘atypical’ antipsychotics with their more acceptable side-effect profile. Nevertheless, chlorpromazine is efficacious and the dose can be titrated up quite rapidly from 50 mg four times daily to as high as 1000 mg daily. Side effects include sedation (which can be beneficial in the acute stages of illness), dry mouth, nausea and parkinsonism (mask-like face, slowing and stiffness of gait, and tremor), although the inherent anticholinergic properties of chlorpromazine mean that this is not so common as with some of the other typical antipsychotic drugs (e.g. haloperidol).

Haloperidol is given at a dose of 0.5–3 mg twice to three times daily, with a maximum daily dose of 30 mg orally. It is also often used in emergency situations as an IM injection of 5 mg or 10 mg, with a maximum daily dose of 18 mg IM. The atypical antipsychotic drugs include risperidone, for which the starting dose is 1 mg twice daily, with a maximum daily dose of 6 mg, and olanzapine, for which the starting dose is 10 mg, with a maximum daily dose of 20 mg. Although these drugs have a low incidence of parkinsonism, they are associated with weight gain and an increased risk of type 2 diabetes.

If a woman on an atypical antipsychotic wishes to conceive, she may want to switch to a typical drug, as there is longer-term evidence for their safety. However, this introduces a risk of relapse, and she may not want to take that risk. Also if a woman has conceived while on an atypical antipsychotic, the balance is probably in favour of continuing it, although, if possible, the dose could be reduced.

In mothers who present with puerperal psychosis, the prognosis is generally good if treatment is available, but they may remain vulnerable for several months even when the psychotic symptoms remit. As the psychotic symptoms improve and insight develops, the mother may experience a period of depressed mood as she adjusts to what has happened. However, recovery is usually complete by 6 months, although there is a risk of relapse at other times, particularly in a subsequent pregnancy.

In a woman with a pre-existing diagnosis of bipolar disorder, the management of labour is important for reducing the risk of a puerperal psychosis. Where possible, sleep deprivation should be minimised in order to reduce the risk of the illness developing. The importance of letting the mother sleep when she can following childbirth should be emphasised to the family, and the father should be asked to undertake as much care as possible during the night.

The effectiveness of using prophylactic antipsychotic drugs has yet to be established. The trigger for puerperal psychosis appears to be biological, but so far the condition has proved difficult to prevent, even when treatment is continued through pregnancy. It is therefore essential to have a plan in place for what to do if the mother becomes unwell, and this can also reduce stress for the family.

**Anxiety disorders and obsessive-compulsive disorders**

Women and girls with a history of anxiety disorders and obsessive-compulsive disorders may relapse postnatally. Anxiety can range from mild concerns about the health of the baby to extreme anxiety that the baby may be seriously unwell, with constant vigilance and fear of a sudden infant death. The mother may seek and receive much reassurance from family and healthcare workers, yet remain concerned.

Mothers may experience obsessional thoughts or images of their babies being harmed, and sometimes the thought is that they will be the person to harm the baby. This can cause great distress, as the mother may fear that she will act on these thoughts, and so will avoid caring for her baby and allow her family to do so instead, which will reinforce her belief that she is a bad mother. Careful diagnostic exploration to identify obsessional rather than psychotic symptoms is essential in such cases.

Non-delusional, non-psychotic obsessions have the following characteristics:

- They come into the mind fully formed.
- They are recognised as the mother’s own thoughts and not placed there by someone else.
- They are not voices telling her to harm her child.
- They are repetitive and intrusive.
- They are difficult to push away.

This analysis should be followed by an explanation of the
nature of these thoughts. The mother will need encouragement to continue to care for her baby despite these abnormal thoughts, and to dispel the belief that she is a bad mother. These intrusive thoughts can lead to immense guilt and feelings of incompetence. Therefore allowing the mother to express her concerns and be reassured can be very therapeutic. Antidepressants may be indicated, even in the absence of other biological symptoms of depression.

**Benzodiazepines such as diazepam must not be used regularly in pregnancy.** When taken later in pregnancy they can cause withdrawal symptoms, hypotonia and agitation in the newborn.

**Effect of maternal mental health disorders on the infant**

For the majority of women experiencing symptoms of depression and anxiety during pregnancy or in the early postnatal period, their ability to care for their baby is not significantly compromised. However, there are many studies describing the adverse effects of maternal depression on early childhood development, and chronic depression does have deleterious effects on the whole family. This evidence needs to be taken seriously from a public health point of view to highlight the problem and aid development of services. However, it is also important to remember that for an individual mother the thought that she may be regarded as causing harm to her baby will reinforce the guilt that she is already feeling, and delay recovery. Several of the factors listed in Box 2.9.2, while predisposing to maternal depression, are also going to disadvantage the child, so addressing these where possible will benefit both mother and child.
Appendix

**Edinburgh Postnatal Depression Scale (EPDS)**

Name:  _________________________________________________________________________________________

Address:  _______________________________________________________________________________________

Your date of birth: ____________________

Baby’s date of birth: ___________________ Phone number: _________________________

**Instructions**

As you have recently had a baby, we would like to know how you are feeling now. Please choose the answer that comes closest to how you have felt IN THE PAST WEEK, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all of the time
- Yes, most of the time *(This would mean: ‘I have felt happy most of the time’ during the past week)*
- No, not very often
- No, not at all

**In the past 7 days:**

**Question 1**

In the past week I have been able to laugh and see the funny side of things:

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

**Question 2**

In the past week I have looked forward with enjoyment to things:

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

**Question 3**

In the past week I have blamed myself unnecessarily when things went wrong:

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

**Question 4**

In the past week I have been anxious or worried for no good reason:

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

**Question 5**

In the last week I have felt scared or panicky for no very good reason:

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

**Question 6**

In the past week things have been getting on top of me:

- Yes, most of the time I haven’t been able to cope at all
- Yes, sometimes I haven’t been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

**Question 7**

In the past week I have been so unhappy that I have difficulty sleeping:

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

**Question 8**

In the past week I have felt sad or miserable:

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

**Question 9**

In the past week I have been so unhappy that I have been crying:

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

**Question 10**

In the past week the thought of harming myself has occurred to me:

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Administered/reviewed by: ___________________________________________ Date: __________

Instructions for using the Edinburgh Postnatal Depression Scale

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All of the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. Answers must come from the mother or pregnant woman.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgement. A careful clinical assessment should be undertaken to confirm the diagnosis.

Scoring

Questions 1, 2 and 4 (without an asterisk) are scored 0, 1, 2 or 3, with the top box scored as 0 and the bottom box scored as 3.

Questions 3, 5, 6, 7, 8, 9 and 10 (marked with an asterisk) are reverse scored, with the top box scored as 3 and the bottom box scored as 0.

The maximum possible score is 30.

Possible depression is indicated by a score of ≥ 10.
Always look at item 10 (suicidal thoughts).

---

2.10 Female genital cutting

Introduction

What is female genital cutting?
Female genital cutting (FGC), also known as female circumcision or female genital mutilation, refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female organs for non-therapeutic reasons. It ranges from very simple to radical, and may be carried out between birth and puberty, or can be performed just before marriage or childbirth.

FGC varies across cultures, ethnic groups and tribal affiliations; there is also some variation in the types of cutting undertaken within cultures, ethnicity and tribes. The World Health Organization has estimated that 130 million women worldwide have undergone FGC. There are an estimated 2 million infants, girls and women at risk each year.

The European Parliamentary Committee on Women’s Rights and Gender Equality states that around 500,000 women and girls living in Europe have been subjected to FGC.

A practice of performing a symbolic form of infibulation to accompany the usual ceremonies has been recently adopted in Somalia. The procedure consists of applying to the clitoris a small needle (sterile insulin needle) to obtain a drop of blood. The practice is called ‘Sunna’ and is not yet widespread in the country. It is performed only by enlightened women in that society, but hopefully it will attract others to adopt this approach while awaiting a time when all forms of this practice end.

Who performs FGC?

FGC is commonly performed by traditional medicine practitioners, including traditional birth attendants, local women or men, or female family members. Such individuals do not have formal medical training, and usually perform cutting without anaesthesia or asepsis with crude instruments such as kitchen knives or razor blades. It is not uncommon for those who perform FGC to cut or damage more of the genital area than they intended to. Increasingly, doctors are also undertaking these procedures.

The health problems associated with FGC are life-threatening haemorrhage, sometimes death during or shortly after the procedure (from haemorrhage or infection), death during pregnancy, the need for assistance during childbirth due to interference with normal delivery, and the spread of HIV/AIDS and hepatitis due to the frequent use of unclean and unsterile instruments. There are also links to mental illness in the victims and to intimate partner violence.

Prevalence of FGC

FGC is practised in about 28 countries in Africa, Asia and the Middle East. A recent interview by Integrated Regional Information Networks (IRIN) in 2012 confirmed that FGC is still being practised in Pakistan. It is estimated that at least 50–60% of Bohra women undergo FGC; this is usually a symbolic snipping of the clitoris.

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<tr>
<th>TABLE 2.10.1 Estimated prevalence of FGC by country</th>
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<tr>
<td>Chad</td>
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<tr>
<td>Central African Republic</td>
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<td>Djibouti</td>
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