Strickland, Julie Lubker. 2001. “Female Circumcision/Female Genital Mutilation.” *Pediatric*

*Adolescent Gynecology* 14:109-112.

Strickland (2001) provides an overview of female circumcision (FC) through a medical perspective, urging other medical practitioners in North America who may come across patients whom have emigrated from other countries where FC is routinely practiced. She briefly describes three of the classifications of FC as defined in 1995 by the World Health Organization (WHO). The categories of FC defined in this article are: Type 1 referred to as “sunna” where part or all of the clitoris is removed; Type II, where the clitoris and part of the labia minora are removed; and Type III refers to infibulation where the clitoris, labia minora, and part of the labia majora are removed, then the skin is cauterized or sutured down the midline of the genital area, leaving a small opening for the urethra and vagina.

An important aspect in understanding this cultural practice is that, when viewed as an “inappropriate” practice, it is often viewed through a Western lens (Strickland 2001: 109). The origins of FC are unknown, but some documentary evidence suggest the practice has roots in Egypt and pre-Islamic Arabia, and is not a traditional Islamic custom. FC practices vary by community and culture, and are often cited as initiation rituals for girls’ transformation into womanhood. Other reasons include marriageability, aesthetics, for male sexual pleasure, or hygiene. FC is observed as a harmful cultural practice because, as Strickland (2001) notes, it has severe health consequences for women and unborn children including urinal tract infections, hemorrhaging, death, and birth complications. Furthermore, FC is claimed to be conducted by medically untrained midwives who may use unsanitary instruments such as razor blades or broken glass.

Increasing immigrant populations may increase the likelihood of obstetricians and gynecologists to have patients (adolescent girls and adult women) who have undergone FC. Strickland (2001) advises practitioners to be aware of child abuse and neglect laws, and to employ culturally sensitive counseling practices when working with patients.

Strickland (2001) uses FC in a general manner and does not provide specific information as to which types of FC are associated with known harmful outcomes, nor to what degree. Additionally, although she rightly advocates for practitioners to be culturally sensitive with patients, her view can be interpreted as patronizing. Understandably, this cultural practice is likely to present awkward situations with providers whom are ill informed of the varying degrees of FC as well as various cultural norms; the cultural norms are not universal amongst those who continue the practice and non-Western girls and women do not need “parenting” from those outside their culture.