Some People are Different from You: A Case Study of a Cultural and Ethical Problem in Global Health

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Medical, Public Health, and Microfinance Teams with local interpreters in Nana Kenieba, Cercle of Kati, Koulikoro Region, Southwest Mali.

Abstract
Pharmacists, student pharmacists, and other healthcare providers are frequent participants on short-term medical service trips (MSTs) to medically underserved areas. Many such MSTs take place in areas like sub-Saharan Africa where cultural beliefs about healthcare and society may be very different from what volunteers from the Global North believe. These cultural divergences may then give rise to ethical problems MST volunteers need to navigate. This case study provides an example of such an ethical problem developing from a difference in cultures – the case of female genital cutting. Often, the ethical training that most MST volunteers receive during their clinical education is inadequate to help them address these kinds of cultural differences and the problems that result. A six-step process to provide MST volunteers with the tools to address such cultural-ethical problems is included.

Keywords: Clinical Ethics; Cultural Body Modifications; Diversities, Cultural; Circumcision, Female; Mission, Medical

Background

Short-term medical service trips (MSTs) have been defined as "trips in which volunteer medical providers from high income countries travel to low- and middle-income countries to provide healthcare over periods ranging from 1 day to 8 weeks".[1] As many as two-thirds of matriculating medical students expect to participate in an MST during medical school.[2]

Schools and colleges of pharmacy have also made student pharmacists' participation in MSTs increasingly common.[3] By some estimates 2.5million individuals and an estimated 32% of physicians have volunteered on an MST.[4,5]

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Despite the doubtless good intentions of participants on MSTs, ethical problems may arise on for which volunteers from the Global North may not be adequately prepared to address.[6,7] This case study provides an example of an ethical problem that arose from a significant cultural difference between a group of MST volunteers and the community they intended to serve. A process that volunteers may find useful to address cultural issues on their own MSTs is included.

Case

After completing a Master of International Public Health degree (MIPH) one of the authors (JR) had the opportunity to serve as the team pharmacist on a medical mission trip to Mali in West Africa. Mali is one of the poorest countries in the world with a Human Development Index (HDI) of 0.434 and ranks 184th of 189 countries in the HDI.[8]

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The Medical Director for the team was a Malian physician who led the group to his home village. Other members included two family practice physicians, two physician assistants, two nurses, two physician assistant students, a public health worker, a pharmacist, and several aid workers who supervised the micro-finance and improved water programs provided by the non-governmental organization (NGO) sponsoring the trip. Other than one of the physician assistants, the aid supervisor, and the public health worker, no one had traveled to Mali before.

Team members traveled to Mali from diverse areas in the United States and had little opportunity to meet before the trip to discuss cultural or social aspects of Malian society. Although the Medical Director was a physician and Malian national, he did not brief the team about any noteworthy cultural practices once the team was in-country and preparing to open the clinic. It also seemed that the local villagers did not expect the team to have much appreciation for local practices, since one of the village elders made a remark that can be paraphrased as, "We like it that you leave the village women alone".

The first week in clinic was a success and approximately 25 patients per day received medical care. There was one after hours emergency where the team worked by flashlight to care for a critically ill baby. The entire team was welcomed into the village and treated like honored guests.

One evening during the second week, the entire team was invited to attend an enormous village celebration. There was a village-wide party including dancing to the village drummers. The team enjoyed the celebration and JR found himself dancing with three little boys who were holding his left hand, and another three little boys holding his right hand. Their hands were wet, and sticky and a generous amount of hand sanitizer was indicated before touching any mucous membranes.

Later in the evening, the team learned that the celebration was in honor of one of the young girls in the village who was to undergo female genital cutting in the morning.

The team was divided as to what to do. Should we have expressed our objection, even outrage, and possibly give cultural offence? What obligations, if any, did we have for the young girl about to be cut? What was the appropriate course of action? In the end, the team could not come to any agreement about what to do and just went to bed for the night. The next morning, clinic opened as usual, and the team tried to act like nothing had happened. Clinic proceeded normally for the rest of the team's time in Mali. Nothing specific happened as a result of learning about the village's tradition of female genital cutting.

Background Information

Terminology: This case study discusses the practice of surgically altering the female genitalia without having a justifiable medical reason to do so. At one time, this was often called female circumcision. The term "circumcision" resulted in the practice being compared to circumcision of the male penis. This term has fallen out of favor because the practice in females bears virtually no resemblance to the practice in males and the consequences of undergoing the practice are more common and more severe in females. Most in the Global North, including the World Health Organization (WHO), use the term female genital mutilation (FGM). The term "mutilation" is now considered problematic by some because it suggests that harm is being intentionally inflicted, and not all cultures see the practice as intentionally harmful. Consequently, this case study uses the term female genital cutting (FGC), which accurately describes the practice, but does not offend those cultures that support the practice by suggesting they intentionally harm their daughters.

The Practice: WHO classifies FGC into four types:[9]

- Type 1: Often referred to as clitoridectomy, is the partial or complete removal of the external clitoris and may also include removal of some or all of the clitoral hood.
- Type 2: Often referred to as excision, is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Sometimes referred to as a sunna circumcision. This is problematic, because the word sunna is a cognate of the word Sunni, which is one of the sects of Islam. The practice of FGC is often incorrectly portrayed as being required by adherents of the Islamic faith.[10] FGC may also be performed by Christians as well as those who follow traditional, cultural religions.
- Type 3: Often referred to as infibulation or Pharaonic circumcision, is the repositioning of the vaginal opening by stitching together the labia minora or labia majora with or without removal of the clitoris. A small opening is created to allow for the flow of urine and menses. The woman must be de-infibulated at the time of first intercourse. Re-infibulation may take place after childbirth.
- Type 4: Any other practice of genital procedure carried out for non-therapeutic purposes including pricking, piercing, incising, scraping, or cauterizing the genital area.

Consequences of FGC: According to WHO, FGC has a substantial risk for both short-term and long-term adverse consequences including pain, excessive bleeding, fever, infection, dyspareunia, difficult childbirth, and psychological problems. [9]

Geographic Variation of FGC Practices: FGC is practiced primarily in a wide swath across Africa from the Atlantic Coast to the Horn of Africa.[11] Prevalence by country is shown in the figure.

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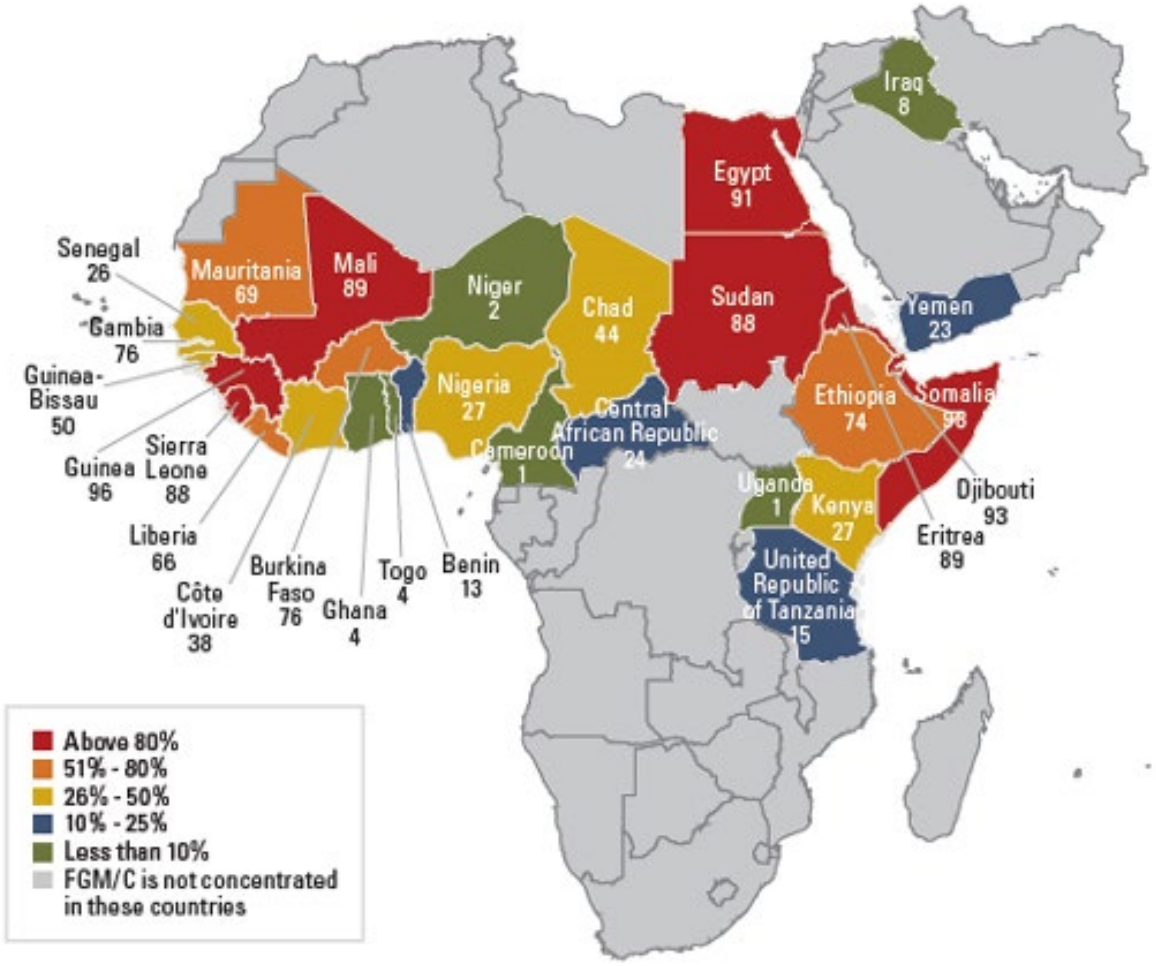

Source: UNICEF 2013[11]

It is important to note that there are substantial differences in the prevalence of FGC both between and within countries. The figure shows national prevalence data, but different regional, ethnic, or tribal groups within and between countries may differ widely in how (or even if) they practice FGC. Although most countries in which FGC is practiced are majority Muslim, Egypt has a high lifetime prevalence of FGC despite having a substantial Christian minority population. The practice is not limited to Islam, nor do most interpretations of the Holy Q'uran conclude that it is a required practice of the Islamic faithful. However, a secondary source of Islamic guidance is known as the Hadith, which are said to be the sayings of the Prophet Mohammed and have been handed down by oral tradition. Islamic scholars vary greatly in their interpretation of the Hadith and some interpretations may be taken to be supportive of the practice.[10] Although the practice is widespread in sub-Saharan Africa, it may also occur in immigrant communities in Europe, North America, and Australia.

Other differences in the practice include the age at which girls undergo FGC. As shown in the figure, in most countries, girls are cut before the age of 15 and often below the age of 5. In other regions, the event may not happen until shortly prior to, or even after, marriage.

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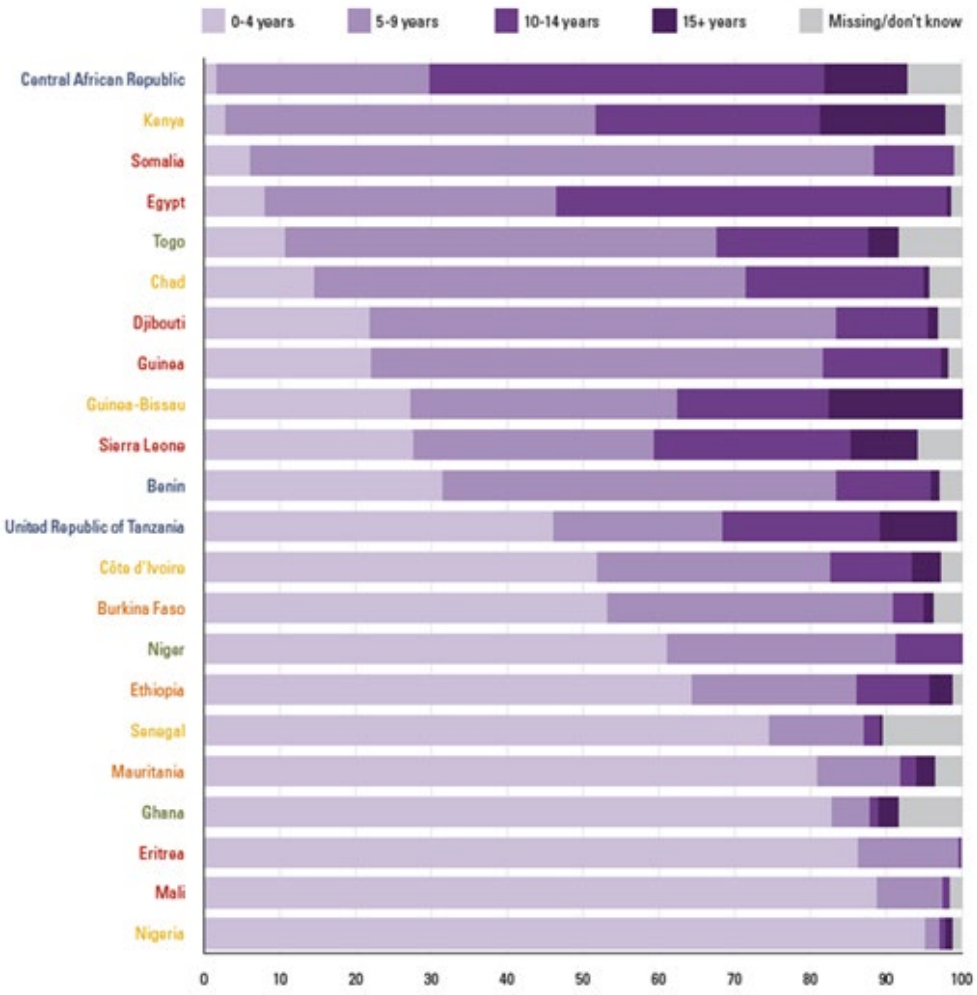

Source: UNICEF 2013[11]

There is also great variability in who performs the procedure. For example, in Senegal, nearly all FGC is performed by traditional practitioners, while in Egypt, nearly 80% is performed by trained health personnel.[11]

Cultural Relativism

Culture, Ethics, Human Rights, and the Global North

Consider the term we use in the Global North to describe genital cutting/mutilation. To deliberately mutilate a person is a violent crime, an offence against their human rights. We are offended by anyone who would mutilate another. We think it's barbaric and no civilized person would do it. It's unethical.

Health professionals from the Global North appear to be nearly universally opposed to the practice of FGC. In 2008, WHO developed a resolution urging member states to create legislation, educational programs, and other supportive measures to eliminate FGC. The resolution claims, "… that female genital mutilation violates the human rights of girls and women including their right to the enjoyment of the highest attainable standard of physical and mental health…".[12]

The belief that there are such things as human rights that all people enjoy, and that they may be violated was most successfully articulated on December 10, 1948, when 48 countries voted to approve the Declaration of Universal Human Rights.[13,14] Since then, the concept of human rights has been expanded and there is now widespread recognition that women and girls should be afforded unique sexual and reproductive rights required by their gender.[14] WHO policy advocating the abolishment of FGC is largely based on these concepts of human and reproductive rights. As will be discussed further below, however, some critics from the Global South may argue that the concept of human and reproductive rights are actually a form of cultural oppression imposed by a small group of Western feminists. And it is this line of thinking that leads us to look at FGC from a different perspective – people living in the countries were FGC is practiced.

Culture, Ethics, Human Rights, and the Global South

Health professionals from the Global North are inculcated early in their careers with the concepts of doing no harm and maintaining a patient's rights and dignity. This can make it very difficult to understand why anybody would perform such a

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potentially harmful procedure on their own daughters. One must turn to the anthropology literature to gain some perspective on how FGC is perceived by those in regions where it is common.

Anthropology is the study of human cultures and one of its basic precepts is the concept of cultural relativism – the notion that cultures are simply different from each other and that comparing cultures in order to judge one superior and the other inferior is ethnocentric, objectionable, and prejudicial. Cultural practices need to be understood within their own contexts, and not compared to an outsider's perspective on that culture so as to denigrate it. Cultures don't exist to make observers or visitors feel better, they exist to provide those who live within them a set of cultural rules, values, behaviors, and practices that make daily life in that culture possible. So, if one can see past one's own cultural biases (e.g., FGC is barbaric) it becomes possible to see (if not necessarily agree with or understand) that FGC may assist women to live within the culture they inhabit.

So then, why do cultures practice FGC? If we can see the practice through the lens of cultural relativism, we learn that it is not the parents' intention to mutilate their daughters, nor is it necessarily the result of living in a deeply patriarchal society. Rather, FGC is often seen as a proper, socially acceptable, cultural expectation that is thought to be purifying.

Research by Gruenbaum gives several explanations for the practice of FGC.[10,15] Although not specifically required by any religious law, Muslims, Christians and those who adhere to indigenous religions all practice FGC and may believe their religious practices require it. In some communities, undergoing FGC provides a sense of identity. It can communicate a wide variety of identities including that the girl has reached a given age or is ready for marriage, that she belongs to a certain social rank or ethnic group, or that she is of good moral character. In other cultures, the external female genitalia are altered in the belief that the procedure removes the "masculine" looking parts of the vulva. The smooth scar tissue left behind after infibulation is seen as especially feminine and aesthetically pleasing. The small opening left reduces the noise of the woman's urine stream hitting the ground, the sound of which is considered unfeminine. In other cultures, the ability to withstand the pain of the procedure is taken as evidence the girl is able to withstand the pains of adult womanhood, including childbirth. Unlike the commonly held Western perspective, FGC is not necessarily performed primarily to preserve a girl's virginity.

Ethnographic research into FGC suggests that the decision-making about whether a girl should be cut can be quite complex.[16] In the Gambia, co-wives or female relatives of the husband may treat uncut women with contempt. The insult *solema* does not just mean uncut, it also means rude, ignorant, uncivilized, or unclean, sexually loose, and incapable of showing proper respect. Even children may insult their playmates who have not undergone FGC.[17] A quotation from one of the women in one study is instructive here:

> *"For example, there was an uncircumcised woman who got married in the home I was brought up in; anytime she cooked, we did not eat and when we cooked, we let her eat alone. And sometimes we always called her "Solima," meaning someone who knows nothing. As a result, she one day went to the [circumciser] and asked her to circumcise her".*[16]

In the same communities, men were sometimes involved in the decision to cut a girl, but more commonly, the decision was regarded as "women's affair." The research concluded that "the communal way of life in the rural areas prevents any radical departures from community values and norms … Grandmothers and paternal aunts, in particular, often exert considerable influence."

Compare this perspective on FGC to how it is viewed in the Global North. It seems clear that in communities where FGC is practiced, it is not considered barbaric. Not to perform it on one's daughter would be the unethical choice since it could impair her ability to live as a respectable woman in her community.

To Intervene or Not to Intervene

The perspectives presented so far in this case study should make it apparent that there is considerable disagreement about whether volunteers or other workers in global health have an ethical or moral obligation to intervene and try to end the practice. One researcher on the topic cites two quotations that reflect varying perspectives just within feminism.[18]

Compare one feminist writing from the perspective of the Global North:

> "*It is evident that female genital mutilation can be abolished and wiped out in our lifetime. We are able to teach those who cling to distorted beliefs and damaging practices some better ways to cope with themselves, their lives, reproduction and sexuality…. These operations have continued for 2,000 years to the present time only because they are demanded by men."*

To another feminist's blisteringly caustic response from the perspective of the Global South:

> *"I am writing this letter to thank you for the compassion you have been showing lately for the hardships I have to go through as an African black woman…. I'm glad you opened my eyes to the fact that circumcision was in fact a male conspiracy to reduce my sexual drive, kill me at childbirth and a means of passing on AIDS to me. For coming to my rescue, I'm eternally grateful."*

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Decisions about whether or not to intervene when working in a community that practices FGC should be influenced by a number of important considerations. Acting solely out of a Western sense of outrage is unlikely to be effective. At the same time, ignoring the practice may result in feelings of regret and helplessness among team members. By utilizing the six-step process for ethical decision-making, a decision to intervene or not to intervene can be made.[19]

Six-Step Ethical Decision-Making Process

Ethical analysis requires time and reflection. The gut instincts that we experience around complex and controversial situations are more likely related to our moral system than an ethical framework. Purtilo presents a formalized process to take a situation apart, organize your thoughts, and come to an ethical decision.[19] The process includes the following steps:

1. Get the story straight: gather relevant information;
2. Identify the type of ethical problem and locus of authority;
3. Use ethical approaches to analyze the problem;
4. Explore practical alternatives;
5. Complete the action;
6. Evaluate the process and outcome.

***Step 1**: Gather Relevant Information*

Factors that may help the team decide a course of action may include:

> How does the local community view FGC? This is part of getting the story straight. Best practices in global health make it a requirement to understand the community the team serves in. Proposing solutions before we even understand what may or may not even be a problem is bad practice.
>
> Are there existing interventions that have been shown to be helpful? If the decision is made to intervene, gathering needed information will require knowing what experts have found to be helpful. Making clinical recommendations that are not evidence-based is unprofessional. So is making cultural recommendations that are not evidence-based.

The Local Community

It is imperative to have a deep and nuanced understanding of the community the team works in prior to doing anything. Unless your team has some history and a solidly functional relationship with a community, it is unlikely any intervention about FGC will be seen as anything other than external meddling. Most communities that have had any experience with Western aid or mission groups are already aware that Westerners disapprove of the practice. If your team is only repeating messages that have already been heard and ignored by the community, changing behaviors is unlikely.

Communities are not monolithic with respect to FGC practices, and even within the same cultural group, practices will vary according to urban versus rural, parental education, maternal age and if she has undergone the procedure, and a variety of other factors.[20] Across Africa, the practice and attitudes towards it are changing.[11] There has been a small decrease in the number of teen-aged girls who have undergone FGC, even if their mothers were cut in their youth. In some countries, a majority of both men and women believe the practice should stop.

Teams should be well aware of FGC practices and attitudes in the communities they serve prior to attempting any education or other interventions to stop the practice. You may need to undertake some basic research into the community before deciding to do anything.[21] At a minimum, ask questions before you start to provide what you think will be solutions to what only you may believe are problems.

What has been found to work?

Although there is existing literature that describes and evaluates interventions to end FGC, it is often not very encouraging. A common finding is that although a community has been exposed to anti-FGC programs and education, and may even agree that the practice should end, it may continue unabated. Ending FGC involves changing cultures, not just educating villagers about the harms of a long-standing practice. Although cultures do change (e.g., cigarette smoking in public in the United States is now prohibited) they may change slowly and from the bottom up, not from a top-down program.

One thing is clear, if an intervention is to have any hope of success, it must be focused as a community change effort. The most effective work appears to have been done by a non-governmental organization called Tostan working in West Africa.[22] Tostan uses a Community Empowerment Program that allows communities to draw their own conclusions about FGC and to lead their own movements for change. The program includes community discussions on human rights, the right to be free of all forms of violence, and the shared responsibilities of communities. Rather than placing blame and discussing risks and harms, the focus is on social mobilization to end practices that hinder community development. They claim that 8,000 African communities have publicly declared abandoning FGC after working with Tostan.

Interventions that target the community rather than the family appear to be necessary. Some interventions use social convention theory, a model that highlights that an individual's actions are interdependent on others in the community and that behavior change needs to be coordinated among such interdependent individuals.[23] The community's readiness to change may be divided into five categories across two dimensions as shown in the Table. Similar to other health interventions to change behaviors, communities may be weighing the cultural risks and benefits of keeping or

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abandoning the practice. The same researchers believed that models like the Tran-Theoretical Model for Change (commonly taught in smoking cessation courses in pharmacy schools) may be applicable in FGC education courses, but because the decision to change is usually a collective one, rather than an individual one, the Trans-Theoretical Model may have limitations.[16]

BEHAVIOR		**PREFERENCE**	
	Supports FGC	Ambivalent	Opposes FGC
PRACTITIONER	Willing practitioner (Non-contemplative)		Reluctant Practitioner
UNDECIDED		Contemplative	
ABANDONER	Reluctant Abandoner		Willing Abandoner

Source: WHO[23]

Three recent review articles provide some potentially useful guidance about programs designed to end FGC.

Berg and Denison claim that most abandonment efforts are based on human rights and legal mechanisms, health risk approaches, health worker training, converting village circumcisers, and social development schemes.[24] Of the 8 reports in their review and meta-analysis, only 2 were peer reviewed and most were reports back to funding agencies. None were randomized trials, most used before-after design. FGC intervention programs included training health personnel, educating female university students, community mobilization and behavior change programs, and programs in village empowerment. The outcomes assessed in each study typically measured changes in beliefs or knowledge about FGC rather than changes in prevalence of FGC. Parents' intention to perform FGC on their daughters was also assessed. Although most results showed a positive change after the intervention, 95% confidence intervals for changes in relative risk often overlapped 1.00, suggesting that no change may actually have occurred. Pooled results from two studies (one that educated health professionals about FGC and one that employed the TOSTAN village empowerment intervention[22] did show the risk-ratio for prevalence of FGC in girls under the age of 10 was 0.77 after intervention, thus demonstrating a measurable decrease in the practice.

Johansen and colleagues note that interventions to abandon FGC have only been evaluated to a limited extent.[25] Some interventions included two or more approaches making evaluation difficult since knowledge of how multiple, concurrent approaches may affect each other is limited. Finally, most evaluations study some secondary outcome and do not list abandoning FGC as their actual objective. These authors reviewed seven common approaches that have undergone some form of evaluation: (i) health risk approaches; (ii) conversion of excisers; (iii) training health professionals as change agents; (iv) alternative rituals; (v) community-led approaches; (vi) public statements; (vii) legal measures.

Health risk approaches assume that educating the population about the risks of FGC will result in better informed communities that will abandon the practice after community members can compare risks and benefits of the procedure. Medical professionals or religious leaders often lead this effort. Health risk information may also influence policy makers to pass laws making FGC illegal. Results of health risk approaches are mixed. In some cases, rather than abandoning the practice, FGC is performed by health professionals. Although this may be safer and result in fewer complications, it also serves to normalize the practice, not cause its abandonment. Other problems with health risk approaches include attendees simply not believing the information if it either does not comport with their personal experience or if there is a cultural belief that complications of FGC are caused by evil spirits or witchcraft. Even if the community acknowledges the risks of FGC, maintaining the practice may be seen as the lesser danger if abandonment results in social ostracism.

Since most FGC is carried out by village midwives or excisers, attempts to convert them from the practice have been made. Although some abandon the practice, others may simply turn it over to their apprentices, lie about abandoning the practice, or argue that they require the income they earn from performing FGC.

Training health professionals may include interventions to prevent FGC as well as building their capacity to identify and treat complications of the practice using WHO guidelines on the care and management of women who have undergone FGC.[26] Some professionals developed a negative attitude towards FGC while others came to realize many gynecological conditions they had been treating were caused by FGC. That said, some professionals remained resistant to working against FGC, the training they received was not always adequate, and they could not always put their new knowledge into practice if there was not adequate structural support to do so in their home communities.

Alternative rites are programs that fulfill the coming-of-age cultural expectations that FGC normally serves to do, without causing damage to the girl undergoing the rite. They may include re-instituting a previous ritual that had been formerly abandoned or providing the girl with a period of training and seclusion followed by a public celebration of the ritual. Girls who underwent this process had a better understanding of their reproductive rights and a better sense of gender egalitarianism. But to work, alternative rites need to be adopted by the whole community.

Community led approaches do appear to have promising results. A four-module program covering hygiene, problem solving, women's health, and human rights has been adopted

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in several countries. Knowledge about FGC was seen to increase, while prevalence decreased. Success, however, may vary between communities and if the program is seen to use a "lecture and educate by experts" approach instead of community engagement, it is more likely to fail.

Communities moving towards ending FGC may wish to make a public statement that they are abandoning the practice. This may create a sense of collective change and help empower individual families once they see a sufficient number of community members joining the effort.

To be effective, the statement needs to be made by the entire community, not just members of one or more sub-groups.

Finally, governments may pass laws against FGC. Although this may just drive the practice underground, legal threats may be an effective tool to end FGC.

A recent review by Waigwa and colleagues, evaluated health education interventions used for FGC.[27] They point out that well designed health education programs do not simply share information about a given health topic, but must address motivations, skills and confidence in the target population. The 12 studies in their review used quantitative, qualitative and mixed measures. Four major themes were identified: sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure, and delivery.

With respect to socio-demographic factors, younger people proved more amenable to discontinuing after health education was provided, possibly because they were better educated. Health education was more effective if those providing it were from the same ethnic group and spoke the same language as those receiving the education.

Important socioeconomic factors were found to be education and occupation/community status. Education and attitudes towards FGC were inversely related, and if influential community members still supported FGC, educational programs were negatively affected.

Religion had a mixed effect on success of FGC. In some cases, it had no effect, while in others, the religion practiced by either the community or the health educator was an important factor. The success of health education was usually influenced by the beliefs of community religious leaders. Overall, religion proved to be a difficult barrier to overcome. If communities' religious beliefs condoned the practice, education was negatively affected. Location was also a factor. Rural communities were more supportive of FGC, had had less exposure to education about the practice, and were generally more isolated from communities that had abandoned it.

The final factor that influenced the effects of health education was program strategy, structure, and delivery. Communities must be approached with caution, lest the program be rejected out of hand. Men educating men, and women educating women was more effective. Previous exposure to FGC education was also helpful. Lectures and workshops were inconsistently effective, while mass media (usually radio) and the use of graphics or other art forms appeared effective, especially in reaching men and young people.

Step 2: Identify Type(s) of Ethical Problem(s) Occurring

After collecting relevant information, it is critical to determine what type(s) of ethical problem(s) are occurring in your particular situation. There are four types of ethical problems:

I. Ethical distress occurring due to an existing barrier to acting on an obvious solution;
II. Ethical distress occurring because two or more solutions are possible; however, value is lost if only one solution was acted upon;
III. A dilemma of justice occurring because resources or benefits are not distributed fairly;
IV. A locus of authority ethical problem occurring because someone other than yourself holds the power to decide and act.

A situation may result in more than one ethical problem. However, this FGC case is a good illustration of a locus of authority ethical problem.

Avoiding Western "Oppression"

Under most circumstances, people would like to be able to live their lives free of any foreign interference. Nobody wants to be judged up against the standards of another country or culture – especially if that culture is Western and extra-super especially if that country is the United States. There may be a Universal Declaration of Human Rights[13] that most countries support but demands for "cultural exceptionalism" are commonplace. When told by Europeans that American attitudes towards capital punishment or gun control are barbaric, the Europeans are likely to be told to mind their own business. Our culture wants an exemption from having to meet a standard imposed from without.[28]

Similarly, supporters of FGC may argue the practice promotes social cohesion, decency and family values in a society that suffered the deleterious effects of colonialism and Western neo-liberal economic policies. The argument that human rights are a Western invention and are by no means universal is not an uncommon one and can result in FGC interventions being interpreted as just more Western oppression in a region that has suffered it for centuries.

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So, are human rights universal and can they be used as an argument against FGC? The answer seems to be "yes". Franck makes three arguments to support the universality of human rights: (i) most of those arguing for cultural exceptions to human rights are protecting their own rank and privilege, not those for whom they claim to speak; (ii) human rights are not grounded in the regional culture of the West but have arisen as societies have developed socially and economically; (iii) universal human rights allow for new, global affiliations that supplement traditions, not replace them.[28]

Ramcharan states the Universal Declaration was created with the support of countries from the developing world and that the African Charter on Human and People's Rights as well as the Arab Charter on Human Rights also exist.[29] Arguments that human rights are a form of Western oppression do not stand up to the facts.

Similarly, Sundaramoorthy argues that although there will be variations on how human rights are conceptualized, they are not a uniquely Western construct.[30]

***Step 3**: Use Ethical Approaches and Tools to Analyze the Problem*

During their training, most health professionals were provided some basic tools to evaluate and proceed when faced with an ethical situation, but when faced with the cultural divide posed by FGC, these tools may not be sufficient.

Consider the Pharmacist's Code of Ethics provided by the American Pharmacist's Association.[31] The Code discusses covenantal relationships with the patient, the need for compassion and confidentiality, patient autonomy and dignity, professional relationships, professional competence, collegiality, and service to the community. Since a young woman about to undergo FGC is not actually the pharmacist's patient, much of the Code does not readily apply. Service to the community is required, but that would also imply that the community sees the pharmacist's actions as a service, which is by no means a certainty.

Consider next the ethical principles of autonomy, beneficence, non-maleficence, and justice that most practitioners are familiar with. Again, our usual ethical tools may be insufficient. Autonomy may not apply since the girl undergoing FGC is usually a minor and parents have the responsibility of making decisions on her behalf. No one has charged the visiting team with making child-rearing decisions. Beneficence and non-maleficence may be stronger arguments, but FGC may be a societal requirement for living sociably within one's community. If FGC is considered a requirement to be considered a respectable, marriageable woman, does working to prevent it actually result in beneficence or non-maleficence? Maybe not. Since Westerners may frequently believe FGC impairs a woman's sexual pleasure, perhaps the best ethical argument against is it justice. However, ethnographic studies of the sexual experiences of women who have undergone FGC found that some women continue to have a satisfying sex life while others think the Western world's emphasis on sexual pleasure and orgasm is misguided.[15,32,33]

Professional codes of ethics began with the medieval guilds.[34] A code of ethics is a detailed, operational blueprint of norms of professional conduct. The code is a public recital of desirable and undesirable actions having an impact on the character of a profession and its functional ability.[34] Let's look at the American Pharmacists Code of Ethics.[31] The eight principles listed are the desirable characteristics that American society desires from a pharmacist practicing in the United States. Therefore, even though we have the Code to assist in what to do in this case, could or should it be applied to an individual who is not your patient and who is not residing in the United States?

At this point, it is probably worth pointing out that team members' experiences in the case above limit discussion of the remaining three steps of the Ethical Decision-Making Process to be fairly general. As noted above, the team proceeded to open the clinic the next day as if nothing had happened. The failure to take action once the team learned of the intended FGC was, in itself, an action that was taken before the remaining four steps of the Ethical Decision-Making Process could even be considered. The remaining four steps are ones that readers may find helpful in their own practice of global public health.

***Step 4:** Explore the Practical Alternatives*

Up until this step, you have had the opportunity to decide what you *should* do. The next step is to take all the information and tools and determine what you *can* do in this situation. This step encourages brainstorming of all possible actions and non-action. It is important to not oversimplify the possible actions. One option to prevent tunnel vision is to bring those who should be involved in this decision to the table to make sure all perspectives are represented in the alternatives. Please keep in mind that non-action is a form of decision. Doing nothing should be considered as a possible alternative.

***Steps 5 & 6**: Complete Action and Evaluate*

Once an action/non-action is taken, take time to engage in personal reflection. Conduct an evaluation of how effective your process was in helping the team to come to a decision. Determine what the outcome of your action was. This is important for personal and professional growth. Additionally, lessons learned may be passed to other healthcare providers and educators.

Conclusions

Practicing global health or volunteering for a medical mission trip to a medically underserved region can be a life-changing experience. Volunteers often gain a deeper understanding of

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themselves and their place in the world. They also come to recognize that what we think of as normal in the United States is not always considered normal somewhere else. As a result, any actions taken (or not taken) may not be the same as what you would do in the usual course of your pharmacy practice in an American setting.

Although most pharmacy curricula include some general education on cultural competence, this case suggests that it may not be sufficient. Team members participating in the mission described in the case were inadequately prepared for the situation they found themselves in. In depth preparation that is highly specific to the kinds of communities served is necessary to avoid the situation the team encountered. There is no reason the team pharmacist cannot be the cultural expert in these cases and use their knowledge to educate the other team members.

In this case study, readers are asked to come to terms with a practice the most Americans would certainly not see as normal. This particular example may even be an extreme case. But different cultures often have very different explanations for sickness and treatment.[35] Providers and patients may disagree about the cause of an illness, the appropriate treatment, or even who is responsible for giving permission for a provider to render care. But the process of working through and identifying an ethical response will be similar no matter the specific cause of cultural disagreement. The take home messages in nearly every case will be the same:

1. Have a process by which to identify and address culture-based ethical problems;
2. Realize there is rarely a right answer for what to do. You may have to make the best choice among several unappealing options;
3. Learn and appreciate the acronym SPADFY – Some People Are Different From You.

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