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Female Circumcision: The Ethics of Harm Reduction Policies

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Abstract

Female Genital Mutilation (FGM) is a critical global health issue for millions of girls worldwide. This harmful practice may include partial or total removal of the clitoris, labia minora, labia majora, or a combination of cutting techniques, resulting in lasting physical and mental distress. The practice is deeply ingrained in many cultures and has been difficult to eradicate, despite campaigns from the World Health Organization and the United Nations, among others. This paper argues for acceptance of a harm reduction policy, which centers on the promotion of medicalized and safe symbolic female circumcision to fulfill cultural norms while promoting the health of women and girls worldwide. Utilizing Bernheim's ethical framework, key ethical dimensions of the harm reduction approach are analyzed, illustrating the viability of female circumcision as an intermediate step towards eventual eradication of FGM. Ethical justifications including the efficacy, proportional benefits, and necessity of such programs further elucidate the importance of a harm reduction approach for this particularly sensitive public health issue. The paper concludes with policy and practice recommendations based on the ethical analysis and suggest various methods with which to implement them.

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INTRODUCTION

Female genital mutilation (FGM), a critical global health issue, has garnered international attention because of the political ramifications of eradication efforts and because of its role in the subjugation of women's rights. FGM may involve a partial or total removal of the clitoris, labia minora, labia majora, or other types of cutting and stitching (Larsen and Okonofua 2002). It is not the intention of this paper to argue for the persistence of mutilation, as mutilation denotes a harmful practice that should not be permissible in any circumstance. As Ruth Macklin (1999) postulates, "if a cultural practice produces manifest suffering or produces lifelong physical disability, there are good grounds for judging that practice to be ethically wrong" (24). It is, however, permissible and valid to argue for acceptance of symbolic *female circumcision* in safe, hygienic environments until culturally sensitive eradication initiatives and policies can be properly implemented. FGM will therefore be used to denote the traditional, harmful form of circumcision, whereas female circumcision will be used to name the hygienic, relatively safe, medicalized practice of this ritual. Although the eradication of FGM should remain an important end goal, this paper will focus on the importance of encouraging harm reduction practices to address this issue in the interim. First, background on the prevalence and history of FGM will be provided, followed by an examination of the critical issues of FGM and an overview of harm reduction. Then, ethical analysis utilizing the Bernheim framework will elucidate the ethical dimensions and justifications of harm reduction program implementation. The discussion will conclude with a brief summary of the critical issues and recommendations for policy and practice.

BACKGROUND

Historians claim that FGM dates back to the fifth century BCE, when the Phoenicians, the Hittites, and the Ethiopians purportedly practiced it (UNFPA). The World Health Organization (WHO) estimates that between 100 and 140 million girls and women worldwide have experienced genital mutilation (WHO 2008). Eight countries in Africa (Djibouti, Egypt, Eritrea, Guinea, Mali, Sierra Leone, Somalia, and Sudan) have FGM frequency rates of over 85 percent, indicating that within these countries the practice is widespread (WHO 2008). The WHO has named thirty-four countries – twenty-eight of which are in Africa, the rest in Asia and the Middle East – where FGM has been officially documented (WHO 2008). However, "anecdotal reports" were not included in this data set, and if included would bring the issue of FGM to South America (WHO 2008). Data collected over the last decade has shown little change in FGM frequency. However, one trend that has emerged is the lowering of the age at which FGM is performed in certain countries. The WHO attributes this to a desire to avoid legal repercussions from anti-FGM legislation that might more easily target adolescents as compared to children (WHO 2013a). Currently, twenty-four African countries have a law

in place against FGM (WHO 2013b). Ten developed countries¹ have national or state laws in place against the practice (UNFPA).

FGM has long been regarded a critical public health issue by the WHO and other national and international health organizations because of its harmful physical and mental implications. Short-term complications may include hemorrhage, pain, shock, and even death, while long-term complications include formation of cysts, problems with sexual intercourse, and chronic pelvic infection (Larsen and Okonofua 2002). Reymond, Mohamud, and Ali (1997) suggest that FGM is likely to increase the risk of HIV infection as the same unsterilized instrument may be used on many different girls. FGM may also cause psychological problems such as depression and anxiety (Reymond et al. 1997). Shell-Duncan (2001) reports, “all forms of female genital cutting are reportedly associated with the potential for diminished sexual pleasure” (1016). Further, obstetric issues are very common among women with FGM. Larsen and Okonofua (2002) determined that there was a significantly greater chance that women with FGM would have a stillbirth and tear compared to uncircumcised women. Additionally, one study claimed that of women who received FGM, eighty-three percent would at some point require medical attention for complications resulting from the procedure (Reymond et al. 1997).

A large factor preventing the eradication of FGM is its importance in the practices of many cultures. Religious reasons are often cited as justifying the practice, as many believe it is dictated by the theology of Islam (Coleman 1998). Religious beliefs related to FGM include the desire to uphold tradition, its place as a rite of passage to womanhood, as well as its purported ability to prevent promiscuity, preserve virginity, and establish young girls as better marriage prospects (Reymond et al. 1997). Religious beliefs regarding the benefits of FGM appear to be valued above health consequences among certain societies where FGM is prevalent. A study in Burkina Faso found that when educated on the negative repercussions of FGM, Protestant and Catholic women were less likely to have undergone FGM, whereas Muslim women’s incidence rates were not affected (Karmaker, Kandala, Chung, and Clarke 2010). Thus, FGM is a serious public health issue based both on its harmful medical effects, as well as its perpetuation due to its strong cultural ties.

The complexity of the FGM tradition is rooted in its significance to women and cultures. Women and girls at risk for circumcision, naturally, are the largest stakeholders in this issue, as they are at greatest risk for mental and physical health complications. Mothers and families have a stake in the practice of FGM, as they have much to lose in terms of social advantage if their daughters are mutilated. Although the pain and harm inflicted as a result of this tradition might suggest that women would be against the perpetuation of this practice, studies have shown that women in these communities are actually strongly in favor of FGM, whether for religious reasons or the desire to increase their daughters’ marriage prospects (Reymond et al. 1997). Mackie (2003) expands on this seemingly strange dichotomy between the aversion to performing a harmful procedure and the lack of will to change this social environment; he suggests that the rationale for female support of FGM is most likely a result of the notion that “no one

¹ Australia, Belgium, Canada, Denmark, New Zealand, Norway, Spain, Sweden, United Kingdom, United States

family stopping on its own would succeed, because unilateral abandonment would ruin the futures of its daughters” (141). Thus, communities and their leaders may find it difficult to effectively argue for eradication as it is so deeply engrained in their culture. Therefore, local and national governments play a large role in establishing harm reduction practices.

Western advocacy groups and non-governmental organizations, though well intentioned, seem to fall short on truly addressing this complex issue. Coleman (1998) suggests that international discussion on FGM eradication and medicalization is “dominated by Western feminists and rights advocates who view FGM as a women’s rights issue, and who seek recognition of a universal human right not to be genitally mutilated” (727). Although these “Westerners,” symbolized by organizations such as Human Rights Watch and Program for Appropriate Technology in Health (PATH), might appear to be critical advocates, without cultural sensitivity and knowledge of the deeply engrained nature of this issue their policies may actually serve to undermine women in these communities. Therefore, it is critical to fully understand the ethical implications of the issue at hand in order to establish effective programs.

Despite well-intentioned policy agendas, large public health organizations have similarly lacked cultural awareness of FGM. Global health organizations operate outside of the communities where FGM is prevalent and may not have the knowledge to fully grasp the complexity of the issue and the consequences of their policy recommendations. The WHO and United States Agency for International Development have declared FGM to be unethical and have tried to implement policy, as well as educational initiatives to decrease its practice (Reymond et al. 1997). The United Nation’s Commission on the Status of Women (2008) stated, “female genital mutilation violates, and impairs or nullifies the enjoyment of the human rights of women and girls.” Additionally, the United States passed the Federal Prohibition of Genital Mutilation Act in 1997, prohibiting the practice (Coleman 1998). However, when countries have attempted to ban or limit FGM their initiatives have repeatedly backfired. Critical examination of these failures, as will be demonstrated in the ethical analysis, suggests harm reduction is the best public health policy for these communities.

Harm reduction is a public health principle in which a practical and culturally sensitive alternative is applied as an intermediate to the ultimate goal of eradication (Shell-Duncan 2001). In the case of FGM, harm reduction suggests symbolic female circumcision, which consists of “a little cut on the external genitals, performed under medical supervision and hygienic conditions” (Galeotti 2007, 91). As such, female circumcision can fulfill cultural requirements while simultaneously preventing complications and lasting harm to women. Harm reduction has been extremely successful in other areas of public health, such as providing needle exchange programs to decrease the spread of AIDS in intravenous drug users, responsible drinking programs (such as a designated driver system), condom distribution, and alternative sources of nicotine such as the patch (Shell-Duncan 2001). One study which examined the difference in improperly disposed syringes among intravenous drug users in a city without a needle exchange program as compared to a city with one found an eight-fold increase in improperly disposed syringes when the harm reduction program was not implemented (Tookes, Kral, Wenger, Cardenas, Martinez, Sherman, Pereya, Forrest, LaLota, and

Metsch 2012). In light of public health's main tenet of preventative care, the harm reduction practice clearly aids in preventing more inevitable harm from being inflicted.

Many cases of harm reduction programs have received backlash, especially, and predictably, in developed countries. In Florence, Italy, a hospital that considered allowing hygienic female circumcision to satisfy cultural requirements was met with hostility from women's organizations, national media, and government representatives. The "government settled the case by passing a statute banning female mutilations of any kind, with hard punishments for parents, doctors, nurses, or women themselves" (Galeotti 2007, 91). The same sort of public outcry was mirrored at the Harborview Medical Center in Seattle, where a similar proposal to perform ritualistic female circumcision on Somali immigrant women was shut down after public outrage claimed it to be an unjust practice, "intolerably giving in to women's subordination in patriarchal cultures" (Galeotti 2007, 91). A Netherlands Welfare, Health and Culture Ministry report recommended distinguishing between female circumcision that did not permanently injure tissues and those that did, in order to determine that doctors were justified in performing a non-impairing, ritual prick (Shell-Duncan 2001). However, this too was met with hostility from the public and quickly rejected by the Dutch government. The same sort of reaction and rejection occurred in Egypt when a law permitting only doctors in government hospitals to perform female circumcisions was initially passed in 1994 and reversed one year later (Shell-Duncan 2001).

Although previous cases of harm reduction have not been well received, this should not indicate that future attempts would be unsuccessful. An ethnographic study of the Rendille in rural Kenya found that harm reduction in female circumcision had evolved almost naturally in their community, with beneficial results (Shell-Duncan, Obiero, and Muruli 2005). Among the Rendille, a specialized medical professional performs FGM on the woman's wedding night. Benefits of circumcision are identified as largely social and economical (Shell-Duncan et al. 2005). The *kamaratans*, or traditional circumcisers, began to gradually implement harm reduction practices in the community, such as more formal training and administering antibiotics, under the guidance of mission-sponsored health practitioners (Shell-Duncan et al. 2005). Generally, women and men favored these medical interventions as methods to decrease complications and risks from the procedure. In addition to community education and acknowledgement of risk reduction from medicalized practices, Shell-Duncan et al. (2005) also found that women who received no medical support had three times greater odds of developing complications. Further, in the urban city of Ado-Ekiti, Nigeria, a study found that 84 percent of female circumcision was performed in the modern health sector, as well as 50 percent in the rural state of Ekiti (Caldwell, Orubuloye, and Caldwell 2000). Through these case studies, it becomes apparent that harm reduction is possible for many countries in which FGM is widely prevalent. In the ethical analysis that follows, evidence will demonstrate that harm reduction is the only viable option at this time to limit harm to women and maintain cultural standards.

ETHICAL ANALYSIS

Bernheim's framework suggests that in order to determine the morality of a public health issue it is necessary to first explore the ethical dimensions of the issue and then make a judgment based on ethical justifications (Bernheim, Nieburg, and Bonnie 2007). The following analysis will demonstrate that female circumcision harm reduction practices are not only ethical, but also necessary in order to maintain the health and quality of life for women.

Ethical Dimensions

A key ethical principle in determining whether harm reduction practices serve a moral purpose stems from the notion of utility and a determination of whether the benefits garnered from the intervention will outweigh any possible harm. Utility is based on the concept that public health practices should provide the maximum benefit and wellness to as many people as possible (Bayer, Gostin, Jennings, and Steinbock 2007). Ethicist John Stuart Mill proposed the harm principle as a mandate that defines an ethical practice as one that reduces damage or injury. Harm can be defined in terms of causing physical or emotional injury or depriving one of their rights; usually, it is intended to denote a practice that causes undue risk or needless injury (Bennet-Woods 2005). Galeotti (2007) argues that although medicalizing female circumcision may be slightly harmful, it is justified compared to the much more debilitating consequences of traditional cutting. It is valid, then, to argue that female circumcision in hygienic environments, carried out by professionals, is actually harm reducing compared with the harm that is proven to occur with traditional forms of FGM. Notably, in certain regions, such as the Sudan, where some forms of cutting are illegal, "women hide medical complications for fear of legal repercussions" (Shell-Duncan 2001, 1017). Legalizing circumcision for ritual purposes will ensure that no lasting damage is done and girls can maintain their status in society. The inevitability of the traditional circumcision being performed and more harm being inflicted is critical in the conviction that female circumcision is harm reducing. Mackie (2003) asserts, "the great importance of the daughter's marriageability outweighs the importance of health, bodily integrity, and consent, even among those who endorse the latter concerns" (141). Thus, it is imperative that less invasive and less damaging methods are used to ensure that this ritual is accomplished.

Justice is another issue to discuss when examining the ethical dimensions of harm reduction. Justice in public health ethics denotes a fair process in terms of decision-making or treatment (Gostin and Powers 2006). Opponents of medicalized female circumcision might question the justice of a practice that seemingly supports the subjugation of girls. However, upon closer examination, it appears that justice is actually being served in harm reduction programs as benefits are distributed fairly to the women who need it most. In Larson and Okonofua's study (2002), women were generally unsure of the circumstances of their FGM; more than one-third did not know specific details such as their age, the location, or who performed the procedure. Allowing women the opportunity to engage in this important ritual in a safe environment serves justice in that it gives these women some understanding in their decision making process. It can be argued that children are without a choice in the matter as circumcision can occur from

youth to before marriage. Yet, justice is still served as the situation is more controlled than it would be under “normal” circumstances, where the mother may have limited direct impact on the environment or way in which the circumcision occurs. James Dwyer (2003) highlights this imperative, arguing that practices such as harm reduction, “should seek to empower those who are often marginalized, and to allow everyone who is affected a real chance to shape the goals and policies of assistance. After all, justice demands respect, empowerment, and some degree of political autonomy” (439). By giving women and adolescents a greater understanding of the process that they would not have received otherwise, as well as moving this tradition to a controlled environment in which a safer treatment is possible, justice is better served.

The importance of liberty, autonomy, and privacy are critical in determining the ethical viability of a practice. A hallmark of an ethical public health measure is consent; deciding whether these women really want the practice is essential in order to make a judgment on whether harm reduction, as a practice, is permissible. Galeotti (2007) states that in the Florence case previously mentioned, immigrants and refugees requested female circumcision from hospitals, clearly indicating consent. She continues, specifying that most women who requested this service were “generally children of Westernized diasporic families; feeling estranged in a not-so-welcoming society, they had rediscovered their tradition and community” (Galeotti 2007, 99). Also, it is important to consider the impact of Western ideology on traditional circumcision. Coleman (1998) postulates that the “lack of respect inherent in the West’s incredulous and categorical condemnation of the practice has contributed to a backlash within the cultural and religious communities that embrace it” (733). By judging the action without taking the time to understand its underlying mechanisms, Western perspectives may serve to diminish the liberty and autonomy of these women, resulting in an increase of the dangerous traditional practice. Further, the ability of trained professionals to maintain transparency and privacy throughout the circumcision process is ideal. When interviewed, 75.6 percent of circumcised women did not know or answer regarding the type of circumcision they had received (Larson and Okonofua 2002). This evidence illuminates the importance of information and how being able to control the environment of the circumcision can empower women.

Ethical Justifications

In order to justify the use of harm reduction as a legitimate practice, its efficacy must be assessed. Regardless of whether it is sanctioned or supported, harm reduction methods are already in use in many parts of Africa where FGM is common. Shell-Duncan (2001) reports that many women who are performing circumcision have taken it upon themselves to begin using less harmful methods of cutting: “one of the most minimal forms involves nurses dispensing prophylactic antibodies, anti-tetanus injections and sterile razors to girls who are later cut by traditional circumcisors” (1018). Standardizing and legalizing this protocol diminishes the harm inflicted by the ritual, by sending girls to be symbolically cut by midwives or nurses that are trained and have access to hygienic environments. Further, harm reduction is critical in decreasing medical complications, thereby saving the community money and resources on medical treatments that might result in its absence. When preventative, hygienic measures are taken, the risk of immediate complications decreases by 70 percent (Shell-Duncan 2001). Legalizing this

practice would only serve to bolster the harm-reducing nature of medicalized circumcision and place girls in safer hands.

The Bernheim framework suggests that benefits must outweigh burdens in assessing a decision as ethical. The benefits of female circumcision over traditional mutilation cannot be overstated. Evidence presented thus far has demonstrated the immense health related harms that accompany traditional circumcision, compared to the symbolic prick and limited complications that arise from medicalized female circumcision. Galeotti (2007) sees symbolic female circumcision as a compromise which “could allow adult women to stay within their traditional culture, devising a practice which they labeled ‘alluding to rather than serving as a replacement for’ genital mutilation so as to avoid bodily harm and disability” (98). The benefits of female circumcision become apparent as physical harms are reduced and women are not being ostracized from their communities.

The necessity of harm reduction programs in the case of female circumcision is apparent through the failure of other types of interventions. Governments have, with good intentions, attempted to ban FGM. However, these restrictions have backfired time and again, resulting in increasingly dangerous situations for girls. Indonesia and Senegal highlight cases where banning FGM resulted in adverse consequences. Indonesia banned FGM outright in 2006. However, religious support for the practice remained high, and because of the ban “most incidents happen in secret, sometimes unhygienic, back-street operating rooms – creating a big risk of infection” (IRIN 2010). Senegal’s ban of FGM was also met with outrage and quickly overturned, as this legislation would have justified the imprisonment of more than one million Senegalese (Hecht 1999). The necessity of creating a more intermediate solution in order to prevent not only worse medical outcomes but also rejection by the public lends further support to the creation of a harm reduction intervention. Further, banning any sort of circumcision violates the concept of “least infringement”, or the notion that a public health effort should be done with minimal intrusion on a local culture. Employing hard and fast limitations might provoke backlash in these societies, as they do not take into account the deep cultural significance of circumcision. Without culturally sensitive and minimalist options, as harm reduction provides, rates of FGM may actually increase.

The need for harm reduction programs can also be seen in the negative aftermath of shutting down these programs. When Somali women were denied medicalized female circumcision at a Seattle hospital, the women vowed to send their daughters either home to Somalia or to one of three midwives in the Seattle area who had limited resources and expertise (Coleman 2008). Denial of their requests might have resulted in an increase in physical harm and also mental distress for the young girls. Galeotti (2007) echoes this reasoning, arguing, “legal restrictions on genital mutilation may save feminists’ conscience, but they do not touch the destiny of girls who are sent back to their home country to be mutilated” (107). This sort of consequence was also the result in Egypt when a law that permitted medicalized circumcision in hospitals was overturned. The practice was quickly pushed underground, where untrained midwives and barbers performed the cutting with unsafe tools (Shell-Duncan 2001, 1019). Dismissal of harm reduction programs may therefore lead to adverse effects on women and girls. This information illuminates the fact that it is imperative that local communities in which

FGM is prevalent are aware of the benefits and necessity of continuing female circumcision harm reduction programs.

FGM is a global threat to the public health of women, and thus requires a culturally sensitive acknowledgement, not only by national and local governments, but also by Western societies in which the practice is often dismissed as harmful and disempowering. Rothstein (2002) posits that “the existence of a public threat demands a public response, and in a representative political system it is the government that is authorized to act on behalf of the public” (146). However, public approval for a harm reduction approach, particularly in Western countries, which tend to set the international precedent, will be difficult to attain. Thus, it becomes imperative that these societies are well informed about the principles of harm reduction and fully understand that symbolic circumcision is the best possible alternative to FGM at this time. Furthermore, it is critical to understand that many women want these interventions and are justified in their volitions, as the alternative leaves them to the harms of traditional practices. Galeotti (2007) speaks to the Western cultural hegemony that seems to dictate these policies, and argues that just because a culture is different does not mean it is suspicious. She questions, “why, then, should we want only women of alien cultures to conform to high standards of autonomy? Why should we accept the self-abrogative conduct of would-be starlets while questioning the choices of lucid, adult African women?” (102). By placing the issue within a framework that Westerners can relate to and question, Galeotti forms a culturally acceptable and reasonable argument.

Western societies and governments should view harm reduction as a stepping-stone to eventual eradication, not a legitimization of a disempowering tradition. In constructing ethical arguments, it is critical to approach issues from a universal, not relativistic perspective. Harm reduction fits this criterion, by applying practices that aim to increase the quality of life for all women, in a cultural context. In applying cultural awareness but maintaining moral standards, it is possible to ethically implement harm reduction programs in the case of female circumcision.

CONCLUSION AND RECOMMENDATIONS

Complete eradication of FGM is an ideal, but unrealistic goal for the near future. One organization, TOSTAN, a Senegalese nonprofit centered on community-based empowerment and education for women, has been successful in decreasing the FGM practice in communities. Although this program was successful in decreasing FGM rates, prevalence continued to stay extremely high (79 percent) for daughters over the age of five at the end of the study (Diop and Askew 2009). Lack of countrywide initiatives like TOSTAN, as well as long-term analysis and resources with which to implement these initiatives, suggest that complete eradication is not possible at this time. As previously discussed, blanket bans of FGM serve to further disempower women and elevate their health risks. Careful ethical reasoning has demonstrated that symbolic female circumcision is the least harmful and most culturally appropriate alternative at this time. Below, policy and practice recommendations based on the ethical analysis will illuminate critical aspects of implementing a harm reduction agenda.

In establishing effective harm reduction programs, it is crucial to work with the communities in which FGM is common, in order to ensure acceptance of its implementation. Macklin (1999) posits that in order to make effective and ethical change, forming alliances with the people within these communities is a critical step. Further, harm reduction must respect transparency and confidentiality in order to maintain public trust (Kleinig 2008). In doing so, health programs will reach more women and be more effective in achieving their objectives.

In addition to community-based work, the importance of access to information in harm reduction programs is essential. The association between lack of education and FGM has been established (Karmaker et al. 2010). Further, Reymond et al. (1997) suggest that most women who want to end FGM do not have enough resources or knowledge to convince men or other community members that it is extremely harmful. Mackie (2003) echoes this sentiment, arguing that increasing education could influence peoples' decisions to not get circumcised. Information may come in the form of pamphlets, group discussions, or small-scale social marketing campaigns. A review of anti-FGM educational interventions among the Maasai in Tanzania suggests that the best campaigns were those that addressed and framed the issue within the changing local community, rather than positioning themselves as "opposite" or "outside" traditional practices (Winterbottom, Koomen, and Burford 2009). The dissemination of information in these communities is paramount, and doing so in a culturally sensitive manner will help to not only bolster harm reduction programs, but also to improve education about the harms of FGM.

Although community-based participatory programs are essential in changing any health behavior, they are not as effective on a broader scale without the implementation of effective national and international policies to guide the practice. In the United Kingdom and Australia, effective policy approaches have centered on the establishment of supportive health services in addition to community education initiatives (Karmaker et al. 2010). Therefore, the formation of culturally sensitive and uniform training programs for healthcare workers is necessary. Medical professionals, such as community nurses and midwives, are critical actors in harm reduction implementation, as their actions can directly ensure that women and girls are not subjected to traditional mutilation. A study of the Yoruba in Nigeria found that among mothers of non-circumcised daughters, two-fifths attributed their decision to abstain to the influence of a doctor or nurse, as opposed to 2 percent who made this choice based on recommendations from religious leaders (Caldwell et al. 2000). Therefore, policy should allow for a medical education in which physicians and nurses, as well as community health workers, are taught the harms of FGM and the appropriate use and implementation of symbolic female circumcision. This will allow women access to a safe and legal female circumcision from trained health care providers, should they choose this practice. Setting a firm policy agenda, which compliments educational campaigns with clear standards for medical personnel, will help to establish medicalized female circumcision as an ethical, viable, and realistic alternative to FGM. The ability to access these services without legal or social repercussions will aid in to empowering women and health professionals in the communities who previously had little or no choice surrounding this procedure.

Internationally, a harm reduction policy approach will be beneficial in setting standards for practices in countries where FGM is widespread. Namely, international

organizations should recognize that symbolic female circumcision is a viable interim solution, and that harm reduction practices are acceptable as long as they are safe and legal, and also address women's needs. The WHO argues that medicalized circumcision "tends to obscure its human rights aspect and could hinder the development of long-term solutions" (WHO 2013a). However, international policymakers must consider the evidence: FGM is an extremely prevalent practice that is not only detrimental physically but reinforces a lesser place in society for women and girls. Social justice demands that policies should reduce inequalities and that programs must work to ensure the health and safety of the most vulnerable (Gostin and Powers 2006). Thus, international organizations have an imperative to instate policies that allow for the implementation of medicalized female circumcision as a harm reducing solution. Further, international regulations should recognize the need for a culturally sensitive approach, and establish directives to allow for the foundation of safe and legal clinics where this is possible. International support of female circumcision as an appropriate practice will legitimize national efforts and aid in establishing effective and educational clinics in communities where change can begin to occur.

Female genital mutilation is a harmful practice; subjecting women to any sort of physical pain, especially one that is lasting and impairing, is unacceptable and must be addressed. Due to the deep cultural rootedness of the matter, however, it becomes clear that symbolic female circumcision is the most ethically and culturally appropriate intermediate practice. When implemented the right way, symbolic female circumcision can make a difference in the lives of millions of women and girls who would normally face an elevated and long-term health risk. It is critical to understand the ethical imperatives that suggest this kind of approach, as well as to ensure that harm reduction programs are implemented with the full support of the community. In order to fully support the health of women and girls, harm reduction policy is the most ethical and promising approach.

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