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LEGAL AND ETHICAL CONSIDERATIONS IN THE DELIVERY OF SEXUAL HEALTH CARE IN TANZANIA

B.R. Simon Rosser (PhD)[1*], Lucy Mgopa[2], Sebalda Leshabari (PhD)[2], Michael W. Ross (PhD)[1], Gift Gadiel Lukumay[2], Agnes Massawe[2], Ever Mkonyi[1], Inari Mohammed[1], Stella Mushy[2], Dorkas Mwakawanga[2], Maria Trent[3] and James Wadley, (PhD)[4]

[1]University of Minnesota, School of Public Health, 1300 S. 2nd St. #300 Minneapolis, MN, USA.

[2]Muhimbili University of Health and Allied Sciences (MUHAS), School of Public Health and Social Sciences, PO Box 65015, Dar es Salaam, Tanzania.

[3]Johns Hopkins Medicine, 615 N. Wolfe St., Baltimore, MD 21205, Washington, DC, USA.

[4]Lincoln University, School of Adult and Continuing Education, 1570 Baltimore Pike, Lincoln University, PA, USA.

Corresponding Author Email: rosser@umn.edu

ABSTRACT: *Tanzania is a country with multiple sexual health challenges including high rates of HIV/STIs, early sexual debut, forced sex, sexual dysfunction, and teen pregnancy. Training in sexual health care is limited, while courses on how to address the ethical aspects of sexual health are non-existent. To address this gap, this paper explores legal and ethical challenges to providing sexual health care in Tanzania. First, we describe the sexuo-cultural and epidemiologic challenges, and the key laws regulating sexual health. Six case studies identify ethical dilemmas in healthcare delivery. They are: (a) how to address sexual and intimate partner violence; (b) treatment of illegal or stigmatized key populations; (c) treatment of couples in HIV serodiscordant, non-monogamous, and/or polygamous relationships; (d) requests for and participation in illegal healthcare; (e) treatment of women and children in the presence of their husbands and fathers; and (f) addressing child sexual abuse. We apply the ethical principles of autonomy, justice, beneficence and non-malfeasance. A second challenge is ensuring confidentiality in a setting where medical record keeping practices vary widely, and violations to confidentiality are perceived as common. Finally, we identify a set of best practices in sexual healthcare delivery tailored to the Tanzanian context.*

KEYWORDS: Clinical Ethics, Gay, Sexual Abuse, Polygamy, Unwanted Pregnancy

INTRODUCTION

Understanding the Cultural and Epidemiologic Context of Sexual Health Challenges in Tanzania

Multiple sexual and reproductive health challenges. Sub-Saharan Africa is the epicenter of the HIV pandemic. An estimated 1.5 million or 5.3 percent of Tanzanians are living with HIV;

57.1 percent of whom are female (Tanzania Commission for AIDS, 2013). With HIV prevalence at 2.0 percent, youth aged 15-24 years are particularly vulnerable (Tanzania Commission for AIDS, 2013). Only 43.4 percent of youth have accurate HIV knowledge, while 55.7 percent report engaging in sexual risk behaviors with a non-marital partner (Tanzania Commission for AIDS, 2013). Sub-Saharan Africa is also the epicenter for (non-HIV) sexual transmitted infections (STIs), where STIs and their complications are "one of the top five reasons adults seek health care" (World Health Organization, 2016). In Tanzania, 2.5 percent of pregnant women are diagnosed with syphilis (Manyahi et al., 2015); a further 2.7 percent of women are infertile (likely because of untreated or recurrent STIs) (Hollos & Larsen, 2008). While 54.1 percent of pregnancies are intended, 32.5 percent are unintended, and 13.4 percent, unintended and unwanted (Exavery et al., 2014; Tanzania Key Populations and Sexual Minorities Working Group, 2016). The leading stated cause of unplanned pregnancy is "not talking about family planning" (Exavery, et al., 2014). Sub-Saharan Africa also has the world's highest rates of teen pregnancy, often leading to poor pregnancy outcomes (Shirima & Kinabo, 2005). An estimated 56-58 percent of adult men report erectile dysfunction (Mbalamula, 2008; Shaeer et al., 2003), while myths about masturbation as dangerous (including fears that it causes erectile dysfunction in adulthood) are common among both healthcare providers and community members (Matasha et al., 1998; Prytherch et al., 2008).

Tanzania has specific cultural issues contributing to these sexual health disparities. In Tanzania, 40 percent of girls are married before age 18. While Tanzania has raised the age of marriage to 14 for girls and 18 years for boys, this may change. In 2019, the High Court ruled that marriage under age 18 was illegal and directed the government to raise the minimum age of marriage to 18 for both genders within a year. (This was in the case of *Rebeca Z. Gyumi v. The Attorney General*, High Court of Tanzania at Dar es Salaam, Miscellaneous Civil Case No. 5 of 2016).

In rural areas, 17 percent of girls report their first sexual experience as forced (World Health Organization (WHO), 2016). The prevalence of female genital cutting has decreased in the last two decades (from 18% to 10% (Ministry of Health et al., 2015-2016)), with rates as high as 45.2 percent reported in rural women (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Physical violence is reported by 47 percent of rural and 33 percent of urban women. Some tribes promote and/or interpret wife-beating as love (García-Moreno, et al., 2005). Sexual violence is reported by 23 (urban) to 31 (rural) percent of adult women (García-Moreno, et al., 2005), 27.9 percent of girls, and 13.4 percent of boys (Chiang et al., 2015).

Abortion is illegal but widely practiced across the region. East Africa had an estimated two million unsafe abortions in 2008, accounting for 16-25 percent of maternal deaths (Sorensen et al., 2010). In Tanzania, most women seeking abortion are "young, single and desperate" (Mswia et al., 2003).

Homosexuality is stigmatized and sodomy an imprisonable offence. In 2016, to protect Tanzanian culture from homosexuality, the then Constitutional Affairs and Justice Minister Mwakyembe banned sexual lubricant, announced lesbian, gay bisexual and transgender (LGBT) groups were no longer legal, and proposed arresting anyone on Facebook with pro-gay sentiments (Tremblay, 2016). Similar to other countries in the region, men who have sex with men (MSM) are fearful to seek HIV/STI care, and have high rates of undiagnosed HIV and STIs (Anderson, Ross, Nyoni, & McCurdy, 2015; Nyoni & Ross, 2012a, 2012b). Among MSM, 29.5 percent report being physically attacked for being homosexual (Anderson, et al.,

2015). “Corrective rape” of lesbians has also been reported (Ross et al., 2015).

While each datum cited above is important; collectively, they reflect a nation facing multiple sexual health crises. Across multiple metrics, women, children, and key populations (i.e., an umbrella term used to describe MSM, injecting drug users, sex workers, and prisoners) are the groups with the most unmet needs and at highest risk of HIV/STI and violence, with the most unmet needs.

The Legal Context Related to Sexual Health

Tanzania is a culturally rich, vibrant country comprising more than 120 tribes, 120 languages, and three main religions (Islam, Christianity, and Indigenous). To address this complexity, the legal system is necessarily more heterogeneous than many other countries. For example, all couples marrying have to indicate, normally in the marriage certificate, if the marriage will be monogamous, polygamous, or potentially polygamous.

Laws directed towards female genital cutting, abortion and homosexuality, illustrate the effects of criminalization of sexual behavior on health. Female genital cutting (also known as female genital mutilation or FGM) is the ritual cutting or removal of some or all of the external female genitalia. A long-standing practice in Sub-Saharan Africa, it affects an estimated 200 million girls, globally (UNICEF, 2019). It is deemed illegal because of its detrimental effects to human health and violation of human rights. In addition, it is condemned in international treaties and conventions (World Health Organization & Department of Reproductive Health and Research, 2008). Nevertheless, the practice is sustained by culture, traditions, and to a lesser extent, religion (UNICEF, 2019). Traditional healers typically perform the cutting, although, in other East African countries, health practitioners may be approached to perform the procedure.

Although it is illegal in Tanzania, many tribes including the Chagga, Nyaturu, Maasai, Gogo, Pare, Kurya and Iraques still practice FGM (Yusuf & Fessha, 2013). Reasons for such perseverance range from community social acceptance, marital values, cultural myths and/or a desire to control women’s sexuality (20TooMany, 2018). To protect women against FGM, Tanzania enacted the Sexual Offences Special Provisions Act (SOSPA) in 1998 which amended Section 169A(2) of the Penal Code to prohibit FGM on girls under the age of 18 years. Penalties on the practitioner include imprisonment from five to fifteen years; a fine not exceeding 300,000 shillings (close to US$150); or both the fine and imprisonment (20TooMany, 2018). Shortcomings in the penal code include lack of precise definition of FGM, limited scope of criminal liabilities, and no clear punishment for FGM practices on women above 18 years old. Other social factors that contribute include poor implementation and enforcement of the law in rural areas. Cross border movements between Tanzania and neighboring countries compound enforcement.

The second impactful sexual health law targets pregnancy termination (abortion). Abortion is illegal in Tanzania but commonly practiced (Keogh et al., 2015). The true rate of illegal abortion is not clear because it is both illegal and stigmatized (Woog & Pembe, 2013). (The stigma is sufficiently severe that Tanzanians use the term “miscarriage” to cover both unintended and induced termination). The Penal Code of Tanzania, Chapter 16 of the Laws of Tanzania, only allows termination of pregnancy to save a woman’s life (Center for Reproductive Rights, 2012). Tanzania signed and ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003, popularly known as

the Maputo Protocol, (Second African Union Assembly, 2007), which defines, as a right, women's access to medical abortion in cases of rape, sexual assault, and incest, or when continuation of pregnancy endangers the physical and mental health of the pregnant woman or the life of the fetus (Second African Union Assembly, 2007). Despite this, Tanzania has yet to domesticate this Protocol into its national laws (Woog & Pembe, 2013).

The third significant sexual health laws revolve around homosexuality. Homosexual behavior is heavily stigmatized in Tanzania (and most African countries). Although criminalization of homosexuality was introduced as part of colonialization, homosexuality is often presented as an "unnatural" or "un-African" behavior. Of the 54 countries which make up the African Union, homosexuality is outlawed in 34 of them and discriminated against in another two. Thus, two thirds of African countries penalize homosexuality, with Sudan, some provinces in Nigeria, and the southern part of Somalia, having the death penalty for homosexuality (Carroll & International Lesbian, 2016). South Africa is the only country in Africa where same sex marriage is legal, and the civil rights of sexual minorities protected in their Constitution. Throughout Tanzania, sex acts between men are illegal and carry a maximum penalty of life imprisonment (Government of Tanzania, 1998). In semi-autonomous Zanzibar, sex between women is also illegal with up to five years' imprisonment. Accounts of LGBT individuals being discriminated against, deprived of their rights, and imprisoned are common (Anderson, et al., 2015). Emotional, physical, and sexual violence by community members and police appears common and linked to increased depression among men who have sex with men (Mgopa, Mbwambo, Likindikoki, & Pallangyo, 2017) .

Ethical Principles in the Delivery of Healthcare

As a health professional, it is not sufficient simply to follow the law when providing care. As the Belmont Report recognizes, "Rules [including laws] often are inadequate to cover complex situations; at times they come into conflict, and they are frequently difficult to interpret or apply. Broader ethical principles will provide the basis on which specific rules may be formulated, criticized and interpreted" (Biomedical & Research, 1978). In Table 1, we highlight four commonly accepted ethical health care principles, providers need to consider in providing sexual health care (Beauchamp & Childress, 2001) .

African healthcare providers have a diversity of attitudes and perception on such issues as female genital cutting, abortion, and homosexuality (Hunt, Bristowe, Chidyamatare, & Harding, 2017; Loi, Gemzell-Danielsson, Faxelid, & Klingberg-Allvin, 2015; Zurynski, Sureshkumar, Phu, & Elliott, 2015), and Tanzania is no exception (20TooMany, 2018; Ross, et al., 2015; Silberschmidt & Rasch, 2001). The cultural background of health care providers may be a potential source of moral purpose in healthcare, and serve as a critical bridge to understanding our patients, ultimately enhancing the welfare of both clinicians and patients (Hordern, 2016).

Legal and cultural proscriptions, cultural beliefs, religion, moral values and ethics all influence how health care providers, practice. But no patient should have to suffer, or be deprived of health services, because of the practitioner's cultural limitations, morals, or personal beliefs. Even in cases where a patient's lifestyle or behavior have contributed to their illness, or where the person has caused great harm to self or others, the provider must provide care without prejudice (Hordern, 2016).

Just as cultural context can enhance medicine, it can also make its practice more challenging. To appreciate the ethical and legal challenges to providing healthcare in the Tanzania context, we provide the following six case studies. Each case highlights a particular cultural or legal challenge to providing culturally-competent sexual health care in Tanzania.

Cultural Case Studies in Sexual Health Care Provision

The following six cases are provided to illustrate the challenges of sexual health care in Tanzania. First, the case is presented, and then the ethical challenges explicated. In each case, the reader is encouraged to ask themselves, "What would I do to provide care?" and "What should I do?" Where applicable, the ethical principle appears in square brackets after the sentence.

1. Addressing sexual and intimate partner violence.

> *Mrs. Q. is a 28-year-old housewife, married for two years, with no children. She presented to the emergency department with bruises on her forehead and elbows, cut wounds on the face with a swollen cheek, and severe hematoma and swelling around the left eye. After her wounds were treated, Mrs. Q. was admitted to the trauma ward. A history was taken as part of the assessment. Mrs. Q. described being a victim of domestic and sexual violence ever since she got married, due to her husband's uncontrolled rage and alcoholic behavior. Her husband, who was 14 years older than she, was her only sex partner. Since her marriage, she tested positive twice for STIs and was successfully treated. After marriage, he forced her to quit her job; promising he would provide financial support for her and her family.*
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> *Mrs. Q. confided in her mother about the violence. Mrs. Q's mother ignored their daughter's complaints arguing on financial and cultural grounds that "African women should remain loyal to their husbands no matter how bad the situation is" and "the family needs his financial assistance to get by". Mrs. Q. was instructed by her parents not to ask for a divorce because it would embarrass her family to the community.*
>
> *Mrs. Q. was diagnosed with a longstanding major depressive disorder with comorbid anxiety symptoms. Her prognosis was poor if she returned home. Mrs. Q. came to medical attention only after a security guard called an ambulance. She could not go to hospital before this or report the violence to police because she was threatened by her husband if she did so. Indeed, she lacked the freedom to leave her own house, the financial independence to pay for treatment, and the social support of her family. For this reason, she declined to give consent for the doctor to disclose the incident to the authorities or police. What should/would you do if you were the health provider in this situation?*

Tanzania is among the countries with the highest rates of gender-based violence (United States Agency for International Development, 2008) and violence against children (United Nations Children's Fund (UNICEF), 2011) in the world. Culturally, tribal groups differ in how much they view gender-based violence as normal. Some tribes have reputations of defending male-on-female spousal violence as reasonable or required. Given the dire statistics on gender-based violence in Tanzania, in 2011, the government issued guidelines on how health care providers must address gender-based violence and violence against children (United Republic of Tanzania Ministry of Health and Social Welfare, 2011). Healthcare providers must provide

services to victims with utmost respect and adhering to professionalism and medical ethics [Beneficence]. Care practices should begin with the medical and psychological management of the victim, which includes informing the survivor of her/his rights and the collection of proper forensic evidence. The law requires the provider not to "blame the victim" and not to tell the survivor what to do, both of which can increase a survivor's sense of powerlessness [Non-malfeasance]. The law is applicable to all, regardless of the cultural or tribal background of the perpetrator and victim (or provider) [Justice]. The provider must show empathy, ensure confidentiality, provide correct information, safeguard the chain of evidence, and ensure the survivor's physical protection and safety [Non-malfeasance]. In cases of sexual assault, the survivor shall receive HIV post-exposure prophylaxis, treatment for STIs, and emergency contraception (as appropriate) [Beneficence]. Support for the survivor includes referral to police and legal justice involvement (to report the crime), and a plan to ensure that the victim is destined to a safe environment [Justice]. However, when the victim is an adult, the provider must get the consent of the patient (or patient's legal guardian) to report [Autonomy].

2. Treatment of illegal or stigmatized populations

> *A 16-year-old male presents with rectal discharge, which is confirmed to be gonorrhea. Upon inquiry, the youth explains that he has sex with men for money. He begs the nurse not to put anything in the medical record because he has family who work at the hospital, and he is worried if they find out, they will disown him or worse, have him beaten or killed. The nurse believes homosexual activity is sinful. If you were the nurse, what would/should you do? What would/should you write in the medical record?*

The principle that governs all health care approaches is the Hippocratic Oath: "First, do no harm" [Nonmalefeasance]. It is wise to consider what damage might be done by words or deeds that cannot be undone. Here, the harm might be the destruction of a family, the death of a young man, or the destruction of the reputation of the nurse or the clinic. First, until there is a laboratory test and it is a confirmed positive, a diagnosis of gonorrhea is premature pending the outcome of testing. So, recording "rectal gonorrhea" in the record is inappropriate, especially as ano-rectal infections often do not have clear symptoms. However, it would be medically safe and clinically appropriate to give presumptive treatment (which is also treatment for several non-sexual infections) and to provide condoms to the patient to enable cure, curb the spread of the infection and to prevent recurrent infections [Beneficence].

Second, if the young man is selling sex that does not mean that he is "homosexual". It is common for male sex workers to perform sexual acts with men for money, food or shelter. The *activity* may be homosexual, but the sex worker may be heterosexual (i.e., erotically oriented to females, married and identify as heterosexual). Labelling him a "homosexual" or calling him "gay" in the record is inaccurate and could negatively change the course of his life [Non-malfeasance].

Third, there is a very real chance of his being disowned or killed if a clinical confidence is directly broken [Non-malfeasance]. This would make the nurse an accessory if divulging his confidential information led to his harm. It would also signal to the community that neither the clinic nor the nurse can be trusted.

Finally, the nurse's personal religious beliefs are important, but they relate to her/his *own* personal conduct, not the patients. Healthcare practitioners are trained and employed to provide medical attention rather than offer judgmental sentiments.

In this case, the wisest practice in the clinical record is to limit it to medical facts so that if the patient is later treated, there is a record of an anal discharge diagnosed (organism unspecified), and the antibiotic treatment prescribed or provided. In addition, the provider should provide risk reduction counseling to prevent future infections (e.g., condoms) and offer HIV and syphilis testing at that visit [Beneficence]. The provider should put the patient's health first, record only the medically relevant facts, and avoid adding medically unnecessary commentary in the medical record [Justice].

3. Treatment of HIV serodiscordant, non-monogamous and polygamous relationships.

> *As the oldest in her family, Ms. Dworkas who is a nurse has always looked after her siblings as they come to her for advice about their health. From their questions, she knows her younger teenage brother, Chris, is popular with girls. Recently, she discovered he has a new girlfriend. Ms. Dworkas found out that his girlfriend is HIV positive after looking at her chart. She is pretty sure Chris, who is HIV negative, doesn't know. She wonders if she should warn him. If you were Ms. Dworkas, what would/should you do?*

We highlight several cultural aspects of this case. First, family is a central, critically important structure in Tanzanian culture. In Tanzania, older siblings (especially health care professionals) play a real part in the healthcare of their family members. Second, Ms. Dworkas knows that most young men in Tanzania lack both accurate knowledge about sexual transmission of HIV, and most do not practice safer sex. She has the knowledge and is in a position where what she says could save her brother from becoming infected. Third, attitudes towards confidentiality and record keeping practices are less strict than in western countries where confidentiality is viewed differently. For example, in the US, the Health Insurance Portability and Accountability Act (HIPAA), protects the medical record from anyone but the provider looking at it. Many clinics in Tanzania still use paper record keeping, and some still even stamp the HIV status of patients on the front of the file. Thus, in Tanzania, it is relatively easy and common for anyone working in a clinic (or anyone who knows anyone who works in a clinic) to access a medical record.

As we consider this case, we should consider how two related situations would be handled. First, in rural Tanzania, a provider may be the only healthcare professional in a village. If one patient tests HIV positive, has a high viral load, and is continuing to have unprotected sex with several others, the others are the healthcare provider's patients as well. When the healthcare provider sees the sexual partners, the provider needs to consider the competing ethical needs to protect the index patient's confidentiality while promoting the health of all her/his patients. Second, a provider tests a married couple for HIV. The husband comes back positive and the wife is negative. He explains that he has a second wife at home, but doesn't want to tell her his HIV status. If the health professional is the provider for all three people, how should the provider respond?

In this case, and its variants, the nurse must absolutely maintain the confidentiality of the patient [Non-malfeasance]. She can certainly work with the index patient to encourage them to

disclose their status. The nurse can offer to disclose this information, with the patient's express consent, or to suggest the provider and patient disclose to the third party, together [Beneficence]. Otherwise, she can say nothing that might alert her brother, another patient, or the second wife to the index patient's HIV status [Autonomy]. Protecting confidentiality includes anticipating what would happen if she counselled her brother, another patient or the second wife either to get HIV tested or to reduce their risk. In practice, some clinicians may create alternative solutions to promote safety for those at risk. These include coming up for a plausible alternative explanation for why the provider is counseling the brother, a sexual partner or a second spouse. An example might be to say, "We are reminding every patient who comes in this week to think about HIV testing" or "we have a new program to counsel young men your age to avoid unsafe sex." While it is ethical to use such pretexts to protect the health of partners and sexual contacts, the pretexts need to be credible and applied to all [Justice].

4. Illegal healthcare

> *A midwife was on her way to the hospital when she was approached by neighbor, a girl aged 17 years, who is in secondary school. The girl asked to talk. She indicated she had an unwanted pregnancy. She requested the midwife to assist her "to get rid of it" as soon as possible, otherwise, she said she will commit suicide. If you were the midwife, what should/would you do?*

In this case, the midwife invited the girl into the hospital for further discussion and investigations. They went to the counseling room so they could talk confidentially. On history taking, the girl revealed that she was raped by a stranger on her way home from school. The midwife took a blood test and ultrasound to confirm the pregnancy and found 18 weeks gestational age. The midwife informed the girl that if she would have reported immediately after the rape, she could have received emergency contraception to prevent the pregnancy. The midwife counseled the girl to keep the pregnancy because abortion is illegal (and because it was against the midwife's personal moral values). After the girl refused to keep the pregnancy, the midwife decided to refer the girl to the hospital psychologist for further counseling.

There are several legal, ethical, and cultural challenges in this case. The midwife is a role model in her community and cannot do anything that is illegal. However, the midwife is caught in an ethical bind between legal, ethical, and cultural norms. She knows that the girl could end up seeking an unsafe abortion which could lead to complications of sepsis (and ultimately death). She is also aware that, if the girl decides to keep the pregnancy and deliver the baby, the school is required by law to expel her (United Republic of Tanzania, 1978). This will likely be the end of her academic studies which has potential to alter the course of her entire life. A referral to the psychologist was appropriate both because the girl reported being suicidal and to help the girl to receive ongoing support. At a personal level, she is pro-life (i.e., believes in the right of a baby to live), although, she also recognizes that many unwanted babies in Tanzania end-up living and surviving on the street.

While there are debates about how to address the issue of abortion, particularly in situations of rape, the law remains intact. The Penal Code, Chapter 16 of the Laws of Tanzania captures the issue of Abortion in Chapter XV covering – Offences Against Morality. Section 150 provides: *Any person who with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable*

to imprisonment for fourteen years. While the cause of pregnancy may be taken as mitigation against penalty, the law is clear that abortion is illegal in all circumstances.

5. Treatment of women and children in the presence of male authorities

> *A husband and wife present with infertility concerns. When the midwife suggests the husband leaves so she can conduct a gynecologic exam, the husband refuses to leave. He says he is her husband and has a right to see and hear everything the midwife advises his wife. If you were the midwife, what would/should you do?*

Privacy in the provision of healthcare is a fundamental human right and indicator of quality of care. While much effort has been directed towards the provision of privacy of health information, there is still limited attention in maintaining privacy and confidentiality when taking a history and in physical examinations. Constraints in space, health facility set up, and medical supplies, have been cited as reasons for failure to maintain such privacy and confidentiality (Mselle, Kohi, & Dol, 2019).

In a male-dominated society like Tanzania, women may lack autonomy to make decisions on various family and personal issues. This includes rights for privacy in healthcare. Legally, the husband has the right to the private information of a patient and/or to be present during an examination provided the patient gives her informed consent for such access (Francis et al., 2017). Similarly, a father or guardian has the legal right to be present during his child's gynecological exam, but the provider should ensure it is done with the child's assent. Albeit rare, due to lack of private space in most public health facilities in Tanzania, when a woman consents, a husband may be allowed, for example, into a delivery room during childbirth.

In circumstances where a woman has a sensitive medical condition or requires a private examination such as a gynecological examination and the husband requests to be present, the health provider must ask the woman for her consent [Autonomy]. To do this ethically, a healthcare worker would, without the husband and in privacy, inform the woman about the husband's request and independently verify if the woman is freely giving consent. The cultural challenge raised in scenario is the fact that in extreme male-dominated relationships (of husband-wife or father-daughter), a woman may consent out of fear of the husband's or father's reaction if they refused.

6. Addressing abuse of minors

> *Ms. B. is a student who studies midwifery in Dar es Salaam. Four years ago, she brought her 4-year-old son, Pete, to a Child and Adolescent Psychiatry Clinic. Her child's symptoms included excessive worries, fear towards men and strangers, and frequent panic attacks. These problems started when she left her son back home (upcountry) with her older brother's family in order to pursue her studies. For six months, her son was sexually abused by her brother, his uncle John. John would threaten Pete that he would be punished if he said anything, molest him, and then give him treats.*
>
> *When it was discovered, John and his wife separated. John's wife implored Ms. B to go and fetch her son from her ex-husband's house. Ms. B did so, finding her son traumatized, physically and mentally. But when she confided to her mother, the mother appeared less concerned about Pete (her grandson) than what would happen*

to John (her son). Her mother pleaded with Ms. B that she should not report John to the police. Instead, they should resolve the case at a family level by elder family members.

Ms. B. decided to first deal with her son's symptoms by seeking medical help. Later, when she confronted her brother, he denied the accusations. On their first family meeting, the family elders asked to Ms. B. to not press charges. If she did, she was warned the family would disown her and she and her son would be chased out of the village. If you were Mrs. B., What would/should you do?

In Tanzania, the "Law of the Child Act, 2009" (United Republic of Tanzania, 2009) defines child abuse as "contravention of the rights of the child by causing physical, moral, or emotional harm, including beatings, insults, discrimination, neglect, sexual abuse, and exploitative labor." Further, section 95 requires "any member of the community who has evidence or information that a child's rights are being infringed … [must] report the matter to the local government authority." From the provider's perspective, any time the provider knows the name of a minor under 18 years who is at imminent risk of serious harm, they are required to report the child to the appropriate authority [Justice]. In larger cities this is normally to the local Department of Social Welfare; or where that is not possible, to the local leaders at village or street level who in turn report to the police. The way the law is worded, the provider can explain they have no choice since health care providers are required to report all child abuse. Two aspects of the law as worded in Tanzania are worth noting. The duty is to report either the child and/or a parent, guardian or relative who has custody of a child. And the abuse needs to be current, ongoing, or imminent to trigger a duty to disclose.

DISCUSSION

The ethical principles health care providers hold paramount and the obligations providers have been universal. Yet, as the case studies above illustrate, complex cultural, tribal, legal, family, relational and other "social environmental" factors intersect with the legal environment and other factors, which all contribute to how providers experience and interpret ethical challenges. Complicating matters further, the physical environment (e.g., limited resources, space for confidential discussions, time) may make ethical practice challenging. And while some ethical obligations may vary by profession, all providers have a responsibility to promote the highest ethical standards.

Health care providers cannot simply rely on the law when considering ethical sexual health dilemmas. Sometimes, advancing the sexual health of patients and communities can mean challenging the *status quo* regarding current law. Three recent examples include, first, the challenge by the High Court to the current law that boys cannot consent for marriage until 18 years of age but girls can marry at 15 (with their parent's consent) [See the Rebeca Gyumi Case above]. Second, Tanzania is required by its international obligations to provide reproductive health services in the case of rape, but its laws remain more restrictive, making it difficult to provide or refer for such services, even when ethically and clinically appropriate. Third, the government's policy that pregnant students should be expelled from school creates a challenge for healthcare providers to weigh what is best for the patient against the pressure to report.

Socially, there is pressure on the government by the World Bank to allow these girls back to school after delivery.

Health care in Tanzania is almost always an exercise in providing care within a resource-constrained setting. Lack of confidentiality, time, an overwhelming number of patients, limited access to treatments, and the huge difference between public and private care are daily realities in most care settings. Unfortunately, this can lead to a second ethical danger: confusing what should be done with what can be done. Just because it can be done, does not mean it should be done. The second and third cases highlight the ethical challenges of what to write or not write in a medical record. Just because it is possible to review a patient's record does not give a provider the right to see a person's confidential information or to share that information with someone else. In resource-rich settings, legal protections, technology (e.g., electronic medical records), and oversight (e.g., audits) have reduced the risk of ethical abuses in these areas.

The cultural, social and familial context is a third dimension that providers working in Tanzania need to be cognizant of. On the positive side, asking about a patient's cultural, social, familial and personal situation can really help in providing culturally-appropriate, sensitive care. Especially when dealing with trauma (including sexual abuse), appreciating the cultural context can aid treatment, prognosis, sensitivity and healing. On the negative side, when a tribe, a community, a family, or a spouse endorses violence or other threats to health, it is imperative for healthcare providers to put the health and safety of the patient first and foremost.

Just as it is critical for healthcare professionals to recognize the cultural, social, familial and relational challenges our patients have, it is equally important to recognize that for those of us born and trained in Tanzania, we are the products of our culture as well. (Immigrants and those trained outside Tanzania have a complementary challenge of recognizing outside cultural influences in providing healthcare). As the third and fourth cases illustrate, providers have multiple competing demands on the role that they must play in the lives of their patients and in their communities. Two ethical principles here guide practice. First, regardless of what is happening in their families or communities, providers must provide the best healthcare to each patient. That includes ensuring their confidentiality is protected. To do otherwise risks destroying one's own personal reputation and can sow distrust of health professionals across the community. Similarly, in the fifth and sixth cases, professionals must prioritize the rights of women, children, and the most vulnerable.

Finally, health care providers should never feel obligated to practice alone. Even when a provider is the only provider in a community, it is critical to consult when ethically conflicted. Providers should weigh the costs and benefits of a course of action with an experienced colleague who can provide an unbiased opinion. This can also mean reaching out to a mentor, former teachers, or the board overseeing your license.

What does it mean to provide health care justly and without prejudice? Three ethical practices, reflected in clinical skills, are important to nurture. First, it is important to be able to distinguish between one's own personal values or biases, and the values and biases held as a professional. Regardless of one's personal, religious, cultural, political or other beliefs, gender and other demographics, and even advocacy of various causes, when at work professionals reflect the values of their profession.

Second, cultivating humility is critical to working in sexual health. Part of being non-judgmental is to recognize that a patient usually knows far more about what will work or not work for them. In sexual health, models of counselling emphasize providing permission and validation for the patient to talk about their sexual health concern (Jack S Annon, 1976; Robinson, Bockting, Rosser, Miner, & Coleman, 2000; Taylor & Davis, 2006). Shared decision-making is an approach to medical intervention where the health provider and patient jointly consider what treatment, if any, is most appropriate (Charles, Gafni, & Whelan, 1997; Elwyn et al., 2010). Indeed, research confirms that many sexual concerns can be solved by the patient working out their own solutions to the presenting concern (J.S. Annon, 1976).

Third, when considering how to treat a sexual concern, it is important to be evidence-based. Sexual health is an area where a lot of exciting advances are occurring, locally, nationally, and internationally. In the last decade, HIV has diminished from a death sentence to a manageable chronic condition. The promotion of sexual rights as inherent and universal has changed how society thinks about women, young people, children and key populations (i.e., sex workers, prisoners, drug users, and sexual and gender minorities). Sexual health remains one of the most fundamental and fascinating parts, not only of health but of society. Health professionals working in policy and advocates working on advancing sexual health have a special obligation to keep informed about the latest research, and to interpret findings honestly and, as far as humanly possible, without prejudice. The ethical standard is to be guided by the evidence (not twisting the evidence or picking particular findings to promote an agenda).

Tanzania, like other countries in Africa, has an additional challenge. Most of the scientific evidence in sexual treatments has been conducted in developed countries. When considering importing programs from other countries, it is ethically imperative to balance the requirement to faithfully replicate the intervention in Tanzania (so it does not lose its effectiveness) with the need to adapt it to the cultural context. Cultivating a curiosity about what is new (in sexual health research), about the diversity of our patients' lives, and about movements for better sexual health locally, nationally and internationally, can help inspire practitioners to work towards improving sexual health in Tanzania.

Declaration of Interest Statement

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