

# Ethics in reproductive health: clinical issues in Zimbabwe

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## Abstract

Reproductive health can present health practitioners with ethical problems because of the complex interaction between cultural practices, the laws of the country and individual personal preferences. In particular, the problems of pregnancy, sexually transmitted infections, family planning, sexual violence, and domestic abuse require a good knowledge of the laws of the country and the culture in which they operate. The practitioner should at all times respect the patient's autonomy and serve their best interests, whilst keeping in mind the legitimate interest of their partners, spouses, parents or guardians.

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## Introduction

Ethical issues in reproductive medicine have become topical in developing countries because of the increasing concern about the failure to deal with the high prevalence of HIV infection and AIDS, maternal mortality, unsafe abortion, sexually transmitted infections, infertility, rape and physical abuse of women. Reproductive health involves several disciplines (urology, obstetrics and gynaecology, nursing, midwifery, paediatrics, internal medicine), and health practitioners working in these areas need to be aware of the ethical problems that may arise in clinical care. The basic ethical principles in reproductive health care are no different from the universally agreed general guidelines in medicine. Some of these have already been discussed in previous articles.<sup>1-3</sup> This article will specifically discuss ethical issues which health practitioners are likely to meet in clinical care in Zimbabwe. Most of the discussion will also apply to those countries in sub-Saharan Africa whose legal systems have similar origins in Roman-Dutch law. The paper is written with girls and women in mind since clinically they bear the greater burden of reproductive health problems.

### Legislation and Conventions in Reproductive Health.

Unfortunately, there is no single source for the ethical principles in reproductive health. Ethical principles in medicine are derived from historical declarations, international conventions, acts of parliament, and guidelines of the regulatory authorities in the different countries. The international conventions and recent declarations which affect reproductive health are shown in Table I. Not all governments in sub-Saharan Africa have signed these conventions or declarations, and many which have done so have not introduced the legislation to make these conventions operative in their countries.

*Table I: International conventions and declarations relevant to reproductive health care.*

1948	Universal Declaration of Human Rights
1979	Convention on the Elimination of all forms of Discrimination against Women
1989	Convention of the Rights of the Child
1994	Cairo Declaration on Population and Development
1995	Beijing Declaration on Women

In Zimbabwe, the acts of parliament which have the most direct impact on reproductive health are shown in Table II. In addition to these acts, the conduct of health professionals in Zimbabwe in relation to their patients is laid down by a code of ethics published by the Health Professions Council<sup>4</sup> and regulations laid down by parliament.<sup>5</sup> Every practitioner should familiarise themselves with the content of these documents.

*Table II: Acts of Zimbabwe with direct impact on reproductive health.*

Customary Marriages Act	1917
Public Health Act	1925
Marriage Act	1964
Legal Age of Majority act	1982
Termination of Pregnancy Act	1977
Infanticide Act	1990
Sexual Offences Act	2001

### Cultural Values and Ethical Principles.

Reproduction is a central fact of human life and many cultural values and practices have evolved around it which are often in conflict with the international conventions and laws mentioned above. This situation is not unique to the developing countries, as illustrated by the current

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controversies involving new techniques such as *in vitro* fertilisation, surrogate motherhood and embryo research in developed countries.

The greatest challenge for the health practitioner in Zimbabwe and in the surrounding countries is the cultural attitude that a woman is always a minor, irrespective of her age or social status. This attitude conflicts directly with several laws and conventions and the resulting ethical problems are felt throughout the whole spectrum of reproductive health. Knowledge of the cultural background of the clients, and sensitivity to their values are therefore indispensable to the practitioner. Resolving these issues in a particular case requires time, which should be spent listening and attempting to understand the issues. Unfortunately, the time available during the average consultation is usually not enough for a proper exploration of the issues. In handling such conflicts, health practitioners should be prepared to consult colleagues who are more senior or familiar with the cultural background of the patient. The discussions which follow will be illustrated with examples showing how the conflicts can be resolved.

#### **Pregnancy.**

In general, maternal rights supersede foetal rights throughout pregnancy. However, the foetus also has rights and these are recognised in law by the distinction between an abortion and a live or stillbirth. The time of this distinction under current law is 28 weeks, but this has been overtaken by improvements in pregnancy care. Babies born after 22 weeks may survive, and any decision to terminate a pregnancy after this gestation should be for overriding maternal interest, and take into consideration foetal viability.

Normally maternal and foetal rights converge, but in cases where they diverge for any reason, termination of pregnancy may be considered. In Zimbabwe the Termination of Pregnancy Act of 1977<sup>6</sup> allows this to be performed for three main indications: physical risk to the life of the mother, presence of foetal abnormalities and a pregnancy resulting from rape, incest or unlawful intercourse. Psychological or social factors are not considered acceptable grounds for termination of pregnancy under this Act. However, maternal infection by HIV constitutes a significant health risk to the foetus and this indication is now accepted by the authorities.

The Act requires signed consent by the woman herself backed by two doctors before it is sent to the authorities. Women above the age of majority (18 years) do not need the co-signature of their husband or partner,<sup>7</sup> although it is always wise to involve them and to recommend this to the woman. If a situation arises in which a partner disagrees with a woman's request for termination, the doctor is bound to follow the woman's wishes, after counselling the couple.

If the patient is between 16 and 18 years, the law requires the consent of the parents or a guardian. In their absence, permission has to be sought from a magistrate of the court. Reluctance by such a minor to involve parents/guardians is

not unusual and in such cases an application has to be made to a magistrate's court. The practitioner should spend time finding out the reason for the reluctance in order to uncover any undisclosed rape, incest or other domestic problems. In girls under 16 years, except where the boy responsible is also under 16 years of age, the pregnancy is deemed to be the result of unlawful intercourse. In such cases, the permission has to be granted by a magistrate's court, even if parents or guardians are available (Sexual Offences Act 2001).

Although the Termination of Pregnancy Act does not allow termination for psychological stress arising out of an unwanted pregnancy, mental disease which constitutes risk to the life of the mother can justify a request. Women who are mentally incompetent or institutionalised for mental disease or handicap can have a request made on their behalf since intercourse with such a person is deemed unlawful.<sup>8</sup> Women with such mental problems are vulnerable to sexual abuse and should be adequately protected as a primary measure.

The Act provides for permission to be sought retrospectively, in cases of medical emergencies. The full documentation should be sent to the authorities within 48 hours of the procedure.

Practitioners who are unwilling to be involved with termination of pregnancy for any reason have an obligation to refer the patient to those who can assist the woman. The religious or moral beliefs of the practitioner should not lead to a denial of treatment to which the patient is legally entitled.

#### **Surgery and Anaesthesia in Obstetrics and Gynaecology.**

Contrary to common misconception, there is no separate law regarding surgery in obstetrics and gynaecology, as opposed to surgery in other areas of medicine. The same law applies regarding informed consent. Women above 18 years can therefore give consent in their own right to any surgery or anaesthesia without consulting a male partner or relative. During pregnancy, however, if the woman is in a harmonious relationship, it can be assumed that her partner has a legitimate interest in the outcome of that pregnancy. His interest and concern can be taken into account by keeping him informed and it is good clinical practice to encourage men to be involved with their partners' pregnancies. However, even in married couples it would be illegal to insist on the husband's signature, say before performing a Caesarean section, for example. This would be an infringement of her right to autonomy under the Legal Age of Majority Act of 1982. Before then, consent forms for obstetric surgery in hospitals reserved a space for the husband's signature, but these have now fallen away. The fact that it is a strong cultural belief that the husband must make such decisions should not lead to a delay or denial of treatment. Unfortunately staff in clinics and hospitals have been slow to accept the implications of this Act, and women continue to face humiliation over their rights. Senior health practitioners have a duty to educate

their colleagues about this Act, to make them more responsive to the client's wishes.

Girls under the age of 18 years need the consent of a parent or guardian, with the qualification that in severe maternal illness or acute emergencies, the practitioner may perform a life-saving operation without such consent and provide the justification later. For cold gynaecology surgery however, it is best to obtain this consent, or to consult a magistrate if no parent or guardian exists.

### **Family Planning.**

The average woman who reaches the age of 50 years and who has had four children will have spent at least 25 of her 37 years of fertility avoiding pregnancy. Because pregnancy still constitutes a substantial risk to the life of a woman, as a general principle family planning (FP) should be denied to those who seek it only in very exceptional circumstances. This includes even in the case of minors, as will be discussed below.

There are no specific laws regarding the provision of family planning and the two main relevant Acts in Zimbabwe are the Legal Age of Majority Act (1982), and the Sexual Offences Act (2001). Any adult woman who requests family planning should be assisted, preferably with the knowledge of her partner. Counselling of both partners is now standard clinical practice. The problem arises when a woman would like a family planning method without the knowledge of her partner. There are certain methods (injectables, implants, even tablets) which can be used by women without the partner's knowledge. Among the reasons given by men for their opposition to birth control are fear of promiscuity or infidelity by the partner. Other men claim that some methods of family planning cause loss of libido in their partners, which is true in the case of certain hormonal methods.

A woman making such a request should be advised that it is the standard practice for the couple to be counselled together, but she should still be assisted if she insists on obtaining a method. Consultation with a colleague (with the woman's permission) and adequate documentation are recommended, in case any problems arise. The woman should be warned of the consequences of inadvertent discovery by the partner and the implications to the relationship of this. However, there are no legal repercussions for the practitioner if he/she has acted in her best interests, and in any case the Legal Age of Majority Act (1982) safeguards the woman's right to autonomy.

If the husband would like a pregnancy, and this is his reason for not agreeing with birth control, then some counselling is definitely required for the couple. It has been argued that the expectation to bear children is implicit in the contract of marriage. This, however, is only an expectation, and not a right. A married woman who refuses to conceive breaks no laws. Most women who request FP methods, which they can use secretly, do so after having had several children. They are only refusing to accede to unreasonable demands.

Tubal ligation deserves special mention because it is a permanent method. Again no written permission is required

from the partner of an adult woman and the consent forms of the Zimbabwe Ministry of Health and Child Welfare have now been changed to reflect this. A space has been left on the form for the partner to sign but this is now optional and is for those couples who feel happier that they have both signed. Hospital forms which still make it mandatory for the woman to seek a partner's consent are now illegal.

A special problem for health practitioners is when minors seek family planning. If they are between 16 and 18 years, they are above the age of consent for sex, so they can be given contraception, after careful consideration of the circumstances. It should still be the aim of the practitioner to dissuade sexual activity until a stable lifelong union has been formed, and to inform the minor of the risk of infection, which most contraceptive methods do not protect against. However, once sexual activity has started, it will likely continue despite the practitioner's exhortations, and it may be the greater risk not to protect her with contraceptives. The minor should be advised to bring her parents, although in most cases this will not happen. If the practitioner is convinced that it is in her interests to accede to her request, and the advice given has been documented, then she should be prescribed contraceptives. The male or female condom, if used correctly, is the best in these circumstances, as it will protect both against pregnancy and infections.

The above guidelines are also recommended for girls above the age of 12 but under the age of 16 years, but more care is needed with the counselling process since sex is considered unlawful in this age group, and this has been reinforced in the Sexual Offences Act of 2001. These guidelines were challenged in the United Kingdom in a case brought by Mrs Victoria Gillick against the Department of Health and Security. However, she lost the case in the House of Lords.<sup>9</sup> In the rest of Western Europe and North America, similar guidelines in one form or another allow girls under 16 years to obtain contraceptives without parental consent, without the practitioner being accused of aiding and abetting unlawful intercourse.<sup>10</sup> More care should be taken in this age group to ensure that the girl is not seeking contraception to protect herself against exploitative sex (eg. with a much older partner, prostitution, incest or exploitation by employers). In practice, few girls in this age group present with such requests in sub-Saharan Africa, and practitioners will face such dilemmas very infrequently. Table III summarises the recommended steps in counselling such clients.

### **Confidentiality and Sexually Transmitted Infections.**

Confidentiality is such an important principle of health care that patients can only lose their right to it in exceptional circumstances. Patients with certain sexually transmitted infections lose their right to confidentiality if this infection is a notifiable disease under the Public Health Act.<sup>11</sup> Under this Act the practitioner can undertake contact tracing and treatment of partners of those with venereal diseases. However, HIV infection is not a notifiable disease, which causes problems if the result is only known for one partner.

**Table III: Recommended steps in the counselling of a 12 to 16 year old girl requesting family planning.**

1. Collect accurate personal, family and social history, including knowledge of risks. Exclude exploitative sex.
2. Dissuade sexual activity, informing her of the psycho-social and physical risks.
3. Recommend involving the parents or guardians.
4. If steps two and three fail, or are not appropriate, prescribe or recommend a barrier method of family planning.
5. If barrier methods not appropriate, prescribe a low dose hormonal method.
6. Document all the above steps.
7. Review frequently.

This problem arises specifically because only one of a couple has been tested. If there is any need for an HIV test, both partners of a stable union should be counselled to take the test together, and each should inform the other partner of the result. However, the practice of testing one spouse, or testing both unbeknown to each other continues, and the clinician is often confronted with the situation in which the male partner is HIV positive and the female is still HIV negative. It is the common experience that the male will either deny the result, or refuse to inform the female partner. He may also refuse to use safe sex practices. The practitioner should advise the male (or female as the case may be!) that it is in their best interests, and that of the spouse (and any children) that the result should be divulged. Such an appeal to the welfare of the spouse and children sometimes resolves the issue, although the counselling session requires a lot of time. If he is still unwilling to divulge his status, he should be informed that the practitioner may do so anyway because it can be justified in order to save the life of the spouse. He should also be informed that under the new Sexual Offences Act (2001), it is an offence to knowingly transmit HIV infection, and that this is punishable by jail, fine or both. Practitioners who hide behind confidentiality and neglect their duty to the HIV negative spouse are either unwilling to devote time for proper counselling as outlined above, or are guilty of professional cowardice.

#### **Intimate Examinations.**

Many practitioners in Zimbabwe are still examining patients of the opposite sex without chaperones. This should be discouraged strongly, especially in the case of male practitioners examining female patients. A chaperone need not be present at the history-taking, but should be present during the physical examination. A few patients will request the chaperone to leave, which they should do, preferably after hearing the patient make the request themselves. The mother of a minor should not be considered as an 'automatic' chaperone and such girls should be informed that they may choose the usual chaperone if they so wish.

Failure to use a chaperone may result in a practitioner being unable to defend themselves against a charge of improper advances or indecent assault. Even if such a charge has been made falsely, and it is successfully defended

against, the damage to the practitioner's reputation may be irreparable.

#### **Rape, Sexual and Physical Abuse.**

Practitioners are often faced with patients who are alleged to have been raped or sexually abused. This subject usually demands an article on its own, so in this review only the general principles will be discussed. The quality of medical evidence depends so much on the assessment done by the practitioner who sees the patient first. Doctors attending to children or women should be competent in the relevant procedures, or refer such patients immediately to those with better skills. A manual of the guidelines and a rape kit are available from the Family Support Clinic, Harare Central Hospital. Family practitioners or district medical officers can also seek advice on the telephone from consultants on duty at the following hospitals: Avenues Clinic, Harare Central and Parirenyatwa Hospitals in Harare; United Bulawayo Hospitals, Mpilo, and Mater Dei Hospitals in Bulawayo. These hospitals have gynaecologists on duty 24 hours a day.

The patient should be accorded privacy and made to feel as comfortable as possible. It is possible to be sympathetic and compassionate with the patient without losing one's objectivity with history-taking and examination. The medical evidence should be assembled as meticulously and dispassionately as possible, and if the practitioner is uncertain about the procedures or any findings, it is better to seek a second opinion early. The patient should be tested for sexually transmitted infections (STIs) and pregnancy at the first contact but also later. Serological tests for certain STIs take several weeks to convert and should be repeated after three months. All rape and sexual abuse victims should be given an antibiotic regime to cover for syphilis, gonorrhea and chlamydia, and a course of prophylactic anti-retroviral drugs for HIV infection. Those not pregnant should also be given emergency post coital contraception.

An ethical issue arises especially in cases of sexual or physical abuse where the practitioner becomes aware of the problem incidentally, before it has been reported to the police. In cases of incest, the issue may threaten to tear the family apart, and the mother and child may implore the doctor to remain silent. However, the interests of the child or woman are seldom served by remaining silent. The worst cases reported in the mass media are always of instances where the abuse continued because the doctors, social workers, teachers and others remained silent, ostensibly to protect the family. If the evidence of sexual/physical abuse is unequivocal, it is the practitioner's duty to report the matter to the relevant authorities, and allow the law to take its course.

The Sexual Offences Act (2001)<sup>8</sup> has now updated several issues to bring them in line with new developments. Rape is now defined as non-consensual sex with anyone, which means rape within marriage is now an offence. Any intercourse with a girl under the age of 16 years is unlawful, unless the perpetrator is a boy in the same age group. The Act also says that any intercourse between a girl of less

than 16 years and a parent, step-parent or adoptive parent is rape. The age below which a person cannot consent to sex or be prosecuted for rape is now 12 years instead of 14. It is also worth noting that under the Marriage Act (Chapter 5:11),<sup>12</sup> a girl of under 16 years cannot get married, and between 16 and 18 years can only marry with the consent of parents or guardians.

However, a loophole still exists because under the Sexual Offences Act, consensual sex with a girl between the ages of 12 and 16 years is only unlawful if it is extramarital. The Customary Marriages Act (Chapter 5:07)<sup>13</sup> allows girls within this age group to marry with the consent of their parents or guardians. There is, therefore, a continuing risk of sexual exploitation of girls under the age of 16 years, especially of those from poor families, religious cults or deeply traditional communities. It is hoped that in the near future these laws will be reconciled, by repealing or superseding the Customary Marriages Act.

#### **Infanticide, Foeticide and Criminal Abortion.**

The practitioner sometimes becomes aware of infanticide, foeticide and criminal abortion before the crime has been reported to the police. In cases of infanticide and foeticide (unlawful death of the foetus after 28 weeks), it is clearly the duty of the practitioner to report the matter to the police. The practitioner must also examine the circumstances of the pregnancy and its aftermath carefully to determine if any mental instability or unfavourable social factors need to be brought to the attention of the court. Mental disturbance during pregnancy is not rare, and puerperal psychosis is fairly common and both may lead to harm of the foetus or infant. The practitioner must also determine if the pregnancy had resulted from rape, incest or unlawful intercourse, even if this had not been previously reported by the woman. The Infanticide Act of 1990<sup>14</sup> takes such factors into account in changing the charge from that of murder to the lesser one of infanticide.

It is more difficult to report every case of criminal abortion even if the legal obligation is still clearly for the practitioner to do so. Firstly, detailed history taking usually elicits severe mental stress leading up to the criminal abortion. The Infanticide Act allows for this but not the Termination of Pregnancy Act. Secondly, such history taking often uncovers unreported rape, incest or unlawful intercourse as the cause of the pregnancy. The woman and the practitioner are aware that reporting this retrospectively will not be credible. Thirdly, it is simply not practical for the practitioners or the police to report every case, because of the large numbers involved. The average gynaecologist working in a public hospital would be in court giving evidence every week if all cases were reported! Lastly, but perhaps most important, the vast majority of criminal abortions are undetected because they either do not present with physical evidence of criminal abortion, or do not even come to hospital. Is it morally justifiable to report and aggressively prosecute the tiny minority who are discovered, whilst the vast majority escape? Practitioners should be aware that reporting such women routinely to the police may result in more deaths from criminal abortions as those

with complications may shun the hospitals. The Termination of Pregnancy Act needs reviewing in these and other aspects.

## **Conclusion**

This paper has described the main ethical issues which clinicians face in reproductive health. In many cases the law is clear and the practitioner is faced with few ethical problems. In other cases the law is clear but cultural factors or individual patient requirements may present the practitioner with morally difficult choices. Ethically, the ideal outcome is obtained when the patient's best interests are served within the legal framework. The guidelines presented here dealt with situations where there is conflict between the cultural environment, the legal framework and the patient's interests.

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