Stump the Professor:
Complex Cultural/Ethical Dilemmas

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Case # 1

- This patient is a 26 yo survivor of sexual and gender-based volence (SGBV) in the Democratic Republic of Congo, where she was repeatedly gang raped by militia forces who raided her village. She contracted HIV as a result and has since suffered PTSD, insomnia, and suicidality.

- This is the first time since her arrival in the U.S. that she has felt safe to openly disclose her SGBV experience, and becomes very tearful and emotional.

- She is currently pregnant, and her sexual partner (who is the father of the baby), also happens to be married with children and is unaware of her HIV+ status.

Case # 1

- The patient discloses that she will not inform her sexual partner of her HIV + status.

- She fears severe ramifications in her community, loss of confidentiality, cultural implications of losing respect and social support, and may possibly even face retaliation against her by her partner.

- If approached by public health officials and social workers regarding her HIV non-disclosure, the patient intends to state that she has no idea who her sexual partner was.

Case # 1

- History of Sexual and Gender-Based Violence (SGBV)
- HIV+
- PTSD, suicidality
- Pregnancy
- Stigma, Shame
  - SGBV
  - HIV
  - Mental Health
- Socio-cultural ramifications within local community
- HIV non-disclosure

Case # 1

- Referral to Behavioral Health evaluation/treatment/counseling for SGBV exposure
  - Trauma-informed care
  - Support groups
- HIV care on HAART
- Prenatal care
- Engage multi-disciplinary team
  - OB/GYN provider
  - HIV provider
  - Social Worker/Case manager
  - Cultural Health Navigator (trusted, shared culture/language)
- Ongoing efforts to encourage patient to disclose HIV status to partner
  - Safe sex practices
  - Overcome stigma on condom use
- Ongoing efforts to engage local community
  - Education on SGBV
  - Stigma reduction
  - Community re-integration
  - Social Support

Case # 2

- A 24 y.o. G1P0 Somali woman presents to L&D in active labor at 39 5 wks GA. She has undergone Type III Female Genital Cutting (FGC) or ***infibulation*** with resultant dyspareunia and inability to achieve penile-vaginal intercourse.

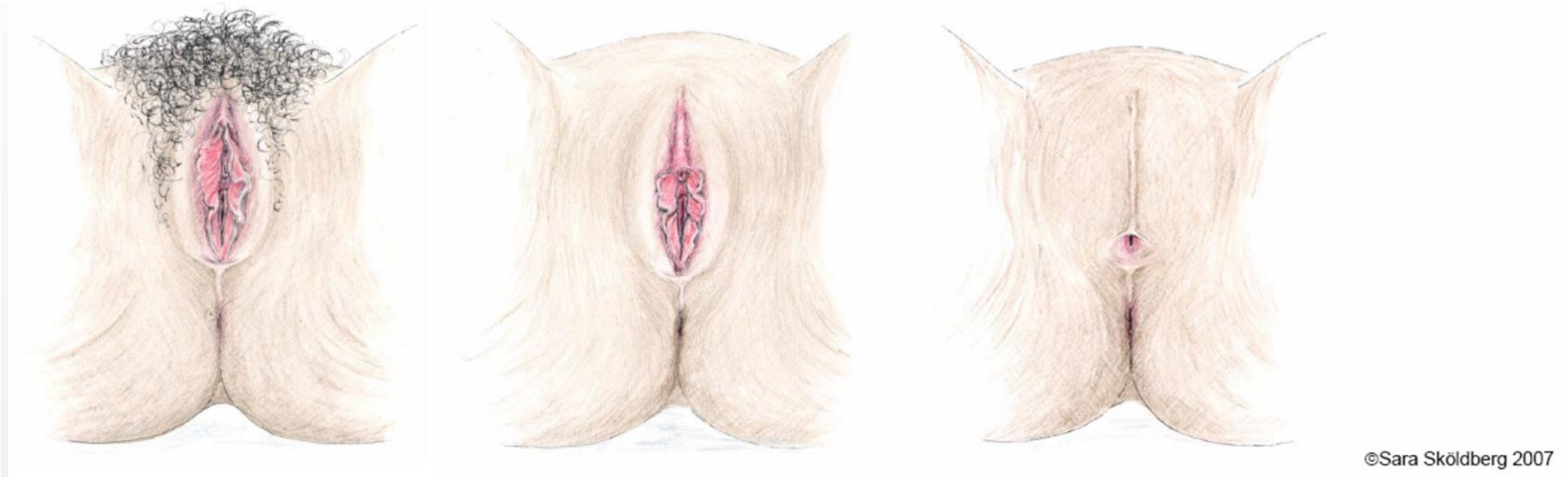
- Throughout her prenatal care, has made it clear that she desires her vulvar scar to be permanently opened at the time of delivery.

- In the labor room, she is surrounded by her mother, grandmother, mother-in-law, aunts, and cousins, all of whom are there to offer their support throughout her labor.

- When you reiterate the agreed upon plan to open her circumcision scar at the time of delivery, her family starts to frown, shake their heads and wave **'No'**, for which the patient changes her mind and desires her scar put back together after delivery (re-infibulation).

- How do you proceed?

Distinguishing the FGC Types



Case # 2

- Cultural mores may not uphold western ideals of patient autonomy
- Family/Community social support (+/-)
  - What are ramifications of non-compliance?

Case # 2

- Engage pt's partner in discussion/counseling
  - Antenatally
  - And again at the time of labor
- Consider antenatal defibulation (if timing appropriate)
- At the time of labor, re-engage in discussion with patient and her partner ***without*** extended family members present
- Legal implications
- Provider discomfort/unfamiliarity
- Consider option of partial re-infibulation

Key Pearls to Consider……

- Engender trust
  - Fostered over time
- Gender-match provider/interpreter
- Engage multi-disciplinary team
- Peer Navigator(shared culture/language)
  - May serve as bridge between health care system and patient's family/community
- Consider patient's local socio-cultural environment
  - Social pressures, stigma, repercussions
  - Community education is essential