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The management of childhood sexual abuse by midwifery, nursing and medical providers in Tanzania

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Abstract

Background: Child sexual abuse (CSA) is a significant public health problem affecting one billion children aged 2 to 17 globally. The prevalence of CSA in Tanzania is one of the highest; however, how health care providers manage CSA cases has not been studied.

Objectives: This study investigated how medical, nursing, and midwifery professionals in Tanzania handle cases of CSA and identified the factors that facilitate or impede the provision of quality care to CSA victims.

Methods: Participants were 60 experienced healthcare professionals and 61 health students working in Dar es Salaam, Tanzania. We conducted 18 focus groups stratified by profession (midwifery, nursing, or medicine) and experience (practitioners versus students).

Results: Three main themes emerged. First, child abuse management involved using a multi-disciplinary approach, including proper history taking, physical assessment, treatment, and referral. Second, factors that enhanced disclosure of CSA included building rapport, privacy, and confidentiality. Third, factors that impeded care included fear of harm to the child if the abuse was reported, abuse reporting being perceived as a “waste of time” for providers, loss of evidence from the victim, family resistance, poverty, corruption and cultural dynamics.

Conclusions: Midwives, nurses and doctors were all experienced in and reported similar challenges in addressing CSA. At a structural level, the ratio of providers to patients in health facilities inhibits quality care. These findings have implications for strengthening CSA policy/ guidelines and clinical practice in Tanzania. Mandated CSA training is necessary for midwifery,

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nursing, and medical students as well as in continuing education courses for more experienced providers.

Keywords

Child sexual abuse; Healthcare professionals; Practitioners; Tanzania; Africa

1. Introduction

Child sexual abuse (CSA) is a significant public health problem affecting an estimated one billion children aged 2 to 17 globally (Deputy Secretary General, 2018, Hillis, Mercy, Amobi, & Kress, 2016), with Africa and Australia being the regions with the highest CSA rates (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). In Tanzania, CSA poses a significant threat to the development of the children and efforts to attain the United Nation's Convention on the Right of the Child and Sustainable Development Goals (SDGs) by 2030. Specifically, target 16.2 of the SDGs aims to "end abuse, exploitation, trafficking and all forms of violence against, and torture of children because it is a right of every child to live free from fear, neglect, abuse and all forms of exploitation" (Department of Economic and Social Affairs Sustainable Development (2016). The World Health Organization (2006) defines CSA as.

involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are—by virtue of their life or stage of development—in a position of responsibility, trust or power over the victim (p.10).

These quotes provide a definition of CSA and grounds for why child rights and wellbeing are essential and need to be protected.

The Deputy Secretary General (2018) states that one in ten girls under the age of 20 have been forced to engage in sex or to perform sexual acts and that "millions more, including millions of boys, never tell anyone" about being abused for fear of stigma or reprisals (para. 3). In a meta-analysis carried out by Pereda and colleagues, Africa was found to have the highest prevalence of CSA (34.4%) compared to Europe (9.2%), the United States of America (15.8%), Asia (10.1%), and Oceania (23.9%) respectively (Pereda, Guilera, Forns, & Gómez-Benito, 2009a). Among 22 countries studied, South Africa was ranked as the country with the highest prevalence rates of both male (60.9%) and female children (43.7%) who experienced sexual abuse before age 18. Tanzania ranked third in the list, with 25% of male and 31% of female children experiencing abuse before age 18 (Pereda et al., 2009a). Further literature review confirms that female children in Tanzania and Ethiopia (21.6–68.7%) and male children in South Africa (4.1–60%) are experiencing the highest incidences of CSA in Africa (Pereda, Guilera, Forns, & Gómez-Benito, 2009b). Although the literature reveals conflicting data about CSA's prevalence in Tanzania and its incidence rate relative to the African continent, overall, the alarming rate of CSA in Tanzania calls for immediate attention, powerful policy changes, and increased interventions to address the problem. Unfortunately, there is limited literature on CSA in Sub-Saharan Africa, including

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in Tanzania, due to unreported and undocumented incidents (Badoe, 2017; Lalor, 2004, 2005; Pereda et al., 2009b).

In 2009, the Tanzanian government passed the "Law of the Child Act, 2009" which defines CSA as any sexual contact with a minor less than 18 years of age (The United Republic of Tanzania URT, 2009). Once CSA had been criminalized, the Tanzanian government conducted the national Violence Against Children (VAC) survey to assess the magnitude of the problem (United Nations Children's Fund [UNICEF] et al., 2011). They found that approximately one out of three girls and one out of seven boys reported experiencing sexual abuse before turning 18. Likewise, about 80% of girls and boys experienced CSA when aged between 14 and 17 years old (Vagi et al., 2016). In pregnant females aged 13 to 24, over 6% of the pregnancies are estimated to be from sexual violence (UNICEF et al., 2011). In 2018 and 2019, more than 2543 incidents of CSA were reported in different areas of Tanzania (Wazambi & Komanya, 2020). Reports to the Tanzanian police force of sexual violence against children have increased 5% from 3543 reports of rape in the first half of 2018 to 3709 for the same period in 2019. In addition to rape (a term Tanzania law restricts to vaginal penetration), sodomy incidents (referring to anal penetration) against children increased from 547 to 688 (26%) during the same period (Wazambi & Komanya, 2020). Over three-quarters (84%) of all reported violence against children was sexual violence (Wazambi & Komanya, 2020). Cases for child-on-child sexual abuse were also found to be more of a significant problem in Kilimanjaro, Singida, and Tabora than in the other Tanzanian regions (Wazambi & Komanya, 2019, 2020; Empower Tanzania, 2018).

Sexual abuse that involves penetration can increase the risk of children contracting HIV or other sexually transmitted infections, as well as increasing the rate of adolescent pregnancy, all of which have lifelong effects (; Oseni, Lawani, & Oyedeji, 2016; Ministry of Health and Social Welfare [MoHSW], 2011; Wazambi & Komanya, 2019). The mental health consequences of untreated CSA include depression, anxiety, low self-esteem, dissociative disorders, social isolation, self-destructive behaviors, and alcohol and substance use (Alaggia, Collin-Vézina, & Lateef, 2019; Fergusson, McLeod, & Horwood, 2013; Kisanga, Nystrom, Hogan, & Emmelin, 2011). The main perpetrators of CSA in Tanzania include teachers, neighbors, family members, and friends (Ezekiel et al., 2017; Kisanga et al., 2011; Kisanga, Nyström, Hogan, & Emmelin, 2013; Wazambi & Komanya, 2019, 2020). The statistics show an increase in CSA reporting; however, less is known about how healthcare providers and other stakeholders manage situations of CSA (UNICEF et al., 2011; Wazambi & Komanya, 2019, 2020).

Significant barriers to disclosure of child abuse exist in Tanzania. One of the most critical structural barriers is poverty. Household poverty and child neglect increase the risk of child abuse due to the victims' lack of and subsequent need for financial resources (Abeid, Muganyizi, Olsson, Darj, & Axemo, 2014; Ezekiel et al., 2017). Transactional sex is common, with sex between older men (termed "sugar daddies" or "buzi" in Kiswahili) and young girls in exchange for food, shelter, car rides, and other goods being normalized (Abeid et al., 2014; Wamoyi, Wight, Plummer, Mshana, & Ross, 2010). Other contributing factors to CSA include long travel distances to school and the high prevalence of superstitious beliefs (Ezekiel et al., 2017; Empower Tanzania, 2018; Wazambi & Komanya,

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2019). Cultural factors include a long-standing tradition of child marriage, with 30% of girls being married before age 18. Tanzania's Marriage Act (1971) had set the minimum age of marriage at 14 years for girls and 18 for boys, which was changed in 2016 to a minimum of 18 years of age for both genders (Odhiambo, 2019). Patriarchal values and conservative sex roles, where power and decision-making default to men, leave women and girls more likely to be held responsible for the abuse (Abeid et al., 2014). At the community, family, and personal levels, fear of stigma (which prioritizes family and community reputation ahead of the victims' need for help), victim-blaming, and concerns that survivors will not be "marriageable" if CSA is disclosed make children, guardians, and families reluctant to disclose CSA incidents (Ezekiel et al., 2017; Kisanga et al., 2013; Wazambi & Komanya, 2019). The presence of these factors deters families from seeking and initiating therapeutic services, accepting restorative referrals, and reporting incidents to the legal authorities (Theimer et al., 2020).

The Tanzanian Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) developed policies, strategies, and guidelines to help healthcare professionals deliver care to patients. Some of the guidelines include the National Plan of Action to end Violence against Women and Children in Tanzania [NAP-VAWC], Gender-Based Violence [GBV], and Violence Against Children [VAC] (Government of United Republic of Tanzania et al., 2016; Ministry of Health, Community Development., Gender, Elderly and Children [MOHCDGEC], 2017). These guidelines aid healthcare professionals in helping to manage patients where CSA is indicated or suspected. The protocol requires taking a sexual history, forensic evidence collection, diagnosis, and mandatory reporting. This protocol is meant to standardize reporting and exemplify how healthcare professionals can use a multi-disciplinary approach to collaborate with social and child welfare services as well as with police to provide comprehensive care and facilitate referrals to the appropriate authorities (Maluka et al., 2018). The 2009 Law of the Child Act (of the United Republic of Tanzania) section 95 requires that "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." Legally, any healthcare professional who knows the name of a minor under 18 years of age that has experienced harm or is at imminent risk of serious harm is mandated to report the child to the appropriate authority (normally the local Department of Social Welfare). These laws and protocols are intended to protect children from harmful practices that affect their welfare, dignity, normal growth and development, and educational advancement.

The presence of adequate and well-trained healthcare professionals plays a significant role in revealing undisclosed cases of CSA during a clinic visit. Relative to middle- and high-income countries, Tanzania has an acute, severe shortage of healthcare professionals, which poses a significant barrier to addressing CSA (Maluka et al., 2018; Sirili et al., 2019; Tarimo, Moyo, Masenga, Magesa, & Mzava, 2018). In Tanzania, the doctor-patient ratio is 0.014 doctors per 1000 patients, well beneath the WHO minimum standard of 1:1000 (World Bank, 2021). Additionally, Tanzania's 0.6:1000 ratio of nurses and midwives to patients is below the WHO's minimum 1:1000 ratio (World Bank, 2021). Given this shortage, most healthcare, especially in rural areas, is carried out by nurses or midwives. This requires them to provide care beyond their traditional roles and training

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to accommodate the healthcare needs of patients (Tarimo et al., 2018). Poorly trained healthcare providers and lack of legal aid support from the courts contribute to ineffective quality care provision for CSA survivors (Wangamati, Sundby, Izugbara, Nyambedha, & Prince, 2019). In public clinics and hospitals, lack of privacy, large patient volumes, time constraints, communication barriers in building rapport between patient and provider, lack of resources, lack of referral facilities, and patient/clinician discomfort in addressing sexual-related problems all negatively affect the provision of quality care to the victims (Frederick et al., 2018; Frumence, Nyamhanga, Mwangu, & Hurtig, 2013; Moore, Higgins, & Sharek, 2013). A health professional's own history of abuse, religious and cultural beliefs can influence how clinicians deliver care to the child; sometimes, the clinician may avoid treatment due to personal values and previous experiences (Frederick et al., 2018; Theimer et al., 2020).

The availability of well-trained primary care providers as well as the appropriate recognition, investigation, evidence-gathering, and management of CSA and referrals of CSA patients are essential to address the health concerns associated with CSA (Maluka et al., 2018; MoHSW, 2011; Tahan & Sminkey, 2012; Theimer et al., 2020; Theimer & Hansen, 2018). Yet, despite the government's mandated reporting policy and the recognition of CSA as a common problem in Tanzania, little is known about how healthcare professionals in Tanzania manage CSA cases and what challenges they encounter in the provision of care. For this reason, as part of a wider study exploring the sexual health challenges that healthcare professionals experience in Tanzania, we explored how healthcare professionals handle CSA in their practices and asked them to identify what challenges they face in addressing CSA. This study was part of a broader investigation of common sexual health concerns experienced by healthcare providers in Tanzania.

2. Methods

2.1. Setting and objective

This formative research study was conducted to inform a comprehensive sexual health training curriculum for midwifery, nursing, and medical students attending a large health science university in Tanzania. The Muhimbili University of Health and Allied Sciences (MUHAS), in Dar es Salaam, specializes in the training of health students in medicine, nursing (which includes midwifery), pharmacology, public health, laboratory skills, and allied sciences. This study focused on the training needs of medical, nursing, and midwifery students as these three disciplines are the most involved in providing patient care. Nurses and midwives were included in this study because they provide most of the healthcare in Tanzania and are mandated reporters of CSA.

2.2. Research design

We conducted 18 focus groups using a stratified "3 × 2" (midwifery, nursing, medicine professions by practitioners versus students) design, with three groups per cell. The goal was to explore providers' perspectives and current practices regarding the provision of sexual healthcare in Tanzania. This design allowed us to explore differences across these three disciplines as well as differences in experience.

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Focus groups were chosen because they are an efficient way to explore the common experiences of a group of individuals who share similar characteristics. This study was conducted under the oversight of the institutional review boards at the University of Minnesota, the Muhimbili University of Health and Allied Sciences, and the [Tanzanian] National Institute of Medical Research (NIMR). These institutions deemed the study exempt from human subjects review since the focus was on clinical practice and anonymous data.

2.3. Study population

The study participants consisted of 60 healthcare providers and 61 midwifery, nursing, and medical students in their fourth year recruited from MUHAS. All providers had at least two years of clinical experience and were recruited from three major public and private health hospitals in Dar es Salaam. All students had at least eighteen months' experience rotating through clinics as part of their clinical training.

The participants' characteristics are reported in Table 1. Most students were male (62%) as opposed to female practitioners (82%). Students were between 23 and 37 years old, and providers were between 24 and 62 years old. Providers had between two and 38 years of clinical experience, and students were all in their fourth year of training.

2.4. Procedures

Each focus group consisted of five to eight participants and lasted between 60 and 90 min. The focus groups with students were conducted in a private room at MUHAS, while the groups for practitioners were conducted at their workplace. Each group discussion had one moderator who moderated the discussion in Kiswahili and an assistant moderator who took notes and observations during the session. Upon arrival, participants completed a short demographic form and signed a consent form. At the start of each group, the facilitator overviewed the study purpose, procedures, focus group rules (that it was voluntary, that they could cease their involvement at any time, that all responses would be confidential, and that the session was being audiotaped), and compensation (TZS60,000 or about the US $25). Snacks and drinks were served during the session. Participants were instructed to write their first name (or an alias) on tent cards and were invited to respond in either Kiswahili or English to the interview questions. The moderator stressed that there were no right or wrong answers and encouraged participants to share their experience even if it differed from other focus group members.

The focus groups' semi-structured interview guide consisted of 14 questions. Each group began with an icebreaker where participants shared their current practice (or, for students, their most recent rotation), then identifying the most common sexual health challenges patients present with in Tanzania. This was followed by several clinical case studies asking participants to discuss how the case presented would be handled at their clinic or hospital. Topics included male erectile dysfunction, female dyspareunia, male rectal gonorrhea, a rape victim, a domestic violence victim, adolescent masturbation, and the question relevant to this paper: child sexual abuse. The scenario was described as: "a nine-year boy with anal bruising and discharge comes to your clinic with his mother: how would this be handled?"

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This was followed by a prompt; "what challenges do you as health professionals face in addressing child sexual abuse?"

2.5. Data analysis

The audio files were transcribed verbatim then translated into English. The codebook development and data analysis were implemented by a team from the onset of the study. Thematic analysis was conducted using both deductive and inductive codes. The analysis followed a modified grounded theory approach and procedure that was informed by Saldana and Omasta (2018). It followed a series of steps beginning with data familiarization and discovery of early themes during an open coding exercise that involved all members of the coding team. This step was followed by two coding cycles where the codebook was applied to the entire data set once consensus was reached on the codes and their definitions. Initial codes were developed from the interview guide. Codes were added during the open coding exercise and during the first and second coding cycles. Individual codes were then organized into larger themes and sub-themes during the second coding cycle (axial coding), further refining the process. Team members met weekly to refine codes, reach consensus, and resolve discrepancies in codes' meaning and definition. During the coding process, if intercoder disagreements were further encountered, they were resolved by bringing the disagreements to the broader team for discussion.

The thematic analysis allowed for data comparison across the different provider groups and the specific topics explored in the interview guide, helping the team identify similarities and differences in the subgroups. This iterative, team-based approach to codebook development and data analysis benefited from the rich insights, cultural awareness, and knowledge of a team of researchers who are also members of the local community and the healthcare workforce. The six moderators who conducted the focus group discussions also undertook the coding process. All were born and raised in Tanzania, were bilingual (Kiswahili and English), and had intimate knowledge of the healthcare system. This helped to bring knowledge, context, and cultural expertise to the data analysis.

3. Results

This section presents the findings on how the participants currently handle CSA cases and the factors that facilitate or impede care provision to the victim. Thematic analysis generated three broad themes: 1) management of CSA, 2) factors that facilitate care provision (which was not originally in the interview guide but emerged during the discussion), and 3) barriers that impede the provision of care to CSA victims. Several sub-themes were also generated, as will be discussed under each broad theme.

3.1. Management of CSA

The management of CSA refers to how healthcare providers manage CSA in the health facility. Participants' responses appeared based on their knowledge of the regulations managing sexual abuse and their work experiences. This section presents four sub-themes that emerged during focus group discussions.

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3.1.1. Sub-theme 1: use of the multidisciplinary approach—Participants who worked in clinics employing a multi-disciplinary approach highlighted the importance of involving multiple disciplines at the hospital to facilitate victim management, thereby saving time for providers and allowing patients to receive appropriate quality services as needed. This includes managing and referral to the psychologists, social workers, police, and the Police Gender and Children's desks. The Police Gender and Children's desks are designated desks located within 400 police stations in Tanzania where women and children can report incidents of assault or abuse and seek support. They were established to address the mistrust between members of the community and the police (Grant, 2018). Some hospitals appeared to have internal referrals for counseling, while others did not. As one medical student noted, "I have met such a case, it was a girl … we treated her and referred her to the psychologist … although not all facilities have these referral systems" (Group 5: Medical Students). Another participant said,

I happen to work in a setting where we have multi-disciplinary systems. For example, we used to have a social worker. Whenever you had such a case, you had to address the medical aspects, and … [the] social worker in the team will proceed with other responsibilities, like reporting to the police and the respective municipal [authorities] (Group 13: Medical Professionals).

Some providers appeared less knowledgeable than others about how their clinic managed cases of CSA. "There is a CSA guideline, but some medical doctors are not aware of it. But this guideline shows the steps about how you should go about the management." (Group 13: Medical Professionals). Additional participants highlighted the lack of guidelines at their workplace as a barrier to the management of CSA. A few appeared unaware of or dismissive of their role as mandated reporters, saying, "I am here to treat, but not to report" (Group 6: Medical Students). Others expressed they had no clear way to ensure a child victim's safety or remove a child from danger. As a result, they worried about a child being sent back into the same situation.

First, I focus on the medical aspect… now, the question becomes, 'How will I protect this child?' The immediate concern is to protect the child from that environment [where it] happens, okay? So, what happens currently in our country [is that] we don't have this service. …but I find it difficult because we don't have national guidelines [on the care of the child]. … You as a clinician are left while really wondering, 'What do I do now?' I mean, as a clinician, what kind of support do you have to handle this case? (Group 13: Medical Professionals).

3.1.2. Sub-theme 2: proper history taking—A detailed history needs to be taken to identify what happened. This is to ensure that the child receives appropriate care. During the history-taking process, participants emphasized that healthcare providers need to 1) assess environmental factors at home and school (e.g., where the child is staying, close relatives, close friends, neighbors, etc.), 2) what happened (the actual sexual abuse), and 3) clinical assessment of any physical and emotional trauma and likely consequences. One participant said,

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I will build rapport with the child to tell me, but I will also talk to his mother. And, if possible, I will find a close relative of the patient because some families hide these issues! … So, I will ask if I can get a close relative to talk to him about the child's history. (Group 17: Midwifery Professionals).

Another participant supported this claim saying, "It's like others have said, first I will take a history and then treat a patient, until he stabilizes…" (Group 6: Medical Students).

3.1.3. Sub-theme 3: physical assessment—

After taking the victim's history, most respondents stated that they would start by taking vital signs (blood pressure, weight, etc.). Next, they would collect the forensic evidence using a rape kit (e.g. evidence of sperm), assess the physical injuries (e.g. anal bruises), conduct HIV and STI tests, and assess emotional and psychological trauma. As said by a member of one of the medical doctor groups, "I would conduct a physical assessment before I refer him/her to the lab for further diagnosis" (Group 10: Medical Professionals).

3.1.4. Sub-theme 4: treatment and referrals—

Consistent with Tanzanian regulations, respondents listed several treatments to offer to a child who has experienced sexual abuse. These treatments include stabilization of the victim/abused child and the provision of antibiotics. Also, they would test for HIV and provide antiretroviral therapy for post-exposure prophylaxis as narrated in the following statement; "we will treat the wounds as they require antibiotics. Actually, we must administer antibiotics because the anus harbors a lot of bacteria so that the bruises should not cause him any trouble" (Group 10: Medical Professionals).

Also, participants reported two primary referrals. The first is a referral for counseling and further testing. As said by one of the medical doctors, "[the] child should be treated and then later on the child has to be seen by the psychologist" (Group 16: Medical Professionals). The second is legally mandated referrals that, depending on the hospital, could be to the gender desk, social welfare, or directly to the police department for further action. As stated by one student, "if CSA happens involuntarily, then I will take the case to the police so that other legal action may occur" (Group 6: Medical Students). However, these referrals depend on the decision by the victim's family regarding whether to file a report or not.

I support the idea, but I will turn to the family [and ask] if they have reported the case to local government offices. As a healthcare provider, I must ask whether they have reported [the case] to the police station. I should communicate with the police as well because I must give a report. We usually give each other a report… therefore, I must ask [the parent] to know whether I should report it [abuse case] directly to the police or not. (Group 11: Midwifery Professionals).

3.2. Factors that enhance disclosure of CSA

Several factors were identified that increase the likelihood that victims and/or parents of victims will disclose abuse information to healthcare providers, especially during history taking and physical assessment. Healthcare professionals identified factors that enhance their ability to acquire in-depth information from the victims or family members. The

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critical factor they identified was having enough time to handle a case and to build rapport with the victim, especially during sexual history taking. Participants mentioned other factors, including confidentiality, the privacy of the surrounding environment, and strong childcare institutions to be crucial for enhancing CSA disclosure.

3.2.1. Sub-theme 1: building rapport—Rapport building was identified as a critical factor in CSA cases. Proper rapport helps the healthcare practitioner build trust with the victim, enabling them to speak out. This process requires sufficient time for a thorough assessment, including taking the patient's history, diagnosis, treatment, and referral. Participants opined that children need more time than adults to build trust and to make them feel open enough to discuss abuse. The following extract presents the ideas that participants shared during the discussion:

It is [easier] to deal with adults than children. Most children would not talk to you until they make sure you are not a threat to them. So, as a healthcare practitioner, you need to befriend them and gain their trust first. This may take a very long time sometimes. Once the child trusts you, the good thing is that he/she will tell you everything about what happened to them and who did that unless they do not remember or [do not] know the perpetrator by their name, but at least they will describe him/her. (Group 4: Medical Students).

3.2.2. Sub-theme 2: privacy and confidentiality—Participants stressed two privacy concerns that enhance disclosure of abuse: namely, they needed access to a private room with solid (i.e., closed) windows to interview the patient confidentially and control who was present. Second, they reported that patients and family members have concerns about record confidentiality; for example, who has access to data/information provided in the health information system (HIS). For instance, a member in the focus group stated that "some children decide not to disclose information because they are scared of their identity being known, which might lead to negative consequences" (Group 16: Medical Professionals). Providers also reported a preference for talking to the victim without family present as a factor that may facilitate the disclosure.

As we said earlier, it's best to talk to this victim alone without parents or guardians present. Sometimes the offender is a relative, probably an uncle, father, or mother. It isn't very easy sometimes. You fail to get detailed information, although he can open up when you befriend the victim. (Group 10: Medical Professionals).

3.2.3. Sub-theme 3: presence of childcare institutions—Abused children need to be assured of their safety to help disclose information about abuse. Participants of this study agreed that having a childcare center or institution helps to instill confidence in the abused children who are sometimes scared of telling the truth because they still have to face their families at home. The following sentiments were common among participants during the focus group discussion:

I think we need to work as a team involving different players to overcome the problem of CSA. As long as the abused children depend on their parents or guardians for care, they will always hesitate to reveal the perpetrators, especially if they are part of the family

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because they will have to face them sometimes at home. But having childcare centers will help protect these children and help them open up about child abuse. (Group 10: Medical professionals).

3.3. Barriers that impede the provision of care to the CSA victim

There are many barriers that healthcare professionals face in managing CSA at healthcare facilities. For example, while most health professionals said they would report CSA cases to the police department, they identified several factors that made care provision and reporting more difficult, as discussed in the sub-themes below.

3.3.1. Sub-theme 1: limited time for the victim's history taking—Time constraints are a significant challenge in Tanzania, given the overwhelming volume of patients and the strain on providers and the healthcare system. These constraints prevail because of the extremely low doctor-patient ratio in health facilities. For example,

The patient's diagnosis is time-consuming. Unfortunately, it becomes hard for any professional to spend enough time understanding the patient due to the inadequate number of professionals. How can you spend more time with one patient knowing that more patients are waiting for you outside? You will just find yourself rushing so that you can at least listen and help other patients as well. (Group 10: Medical professionals).

3.3.2. Sub-theme 2: fear of harm to the child if the abuse is reported—Professionals said they worried about cases where children are told that they will be punished if they disclose the abuse to anyone. "[The] child is afraid, and he/she cannot talk because he/she has been threatened that if he/she says so and so [name of perpetrator] did this to me, he/she will be punished" (Group 11: Midwifery Professionals). Others worried about threats to life, including the perpetrator threatening to kill the victim or their parents. As expressed by one of the midwives during the discussion, "Because he was told, maybe, if you say [anything] I will kill you, or I will kill your mother or your father" (Group 14: Midwifery Professionals). A related concern was for the child or parent's safety when offenders are family members or close relatives. In such a scenario, the child could be threatened by the offender(s), other family members, or both.

[Often children have] difficulties in explaining or in providing information about their sexual abuse. Because children who have been abused sexually are threatened, they [may] fear telling the truth. Sometimes, it involves their closest friends or relatives. So, even if you may treat him/her, you remain without clear facts to record in the patient's history. (Group 5: Medical Students).

Providers also reported their concern about the long-term safety of CSA victims and whether reporting an act of CSA would increase the child's risk. For example, the medical professionals expressed their dilemma in fulfilling their professional duty without causing harm to the victim by saying,

The other thing is the issue of child safety. When you think the abuser may be at home, how can you send back the child? And if you refer the child to the social worker again, the

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question becomes, 'How will he address that thing [abuse] to the family members?' (Group 16: Medical Professionals).

Similarly, another participant highlighted the need for education to the family members where abuse has been confirmed, saying, "after knowing the cause, there are ways of preventing it [CSA], and then you can provide health education on how to prevent it" (Group 11: Midwifery Professionals). Another challenge is the danger to other potential victims if the abuse is not addressed adequately within families. The following quotation exemplifies this:

Another challenge is like what has been discussed here with my friend tracing the family relationships. If that case is not taken seriously, it might happen again to another person in the same family if the offender is not prosecuted and punished. (Group 11: Midwifery Professionals).

3.3.3. Sub-theme 3: abuse reporting as a waste of time for providers—

Sometimes, providers are reluctant to report a case because they fear it will be a "waste of time." Even if the provider reports the case to the police, if family members are not ready to be reported, or unhappy at it being reported, they may withdraw from the case. The following statement illustrates this opinion: "the challenges we face in addressing CSA issues include the process of resolving the case. Children are not supported, or no family member can defend them. So, we don't have the strength to continue with the case" (Group 12: Nursing Professionals).

Similarly, professionals may take considerable time to collect crucial evidence for the court, only to have the case thrown out or the offender found not guilty. These scenarios make some professionals less likely to report this type of incident to the police. "You may be sending him to the police as you are struggling to find evidence and are wasting much of your time. But at the end of the day, you find the offender just loitering on the streets" (Group 12: Nursing Professionals).

3.3.4. Sub-theme 4: loss of evidence from the victim—

Participants highlighted three situations that prevent the collection of forensic evidence in cases of abuse and rape. First, too much time may have elapsed between the abuse and the collection of evidence. As described by one of the participants from the nursing professionals' group:

"But now when you see a child going through an emergency, you get to see him the next day. Sometimes the mother has already bathed this child then you can't get evidence" (Group 12: Nursing Professionals). Likewise, one of the medical professionals highlighted this as well:

The other challenge is that most of these kids are brought late to the hospital when the incident occurred more than two weeks ago. The parent will bring this child after seeing symptoms like the foul smell from the child and, apart from taking a history, you can't get the forensic evidence because of such delays. (Group 10: Medical Professionals).

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Second, time constraints and the volume of patients, particularly for those professionals working in public hospitals, severely limit a provider's ability to conduct a thorough assessment. Third, some offenders used condoms both to avoid HIV/STI infection and to hide the evidence. The following quotation explains, "another challenge is about the offenders who are used [to] and experienced in raping women. They use condoms and ensure no sperm contact with the victim. Therefore, without the specimen [it] would be challenging to identify the offenders" (Group 10: Medical Professionals).

3.3.5. Sub-theme 5: family resistance and cultural dynamics—

Findings revealed that family resistance and cultural dynamics also limit the disclosure of CSA. For example, many families may feel that it is better to resolve the abuse within their family rather than involving a legal authority. This is particularly common when the perpetrator is a family member, close friend, or a neighbor, as stated by a midwife below:

Now the challenge is a bit huge. You find that most people who abuse the children sexually are blood relatives, maybe an uncle or a stepfather. This is where the problem starts. When they come to the hospital and found that you are reporting [the abuse] to the police, they would say the family has already resolved this matter. (Group 11: Midwifery Professionals).

The family may also fear that if the law gets involved, the perpetrator could be jailed or sentenced to death. While the laws in Tanzania restrict the death sentence to crimes of murder and treason, many citizens may not be aware of this. In turn, children may fear nothing will be done because the family relies on the perpetrator. This leaves providers having to choose what is in the best interest of the child.

So, she said, 'I'm sorry for what happened, but what can I do? I depend totally on him.' So, what we did, we went the extra mile not to involve the police or anybody. Instead, we called the man, and we told him, 'we know what you're doing, and if you repeat [the abuse], you will face the law'. That was the end of it. But who knows if that will work for every abused child? (Group 16: Medical Professionals).

Participants stated that most families believe CSA is uncommon within Tanzanian culture, although some associate it with witchcraft; as stated by one of the participants, "these issues of child rape are taken as witchcraft. Others [family members] went to witch doctors and are asked to rape a child [so] they will become successful. So, relatives will not follow up on the case because they were given the money" (Group 14: Midwives Professionals). In addition, many families may not want to disclose the abuse because of the stigma, shame, and discrimination attached to rape if the abuse becomes public, as expressed by this medical student:

Most parents know and choose to hide these cases of rape, especially when the perpetrator is a family member. They also hide [it] because they see it as a shame, and the child will be discriminated against or [the child will be] afraid of not being supported by the family after returning from the hospital. (Group 4: Medical Students).

3.3.6. Sub-theme 6: economic status or life hardship—

The family member's financial status may influence whether an incident is reported or not. Providers identified

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three key concerns that limit reporting of incidents: corruption, poverty, and loss of a breadwinner. First, providers identified two forms of corruption: a perpetrator bribing the family members/child not to report the incident and a perpetrator bribing the legal authority not to investigate the incident. This is exemplified by the following quotation from a nursing student.

Yes, I concur on economic status because as a provider, I can suggest, let's go to the police. But, after we go there, they may end up reacting against you. If the patient is less wealthy than the other side [the perpetrator] because of corruption, you may find the person assigned to the case is corrupt. This changes the direction of the case or ignores it. (Group 1: Nursing Students).

Participants also raised the possibility that some health professionals may be bribed not to report the case to the police, as described by one participant from a midwifery professionals' group, "but you may find the law is not taken because of corruption, either from the police to doctors or victim's parents to doctors. They might bribe doctors not to collect forensic evidence from the child" (Group 14: Midwifery Professionals).

Second, participants mentioned that poor or low-income families might choose not to report these incidents for fear that they cannot afford to follow up on the incident with the police department, or they may be bribed not to report. As one respondent put it: "I think the other challenge is poverty. You may find a child has been abused sexually, but parents are paid not to take any legal action, and because of economic weakness, parents get tempted to receive money" (Group 5: Medical Students). Also, one of the midwifery professionals had this to say, "you may find someone who raped the child, [and then] promised to give money to the parents so that they would not report them" (Group 14: Midwifery Professionals).

Third, the victim and the victim's family may not want to report the abuse, especially when the offender is the breadwinner. The family fears that if the offender is jailed, their lives will be in danger because they will have no other income source to pay for school fees and household budget. Participants shared such feelings in the focus group discussions as they said,

Also, regarding marital status, things can be very complicated. Sometimes, a woman gets married in a family where a husband has another child from another mother. Maybe a woman comes with a small child from another father. Then, the father's son abuses that child, and the mother cannot take any action because she depends on him. For that reason, many cases go unreported. (Group 16: Medical Professionals).

3.3.7. Sub-theme 7: normalization of abuse—

Participants reported that the normalization of abuse is another challenge, especially when the child and family members do not perceive it as abuse. Some families may feel it is normal for the child to have sex with older children or adults. Also, other professionals saw loopholes in the culture and/or family, and lack of severe punishment, as contributing to normalizing abuse. This quote from one of the focus group discussions is illustrative: "our country's laws are not strict enough to safeguard children. There are a lot of loopholes, and even when problems appear, you

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don't see people being punished severely to let society know that this is a bad thing" (Group 13: Medical Professionals). One participant stated that the normalization of abuse among children occurs because there may be a poor relationship or poor communication between the children and their parents, making the child internalize abuse. These broken ties affect a child's ability to report the incident to their parents.

The absence of intimacy between parents and the child creates a communication breakdown between the two. With good communication, the parents would realize some changes happening to the child the moment the abuse (e.g. rape) happens for the first time. Thus, children see it as a normal thing and keep it to themselves until probably his/her adulthood. (Group 14: Midwifery Professionals).

3.3.8. Sub-theme 8: unaware of reporting centers—Participants mentioned that some parents lack knowledge of where and how to address abuse issues once it happens, as revealed in this statement, "Another thing I think is lack of knowledge on how to address those things. So, for example, you may find that the child is abused, but all of them [the family] don't know how they can start reporting it" (Group 2: Nursing Students).

4. Discussion

In this paper, we explored healthcare professionals' current practices in handling CSA cases in Tanzania. Participants shared a wide range of practice, from using a multi-disciplinary approach to management and referral as required in national guidelines, to tailoring management of the abuse to individual patient care, and, in some cases, to not following guidance, especially in reporting the abuse. In addition, providers identified multiple facilitators and barriers to the effective management of CSA.

As noted in the introduction, Tanzania has an acute shortage of healthcare professionals, which results in inadequate healthcare access for its citizens (Maluka et al., 2018). Most providers claim to have large caseloads parallel to other studies, so time constraints become a significant barrier (Mboineki, Chen, Gerald, & Boateng, 2019; Sirili et al., 2019; World Bank, 2021). Despite the caseloads and time constraints, providers saw their role in managing CSA as taking a good history, treating the physical effects of the abuse, collecting evidence, diagnosing and assessing, and initiating prophylaxis against HIV and other sexually transmissible infections. This study suggests that effective diagnosis and management of CSA requires disclosing information about the victim's history which is only possible through trust. This claim also coincides with Tahan and Sminkey (2012), who argue that rapport building helps build trust and, therefore, collect accurate and wide-ranging information to support patient care. This study's findings further suggest that ensuring privacy in crowded hospitals enhances disclosure as well (Moore et al., 2013). Additionally, effective management also included providing victims with referrals to other professionals (e.g. social workers and psychologists) and the police for social justice. In urban hospitals, these referrals were operationalized as standard operating procedures. However, such procedures were not universal. Other providers were less knowledgeable or appeared less committed to reporting CSA. Some mentioned they were less likely or unlikely to refer the victim to the police. Across the focus groups, several healthcare professionals (who are

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mandated reporters according to Tanzanian law) argued that they might choose not to report after weighing the benefits and risks to the child.

Findings depict that providers are reluctant to report the CSA incidents to the police, but parents and guardians are also at the crossroad. Analogous to several other studies (Theimer et al., 2020; Theimer & Hansen, 2018; Wazambi & Komanya, 2019), these findings illustrate that when the perpetrator of CSA is the family member or breadwinner, it decreases the likelihood that the abuse will be reported to the legal authorities. CSA involving a perpetrator outside the immediate family is more likely to be reported. Parents may be concerned about what may happen to the perpetrator (e.g. sibling) or how the family will survive if the breadwinner is jailed/prisoned (Alaggia et al., 2019; Ezekiel et al., 2017; Hébert et al., 2009; Kisanga et al., 2013, 2011). Although a multi-disciplinary approach seemed to be an effective practice in providing comprehensive care to victims, not all health facilities are equipped with these resources, making it harder for professionals and families of victims to attain quality care. Similar to the Jones, Pincock, Emirie, Gebeyehu, and Yadete (2021) study in Ethiopia and Wessells (2021), limited multi-systemic and multi-disciplinary approach to children's resilience such as social protection, justice for survivors, case management, referrals services, peer groups, and community leaves children at high risk of age- and gender-based violence and abuse. Numerous findings show consistent and comparable results that most adulthood mental and psychological problems have resulted from undisclosed incidents of childhood sexual abuse (Alaggia et al., 2019; Fergusson et al., 2013; Jones et al., 2021; United Nations Children's Fund [UNICEF] et al., 2011; Wazambi & Komanya, 2020, 2019). These results imply that providers need to increase efforts to discover and manage all CSA incidents when they happen, strengthen multi-disciplinary systems (Jones et al., 2021; Wessells, 2021), and elevate the perceived and actual significance of immediate actions (report and penalty) to the perpetrators.

The challenges participants reported in the management of CSA were similar across midwives, nurses, and medical providers. While in middle- and high-income countries, midwives may be less likely to encounter CSA than medical doctors, in Tanzania, participants from all three professions reported experience in managing CSA cases. This suggests that in Tanzania and perhaps in other parts of Africa, it is essential to include midwives and nurses in research, clinical management, and policy concerning CSA.

While students reported experience in seeing CSA cases, knowledge about the government requirements to report was higher among professionals than students. This suggests that sexual health curricula in medical, nursing, and midwifery schools needs to teach both the mandated responsibilities of providers in reporting CSA as well as the best practices in the management of CSA. Because some professionals were uncertain about how to handle referrals, continuing education also appears appropriate and needed. Additionally, due to providers describing different challenges depending on whether the clinic setting enabled a multi-disciplinary approach, curricula should cover both what to do in settings using a multi-disciplinary approach and what to do in settings that lack referral options.

As summarized in the introduction, many of the findings in this study support prior research on CSA in Tanzania and elsewhere. Factors such as family reluctance to acknowledge CSA,

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fear of stigma, and loss of evidence due to late reporting of incidents (Alaggia et al., 2019; Ezekiel et al., 2017; Kisanga et al., 2013, 2011; Wazambi & Komanya, 2020, 2019), and the need to build trust, rapport and to provide confidentiality and privacy to the victims (Moore et al., 2013; Tahan & Sminkey, 2012) are perhaps universal factors common across countries. Factors identified as more unique to Tanzania, and possibly other countries in Africa, including how family and community poverty, transactional sex, and perceptions of widespread bribery of police and justice officials' corruption may privilege the perpetrator over the victims (Abeid et al., 2014; Ezekiel et al., 2017; Wamoyi et al., 2010). This, and the lack of resources to remove the child from unsafe settings, leave providers questioning the efficacy of reporting CSA if the outcome is unlikely to help the child.

5. Limitations of the study

This study had four main limitations. First, all the participants were recruited from MUHAS and three major hospitals in Dar es Salaam, so findings may not reflect practice in other parts of Tanzania. This is especially true for rural regions where healthcare is even more limited, and multi-disciplinary intervention is not feasible. Second, while the moderators encouraged all participants to share and encouraged differing views, some participants might have withheld sharing experiences that were less than the standard of care or different from the experiences being shared by others in their group. Third, this study only used qualitative data collection methods. Future research should test the generalizability of these findings by replicating methods at other health universities and by using quantitative methods, ideally with a representative sample of providers, to assess knowledge, current practices, facilitating factors, and barriers to the reporting of CSA in Tanzania. Also, observational studies on this topic may work to improve protocols at specific sites. Fourth, because the health university in the study does not have social work or psychology training programs, we could not assess practices beyond primary healthcare providers.

6. Policy implications

The key implication from this study is that CSA cases receive suboptimal care in Tanzania for multiple reasons, ultimately resulting in the under-reporting of CSA. Participants expressed uncertainty at knowing when to follow protocols and knowing which protocols were relevant. For providers, structural factors (time constraints, patient volume), resources (private rooms, access to referrals, rape kits), and training in mandated reporting practices appear to be key to improving current clinical practice. While a multi-disciplinary approach to CSA management was identified as a best practice and should be implemented wherever possible, several providers reported that where they worked, components of such an approach were missing making such an approach not feasible. Limitations described in this paper are not unique to Tanzania and are present in other African countries; therefore, consideration and training should be given to what to do in settings that lack referral to social workers and psychologists for follow-up care or lack resources for children to ensure their safety.

Based on the emergent themes identified in this paper, we recommend that more training of healthcare professionals in CSA management is needed. This training should be required as

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part of medical, nursing, and midwifery training for students and available to providers as part of continuing education. Such training should familiarize providers and students with the government protocols in providing care, emphasize their role as mandated reporters, and promote best practices in management and referral.

To improve CSA management in Tanzania and in other countries where the CSA rate is high, referral and reporting clinics and hospitals need to address the time challenges inherent in reporting CSA. Long-term, increasing the ratio of healthcare providers to patients and/or possibly shifting some roles to ancillary care is needed. Given widespread perceptions of corruption globally and Tanzania in particular, there may be a need to address corruption at the family, police, justice department, and community levels. Globally, there is a need to strengthen family unit to safeguard children's rights as stipulated in the law, to enhance child-parent relationships, and improve communication about abuse to combat stigma and discrimination towards victims. In addition, because family reluctance to report CSA for fear of losing a breadwinner or family member is a widespread phenomenon, more community and or multi-disciplinary interventions are needed to address the issue, as recommended by other scholars such as Wessells (2021).

7. Conclusion

This paper examined healthcare professionals' experiences and practices in managing CSA cases, including best assessment and treatment practices, referral to other specialties, and reporting to police. Several factors that facilitate or impede the disclosure of abuse were identified. Time constraints, normalization of abuse, corruption, poor knowledge among healthcare providers about the laws and procedures in dealing with CSA cases, ethical dilemmas in reporting abuse incidents, and lack of privacy to conduct confidential interviews were the main barriers cited. Addressing the structural barriers in clinics and hospitals, increasing resources needed to address CSA, and creating more in-depth CSA training programs for health students and providers are key recommendations to improve practice.

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Data availability

The datasets used and/or analyzed during this study are available from the corresponding author on reasonable request.

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Table 1

Socio-demographic characteristics of the participants.

	Midwifery	Nursing	Medicine	Total
Sample size Students	20	19	22	61
Providers	21	21	18	60
Total	41	40	40	121
Gender Students	14M; 6F	13M; 6F	11M; 11F	38M; 23F
Providers	0M; 21F	5M; 16F	6M; 12F	11M; 49F
	14M; 27F	18M; 22F	17M; 23F	49M; 72F
Age (in years) Students: mean	27.7	25.1	24.0	25.5
- Range	23–37	23–27	22–28	23–37
Providers: mean	44.5	41.1	43.5	43.1
- Range	26–58	24–59	31–62	24–62
Experience (in years) Students: actual	4	4	5	4
Providers: mean	18.0	13.1	11.9	14.6
- Range	4–38	2–30	4–25	2–38