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Factors Affecting the Quality of Services Provided to Female Survivors of Sexual Violence in Nairobi, Kenya: Perspectives from Health Practitioners

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**FACTORS AFFECTING THE QUALITY OF SERVICES PROVIDED TO
FEMALE SURVIVORS OF SEXUAL VIOLENCE IN NAIROBI, KENYA:
PERSPECTIVES FROM HEALTH PRACTITIONERS**

A Dissertation Presented

by

LESO MUNALA

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2015

Public Health

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DEDICATION

This dissertation is dedicated to my Mother, Rebekah Achungo and my Father, Otieno Mare Munala.

Your daily prayers and unceasing encouragement are what got me through this long and arduous journey. Ndakhuyanza muno.

“Khumagwa tsembeka tsiosi, nebutswa sikhamintha; khung’ang’asibwanga, nebutswa sikhufwitsanga emioyo; khulondel’lwanga, nebutswa sikhulekhwanga; khukhupwanga hansi, nebutswa sikhukhuywa tawe”. II Bakorintho 4:8-9

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ABSTRACT

FACTORS AFFECTING THE QUALITY OF SERVICES PROVIDED TO FEMALE SURVIVORS OF SEXUAL VIOLENCE IN NAIROBI, KENYA: PERSPECTIVES FROM HEALTH PRACTITIONERS.

MAY 2015

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This study examined the experiences of practitioners facing the challenges of providing services to female survivors of sexual violence in Kenya. Specifically, the study examined how health practitioners understand their experience in responding to the needs of sexual violence survivors, how they view these women, in what ways they are helping them to heal, and in what ways the health system fails to help these women. In-depth interviews were conducted with 28 health practitioners, from eight post-rape care facilities located in Nairobi, Kenya. The questions focused on the practitioners' workload, challenges and rewards, the emotional impact of working with survivors, and recommendations for improving the quality of services that they provide.

The study documented a myriad of detail about the working conditions of the practitioners, the problems they face, and the quality of services they provide. The results revealed three findings that were particularly salient and significant. The most striking result is the severe shortages of personnel, equipment and competency in delivering services to survivors. Second, the study uncovered complex and troubling issues concerning the question of "genuine" clients. In recounting their experiences, the

practitioners described cases where it became apparent that the women presenting in the clinic had not actually been raped, but used the pretext to obtain HIV pre-exposure prophylaxis medication. Thus, doubts about the veracity of the client's story added to the emotional drain on the providers. The third significant finding was the great pressure exerted on survivors not to report or to follow-up on cases when the perpetrator was a family member. The experience was less often voiced as feelings of shame about the act of incest, but more often expressed as the fear of financial ruin for the family if the male primary income earner were sent to jail.

An explanation for the occurrence of these disparate results points to common origins in social structural inequities driven by the global political economic policies that perpetuate poverty and dependency throughout Africa and the developing world. The results of this study have many important implications for improving the quality of services provided to rape survivors in Kenya.

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CHAPTER I

INTRODUCTION

The research presented in this dissertation examines factors affecting the quality of health services provided to rape victims in Kenya. This chapter starts with a discussion of the public health impact of violence, in general, then violence against women, and then focuses in on sexual violence against women. The discussion turns to levels of sexual violence against women in Kenya and recent policy changes enacted by the Kenyan government to address the problem of sexual violence against women, including the passage of national guidelines on the management of sexual violence by health care providers. The chapter concludes with an overview of the purpose and key research questions addressed in the dissertation and their significance. This study seeks to identify and analyze the major factors affecting the quality of rape counseling services in Kenya, in order to prevent women from suffering any further harm at the hands of the health care system.

Violence as a Public Health Issue

Violence is a global health concern. The World Health Organization (WHO) defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation”(Krug et al, 2002 pg. 5). Violence takes various forms. The WHO (1996) divides violence into three broad categories: self-directed violence; interpersonal violence; and, collective violence. Violent acts can be physical, sexual, or psychological in nature.

Violence is one of the leading causes of death worldwide for people aged 15-44 years (Krug et al., 2002). According to the WHO Global Burden of Disease Report (2010), an estimated 1.6 million people worldwide died as a result of self-inflicted, interpersonal or collective violence in 2000. The majority of these deaths occurred in low and middle-income countries. Of these deaths, approximately half were as a result of suicide, a third of them were as a result of homicide and a fifth as a result of war. The costs of violence include loss of life, injury, psychological trauma, as well as an economic burden for countries (WHO, 1996; NSVRC, 2004).

Violence against women and girls is a key global public health problem. Both men and women can be victims or perpetrators of violence, but the types of violence committed against men differ greatly from the types of violence most commonly committed against women (Ellsberg & Heise, 2005). Violence against women is defined by the United Nations (UN) as:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Unesco, 1999, p.53).

Women are more likely to be assaulted both physically and sexually or killed by a family member or intimate partner, while men are more likely to be killed or injured in war or gang violence at the hands of a stranger (Harvey, Garcia-Moreno, & Butchart, 2007). Men are most often the perpetrators of violence irrespective of the sex of the victim (Krug et al., 2002).

Globally, violence against women cuts across race, socioeconomic status, age and geography (Ellsberg & Heise, 2005; UNIFEM, 2009). A study conducted by the WHO in 10 developing countries found that 15-71% of women reported experiencing either intimate partner or sexual violence at some point in their lives (WHO, 2011). Violence against women violates many human rights including but not limited to their rights to autonomy, equality and non-discrimination (WHO, 2010).

Violence is the leading cause of death and disability for women and girls in the 16-44 year age range worldwide (Krug et al., 2002). This violence can happen anywhere, in both formal and informal settings. The damage caused by such violence can last a lifetime and result in serious adverse effects on health and other aspects of human existence. Adverse effects include injuries, chronic pain, physical disability, hemorrhaging, mental illnesses such as post-traumatic stress disorder and depression, and sexual and reproductive health complications, including sexually transmitted infections, among others (Brown, Thurman, Bloem, & Kendall, 2006; Heise, 1998; Campbell, Lichy, Sturza & Raja, 2006; Coker, Smith, Bethea, King & McKeown, 2000; Ellsberg & Heise, 2005).

Sexual violence is a major public health and human rights concern worldwide and in Kenya. The WHO defines sexual violence as:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work (Jewkes, Sen, & Garcia-Moreno, 2002, p.149).

Sexual violence is a common form of violence against women (Du Mont & McGregor, 2004). Sexual violence is different from other aggressive behaviors in that it is often covert, encompasses power differentials, and chronic in nature. Sexual violence has both short and long term negative consequences to the physical, social and psychological wellbeing of survivors and their families (Campbell, Patterson, & Cabral, 2010; Krug et al., 2002). In addition, mounting evidence indicates that sexual violence is recognized significant risk factor for acquiring HIV/AIDS, especially for women (Ministry of Public Health and Sanitation & Ministry of Medical Services, 2009).

Girls and women are the vast majority of sexual violence victims. It is estimated that one in every four women have experienced sexual violence in their lifetime; constituting nearly 22-million women worldwide (Saidi, Odula & Awori, 2008). Kimuna and Djamba (2008) observed that perpetrators of sexual violence target women, regardless of the race.

While the true extent of sexual violence is hard to know due to underreporting, it is estimated that six out of every ten women globally experience physical and/or sexual violence in their lifetime (Krug et al., 2002). Sexual violence occurs both within and outside intimate partnerships (Harvey, Garcia-Moreno & Butchart, 2007) and affects both men and women. There is, however, a strong gender skew, with the majority of those experiencing sexual violence being women and the majority perpetrating this form of violence being men (WHO, 2010).

Sexual Violence in Kenya

One of the most prevalent violent crimes committed in Kenya is rape (Muchoki and Wandibba, 2009). Research suggests that between 40% and 50% of women in Kenya

have been subjected to some form of violence in their lives, with a nationwide study showing that 25% of women between the ages of 12 and 24 reported having lost their virginites due to forceful or coercive sex (Erulkar, 2004; Muchoki & Wandibba, 2009; Singh, 2013). Rape has been a major vehicle for the spread of HIV/AIDS and other diseases in Kenya (Muchoki and Wandibba, 2009).

Data on the level of sexual violence in Kenya come from health settings, police, nongovernmental organizations and national surveys (Krug et al., 2002). The sexual violence prevalence rate in Kenya is unknown; as survivors may not report due to shame, stigma, as well as the lack of adequate services among other reasons (Kilonzo et al., 2008).

According to the 2003 Kenya Demographic and Household Survey (KDHS), 49 % of women in Kenya indicated that they had been violated sexually since the age of 15 (Kenya National Bureau of Statistics, 2010). Additionally, it was estimated that one in every four separated, divorced or married women indicated that they had experienced sexual violence by their most recent or current husband, with 16 % reported as having been violated sexually by others persons in the community (Kimuna & Djamba, 2008). The 2008-09 Kenya Demographic and Health Survey (KDHS, 2010) indicated that about 12 % of Kenyan women between the ages of 15-49 years reported that their first sexual intercourse was forced. The 2003 Kenya demographic and health survey was the first nationally representative data on sexual violence (Maternowska, Keesbury & Kilonzo, 2009). According to this report, there was an increase in the number of reported cases of sexual violence between 1991 and 2005. The age range of victims in sexual violence cases reported was as young as five months old to the oldest reported case from an 86

year old woman (Onyango-Ouma, Ndung'u, Baraza, & Birungi, 2009). A study by Erulkar (2004) that looked at sexual coercion among young people in Kenya revealed that non-consensual sex is common, with 1 in 5 sexually active women reporting non-consensual sex.

Likewise, Kenyan police statistics document more than 2,800 cases of rape reported in 2004, an increase of 500 cases or more than 20% from the previous year. The 2010 Kenyan police crime statistics showed an increase in “crimes against morality,” which include rape. The total number of crimes against morality in 2010 was 3,972, up 12% from 2009 when the total was 3,496 cases (Kenya Police, 2010). Health care workers at primary health centers and Voluntary Counseling and Testing (VCT) sites around the country also reported a steady increase the numbers of rape clients (Kilonzo et al., 2008).

Such statistics sound a warning about the levels of sexual violence in Kenya. However, in addition to inadequate documentation of reported cases, some victims of sexual violence fail to report. In Kenya, failure to report cases of sexual violence has been associated with fear of victimization and trauma on the part of victims. Indeed, the level of sexual violence is profound in Kenya, yet the number of reported cases is likely far fewer than cases that are not reported (Kimuna & Djamba, 2008). The reluctance to report cases of sexual violence is linked to the fact that it is a sensitive issue surrounded by traumatic experiences. Hence, fieldworkers may under-report it in Kenya, regardless of the careful survey designs that fieldworkers formulate.

Government Response

Sexual Offenses Act

As late as 2003, Kenya had virtually no policies and service procedures for post-rape care (Kilonzo et al., 2008). Compounding the problem, sexual violence survivors were required to pay out of pocket to receive the minimal services available from public institutions (Kilonzo et al., 2008). The violence that followed the elections in 2008 included a huge increase in sexual assaults that were said to be politically motivated (Robins, 2011). While gender violence is endemic in Kenyan society due to gender inequality (among other issues), it is exacerbated during conflict. Rape, sexual mutilation, as well as forced circumcision were perpetrated along ethnic lines to terrorize those communities (Human Rights Watch, 2011). The serious nature of the events demonstrated the need to have national guidelines to inform service providers (Ministry of Public Health and Sanitation & Ministry of Medical Services, 2009), and subsequently, the Kenyan government committed itself to addressing sexual violence.

The Sexual Offences Act was enacted in 2006 (Kenya Demographic and Health Survey [KDHS], 2010). The bill is Kenya's first legal protection against the many sex crimes that occur in the country. As outlined in the Kenya Sexual Offences Act of 2006, sexual violence includes rape, attempted rape, defilement, attempted defilement, gang rape, indecent acts, sexual assault, incest by both males and females, deliberate transmission of HIV/AIDS or any other life threatening sexually transmitted diseases and sexual offences relating to positions of authority and persons in position of trust (Republic of Kenya, 2006). This act was as a result of extensive and ongoing advocacy work from civil society groups in Kenya. These groups were able to garner support from

the public by mobilizing religious groups and community-based organizations to speak up against sexual violence perpetrated in their communities; educating women on their rights; participating in drafting the bill; and raising national awareness and support for the bill as it was being debated in parliament.

The sexual offenses act broadened the range of recognized sex crimes to include sexual harassment, rape, and the deliberate transmission of HIV/AIDS (Onyango-Ouma, Ndung'u, Baraza & Birungi, 2009). This act also mandates that rape survivors are provided with free counseling and medical care at public institutions, which was not previously the case. Unfortunately, a major gap in the bill was the failure to include marital rape, which male parliamentarians removed (Onyango-Ouma, Ndung'u, Baraza & Birungi, 2009).

National Guidelines on the Management of Sexual Violence

National guidelines on the medical management of sexual violence were first produced and disseminated in 2004 (Matanuska, Keesbury & Kilonzo, 2009). In 2004, the Government of Kenya, in collaboration with other stakeholders, developed the National Guidelines on the Management of Sexual Violence. These guidelines were further revised following a study by Liverpool VCT Health (LVCT) (Ajema et al, 2011), which found gaps in health providers' knowledge about the delivery of Post Rape Care (PRC) services. Clinical guidelines are imperative as they assist health practitioners in providing appropriate care and ensuring the delivery of effective, compassionate health services. They also help providers comprehend the rationale for the services, the methods and procedures, and timing of service provision. In addition, they can serve as a

mechanism for evaluating service delivery (Stuart, Van Praag, Keshinro & Ya Diul, 2009).

The revised guidelines provide standards for care and step by step procedures that health providers are required to follow when providing care to survivors of sexual violence. The guidelines outline the procedures relating to medical management of sexual violence, including information on the first steps to be taken after meeting a survivor, obtaining a medical history, ethical matters, and other information every healthcare practitioner in every facility needs to know about managing health related problems of sexual violence. Additionally, the guidelines provide information on the main psychological consequences of sexual violence and outline proper counseling procedures. Issues pertaining to the forensic management of evidence are described in great detail in the guidelines. This includes information on the proper collection and preservation of specimens as the well as the proper documentation and maintenance of the chain of evidence. These procedures are essential in helping survivors to gain justice in response to the criminal act, by documenting that sexual violence took place and providing credible evidence to link the perpetrator to the crime.

These guidelines include:

- clinical care and treatment for injuries;
- examination and documentation for legal purposes;
- post-exposure prophylaxis (PEP) to prevent HIV infection;
- pregnancy prevention services; and
- psycho-social support in form of counseling services (Ministry of Public Health and Sanitation & Ministry of Medical Services, 2009).

By law, these services are provided free of charge to survivors of sexual violence at all government health institutions. However, adherence to these national guidelines for the management of sexual violence in public health settings in Kenya has never been systematically assessed and the subject of this dissertation.

Purpose of Study

The purpose of this study is to identify and analyze the factors that influence the quality of services provided to female survivors of sexual violence in Kenya. The study objectives were accomplished by interviewing health care practitioners who provide services to female survivors of sexual violence. The research examines how health practitioners understand their experience in responding to the needs of sexual violence survivors, how they view these women, in what ways they are helping them to heal, in what ways the health system fails to help these women, and in what ways they see the health system being abused. Health practitioner-informed research on survivor recovery and on what improves quality of life, promotes healing for survivors and the challenges practitioners that face in service delivery is needed as the health care response is a core component of comprehensive care.

A number of studies have been conducted on the need for better health services to address the needs of sexual assault survivors (Ajema et al., 2011; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Kilonzo et al., 2008; Martsolf et al., 2010; Ullman & Townsend, 2007). Numerous studies have been conducted at global, regional and local levels on the services provided to women who have suffered sexual violence (Keesbury & Thompson 2010; Kilonzo et al., 2003). These studies provide insight into the care of the survivor from the perspective of health care providers. The studies indicate the

different challenges faced by medical practitioners and the consequent effect on survivors. Some identified challenges faced by public facilities are lack of specialized training on sexual violence for practitioners, lack of resources and overall understaffing (Keesbury & Thompson, 2010). In addition, the studies identified societal attitudes to rape, especially when working with survivors from marginalized groups such as the elderly or those with any type of disability, organizational barriers such as the physical work environment, the institutionalization of post-rape centers as well as the standardization of services that may not meet individual needs as some of the barriers providers face.

Published literature on sexual violence in Kenya, however, is limited (Maternowska, Keesbury & Kilonzo, 2009; Njenga, 2010). As survivors of sexual violence are in a highly vulnerable position when they seek services, it is imperative that healthcare practitioners provide the best possible quality care. Understanding what it is like to provide care to victims of sexual assault as well as how the practitioners understand the causes of violence, and the role and responsibilities of the women who suffer these attacks is essential to improving the quality of health practices. Understanding the challenges practitioners face in service delivery is crucial as the health care response is a core component of comprehensive care (Keesbury & Thompson, 2010).

Working with survivors of violence is a challenging task for providers of health care in a number of ways. It requires that practitioners make use of a broad range of clinical skills, which they may not have acquired in the course of their medical training. Listening and supporting the survivors of rape requires providers of health care to

empathize with the survivor (Orth, 2002). It becomes a hard task when suppliers of health care are exposed to such violence daily. It implies that health care providers listen to the same stories time and again which may over time result in accumulated stress and ultimately burnout and trauma.

The main questions for this inquiry are:

1. What are the histories and politics of the systems and structures that inform broader understandings of sexual violence in Kenya?
2. How is sexual violence socially/culturally constructed in the global, African, and more local Kenyan context?
3. How do practitioners draw on these understandings to make sense of sexual violence and service provision in their own practice/lives?

Significance of the Study

Research reveals that there is a strong tendency for victims of rape to experience strong secondary victimization in courtrooms and medical settings (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2006). The secondary victimization that can occur in medical settings is generally the result of victims giving their accounts of events and medical professionals examining and performing minor procedures on areas that were highly affected by the violent sexual encounter (Campbell, 2006). Research suggests, however, that most of this secondary victimization can be reduced and minimized given proper counseling and treatment by trained professionals (Campbell, 2006). Secondary traumatization of rape survivors by health practitioners has been acknowledged in studies conducted with health professionals who work with survivors of trauma and abuse (Goldblatt, 2009). Secondary victimization is the re-traumatization of

sexual and abuse of the rape victims. It is an indirect method of assault that occurs through remarks and responses made by people and various institutions to victims. Secondary victimization includes blaming the victims, inappropriate languages and behaviors by the medical personnel and other organizations that have access to the victim post-assault case. This study examines the quality of these services toward the goal of reducing the occurrence of this secondary victimization.

My personal experiences bear witness to this secondary victimization. I spent my formative years in Nairobi, Kenya and hence my interest in focusing on the Kenyan context. While I do not have personal experience with sexual violence I grew up in that environment that attributed the blame of sexual assault to the survivor. While in high school, one of my good friends was raped at the age of 13 during a school holiday. When we returned to school, she shared her survival story with me. As I was only 13 and had never heard or experienced anything that traumatic, I was deeply affected by her story. I had a very sheltered religious upbringing and violence, particularly sexual violence, was not something anyone I knew could possibly experience. I could not imagine anyone I knew personally having to go through something like that. She told me of her trip to the clinic and the nasty experience she had with the clinic personnel and the questions she was asked as though the rape were her fault. At 13, I did not have the skills to be the kind of supporting friend she needed. I decided to distance myself from her that semester because every time I saw her, her traumatic experience rushed through my mind, as though I was watching it happen to her and could not save her from it. I could not get myself to talk to her about what she was going through because I could not bear hearing any more. I knew I was not capable of processing what had happened to my friend

emotionally at the time. I often wondered how she was able to deal with the sexual assault and go about life in high school seemingly like nothing happened. For me, just hearing her survival story was enough to traumatize me for an entire school term. She was doing well academically and quite popular in school, and I wondered if she was “denying” her experience.

Then, later in my academic career, while pursuing my master’s degree, I conducted an internship at The Enterprising Kitchen (TEK), a non-profit organization dedicated to empowering women from low-income areas in Chicago. During my yearlong internship with this organization, I, along with my field supervisor, facilitated a support group for women who were recent immigrants and refugees. These participants were referred to TEK by domestic violence shelters, parole officers, and counseling agencies. In talking with the women, many of whom had entered the US through human trafficking, the theme of violence was persistent. Often, these immigrant women would sometimes relate stories of poor treatment by frontline social service workers and health providers.

This study contributes to the discussion of the WHO’s recommendations on the need to strengthen care and support services for victims. Gaining knowledge of health practitioners’ experiences in providing services will inform how services to survivors of sexual violence can be improved. The research will also identify a way to strengthen support and training for health practitioners, whose experiences and needs are often overlooked. To my knowledge, no published research has been conducted in Kenya that examines the experiences of health practitioners in providing services to survivors of

sexual violence and the factors that they perceive to have the greatest impact on their ability to care for these women.

CHAPTER II

ECOLOGICAL MODEL

Many factors affect the occurrence of sexual violence against women, and many factors affect social responses to it. Thus, many must be taken into account in figuring out how to respond most effectively to its incidence. Sexual violence results from the complex interplay between individuals and their social environments (Reproductive Health Response in Crises Consortium, 2004). The Ecological Model provides a sound heuristic framework for organizing these diverse influences, and for thinking about their amelioration. In addition, the Ecological Model systematizes the different theories appropriate to each level of analysis depicted in the model: individual, interpersonal, community, and institutional or social structure, and for examining their interaction. This chapter opens with a brief overview of the ecological model in its generic form, and then turns to populating the different levels of analysis with different factors that have been identified in previous studies of the causes of sexual violence against women.

The ecological framework of human development was developed in the 1970s by the psychologist Urie Bronfenbrenner. Bronfenbrenner (1979) was mainly interested in how the social system influences human development. The term ecology is a biological term referring to the relationship between organisms and their environments (Sallis, Owen, & Fisher, 2008). Bronfenbrenner asserted that, to understand a person's behavior, it is necessary to consider the individual's entire ecology (Flake, 2005). The basic premise of this model is that behaviors are affected by multiple levels of influence (Sallis, Owen & Fisher, 2008). The model identifies five main levels of influence: intrapersonal, interpersonal, institutional, community and public policy (Krug et al., 2002). In

Bronfenbrenner's model behavior is regarded as both being affected by and effecting multiple levels of influence. McLeroy and his colleagues proposed a variation of Bronfenbrenner's ecological model, which focuses attention on both individual factors as well as social environmental factors that have an impact on health (McLeroy, Bibeau, Steckler & Glanz, 1988). Four core principles of ecological models for understanding health behaviors have been proposed:

1. There are multiple influences on specific health behaviors, including factors at the intrapersonal, interpersonal, institutional, community(cultural) and public policy (historical and political) levels.
2. Influences on behaviors interact across these different levels.
3. Ecological models should be behavior-specific, identifying the most relevant potential influences at each level.
4. Multi-level interventions will be more effective in changing behavior than single level interventions (Sallis, Owen & Fisher, 2008, p.466).

The ecological model stipulates that factors at multiple levels influence health behaviors and that understanding their interactions is essential for developing a comprehensive understanding of human behavior (Newes-Adeyi, Helitzer, Caulfield, & Bronner, 2000; Sallis, Owen & Fisher, 2008). The inclusion of the various levels of influence distinguishes this model from other theories (Glanz et al., 2008). An ecological model for understanding violence has been used widely by public health researchers and practitioners (Casey & Lindhorst, 2009).

The major task faced by scholars who adopt the ecological model lies in the empirical examination of particular influences on such issues as sexual violence. Hence,

it is important to review variables that are associated with sexual violence at the different levels delineated in the Ecological Model.

Levels of the Ecological Model

The ecological model has been used to conceptualize sexual violence (Glanz, Rime & Viswanath, 2008). Research has shown that sexual violence is influenced by individual factors, family practices, school set-up, peer group activities, community, and societal factors (Dahlberg, & Butchart, 2005; Shumaker, Ockene & Riekert, 2009). The ecological model reflects a public health approach in which factors at many different levels are comprehensively assessed.

Significance of the Ecological Model to the Current Study

Sexual violence against women is complex. The ecological model provides a framework for organizing the numerous factors related to sexual violence. Moreover, the model is instructive in informing intervention development, implementation and evaluation (Reproductive Health Response in Crises Consortium, 2004). The utility of an ecological framework in researching sexual violence is that it can propose multiple approaches at different levels of analysis (Campbell, Dworkin & Cabral 2009). It provides a framework to gather content-specific as well as contextual information in a methodical way (Newes-Adeyi et al., 2000). When a researcher conducts an ecological analysis, the approach emphasizes that all levels are important and need to be assessed if a complete depiction of the problem is to be gained (Sidebotham, 2001). Framing sexual violence in an ecological model makes it possible to explore the interactions between variables, as well as different levels of influence. This model takes into account the fact that an individual's behavior does not occur in a vacuum and tackles the embeddedness

of the individual within her environment. An approach employing this model is more likely to maintain prevention efforts over time than any single intervention. Importantly, it addresses the structural factors that promote sexual violence, rather than just focusing on the individual's behavior. It focuses on multi-level interventions that broaden options for interventions that can affect entire populations, particularly policy level interventions (Sallis et al., 2008).

Intrapersonal Level Factors

Intrapersonal level factors include individual demographics, biology, education, personal history of abuse, and other factors that increase the likelihood of an individual being either a victim or perpetrator of violence (Bechtel, Ryan & Gallagher, 2008). For instance, factors like drug and/or alcohol use, beliefs and attitudes that support sexual violence, and anti-social and impulsive tendencies are some of the influences that contribute to sexual violence against women (Astbur & Jewkes, 2011). Studies show that there are a number of factors that induce men to rape women in Kenya. In one study, the most prominent factor leading to rape by Kenyan men was drug consumption (Muchoki and Wandibba, 2009). At least half of rape occurrences in Kenya are thought to have been at least partially influenced by the presence of drug or alcohol consumption (Muchoki and Wandibba, 2009). Consumption of alcohol, cannabis, cocaine, and heroin are the most commonly associated with sexual violence events. Self-reports by those convicted of sexual violence crimes indicate that around 15% of such convicts report that drug use was the primary reason that the sexual assault event occurred (Muchoki and Wandibba, 2009).

Meanwhile, studies show that up to 5% of rape victims in Kenya were under the influence of drugs, impaired to the point that the rape would have not occurred (Muchoki and Wandibba, 2009). This is not a matter of the willingness of the women due to consumption of drugs but more an issue of women being too heavily under the influence of drugs to be able to fight back adequately.

Interpersonal Level Factors

The interpersonal level includes factors that may increase the risk of violence to an individual as a result of relationships that they have with their family members, intimate partners, peers, as well as other individuals. Intimate partners, family members, and peers form an individual's closest social circle and have the potential to shape both an individual's range of experiences and their behavior (WHO, 2010). These close social circles shape the range of individual experience and behavior (AIDSTAR-One, 2011). For example, the associates of men who perpetrate violence are also likely to accept and condone sexual violence (Go, Srikrishnan, Salter, Mehta, Johnson, et al., 2010).

Researchers have begun to focus on early developmental processes like family socialization, sibling relationships and parenting style as key factors that contribute to sexual violence against women (Bechtel, Ryan & Gallagher, 2008; Shumaker, Ockene & Riekert, 2009). A study by Muchoki and Wandiba (2009) suggests that almost all individuals who commit rape in Kenya belong to families where such individuals have at least four siblings. While large families are still quite common in Kenya (despite high rates of infant mortality), the findings that so many men convicted of rape belong to such large families is striking. In fact, 92% of the convicted respondents in this study had four or more siblings while only 8% with three or fewer. There may be a variety of reasons for

this finding, but, in general, families with many children have greater economic stresses. Thus, the number of children may be a proxy indicator suggesting that individuals who grow up in more economically strained families are more likely to engage in deviant behavior, such as rape (Muchoki and Wandibba, 2009).

Like many parts of the world, research suggests that girls in Kenya tend to talk to their peers instead of their parents, suggesting that the girls believe their peers will be more helpful in providing advice about sexual violence (AIDSTAR-One, 2011). The reluctance of children to talk to their parents about sexual violence is likely to contribute to its underreporting (UNFPA, 2009; Kimuna & Djamba, 2008). Parents are crucial role models because children base their expectations for future interactions with peers on them. In examining the connection between Kenyan families and sexual violence against women, Heise, Ellsberg and Gottmoeller (2002) observed that there is a similarity between families of perpetrators and families of victims. Ellsberg and Betron (2010) noted that caregivers of perpetrators tend to lack warmth and involvement towards their children. Furthermore, families of perpetrators tend to apply “power assertive” parenting practices, including violent emotional outbursts and physical punishment in which permissive attitudes are demonstrated regarding sexual violence behaviors (Reproductive Health Response in Crises Consortium, 2004). The Kenya National Bureau of Statistics (2010) confirmed that conflicts in marriage influence child propensity towards sexual violence. In general, perpetrators and victims of sexual violence in Kenya have relatively authoritarian parents (Chitando, 2007).

A study by Chitando (2007) demonstrated that differences in parenting styles are related to sexual violence. Parents of victims tend to have indifferent-uninvolved

characteristics. In particular, victims of sexual violence report troubled relationships with parents, describing their upbringing style as being abusive, with little warmth and inconsistent discipline. Furthermore, victims of sexual violence reported neglect and little parental support as factors that contributed to their fate. Similarly, findings by Kimuna and Djamba (2008) indicate that sexual violence occurs when parents are unaware of their child actions, or the parents are absent. The authors indicate the need for parental monitoring of child activities in and outside their homes.

Victims of sexual violence have also been found to correlate with overprotective and over-involved mothers, the polar opposite of the situation in which families lack warmth and involvement. Victims indicated that the nature of control demonstrated by their mothers inhibited the development of self-confidence, assertiveness and independence among children, which appears to increase risk of passive victimization (Yoder, Wang & Johansen, 2012).

A review of studies of fathers of victims found that the fathers were often distant and critical. Sexual violence against women has also been associated with parental maltreatment, including emotional, sexual, physical abuse, and neglect. Lastly, studies have found a relationship between sibling relationships and sexual violence against women. In another survey by Johnson (2006), forty two percent of females who had experienced sexual violence reported that siblings had sexually violated them. This was associated with ambivalent and negative relationships with their siblings. Hence, victims tend to perceive their siblings as people who have more control or influence over them (Mayhew & Percy, 2009).

Another potential factor affecting the high rate of rape in Kenya is the lack of parental advice on sex. Ninety-three percent of convicts in the aforementioned study stated that they had never had any discussion about sex with their parents. Scholars suggest that this leads to a lack of understanding about respect and deference given to women when considering engaging in sexual behavior (Muchoki and Wandibba, 2009). While there are a number of explanations for these results, the almost complete lack of communication between parents and children concerning sexual relations is certainly significant.

Peers have also been found to be a considerable influence in explaining the high rate of rape in Kenya. A significant number of convicts reported that they committed sexual violence because they were persuaded to do so by their peers (Muchoki and Wandibba, 2009). As we will see later, peer pressure must also be understood in the larger context of cultural norms.

Similarly, a study by Erulkar (2004) that looked at sexual coercion among young people in Kenya revealed that non-consensual sex is common, with 1 in 5 sexually active women reporting non-consensual sex. The study also suggested that for women, marriage was a risk factor for sexual violence as marriage is deemed to be blanket consent to sexual intercourse. The misguided idea is fostered in Kenya by the cultural practice of bride price that men pay, which suggests that men own their wives and, therefore, women are obliged to gratify their husbands sexually. In this cultural climate, claiming exhaustion or sickness as reasons for declining sex results in physical battering and marital rape.

Institutional Level Factors

The major health care providers in Kenya are the Ministry of Medical Services and the Ministry of Public Health and Sanitation (KDHS, 2010). These two ministries manage and administer over half of the health facilities in the country. Health facilities in Kenya are dispersed regionally, with the most sophisticated services offered only in the major cities or at the national level. The health delivery system in Kenya has a pyramid structure with three main levels (Glennard, & Maina, 2007).

The first level consists of dispensaries and clinics. Dispensaries are the health system's first line of contact with patients. They offer more services for preventive health measures than are provided at the other levels (NCAPD, 2005). The second level is comprised of health centers and sub-district hospitals. Health centers offer both preventive and curative services for children and adults. Health centers are usually tailored to the health needs of those in the locality (NCAPD, 2005). The third level of the health care system is district and provincial hospitals (Ministry of Public Health and Sanitation, 2011). District hospitals provide clinical care at the district level and are the first referral hospital attended by people in the particular district. They provide curative care, clinical care, emergency care as well as referral services. Provincial hospitals are used for secondary referrals from district hospitals for a defined geographical area. They provide specialized care not available in district hospitals (Muga, Kizito, Mboyah & Gakuruh, 2005). National, Referral, and Teaching Hospitals (NRTH), such as Kenyatta National Hospital in Nairobi and Moi Teaching and Referral Hospital in Eldoret, are at the top of the health care system (Turin, 2010), providing sophisticated diagnostic, therapeutic, and rehabilitative services (Muga et al.,2005).

Comprehensive post-sexual violence services are available in Kenya's capital of Nairobi. They include Nairobi Women's Hospital and Kenyatta National Hospital. However, these services are under-utilized and not well-known. Because Nairobi Women's Hospital has a large catchment area, it is geographically inaccessible to many girls and women. Survivors are faced with additional challenges upon being referred to clinics that are less well staffed to handle post-sexual violence.

Systematic and specialized treatment for rape care victims is governed and regulated by Kenya's Division of Reproductive Health (Kilonzo, 2009). The medical management of sexual violence includes the following services: the medical treatment for management of physical injuries, the provision of medical treatment including emergency contraception, HIV Post-exposure prophylaxis and medication for sexually transmitted infections, psycho-social support and forensic management.

One important factor, especially in countries like Kenya, is the administration of a comprehensive STD test and STD prophylaxis (Campbell, 2006). With Kenya's very high rate of STDs and in particular HIV/AIDS, it is crucial that healthcare professionals immediately administer such STD protocols for rape victims. The procedure is considered most important for the care of rape victims (Kilonzo, 2009).

The relatively high cost of STD prophylaxis, despite the strong attempts by government at reducing the costs of prescription drugs through increased healthcare expenditures, may be part of the issue. Administering STD prophylaxis can alleviate or halt symptoms if taken quickly enough (Campbell, 2006). However, the greatest STD threat currently in Kenya is HIV/AIDS. While there is no cure for HIV/AIDS, detecting

the disease early can help considerably with the disease's management and its symptoms (Campbell, 2006).

Another highly important factor in quality care for rape victims is a rape exam, to determine the severity of any wounds caused by the violent incident. This is highly important because such wounds, if left untreated, can quickly lead to infection (Campbell, 2006). Rape exams can quickly be administered to rape victims. However, the administration of such exams has been shown to have possible negative psychological effects for rape victims (Campbell, 2006).

Pregnancy tests and the administration of emergency contraceptives are also important factors, as pregnancies that result from rape can be extremely difficult for rape victims to cope with (Campbell, 2006).

Given the gravity of the matter, various police actions have been developed to manage the problem, but more remains to be done. More often than not, the matter of sexual violence against women in Kenya is subject to the interpretation and enforcement of the Kenyan law. In Kenya, in principle, policing options are founded on the decree that sexual violence is a crime, and the role of the police is to protect the victim and take positive action against assailants. In practice, however, the police say that they are protecting the family, where "everyone knows" that men have a right to control their wives (Simister, 2010). Feminists in Kenya argue that sexual violence has been normalized by the lack of sensitivity to the problem. Additionally, women have been acculturated in such a way that they consider sexual violence as ordinary and acceptable, even justified. This is especially the case for women raised in homes marred by sexual violence (Yoder, Wang & Johansen, 2012).

Community Level Factors

Besides family, peer, and individual characteristics, factors in the community have an effect on sexual violence against women. The fourth category in the ecological model involves community-level factors such as neighborhood, community environments and cultural influences (Kimuna & Djamba, 2008). These are larger macro-level factors, in which sexual violence against women is affected by cultural or religious belief systems and societal norms (Ellsburg & Betron, 2010). Community-level variables include delinquency, child maltreatment, externalization of behaviors, aggression, and violence (McDonald, Ernest & Jouriles, 2006). These factors can be direct and/or indirect and often sustain or create tensions and gaps between groups of people. An example is the lack of reinforcement of laws at the local level, which suggests that sexual violence is tolerated in particular communities. This means that the affected communities permit little to no consequences for the perpetrators of sexual violence against women.

Sexual violence is especially prevalent in patriarchal cultures (Jewkes & Morrell, 2010), such as societal tolerance for violence and sexist, patriarchal social norms. The low status of women in a patriarchal society puts them at a higher risk for marital rape as people expect women to be subservient in relationships (Moore, 2008). It is of particular concern these days due to the emerging evidence worldwide that sexual violence is a major factor contributing to infection with HIV/AIDS (Ministry of Public Health and Sanitation and Ministry of Medical Services, 2009). Studies suggest that community beliefs about sexual violence against women are that it is a consistent and unchangeable aspect of local culture (Hatcher et al., 2013). A study by Adegoke & Oladeji (2008) conducted in Nigeria looked at community norms, cultural attitudes and beliefs that

influence violence against women. The study found that strong predictors of violence included culturally conditioned beliefs about a man's right to control their wives behavior, to discipline their wives and perceived links between male honor and female chastity. Considering the high rate of rape in Kenya, it seems apparent that Kenya's culture sanctions the idea that is acceptable for males to engage in forcible acts of sexual behavior that elsewhere would be considered rape.

Traditional beliefs and myths dominate the Kenyan society. For instance, having sex with a virgin is perceived to be a cure for HIV (Obure et al., 2009) and this belief has resulted in many girls being raped and sexually abused. As but one indicator of its patriarchal culture, the majority of Kenyan families prefer male children, to the detriment of female children (Mayhew & Percy, 2009). A notable example is in the Luo community (of Kenya), in which the boy child is recognized as "siro" (meaning pillar of the community). Likewise, a woman who gives birth to a male child among the Luo is recognized as a truly and fully married person, and according to this cultural practice, such a woman therefore cannot be divorced (Nyabera & Montgomery, 2007). These cultural beliefs promote sexual violence because women who give birth to girls are ridiculed, whereas women who give birth to boys attain higher social status. Not only preferring male children, but also treating women as objects for bearing children, rather than recognizing them as equal members of society, further denigrates the social position of women.

Another example can be seen in the Kikuyu language, the language of the largest ethnic group in Kenya. The word used to describe a man is *mundu murume*, derived from the word *urume*, which means "very brave." In contrast, the word used to describe a

woman is *mutumia*, derived from the word *tumia*, which literally means “to use” (Kangara, 2006). The idea that women exist for the use of men is deeply embedded in the culture, even the very language used to name persons.

Sexual violence against women is also exercised when husbands feel entitled to sexual gratification from their wives any time they wish. Furthermore, women in Kenya are not expected to have sexual desires, nor experience sexual satisfaction. The practice of female genital mutilation, which covers a variety of procedures, has evolved to ensure that women do not experience sexual desires, with rampant cases of the practice being reported in the North-Eastern parts of Kenya (Simister, 2010). Female Genital Mutilation (FGM) has been practiced for a long time as part of cultural traditions. FGM is thus a culturally charged issue that international development programs have been hesitant to tackle due to the cultural implications (McKee, Manoncourt, Yoon & Carnegie, 2000). FGM is usually carried out by relatives in the misguided belief that it can prevent girls from having sex before marriage and to discourage promiscuity (Simister, 2010). There have been some small steps towards the prohibition of FGM; it is now illegal for minors as a result of the enactment of the Children’s Act of 2001. The prohibition of FGM, however, has resulted in forcing it underground. The only way that practices like this can change is through the participation of the whole community.

Popular cultural belief has also given rise to a myth that a real man cannot be satisfied sexually by one woman. This has given Kenyan men permission to practice sexual adventures and liaisons while the wife is assumed to need no more than one man to be satisfied. The cultural license for adulterous affairs has exposed many women to the risk of contracting diseases, as cultural practices do not permit them to negotiate safe sex.

The practice of having concurrent and multiple wives is permitted in Kenya (World Health Organization, 2006). A marriage bill signed by the Kenyan President permits men to be polygamous without consulting their first wives.

Most women in Kenya do not have decent standards of living. Poverty results in the denial of choices and provision for basic commodities, and also, the respect of others. Sexual violence is also perpetuated by the need to sleep with men in exchange for food (Chitando, 2007). First, women do not feel secure; many women still feel that the actions taken by domineering husbands are often justified (Nyabera & Montgomery, 2007). Further, there are no proper shelters for women to stay in times of need, and thus, even if they report abuse, they are not safe and often have to return to their homes and endure further violence (Waits, 2011).

Sexual violence against women is widespread. High levels of poverty have a direct and strong link with sexual violence. Most female survivors are from poor socio-economic backgrounds. A woman's lack of economic resources perpetuates cycles of dependence and violence (Simister, 2010). The dearth of economic resources reinforces a woman's susceptibility to violence and makes it difficult for them to extract themselves from a violent relationship. The observation by Simister (2010) fails to examine the precise level of poverty at which sexual violence may set in for the women, in exchange for money, food and related benefits. Glanz, Rimer and Viswanath (2008) also note that the criminal act has not been given adequate attention by policy makers. This neglect has far-reaching implications for reducing sexual violence against women, globally and in Kenya. The effects include people's well-being, health, and development at the community and society levels (Nyabera & Montgomery, 2007).

In Kenya, men have authority and power. Women do not have the authority to make decisions, and those who do not submit to men should be disciplined and taught “how to behave” (U.S. Department of State, 2008). Hence, women cater to the sexual needs of men for fear of provoking controversy, potentially ending in violence. Additionally, women in Kenya adhere to sexual needs of men as a sign of upholding community norms and structures.

According to Saidi, Odula and Awori (2008), studies focusing on community factors pertaining to victims of sexual violence tend to employ aggregate community demographics that encompass police and census data. Senn, Carey, Vanable, Doniger and Urban (2007) found that significant community factors include the degree of racial diversity, single-parent families, crime, mobility, and measures of poverty. Such factors have all been associated with sexual violence against women (Simister, 2010). Such community influences as historically unequal power relations between men and women, deep-rooted impunity within a humiliating, burdensome and complex justice system, socio-cultural factors, and the breakdown and conflict of law and order have also been associated with sexual violence in Kenya (UNFPA, 2009).

Public Policy

Sexual violence against women continues largely unabated in Kenya because of inadequate laws that deal with the criminal act. The patriarchal order of the Kenyan society has crucial effects on service-seeking by survivors of sexual violence. Silence and secrecy have also engulfed cases of sexual violence against women because of patterns of socialization in Kenya (Nyabera & Montgomery, 2007). Inadequate linkages and feedback between the police, government doctors, health institutions, and judicial

officials have also undermined the process of controlling sexual violence (McDonald, Ernest & Jouriles, 2006). A study by Rumney & Van der Bijl (2010) conducted in South Africa, for example, looked at rape attitudes and law enforcement. The study suggested that the prevalence of rape is minimized, especially when it takes place in a current relationship where sex is seen as a duty. Rumney & Van der Bijl (2010) attributed this to the negative social attitudes and myths surrounding rape and rape victims.

The use of regulatory policies and laws to protect the health of the community is one of the central characteristics of public health (McLeroy, et al. 1998). Public policy, including local, state and national laws, shapes social structural factors (also known as Macro level factors). Measures to criminalize different acts of sexual violence and broadening the definition of rape to include marital rape are examples of policy level interventions. Weak, insufficient sanctions and human services are examples of risk factors that place certain groups at risk for sexual violence at the policy level.

The Ecological Model and Interventions for Victims of Sexual Violence

Kenya has successfully designed policies and enacted laws to combat sexual violence over the last decade, but the crime persists. While the number of victims reported to be receiving medical care at health facilities has increased, the rates of perpetrator conviction remain low. Interventions for individual-level factors in the ecological model are geared towards affecting the cognitive and social skills of survivors. Such approaches include educational training sessions, therapy, and counseling (Liverpool Voluntary Counseling & Testing, Care and Treatment, 2012). Interventions geared towards the interpersonal level focus on such things as parenting training, development of skills for bystander intervention, and family therapy (UNFPA, 2009).

Many programs about prevention and management of sexual violence incorporate components that address factors in the community (Nyabera & Montgomery, 2007).

Interventions regarding the social structural level of sexual violence encompass the design of systems, policies, and the socio-cultural climate to curb such violence. Language that perpetuates norms supportive of sexual violence can be interrupted only by engaging the community members (Berkowitz, 2004). Additional interventions include changing societal norms that tolerate sexual violence (Heise, Ellsberg & Gottmoeller, 2002). As such, preventive mechanisms have focused on public education about the rights against sexual violence and, the need for socio-economic empowerment. Finally, interventions at the societal level encompass collaboration among multiple partners to spearhead changes in current policies and laws.

In principle, justice regarding sexual violence should result in punishment and prosecution of those who are guilty (Johnson, 2006). However, such actions have been hindered by socialization in patriarchal norms and the lack of empowerment of women. In response to the insensitive, unfriendly, and stigmatizing systems of justice, non-governmental organizations (NGOs), such as FIDA-Kenya, have emerged to intervene to give women a voice. FIDA-Kenya offers a safe space for survivors of sexual violence to tell their stories. These practices cultivate self-representation skills, which often result in counseling and building life practices of post-sex violence survivors (Chitando, 2007).

Despite the efforts of such NGOs, few women survivors of sexual violence leave their husbands. In most cases, survivors also fail to pursue legal remedies. The reluctance is associated with economic dependence on their husbands (Kimuna & Djamba, 2008).

Other factors include high costs of legal procedures, communal stigmatization and lack of confidence in judicial systems and, the police.

In Kenya, acts of sexual violence against women continue to go underreported, even though policy and legal frameworks are now in place (LVCT, 2012). In the Kenyan setting, key considerations include cultural acceptability and the lack of trust in the police in filing official reports and following up with careful investigations and arrests. Furthermore, the level of awareness about and availability of medical assistance services are crucial considerations in planning effective responses to sexual violence against women (Simister, 2010). Access to effective interventions has been hindered by the lack of victim awareness about existing services, difficulties in documenting proof of sexual violence, the expense of post-rape services, and the lack of comprehensive integrated facilities that would enable victims to get examined, report complaints, receive treatment, and, counseling services (AIDSTAR-One, 2011).

Factors that Affect Quality of Services

Stewardship and regulation, defined as the “function of governments responsible for the welfare of populations and concerned about the trust and legitimacy with which its activities are viewed by the general public, are primary factors in the proper and effective care for victims of rape in a country’s institutional response” (Saltman and Ferroussier-Davis, 2000, 735). Increased government spending on healthcare, in general, is a major part of this stewardship, while the specific level of expenditures allocated to the treatment and care of victims of rape, including training and educational programs for healthcare professionals to provide appropriate professional care to victims of rape, is also critically important. Governments are responsible for setting the minimal amounts of care that are

required by law. For example, government regulations are essential to set the standards of care for victims of rape.

Prior to 2005, Kenya had very high rates of disease and very low levels of spending on healthcare (Glenngard, & Maina, 2007). From 1990 to 2003, the life expectancy in Kenya, in fact, dropped by five years and infant mortality rose by 30% (Demery & Gaddis, 2009), contrary to global trends in most other low-income countries. In 2005, per capita government expenditures on healthcare were less than half of what the World Health Organization declared was required for minimally adequate health care (Glenngard, & Maina, 2007). Moreover, the number of medical doctors in Kenya was very low, with only 1 doctor per 6,400 inhabitants, putting Kenya near the bottom of the ranks relative to other developing countries (Were, Ngugi, & Makau, 2013). The deterioration of Kenyan health led to an increase in healthcare spending.

In 2005, Kenya launched a new healthcare initiative that increased public expenditures on Kenya's healthcare system (Glenngard, & Maina, 2007). The 2005 policy proposed to increase expenditures significantly for the Kenyan health care system, both to increase the quality of healthcare provided to Kenyans and to decrease the economic burden that individuals had to pay for healthcare. As a result of this new policy, the healthcare budget in Kenya increased by 30%. Increased expenditures focused on five issues: (1) reducing the costs of prescription drugs, (2) increasing the quality and quantity of medical equipment available in healthcare facilities, (3) improving the quality of rehabilitation facilities, (4) increasing the availability of immunizations, and (5) improving reproductive health (Glenngard, & Maina, 2007).

In spite of Kenya's efforts to improve healthcare, recent research suggests that Kenya still spends far less money on healthcare than recommended by the WHO and generally delivers subpar healthcare to its citizens (Chuma, Maina, & Ataguba, 2012). Kenya still spends less than 6% of its GDP on healthcare, which is much less than the average that developed countries spend on healthcare, which is around 10% on average (Chuma, Maina, & Ataguba, 2012). In addition, the burden of disease is quite high (Glennard, & Maina, 2007). Despite the professed goals of this initiative, there were many problems with the implementation of this policy. Many donors chose to channel funds outside of the Ministry of Health in order to bypass bureaucracy concerns such as the slow distribution of funds from the central level (Glennard, & Maina, 2007). Additionally, a number of questions arose concerning expenditures on drugs. Some alleged that the spending on prescription drugs largely went to increase the profits of drug companies, rather than decrease the price of prescription drugs for patients. Furthermore, the spending has not led to the expected improvements in health and seems to have exacerbated inequalities in healthcare. The funds were not distributed fairly across Kenya, as urban areas tended to receive much more per capita funding than rural areas (Glennard, & Maina, 2007), despite the fact that rural and lower class families have much greater need, as indicated by a much lower life expectancy rate and have higher rates of infant mortality (Demery & Gaddis, 2009).

Further evidence suggests that there are gender biases in the distribution of healthcare resources in Kenya. Research shows that men receive a disproportionately high amount of healthcare services than women (Demery & Gaddis, 2009). This inequality is exacerbated by socioeconomic status, with poor men receiving much better

health care services than poor women in Kenya (Demery & Gaddis, 2009). The fact that men, rather than women, receive more of the benefits from increased healthcare spending in Kenya plays a significant role in the country's inability to properly care for rape victims.

Unequal benefits resulting from increased healthcare spending have several important effects on the care that victims of rape receive in Kenya. For one, unequal benefits indicate that the persisting health problems affecting women in Kenya will be inadequately addressed. This will necessarily reduce the resources available for healthcare providers to deliver proper care of rape victims. Instead, Kenyan healthcare providers will continue to allocate funds on other health concerns, which results directly in fewer resources to improve the care of victims of rape.

One major problem with the Kenyan healthcare system is that it relies heavily on out of pocket payments from patients (Arnold, Theede, & Gagnon, 2014). Research indicates that most of the cost of healthcare in Kenya is covered by out-of-pocket payments, which deters many Kenyans from seeking health services altogether. Out of pocket payments have a significant impact on the average Kenyan household budget and are often unaccounted for in research on poverty (Chuma & Maina, 2012). Out-of-pocket payments for health can cause households to incur exorbitant expenses, which often push them into poverty (Xu et al., 2003). One recent study found that, on average, 7.3% of the Kenyan household budget is spent on out of pocket healthcare payments, with households in the lower class spending, on average, 15.3% of their income on out of pocket healthcare payments (Chuma & Maina, 2012). This is similar to other low income

countries where the poor seek health services less frequently than those who are well off (Glennard, & Maina, 2007).

However, these data do not tell the whole story about how the high costs of out of pocket healthcare payments affect Kenyans. For example, there is wide variation in the amount that Kenyans personally pay out of pocket (Chuma & Maina, 2012). The high standard deviation indicates that many Kenyans are paying a much higher percentage of their annual income for healthcare out of pocket costs, while other individuals are not paying anything at all. From these data, one can infer that rape victims may avoid the healthcare system because of the high costs.

Another important factor to consider is the general avoidance of medical attention from ‘victims of rape due to its severe stigmatization (Wakabi, 2008). In many cases, victims of rape are ostracized by their communities. While many rape victims underestimate the psychological damage that sexual violence can cause, it is often the more serious type of damage. The physical injuries sustained from rape are not often considered life-threatening, which may lead many victims to decide against medical treatment. Rape, then, harms women who are already hesitant and resistant to medical care, factors compounded by the need to decrease out of pocket cost for victims of rape.

With the prevalence and severity of disease remaining high in Kenya, along with insufficient government spending on healthcare, it is important to investigate what is happening on the ground when these two problems collide. The recent increase in expenditures dedicated to improving healthcare has not shown the same benefits for women that it has for men; the healthcare needs of women are being overshadowed.

There are too many healthcare issues that are considered more pressing to the Kenyan government than specialized care for rape victims.

As a result, there are certain inadequacies in the ability of Kenya's primary healthcare system to get rape victims into programs that offer post-rape care. Many medical sites did not have proper protocols in place to get rape victims the specialized care that they require (Kilonzo, 2009). Even those medical sites that do have protocols in place too often lack private, confidential spaces to conduct post-rape questioning and medical services (Kilonzo, 2009). Moreover, many rape victims are still required to pay out of the pocket for most specialized care services, such as STD testing and rape exams, leaving many rape victims with hefty bills, which is likely to turn many rape victims away from such care.

Even if the clinical treatment was administered, many rape victim patients are not properly referred to post-rape counselors or trauma counselors (Kilonzo, 2009). Moreover, because the counseling sessions are often expensive, many rape victims forego psychological counseling. One study claimed that the most significant problem in providing specialized care for rape victims lay at a procedural level in medical settings. That is, inadequate collaboration between primary medical settings and specialized rape programs is far too common (Kilonzo, 2009).

Also, there was a lack of collaboration between the justice system and health systems, such that often rape victims engage with legal officials or health professionals one at a time, meaning such that patients were often questioned by legal officials before receiving medical attention (Kilonzo, 2009). With the best treatment options available requiring counseling, Kenya's current response to rape victims is terribly deficient. The

relatively small amount of funding being dedicated to the healthcare industry is made worse by its disproportionate offerings to men.

Another large-scale factor that affects the care that victims of rape receive is the organizational structuring of healthcare systems (Preker and Harding, 2003). Well-defined organizational structures make service delivery across a country much more uniform in providing care for victims of rape. However, if the structures are too rigid, the budgets of healthcare systems can become strained, and there may be no specialized forms of care for victims of rape. Although governments are responsible for devising organizational structures in developing countries, nongovernmental organizations also play a very large role in delivering services in these countries (Jameson et al., 2006). In general, nongovernmental organizations provide specialized training, and funding for healthcare systems in low-income countries, especially during emergencies.

The presence of quality assessment and assurance is a primary factor in improving the adequacy of health systems to care for victims of rape. Quality assessment and assurance depend on a commitment to long-term solutions of providing quality care to patients relative to the baseline of established specialized care now provided for victims of rape.

In spite of several recent initiatives to address sexual violence against women, Kenyan communities have not significantly reduced, let alone stamped out cases of sexual violence (U.S. Department of State, 2008). Women remain the most affected victims of sexual violence (Waits, 2011). A number of the causes of sexual violence against women in Kenya have been identified, ranging from flimsy legal frameworks and inadequate policies that ignore (and hence condone) the prevalence of sexual violence, to

the low social status that Kenyan society affords women (World Health Organization, 2006).

Research on the health services provided to victims of rape must focus on health outcomes and the costs of implementing such solutions (Jameson et al., 2006).

Additionally, research should focus on the scalability of such solutions, as many solutions in the healthcare industry either require the support of large scale health systems, such as public hospitals, or are constrained to small health systems, such as specialized clinics (Jameson et al., 2006). Also, research indicates that evidence is severely lacking in the healthcare field on the types of health services that are culturally appropriate and permissible in developing countries, where many services may be rejected on religious or ideological grounds (Jameson et al., 2006). While certain healthcare solutions may be ideal for the victims of rape in Kenya, it is unclear whether such solutions would be allowable or supported in Kenya.

CHAPTER III

THEORETICAL FRAMEWORKS

This chapter describes and explains the key theoretical frameworks that have guided and informed this research. As with the preceding chapter, these theories can be framed in the context of the Ecological Model. The three theories that are most pertinent to the analysis of sexual violence in the Kenyan context are: at the broadest social structural level, theories of the political economy and globalization; at the cultural, community and interpersonal levels, social constructionism; and finally, at the individual level, the major psychological theories that have been used to guide the development of rape counseling services in Kenya.

Theories of Political Economy

Over the last two decades, there have been on-going debates about the role of the global political economy in influencing internal domestic policies and programs directed at improving various health and social indicators in different countries, particularly, low-income African countries. At the heart of these discussions is the impact of global financial institutions, especially the International Monetary Fund (IMF) and the World Bank, on the development of poor nations. Critics claim that they do not work for the benefit of these countries; instead, they are only concerned with expanding neoliberal ideology into national economic systems across the world. This is disturbing because governments may be forced to cut programs designed to alleviate the effects of poverty, such as health and education programs, in order to meet the conditions imposed to be eligible for loans and other forms of financial aid. These reductions may harm the quality of living in the countries affected. Instead, it is the creditors who benefit by forcing them

to privatize key industries and maintain stringent financial controls (i.e. balancing the budget, currency reserves and producing budget surpluses) (Gillingham, 2008;Vreeland, 2003).

In Kenya, the government is facing considerable challenges in supporting anti-poverty programs. There is ample evidence now that any gains that have been realized are quickly negated, as funding is cut from these initiatives based on assumptions about the conditions necessary to stimulate long-term economic growth. Critics argue that the measures placed by the funding agencies and governments prioritize the interests of lenders ahead of the poor. According to a study conducted by the Center for Economic Governance and AIDS in Africa, researchers determined that the IMF harms the ability of the government to deal with critical situations, stating, for example,

"The macroeconomic policies and targets laid out in Kenya's recent IMF program, the Poverty Reduction and Growth Facility (PRGF), were overly restrictive, limiting the government's options for fighting health crises like HIV/AIDS and tuberculosis, addressing the massive health worker shortage faced by the country, and having the flexibility to respond to the current economic crisis. As a result, Kenya's PRGF was closed in January 2009. In May, the government signed a new U.S. \$209 million loan agreement through the IMF's Exogenous Shocks Facility (ESF) to help plug budget holes caused by declining revenues and previous increases in the cost of food, fuel, and fertilizer. This ESF loan includes no new conditions, but past policies have resulted in insufficient availability of resources to invest in the health system and to finance development" (The IMF in Kenya, 2009).

Kenyans have little say in these critically important policies, as the policymaking process between the IMF and the Ministry of Finance excludes input from other ministries such as health and education, parliamentarians, civil society, and other stakeholders. These observations show how the IMF and World Bank policies make it difficult for the Kenyan government to address critical human and social needs. Similar cuts enacted in the name of fiscal austerity are occurring throughout Africa, with most

governments frustrated by the process. To understand what is happening requires focusing efforts on the political economy and the impacts that IMF and World Bank mandates are having on domestic social and health care expenditures. Together, these policies will illustrate how neo-liberal thinking is aggravating local health and social conditions.

Theories of the political economy focus on how politics interacts with economics, law, and the way that institutions develop. Political-economic analyses examine how these variables are connected and their impact on various stakeholders, such as political parties, social institutions, civil society and citizens. At the heart of these challenges, the government is forced to make untenable decisions about where their limited resources can be utilized and which groups will receive them. They then use different standards to evaluate how well they are reaching specific objectives. The choice of objectives, however, is deeply contested, as various stakeholders have conflicting goals and methods for accomplishing them (Branch, 2011; Hornsby, 2012).

For example, the IMF and World Bank prescribed policies based on neoliberal capitalist assumptions about the primacy of economic growth as a way to influence the fiscal soundness of the government and its spending priorities. They are interested in reducing debt; increasing reserves and engaging in practices that they claim are aimed at long-term economic growth. The problem is that these ideas are based on neo-liberal assumptions that have, at best, checkered empirical support over the last 60 years, since the creation of the IMF and World Bank at the end of World War Two. These policies often undermine long-term government initiatives to reduce poverty by alleging that social spending is wasteful and unnecessary. Instead, the government must focus on

fostering the conditions for creating jobs by identifying niche markets, privatizing industry, targeting the development of “competitive” (low-wage) industries, lowering corporate taxes, and reducing or eliminating regulatory policies (e.g., to protect the environment). As a rule, these policies are designed to attract more foreign direct investment capital, which is driven by assessments of profitability (Branch, 2011; Hornsby, 2012).

These ideas are based on neo-liberal economic philosophy. Neoliberals believe that free trade is the key to reducing poverty, where different countries need to identify specific niche markets that can exploit indigenous raw materials and local labor markets sectors to advantage in selling inexpensive products in world markets, and thereby create jobs and ultimately, improve standards of living. However, during this process, national governments are forced to reduce taxes, eliminate trade barriers and cut back on social programs. Neoliberal economists believe that this will create stable economic growth in the long term, such that the poor will eventually benefit from having access to jobs. The hope is that this will increase income and slowly change society for the better. A good example of neoliberal thinking can be found in Bannister (2010) who says,

"There is a general concern that trade reform may lead to lower government revenues as trade taxes are reduced and that, in an effort to maintain macroeconomic stability, governments may cut social expenditures or implement new taxes that could disproportionately affect the poor. At the initial stages of trade liberalization, however, replacing nontariff barriers with tariffs and eliminating tariff exemptions will generally increase government revenues. Similarly, if initial tariffs are prohibitively high, reducing them can result in higher trade flows, which will increase revenues. Lowering high tariffs also reduces incentives for smuggling and corruption, which, in turn, can increase the volume of goods recorded at customs and boost revenues. Finally, simplifying the tariff regime to create a more uniform structure, with just a few tariff rates, could increase fiscal revenue by increasing transparency and simplifying tax administration. In the latter stages of reform, however, lowering tariffs may lead to lower government revenues. In this instance, domestic tax reform (particularly

the introduction of broader-based and less distortionary taxes) or expenditure restraint may be required to maintain macroeconomic stability" (Bannister, 2010).

Such statements are good example of how neoliberal ideas influence the policies of international aid agencies (Branch, 2011; Hornsby, 2012).

In the case of Kenya and other African countries, such policies subvert programs designed to reduce poverty in the long term. For example, cuts are now occurring in government programs providing assistance to families to encourage better nutrition, healthcare, and education. These programs have been shown to benefit their standard of living by providing greater access to resources and opportunities, but it has been much more difficult to demonstrate that they led to immediately measurable results in terms of productivity. The failure to find short-term economic benefits is because investments in educating and improving quality of life require many years to yield tangible increases in gross national product. During this process, it will appear as if these programs are failing to achieve key economic objectives. Over the long-term, they are making people self-sufficient. To achieve gains in human capital takes time, and it requires having a certain amount of vision and patience (Branch, 2011; Hornsby, 2012).

The policies proposed by aid agencies can be effective if they are given the opportunity and time necessary to produce measurable results. However, the reality is that programs introduced by international lenders have not been found to have the desired effect in eradicating poverty. Instead, it seems that they have only exposed domestic economies to more shocks. For instance, most recently Kenya was forced to seek out emergency assistance from the IMF. This is because the economy has begun to experience stagnation. To deal with these challenges, the government has reduced entitlement programs and engaged in liberalization reforms. These recommended changes

did not produce measurable gains in employment and poverty reduction. Rather, the effects continue to make the situation worse, by, not dealing with the root causes of poverty. According to Kenya's Treasury Cabinet Secretary Henry Rotich, these moves are necessary to improve conditions, as he says,

"The IMF is to disburse, as a lender of last resort, more aid. It will be priced on commercial terms – signaling its possible impact on Kenya's external debt burden. We are recommending that we request the IMF for significant access to a blend precautionary facility to help cushion us against unexpected external and internal shocks that Kenya remains vulnerable to. Though packaged as a form of insurance that Kenya does not have to take, the terms of the loan are similar to those that the Central Bank of Kenya (CBK) applies while lending to commercial banks as a lender of last resort. IMF lending on commercial terms means Kenya can only access the money at a higher price that is intended to encourage thrift and sound financial management by the borrower." (Kenya Seeks IMF Emergency Loan, 2014).

This statement illustrates how the neo-liberal philosophy of the IMF and World Bank are intended to transform the policies and programs of developing countries. These shifts occur through offering financial assistance with conditions tied to them. In this respect, the IMF's neo-liberal mandates are forcing the Kenyan government to cut back on programs to alleviate poverty and are becoming even more pronounced. This effect on poverty is based on the larger number of loans that the Kenyan government is receiving and the financial impacts that the loans is having on them.

Africa is facing similar challenges, having to cut back on programs to reduce poverty. In these situations, the IMF and World Bank have prerequisites to receiving the money. These provisions are increasing the number of problems, as it forces these governments to accept their terms and conditions. In the long run, these initiatives are ineffective in dealing with critical challenges impacting low-income countries. Instead,

they take a limited approach by combining politics, law and economics into a single theory that works for IMF officials.

The Impact on Healthcare Expenditures

Healthcare is an area greatly affected by IMF loan conditions and restrictions. Under the conditions of the loans, the IMF demands that recipient governments adhere to certain specified fiscal policies and practices. The main problem is that national domestic resources are limited, given the high levels of poverty and the other challenges that low-income countries face creating conflicts between government officials and the IMF. Government officials feel that the IMF does not understand what is happening on the ground and the social effects of their policies are not captured by their models (Quaye, 2010).

In the case of Kenya, IMF dictates have led to draconian cuts in health and other social spending, which are severely impacting the ability of the health sector to address critical challenges. Wafula (2013) provides a good example. He determined that IMF-enforced reductions are affecting the health care system's ability to deliver basic services, stating:

"For every Sh100 President Uhuru's Government will spend this year, only about Sh5 will go towards the ailing healthcare system. In 2010, Kenya spent Sh7.20 for each Sh100 on healthcare. This fell to Sh6.10 in 2011 and last year, it was further cut to Sh5.9. This year, the national and county governments plan to spend Sh5.70 per Sh100 on the sector, translating to 5.7 per cent of the Sh1.6 trillion budget. Doctors have termed the trend a catastrophe. They note the Government will spend Sh2.50 this year for every Sh100, and worry that counties are likely to follow the precedent set by the National Government. The underfunding is happening at a time when most medical equipment in public health facilities are more than 20 years old, some double their lifespan, and may experience frequent breakdowns" (Wafula, 2013).

Wafula's analysis illustrates how government cutbacks are hurting the quality of healthcare provided in Kenya. At the heart of these reductions, the IMF has required cuts in entitlement spending, which includes government expenditures on health care programs in order to meet the terms of their loan agreements. Within the healthcare system, these cuts are leading to drastic reductions, making it impossible to provide quality services. These restrictions keep the standard of living and levels of health low, by not allowing the provision of the most basic services. As a result, the poor will suffer most, as they do not receive any assistance other than that delivered by the Ministry of Health.

According to Easterly (2007), these policies do nothing to help developing countries move out of poverty. Easterly provides impressive empirical evidence demonstrating that these programs benefit only the lenders and foreign direct investors from Western nations and governments. Their main interests focus on ensuring that debtor nations repay the loan, above everything else. To achieve these objectives, they aim to ensure that the government is fiscally stable versus spending money on social programs (Easterly, 2007; Quaye, 2010).

Healthcare requires continuing investments on the part of government officials, the private sector, and nonprofit entities. Great expenses will occur because they have to spend money to purchase equipment and provide high-quality services to the entire population. As these investments do not produce measurable economic benefits, they are viewed as a drain that will not lead to economic gain. Unfortunately, it seems clear that IMF officials fail to understand that these long term investments will have an effect on the person's level of health, which, in turn, will increase their productivity. In this case,

the benchmarks are counter-productive by failing to take into account the impact of these programs beyond a financial perspective (Easterly, 2007; Quaye, 2010).

The neo-liberal thinking of the IMF and World Banks harms poverty reduction efforts in Africa, in general, and in Kenya, in particular. Their models do not capture the economic benefits that improvements in health and education will bring. Instead, they are concerned that these programs will create waste and mismanagement. As a result, loans are tied directly to cutting health programs and improving the position of the government to pay the interest on their loans. Social programs demonstrate their impact in human terms, i.e. improvements in the level of education, health and quality of life. These are indicators that the actuaries at the IMF do not incorporate into their calculations.

For the Kenyan healthcare sector, the effects of the global political economy are evident in the lack of resources and financial support. In the last four years, the health sector was forced to cut spending as a condition of their IMF loans. The short-term focus on loan repayments schedules makes it difficult to address the pre-conditions that would truly make the eradication of poverty possible. The effects of participation in a global, neo-liberal, political economic system are that the quality of life, standard of living and health of Kenyans are becoming worse. This trend is now happening all across Africa.

Social Construction of Rape

The issue of rape is gaining more attention globally. In the US, for instance, a number of high-profile politicians have made verbal gaffes about the subject in the last year, thus raising awareness of the pervasiveness and intractability of “rape culture,” even in the so-called “advanced,” “enlightened” west. The off-hand, unguarded comments of these politicians have stimulated a very real conversation in America about how it will

deal with rape and prevent it from happening. While one might think that public discourse about rape in America is reflective of how the modern world thinks about the issue, this is simply not true.

Different cultures have different ideas about rape. In some parts of the world, people believe it to be a social norm, where victims bring the act upon themselves. Others see it as a major problem to be confronted and challenged with appropriate seriousness. The theory of social constructionism can provide insight not only into *why* there are differences in how various cultures view rape, but also into what has brought about the various perceptions of rape. Views about rape are influenced by many factors, especially religious and cultural influences that “construct” how individuals form their ideas about its occurrence and gravity.

Social constructionism is a theory of knowledge that has its roots in sociology (Andrews, 2012). This theory is an attempt to understand the nature of social reality and the ways that the social world may be distinct from the physical universe normally studied by the scientific method. It is the idea that much of human life is based on interpersonal and social interactions. This theory is concerned with explaining the processes by which people come to understand the world around them. Social constructionism is contrasted principally with essentialism (Sayer, 1997). In an essentialist framework, ideas about how things “really” are themselves are the results of an inherent way we think (Bohan, 1993). Essentialists believe that ideas about various subjects arise organically, naturally, in their essence, and are not shaped by the perceptions or choices made by individuals. In contrast, social constructionism proposes a very different stance on the nature of reality.

Social constructionism proposes that constructs within a given society are shaped by intentional and unintentional human choices (Gergen, 1999). People make decisions based on a range of different influences. People act on the basis of their perceived knowledge. This theory suggests that individuals and groups play an active role in constructing the reality in which they live. In this view, social phenomena do not come to be accepted as true out of nowhere, simply in the confrontation with their essence. Rather, there is a specific process by which perceptions of the nature of social reality take place. Ideas in society, and over time, shape the specific ways that people think about issues, until they have been understood, accepted and unquestioned for so long that they become a part of the implicit, taken-for-granted assumptions of a given society (the commonsense). Likewise, social constructionism maintains that things are not simply established and then become permanently fixed forever. Rather, social phenomena are fluid, and they morph and evolve in response to changes in society. People interpret and respond to events based on their assumptions about the meaning of a given phenomenon. In basing their actions on extant assumptions about what has happened and why, the decisions that people make reinforce the reality that gets created in a given society. While essentialism argues that things have inherent fixed properties and characteristics, social constructionism argues that the elements that constitute the social world of human interaction do not have an intrinsic and immutable nature, but as they are used and remain in society, they must be re-affirmed and maintained, much like a garden. Social constructionism understands that social trends, norms, values, etc. are not simply stuck from one generation to the next. For example, there is nothing inherent in a predominantly Muslim place that subordinates women's rights as a static piece of the

way things are, in and of themselves. Perceptions and meaning making can, and do change over generations, according to the local cultural values of different generations and subgroups. Drawing insights from this theory, one can begin to understand why the subculture of healthcare and service providers who work with survivors of rape have different ideas about what rape is and how to deal with it.

There are many different ways of viewing rape, even if it does not seem obvious on the surface. While some look at rape as an open and shut case of aggression against the weak, and, in particular, against women, others view rape as something that victims bring upon themselves (LaFree, 1989). Some cultures, including sub-cultures in the United States, view rape, not as something serious that a person has done against a victim, but rather, as something that the victim has invited upon herself. Such perceptions may derive from narrow interpretations of certain religious texts. While religious texts are open to many interpretations, it is, unfortunately, all too common for individuals and society to define religion in terms of male domination over women.

For instance, there is a strain in Christianity that views women as potential distractions for men. This is a part of the reason certain sects of Christianity have rejected the idea that women should hold positions of power in their churches and within society at large (Jones, 2005). In this view, if women are allowed to insert themselves in these situations, then they will distract men from upholding and fulfilling their religious duties and obligations (Brown, 1989). The onus is put on women to ensure that *they* are conscious of their effect on men, rather than expecting men to accept responsibility for controlling their behavior around women. This view is not simply limited to Christianity. Other religions likewise propagate the idea that men have dominion over women. In

places like Saudi Arabia, women are not allowed to work unless they have a male sponsor (Burn, 2005). It is also why they have been restricted from driving and holding political office. The assumed worldview is that men must control women because women are primarily a temptation and distraction. This view conflicts with the tenets of many cultures that demand personal responsibility for those people who commit criminal acts. In cases where different social constructs compete, it is often the strongest and deepest held social construct that wins out. In many fundamentalist Islamic countries and parts of the world where hardline fundamentalist Christianity is practiced, the belief that women are a carnal enticement who allure men from the path of righteousness helps to shape the view that any time there has been a rape, women are to blame because men would not have done so but for women's flaunting their sexual attraction. It is important to note in social constructionism that people also play a part in this, in on the ground meaning making and interpretation. Their biographic particulars and social situation also inform understandings.

Ultimately, rape is something that might seem easy to question. Rape, it seems, is sinister, it is a horribly violent crime committed by one person against another. Many societies see it this way, but not all societies. The theory of social constructionism enables us to see that there are different ways of perceiving and constructing the issue, and those elements have been shaped and hardened over time by human cultural practices. People, reproduce social phenomena as a result of a number of cultural influences. Differences in national values can be the product of differences in religious interpretation, just as they can be shaped by political ideologies. They can also be the result of a diverse understanding of the things that are most important in a nation. In

some parts of the U.S., the goal of protecting the defenseless has long been a tradition, but harsh views of rape are also shaped by perceptions of just *who* commits rape, even if those perceptions are not true. In other parts of the world, the idea that women are a distraction to men, and that they are responsible for the behavior of men, drives perceptions of just what rape *is* and how it should be handled.

In Kenya, the common view is that rape is committed only by individuals who are sick or extremely deviant (Muchoki and Wandibba, 2009). Thus, there is a strong social stigma that goes along with being considered a rapist in Kenya. In addition to the individual factors that contribute to sexual violence in Kenya, there are a number of sociocultural factors that are thought to predispose men to committing acts of rape. Even though rape is currently perceived extremely negatively and is highly stigmatizing in Kenya, several culturally prized factors in Kenya may predispose men to committing rape. One of the most important factors is the strong male-dominated culture in Kenya (Muchoki and Wandibba, 2009). Evidence suggests that rape is more common in societies that value males for being strong and dominant (Banyard, Plante & Moynihan, 2004; Wandibba, 2009). In Kenya, physical dominance and strength is viewed very positively as a male attribute and negatively as a female attribute in some local subcultural groups (Muchoki and Wandibba, 2009). Honor is also a prominent feature of the archetypal male in Kenyan society. Although there has been considerable cultural shift away from the traditional practice of older males dominating their younger female partners, this perspective still exists in certain Kenyan subcultures, especially among the elderly. In fact, around 3% of marriages are estimated to result from initial rape (Muchoki and Wandibba, 2009). The low status of women in a patriarchal society puts them at a

higher risk for marital rape as they expect women to be subservient in relationships (Moore, 2008). This view that rape can only be committed by the sick and deviant is problematic as it defines the act as something that only sick and twisted men do. Thus, if men, in general, are not as a whole sick and deviant, then the act that they perform is not rape, but must be something else.

Another prominent sociocultural factor in Kenya is the perspective that rape is a sexual act, rather than an act of violence. Research has shown that Kenyan men convicted of rape consider the woman who was raped at least partially to blame (Muchoki and Wandibba, 2009). Similarly, most felt no sympathy for the woman while another large portion never thought about the act of violence (Muchoki and Wandibba, 2009). These findings indicate that men convicted of rape in Kenya believe that they were right in their domination over a woman, or at the very least, their actions were justified. The lack of sympathy would seem to suggest a psychological personality disorder, but the very high rate of rape in Kenya suggests otherwise.

There is also considerable evidence that many Kenyan men think that women invite acts of rape or defilement. Of the convicts in the study noted above, 35% believed that the women in some ways precipitated or invited the act, justifying the rape in the eyes of the men (Muchoki and Wandibba, 2009). It is difficult to determine to what degree this perception is shared among men in the general population, but given the responses from this study, as well as the very high rate of rape in Kenya, it seems that a significant portion of the male population believes that it is common for women to want or to implicitly offer themselves for aggressive, brutal sexual encounters.

Theories of Rape Counseling Care

Up to this point in the chapter, I have discussed the social, political, and cultural factors that inform meaning making around rape, in order to examine how the high rates of rape and poor quality of services are justified in Kenya. Now, I turn to the theoretical foundations of care for victims of rape. Research reveals that there is a strong tendency for victims of rape to experience strong secondary victimization in medical settings (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2006). Research also indicates that most secondary victimization can be relieved by proper counseling from a trained psychologist (Campbell, 2006).

Many theories and findings are directly applicable to Kenyan victims while others are only partially applicable, in light of cultural and societal differences. As noted in Chapter two, some theories and findings developed in western liberal democratic contexts may be rejected by the parties responsible for funding healthcare programs in Kenya. Nevertheless, a review of current theories for treating rape victims is essential for conducting a study investigating the quality of health services for Kenyan rape victims.

A number of factors contribute to high-quality health care for rape victims. Specialized training in the proper administration of rape exams is crucial for minimizing the potential psychological trauma of such exams. The presence of a rape victim advocate has also been shown to have a significant positive influence on the quality of care received by rape victims (Campbell, 2006). Part of the reason for this is that such advocates help ensure that all of the medical procedures are administered and that they are administered properly. Additionally, advocates help rape victims cope with their situations.

These are universal features associated with positive care for rape victims, even if we must never forget that each victim comes with specialized needs. To address common overarching needs, several theories on treating rape victims have emerged, some theories more empirically based and some are more focused on general, positive, and therapeutic treatments (Vickerman & Margolin, 2009). Empirically, two of the well-supported theories on the treatment of rape victims are Cognitive Processing Therapy and Prolonged Exposure (Vickerman & Margolin, 2009). Cognitive Processing Therapy is based on the belief that there are certain problematic points that often do not allow victims to healthfully process such traumatic events, which, according to this approach, is necessary for healthy recovery (Vickerman & Margolin, 2009). The primary goal of this therapy is to have victims overcome their processing blockages, by recounting the traumatic event through the use of acceptable depictions. A related therapy is Prolonged Exposure, which attempts to desensitize victims to the violent events that occurred by repeated and controlled exposure to such events (Vickerman & Margolin, 2009). The desensitizing exposure uses thought experiments, not of course real-life participation in similar events. Both therapies rely on cognitive reconstruction to make the harmful events easier to tolerate.

Other popular therapies include Eye Movement Desensitization Reprocessing and Supportive Counseling. Eye Movement Desensitization Reprocessing requires video footage of figures that are intended to represent the victim and the perpetrator (Vickerman & Margolin, 2009). The victim watches the video and vocally recounts the traumatic events while partially attending to the oscillating finger of a therapist. The moving finger is intended to draw the attention of the victim to the external stimuli,

allowing for internal attention to be focused on the traumatic events (Vickerman & Margolin, 2009). Supportive Counseling refers to a wide array of counseling that asks the victim to confront and recount the events of the rape, often in the presence of a group whose members have similar experiences (Vickerman & Margolin, 2009). A goal of this therapy is to put the events in a more positive light by neutralizing and generalizing them. There are a number of other types of treatment options available for victims of rape; the most empirically successful therapies involve counseling. While these therapies have strong empirical backing, their usefulness and applicability in the strained health care system in Kenya is questionable.

The Kenyan Ministry of Health, Division of Reproductive Health, developed a training manual (Clinical management of sexual violence- A training course for health service, 2011) to ensure the standardization of training and delivery of quality services to survivors of sexual violence. This manual was informed by the revised National Guidelines on Management of Sexual Violence. Its objective is to equip practitioners with competencies for provision of comprehensive care to survivors of sexual violence that includes: forensic examination, specimen collection, analysis, documentation and provision of clinical care and psychosocial support (see Appendix O). This training is designed to be an on the job training (OJT) for practitioners. This is done during the Continuing Medical Education (CME) sessions and the duration proposed for the complete training is 35 hours of classroom training and 32 hours for OJT. This way, the practitioners can learn practical skills while working, and it minimizes the time taken out of their normal responsibilities. These training sessions are supposed to be conducted at the health facility, and the proposed allocated time is two hours per session.

Psychosocial care and support is one of the modules covered in the training manual. It includes “psychological assessments, psychological counselling and follow up, social intervention and referral for specialized mental health services where appropriate” (p. 70). The counseling model used is the Egan’s Generic Model of Counseling Skills. This counselling is a three-stage model and each state consists of specific skills that the therapist uses to help the client move beyond the traumatic experience (Downing, Smaby & Maddux, 2001). There are 3 main questions that this model helps to address with the client/victim: 'What is going on?'; 'What do I want instead?' and 'How might I get to what I want?' Stage one of this model is the storytelling phase, allowing the counselor to explore and understand the clients’ condition. In this stage, the survivor would be able to tell their story in a safe environment. The counselor in this stage is to provide the safe space where the survivor can feel fully heard and acknowledged. Stage two of this model is about helping the victim/client visualize what they want for themselves going forward. The aim of stage 3 is about strategy and implementation. In this stage, the counselor helps the client move towards the goals that they identified in stage 2. (Russell & Petrie, 1995)

While this counseling model is good, it requires time as well as follow-up appointments with the survivor. In later chapters, we will see the issues that arise with the current training model, as well as the feasibility of on the job training for the health practitioner’s on the ground.

CHAPTER IV

METHODOLOGY

The research process involves a series of steps that include formulating a research question, a review of previous literature on the subject, identifying relevant variables where applicable, constructs and theories, selecting a research design, data collection, analysis and finally, reporting the findings. Qualitative research involves exploration of social phenomena and uses non-statistical methods of analysis. Qualitative research is concerned with understanding behavior and phenomena, examining variables such as attitudes, knowledge and beliefs (Denscombe, 2004; Monette, Sullivan and DeJong, 2005). This chapter begins with an overview of qualitative research and focuses more specifically on content analysis. The chapter then discusses the constructs of trustworthiness and validity. Specifically, it examines how terms such as conformability, dependability and credibility run parallel to the concepts of validity and reliability used in quantitative, positivist research. The chapter concludes with a description of the methods of data collection and data analysis used in this research.

Overview of Qualitative Methodology

Qualitative research aims to provide a richer, more detailed account of complex issues. Qualitative research enables an in-depth understanding of phenomena (Nicholls, 2005). It is often used to elicit and explore perceptions of experiences that are unattainable using quantitative research methods. The purpose of qualitative research is to describe and explain the perceptions that individuals construct to make sense of their experiences (Creswell, 2007; Hoepfl, 1997). Qualitative interviewing is concerned with uncovering individual and collective perceptions related to specific phenomena. Thus,

qualitative research is intrinsically interpretive (Daly, Willis, Small, Green, Welch, Kealy et al., 2006; Draper, 2004; Lincoln & Guba, 1984). Qualitative studies offer participants the opportunity to respond to questions in their own words (Lincoln & Guba, 1984), but the significance of the words that people attach to different experiences is always a matter of interpretation (Draper, 2004). The subjective experience of respondents can never be fully captured and rendered through objective empirical methods.

Interactions between the researcher and the participants in qualitative research studies are often informally structured, in order to promote trust, candor and full disclosure, and to afford the participants the opportunity to speak freely and the researchers to follow up immediately with questions for clarification (Lincoln & Guba, 1984; Shenton, 2004). Qualitative research methods open a window for the researcher to access the framework that participants use to explain their actions and the meaning and significance that they ascribe to events (Marshall, 1985). The primary source of data in qualitative research is the participants' descriptions of their lived experience. Qualitative research interprets the participants' accounts of experiences to understand how and why someone acted the way they did, in a particular context, setting or circumstance (Flood, 2010). The methods of qualitative data analysis range from hermeneutical analysis, heuristic analysis, to grounded theory, domain analysis, and analytic induction.

Content analysis: In applied health studies, content analysis is a common and widely used approach to qualitative data analysis (Tullis & Albert, 2008). It describes a family of analytic methods that include strict textual analysis, semantic analysis, interpretive analysis, intuitive, and impressionistic analysis (National Institute of Nursing Research, 2003). According to Patton (2002), qualitative research that employs content

analysis tends to focus on language characteristics as a communicative device, with particular attention given to the contextual or content meaning. Text data may come in electronic, print, or verbal form. Methods of data collection include secondary sources (manuals, books, and articles), observations, focus groups, interviews; open-ended survey questions, ethnographic field work or narrative accounts (Zhang & Wildemuth, 2009).

Among the most common form of qualitative data collection are individual interviews, focus groups, case studies and participant observation. Focus groups usually comprise of about seven to twelve people and enable in-depth discussion of particular topics led by a moderator. The use of focus groups is identified as a best practice approach in this type of research as it yields high-quality data that is important for natural settings (Brod, Tesler and Christensen, 2009). Case studies provide in-depth reviews of relationships, events, and experiences (Denscombe, 2004). Participant observation as a means of data collection involves the researcher playing a singular role of recording actual behavior but not attempting to influence or control the phenomenon being studied in any way (Brod, Tesler and Christensen, 2009).

Tullis and Albert (2008) observe that qualitative analysis does not just focus on mere examination of language and use of words. The goal of qualitative content analysis is to provide an understanding of the phenomena being studied (Patton, 2002).

Qualitative content analysis is a research method designed to analyze the subjective interpretation of events; it accomplishes this by systematic classification in which patterns or themes are identified and coded.

Common research objectives in qualitative research aim to explore or discover and to construct meaning. Qualitative data sets such as words, feelings, objects, and

vision are collected and presented as text usually. Such data are particularly useful for developing theories on the issue being studied. The purpose of qualitative research is to provide understanding of phenomena. Qualitative research shares the general characteristics of all social scientific research in seeking answers to questions using well-defined procedures to answer that question and produce findings that are applicable beyond the bounds of the particular study (Creswell, 2007). It is particularly well-suited to study new, previously unexamined or little-studied phenomena and to develop new theories.

Qualitative research usually adopts a wide-angled lens; it is designed to explore the full scope and depth of the phenomena of interest. This contrasts with quantitative research where a narrow lens is adopted, and one specific hypothesis is tested. Qualitative research adopts a bottom-up or exploratory approach to scientific inquiry, where the research often results in the generation of new hypotheses and new theories from the data collected. This is also described as an inductive approach (Denscombe, 2004; Monette, Sullivan and DeJong, 2005). The inductive approach generates general propositions from observing specific examples of the phenomena.

In qualitative research, the behavior or phenomena of interest is often studied in a natural environment. Human behavior is viewed as dynamic, situational, social, and personal (Denscombe, 2004; Monette, Sullivan and DeJong, 2005). The interpretive researcher attempts to find out the essence of the phenomenon and assumes that this essence can be understood. Thus, subjective phenomena are investigated based on the assumption that reality is grounded in people's experiences (Rolfe, 2006).

The main data types in qualitative research are texts, images, and sounds. These data are usually analyzed as text (Denscombe, 2004; Monette, Sullivan and DeJong, 2005). The instruments used in data collection are flexible. The inherent flexibility in qualitative designs means that designs can be adjusted as the study progresses to incorporate new factors as they arise. It also has the benefit of allowing the researcher the flexibility to deepen investigations to find out why or how.

Sampling and Representativeness in Qualitative Research

Given that collecting data from an entire population is not feasible in most research, choosing a study sample is a key step in any research design (Marshall, 1996). Sampling refers to the process that researchers use to choose a portion of the population to study (Ploeg, 1999). The significance of a sampling method is directly related to validity (Malterud, 2001). In qualitative research, sampling should be clear and result from well thought out research questions (Harris, 2009). In qualitative research, the phenomenon being studied drives the selection of participants. Samples are selected based on the research aims as well as the researcher's judgment regarding participants who have had experiences with the phenomenon of interest (Groenewald, 2004). Qualitative researchers usually focus their sampling on the setting or participants that are most likely to provide the most significant or relevant information about the phenomenon (Daly et al., 2006).

Purposive sampling is one of the most commonly used sampling technique in qualitative studies (Collingridge & Gantt, 2008; Harris et al, 2009; Lincoln & Guba, 1984; Ploeg, 1999; Sandelowski, 2000). Purposive sampling is a type of sampling that involves the intentional selection of a small number of participants or data sources that

meet the study criteria (Malterud, 2001; Russell & Gregory 2003). The participants are selected to serve a purpose consistent with the study objectives (Collingridge & Gantt, 2008).

The type of purposive sampling employed in this study was criterion sampling. In criterion sampling, the researcher purposefully selects participants who have experienced the phenomenon.

The sample size for qualitative studies cannot be pre-determined in advance (Cutcliffe, 2000). The intent of qualitative studies is to describe, capture and articulate the lived experience to the fullest extent possible (Porter, 1999). Because the amount of data collected from each participant can be extensive and potentially overwhelming, it is generally recommended to use much smaller sample sizes than are typically used in quantitative studies (Hycner, 1985; Maggs-Rapport, 2001; Mays & Pope, 1995). In qualitative research, it is considered better to study a smaller number of the participants' experiences in depth than a larger number only superficially (Russell & Gregory, 2003). Qualitative analyses often find and attribute significant meanings in every sentence in each interview (Maggs-Rapport, 2001).

Instead of making *a priori* decisions about the sample size as researchers using quantitative methods do, in qualitative research, the number of subjects is commonly a decision made during the course of data collection. This typically occurs when the researcher determines that no new themes are emerging, and the new interviews are providing redundant information (Thompson & Walker, 1998). When this point is reached, it is known as the point of data saturation (Cutcliffe, 2000; Marshall, 1996; Ploeg, 1999; Sandelowski, 2000).

In qualitative research, participants are not randomly selected and are often selected on the basis of having some issue of research interest in common. This contrasts with quantitative studies where larger groups are studied, usually randomly selected, with samples being representative of the general population.

In terms of disclosures, the researchers in qualitative research and their biases may be known to study participants (Denscombe, 2004; Monette, Sullivan and DeJong, 2005). This means that experiences, values and biases that the researcher holds that may impact on the interpretation of the findings of the study are disclosed (Mehra, 2002). Likewise, the characteristics of the participants in the study may also be known to the researcher, which then need to be taken carefully into account in conducting the analysis to assure that they do not bias the results (Denscombe, 2004; Monette, Sullivan and DeJong, 2005).

Content Analysis in Qualitative Research

Content analysis is a widely used and effective method of data analysis in qualitative research. According to Hsieh & Shannon (2005), it encompasses a range of methods crossing textual, impressionistic and intuitive approaches, thus, making it valuable for diverse studies. There are three main approaches to content analysis – conventional, directional and summative; the differences between these are based on their coding schemes, threats to trustworthiness, and coding categories.

Conventional Content Analysis: Conventional content analysis is used mostly with descriptive study designs. In this method of data analysis, preconceived categories are not used; rather, categories are derived from available data. This process is also known as inductive category development. Open-ended questions and probes are used

where interviews are the main source of data. Repeated readings allow immersion in the data, usually followed by word by word reading to generate codes; words that highlight key concepts are captured in this process.

Codes in turn are placed in categories, based on their connections and differences. Emergent categories are used to group codes into clusters of information. The numbers of clusters are usually kept between 10 and 15 to enable broad sorting of codes. The relationship between subcategories drives further organization and the hierarchical structure of the categories. The concurrence of relationships is used to identify categories between them based on the research goal. The advantage of this approach to content analysis is that direct information is obtained from study participants without the imposition of preconceived categories (Hsieh & Shannon, 2005; Miles & Huberman, 1994).

Directed Content Analysis: Hsieh & Shannon (2005) describe directed content analysis as a deductive application of theory in qualitative research. The goal of this approach is to authenticate or extend a theory or conceptual framework; research questions are derived from existing research and theories. Existing theories guide predictions about how the variables relate to each other, and so guide the coding scheme adopted. The directed approach to content analysis represents a more deductive approach than the conventional approach. Open-ended questions can be used where interviews are the primary method of data collection followed by targeted questions that investigate predetermined categories. Transcripts are read to identify themes and to group those using pre-identified codes. New codes are developed for texts that do not fit into existing categories. The directed approach has some challenges such as admitting potential biases

into the research, and the effects of contextual factors may be lost by the attention to theory (Hsieh & Shannon, 2005; Miles & Huberman, 1994).

Summative Content Analysis: The summative approach to content analysis begins by identifying and assessing content within the text in order to understand how words or contents are used contextually. After this exploration of usage, latent content analysis is done. This is a process of interpretation of content to find the underlying meanings of words. The summative approach to content analysis has the advantage of being non-reactive and prominent; it provides a basic understanding of how words are actually used. However, one significant limitation to this approach is that attention focused on the broader meanings that are latent in the data. This approach relies on credibility as a measure of quality or trustworthiness. This is done by showing consistency between data and its interpretation (Hsieh & Shannon, 2005; Miles & Huberman, 1994).

Benefits of Qualitative Research

Qualitative research has numerous benefits and advantages. It provides rich textual descriptions that enable an understanding of the human perspective in social phenomena just as in contrast to statistical relationships. Thus, the intangible forces that impact the phenomena (intangible factors like gender roles and religion) can be identified and taken into account in thinking about what needs to be done to improve a situation. Participants use their expressions to try to capture their perceptions clearly. Qualitative research is thus important for certain fields and professions where broad understanding of phenomena is critical for assessing and appreciating the full gamut of factors affecting complex phenomena.

Qualitative research provides textual descriptions, and thus addresses the human side of people's experiences. It has the benefit of using methods that allow participants to use their words, rather than fixed forced choices as occurs in quantitative research (Rolfe, 2007; Porter, 2007; Morrow, 2005). Qualitative research is also able to provide broader views of situations; for instance, a case report can provide thick description of an issue where one can see its potential relevance and application to many other situations (Nicholls, 2005).

Trustworthiness and Credibility

Trustworthiness is an important standard of quality in qualitative research. Trustworthiness is composed of different dimensions that run parallel to positivist quantitative constructs regarding quality and the confidence that one has in the conclusions drawn from the data. For example, dependability relates to reliability, credibility corresponds to internal validity, confirmability relates to objectivity, and transferability corresponds to external validity. While these criteria run parallel to positivist constructs, they do not accomplish the same goals since positivist quantitative research yields different information than that of interpretive qualitative research.

Trustworthiness and credibility are the key standards of quality used to assess qualitative research (Hoepfl, 1997; Long & Johnson, 2000; Thompson & Walker, 1998). These standards cover the data collection procedures, researcher's biases and assumptions, data quality checks, as well as monitoring differences in data interpretation (Marshall, 1985; Orcher, 2005). These criteria are concerned with the strategies used to ensure honest responses from participants, as well as the experiences and qualifications of the researcher (Shenton, 2004). However, Morrow (2005) states that these parallel

criteria do not accomplish the same goals as the corresponding quality standards since quantitative and qualitative research lead to the different types of knowledge claims. Qualitative research, for example, obtains knowledge from large samples while quantitative research focuses on smaller samples.

Dependability corresponds to reliability and refers to the issue of consistency in the way a study was carried out, looking at researchers, time and analysis of data. The research findings should be derived through elaborate processes. Such processes should be repeatable and described explicitly. This is done through careful monitoring of the research design, audit tracking (detailed record of activities and processes in the study), emerging themes, memos, and models (Rolfe, 2007; Porter, 2007; Morrow, 2005).

Credibility corresponds to internal validity and involves how rigorously the research process is conducted and how that fact is communicated to others. Credibility is achieved through processes such as the use of peer researchers; prolonged engagement with study participants; continuous field observations; the reflexivity of the researcher; participant checks; negative case analyses; co-analyses and validation. Credibility is also reinforced by detailed descriptions that include culture and the context of experiences (Rolfe, 2007; Porter, 2007; Morrow, 2005).

Transferability refers to the extent to which the findings of a study can be generalized to different contexts or how far a researcher can claim a general application of their emerging findings theory. Confidence in the transferability of findings is promoted by providing adequate information about the researcher, the context of the research, its processes, and participants, as well as the relationship between the researcher and the participants. Such information enables a reader to assess how far the information

can be transferred. However, since qualitative research does not use statistical analysis and involves small samples, qualitative data is commonly criticized for not being as generalizable as quantitative research results (Rolfe, 2007; Porter, 2007; Morrow, 2005).

Confirmability refers to the fact that the findings from the study should represent the phenomena being studied, rather than the biases and beliefs of the researcher. The integrity of the data, the analytic process and bracketing of subjectivity are important here. Furthermore, the criteria for dependability are also important for confirmability (Rolfe, 2007; Porter, 2007; Morrow, 2005).

Study Design

Study setting: Nairobi is the capital city of Kenya with a population of 3.2 million (Kenya National Bureau of Statistics [KNBS], 2010). It is an urban center populated by multiple ethnic groups and religions. Nairobi is a commercial center for Kenya nationally as well as regionally (City Council of Nairobi, 2011). Nairobi contains a mixture of high-income, low-density residential areas as well as low-income densely populated areas (KNBS, 2010). Private health care centers are located mainly in high income neighborhoods, and the public hospitals are mainly located next to middle and lower income neighborhoods.

Research sites: For this study, LVCT Health served as the primary research conduit. LVCT Health is a Kenyan non-governmental organization that specializes in evidence-based policy formation and programming. It partners with the Kenyan government in service provision for HIV positive individuals and sexual violence survivors, among other populations in need (Kilonzo et al., 2009). Most of its funding comes from competitively-awarded grant proposals from donors such as the Centers for

Disease Control (CDC) and USAID (LVCT, 2013). Among other things, the organization provides personnel to sit on different health care task forces, such as the national AIDS council. I participated in research internships (2011 and 2012) with LVCT health. During this time, I familiarized myself with the study setting, the local institutional review board guidelines and local terminology that I might need to be aware of. This helped me better understand the contexts in which health care practitioners in Nairobi city work. I met with the executive director of the organization to discuss my research interests, and afterward, I drafted a letter of agreement. The agreement detailed the procedures that LVCT and I would follow in conducting the research (see Appendix C).

Per the agreement, as part of the recruitment process, LVCT Health sent out letters of introduction to administrators at various health care facilities in the Nairobi area that are affiliated with LVCT and provide services to sexual assault survivors. In these letters, I requested the assistance of the administrators in identifying appropriate frontline health practitioners who could inform the study objectives. The letter of introduction explained the purpose of the study as well as study procedures, including confidentiality. The practitioners at the private health facilities were recruited by the manager for medical services and psychosocial support.

The public health facility sites in Nairobi were level 2 and 3 health centers and a sub-district hospital. The private health facilities were all full-service hospitals that have Gender Violence Recovery Centers (GVRC). The private facilities are seen by the practitioners in public facilities as the model service centers.

Study sample: Health care practitioners were recruited from the LVCT Health supported sites in Nairobi that have functional Post Rape Care (PRC) services and from

four, Nairobi Women Hospital Gender Violence Recovery Centers (GVRC) in Nairobi that also have functional PRC services. The LVCT Health supported sites are in public health facilities and the GVRC sites are private health facilities in order to participate in an interview. The health care practitioners had to have worked at the facility for a minimum of six months. The health practitioners eligible were from all ethnic groups in Kenya and could self-identify as male or female.

The health practitioners excluded from this study were those who were in supervisory roles in their respective facilities. The rationale for excluding supervisors was that they are often in charge of conducting ongoing training on the management of sexual violence and they also don't work directly with survivors. In addition, those practitioners who had not yet worked a minimum of six months at their respective facility were also excluded from the study. The rationale for excluding health practitioners who had worked less than six months was that they might not have had adequate experience in serving survivors of sexual violence. The rationale for excluding minors is that this study focuses on health practitioners working in the field of post rape care services. The health practitioners' training in Kenya requires enrolling in and completing an approved medical training and licensure exam post high school.

In this study, the criterion that was used was that the participants were health care providers who were responsible for providing services to female survivors of sexual violence (Collingridge & Gantt, 2008). I decided to interview providers occupying a range of different positions because the services provided to survivors are provided by a range of practitioners each delivering specialized services.

Sample size: In total 28 participants were interviewed for this study, 16 female and 12 male, from eight post-rape care facilities, four public and four private, throughout Nairobi Kenya. The health practitioners eligible for this study were both male and female who were over 18 years old and provided direct services to female survivors of sexual violence. They comprised nine clinical officers, seven nurses, five trauma counselors, three social workers, one clinical psychologist, one pharmacy technician, one reproductive health officer and one Voluntary Counseling and Testing (VCT) counselor. Their years of medical practice ranged from two years to 30 years. The interviews took place in a private office at the respective health facility. All practitioners interviewed had worked at their current facility for a minimum of six months, and their time at the current medical facility ranged from six months to 48 months. The practitioners worked at various levels of the healthcare system, including health center, Level 2 health center, Level 3 health center, Sub- District Hospital and Hospital.

Data Collection

Instruments: The research was designed to conduct in-depth interviews to gain an understanding of the provider's experiences of providing services to female survivors of sexual violence in Nairobi, Kenya. The in-depth interview is a way for the researcher to explore and collect information about experiences (Ploeg, 1999). It is also a means to build rapport with research participants. In-depth interviewing is the most commonly used tool for qualitative data collection (Osborne, 1994; Ploeg, 1999; Wimpenny & Gass, 2000). The interviewing was conducted one-on-one between the interviewer and the participant (Bradbury-Jones, Sambrook & Irvine, 2009; Harris et al., 2009). The interviews followed a semi-structured interview protocol format. The semi-structured

interview is ideal because it allows for follow up questions to arise during the course of the interview.

The interview began with an introductory script and was followed by semi-structured interview questions, allowing the participant to elaborate on their experience and ask follow-up questions as necessary. The interview schedule contained ten main questions with follow-up probes. Demographic information was collected at the conclusion of the interview (see Appendix B). The questions were generated based on a review of the literature on service provision to survivors of sexual violence (Campbell & Johnson, 1997; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Christofides & Silo, 2005; Keesbury & Thompson, 2010; Kelleher & McGilloy, 2009; Kilonzo et al., 2008; Martsof et al., 2010). These questions were further refined based on my research internships that included visits to various PRC sites in and around Nairobi, Kenya.

As can be seen in the interview guide (Appendix B), the questions focused on the practitioners' attitudes, workload, challenges and rewards and emotional impact of working with survivors, coping mechanisms and strategies, ongoing medical training and recommendations that can improve their work. The questions addressed the daily experiences of health practitioners as they serve survivors of sexual violence. Key issues included: describing their role and designation within the facility, describing how disclosures of sexual assault occur and how they respond to them; describing their coping mechanisms/strategies; describing both challenging and rewarding aspects of working with survivors, the training received connected to working with survivors; and their overall experience of providing services to a survivor of sexual violence been like for them.

The interview questions were constructed to encourage in-depth reflection on the experiences. Prompts were used to encourage participants to provide more depth of explanation on certain points and to keep the interview focused on the experience of caring for survivors. The questions elicited rich descriptions from the practitioners about their experiences. Anecdotes, stories and recollections of the practitioners work with survivors were encouraged. The demographic information provided descriptive data on the participants that helped put the responses of those providing services to female survivors of sexual violence in context.

The time allotted for each of the interviews was an hour and a half. Actual interviews were 42-87 minutes in duration, and the average was 59 minutes. The researcher kept a journal after each interview, writing down thoughts about the exchange, notes about the interview itself, as well as anything that stood out during the interview.

English and Kiswahili are the official languages of Kenya. All interviews were conducted primarily in English. Medical training in Kenya is conducted in English which led to the decision to conduct the interviews in English. Continuing Medical Education (CME) sessions are also conducted in English further supporting the decision to conduct interviews in English. As all the practitioners are literate, I did not perceive this as influencing the participants in a particular direction. Participants were informed that they could answer in English or Kiswahili depending on their comfort level.

Study participants were debriefed at the conclusion of the interview to provide an opportunity for them to reflect on the interview and clarify or expound on anything that they said. They each received 1,000 Kenyan shillings (the equivalent of \$10) for participation in the study at the conclusion of the interview.

IRB Approval

Ethical approval to conduct this study was obtained from University of Massachusetts Institutional Review Board (IRB) and the Kenya Medical Research Institute (KEMRI) Ethics Review Committee. A research permit from the National Council of Science and Technology was also secured. A clearance letter granting permission to conduct research at the government health facilities was obtained from the Ministry of Health, Division of Reproductive Health. In addition, district level clearance was obtained from the Dagoretti, Embakasi and Makadara District Medical Officers of Health (DMOH) informing the health facilities in charge that I was granted access to their particular health facility.

To protect the confidentiality of the participants, all interviewees were assigned a pseudonym post interview. Identifiable information was deleted from the digital files and the transcripts. All study records, including any codes of the data, were stored on password-protected computers and on a secure server. The recording equipment was maintained in a locked file cabinet located in the principal researcher's locked office.

All interviews were digitally recorded with the permission of the study participants and transcribed verbatim by professional transcriptionists who had prior research experience. The transcriptionists all signed confidentiality agreements (see Appendix C) prior to engaging in the transcribing. Once the interviews were transcribed, any additional field notes were attached to the corresponding transcript. The digital files will be destroyed three years after the close of the study. The two computers where these files are stored have password protection to prevent access by unauthorized users. Only the principal investigator has access to the passwords.

Data Management

To manage the study data, the interview transcripts were entered in NVIVO 10, a software program for qualitative data analysis that enables researchers to organize, analyze, and ultimately, develop the final themes. Data entry was completed by importing the transcribed interviews and additional typed field notes directly into the software. I utilized this software for content organization, coding and theme identification.

Data Analysis

A marked contrast exists between data analysis in qualitative and quantitative research. Unlike quantitative research that uses structured tools and standard measurements to explore statistical relationships, the goal of qualitative research is to identify patterns, themes and features of the phenomena. Thus, the methods used in this type of research were appropriate to the goals of the study. As a result, it is important to be clear that the interpretation of qualitative data is always ultimately subjective, as the researcher adopts, identifies and constructs explanations that best explain the results found in the data. While the confidence level in quantitative studies has a stated degree of certainty (typically, $p < .05$, meaning that, in one of twenty cases, the conclusion drawn is erroneous), in qualitative studies, the confidence level is less well defined.

The data analysis technique followed was Colaizzi's (1978) approach to analysis (Alexis & Shillingford, 2012; Arthur et al., 2006; Martins, 2008; Saghafi, Hardy, & Hillege, 2012; Scannell-Desch & Doherty, 2010). The steps are: 1) reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account; 2) extracting significant statements that pertain directly to the phenomenon; 3) formulating meanings for these significant statements; 4)

categorizing the formulated meanings into clusters of themes that are common to all participants; 5) integrating the findings into exhaustive description of the phenomenon being studied; and, 6) incorporating any changes offered by the participants into the final description of the essence of the phenomenon (Martins, 2008; Taylor, Magnussen & Amundson, 2001; Wojnar & Swanson, 2007). The analysis of the transcripts was initiated as soon as the transcript of each interview was available in order to incorporate insights from earlier interviews into the ongoing data collection.

The first step was to listen to the recorded interviews alongside the transcripts to ensure that all the interviews were transcribed accurately and add any content that may have been missed by the transcriptionists. As the principal investigator, I read all the transcripts at least twice and listened to the interviews twice to gain an understanding of the flow of the interviews and ensure that I fully understood the depth and meaning of each interview. During this stage, any thoughts and ideas that came to me from my previous knowledge of sexual violence service provision were noted along with my biases and suppositions. I then looked for key emerging words, phrases, and significant statements. For example, key words were: “frustration, challenging” and so forth. I critically searched for themes that appeared in the interview transcript that most described the health practitioners’ experiences providing services to female survivors of sexual violence. I then formulated meanings from the significant statements that appeared in the transcripts. Next, I grouped the formulated meanings into clusters of themes. The groups of clusters of themes that reflected a specific idea around service provision to survivors were incorporated together to form a distinctive theme. I then merged the themes into an

exhaustive description of the factors affecting the quality of services to female survivors in Nairobi, Kenya.

Trustworthiness and Credibility: For this study, I maintained an audit trail, a comprehensive account of what was done and why. The audit trail consisted of detailed notes about the collection of the raw data, the analysis of the data, and the production of the findings. I noted any changes in my approach to interviews and why. Moreover, during the data collection process, I had biweekly phone conversations with a faculty member to review the interviewing procedures. We talked about how the interviews were proceeding, different wording of the questions when participants seemed not to understand, my methods for self-care during the process and the spacing of the interviews.

To achieve credibility, I conducted all interviews and allotted sufficient time for each interview to exhaust all topics related to the participants' work with survivors of sexual violence. This allowed the participants ample time to respond fully or "tell their story," avoiding premature closure. To further ensure the credibility of the study, I had a second reader, a member of the dissertation committee, engage in the data analysis process. The second coder read a subset of the interview transcripts and engaged in biweekly discussions with the researcher around emerging themes. These meetings served as a way to cross-check my findings as well as serve as a sounding board to ensure that I remained on track. The suggestions and feedback from the committee member were incorporated into the final study results.

While English is one of the official languages in Kenya, it is often not the first language learned. Some practitioners used phrases that may not be commonly understood

by native English speakers. In instances where this occurred, I explain in brackets the native Swahili interpretation of what the practitioner was expressing. In some areas, I took out filler words such as “eh,” “ah,” and “um,” to facilitate better comprehension for the reader .

Limitations

This study focused on practitioners’ experiences in providing post-rape care services to female survivors of sexual violence. It is based primarily on conducting qualitative, in-depth interviews to reveal the practitioners’ experiences. One of the study limitations is that, although all study participants were chosen based on their direct contact with survivors of sexual violence seeking services, their contact with survivors on a day-to-day basis varied considerably by location.

This study sample was limited to a small geographical area in Kenya, namely the capital city. Health practitioners that serve survivors living in different geographical areas of the country may have different experiences that inform understanding of this phenomenon. Although it is important to note these potential limitations, in the end, I believe that the perspectives of the practitioners discussed in this dissertation are representative of the predominant attitudes and experiences of other practitioners in Nairobi city.

CHAPTER V

RESEARCH RESULTS

The results of this research reveal many new and significant insights into the factors affecting the quality of services provided to survivors of rape in Kenya. The analysis is guided by the four major domains of the ecological model and spelled out as they inform the quality of services provided to rape survivors: the personal, interpersonal, institutional, and cultural. Key themes arising from the data analysis are reviewed under each of the domains. It is also important to note that themes cross domains.

Individual Level

At the Individual level, the most salient, felt experience is the shortage of trained personnel. The most common concern expressed by the practitioners was that they were doing too much with too little help. In Kenya, the health facilities are severely understaffed, which greatly affects the quality of services provided by the practitioner. Practitioners emphasized the need to increase the number of trained medical professionals.

Practitioners identified a number of specific stresses that follow from the limited number of medical practitioners trained to provide post-rape care services. Among the major concerns to emerge at the level of individual factors were high workload, major time constraints, and having to multi-task. The shortage of trained personnel leads to main three problems: 1) high workload, 2) time constraints, and 3) multi-tasking. These three issues, in turn, give rise to the problem of burnout. One way that burnout is particularly worrisome is that it leads to the formation of negative attitudes towards the survivors. As the practitioners feel the stress and begin to feel the threat of burnout, to

deal with the situation, some then just unilaterally modify the (scope of) services, deciding that they simply will not provide counseling, assessing it on the basis that they think that they are only qualified to provide medical services, and they do not have the time to counsel survivors. The situation can be schematically represented as follows:

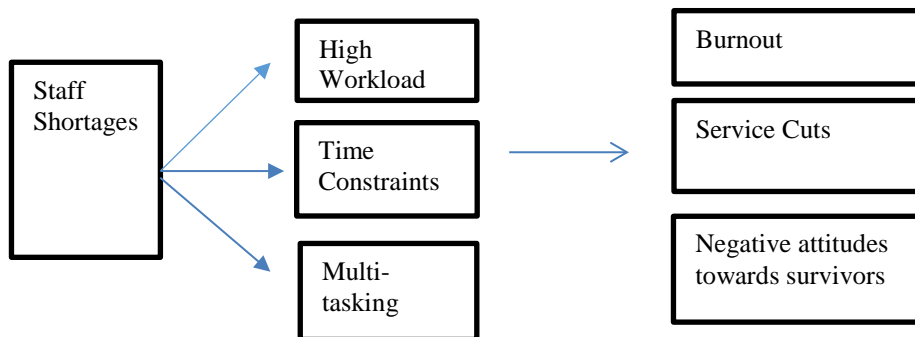


Figure 5.1: Individual Level Factors

High workload: Practitioners on call provide services to all patients that come to the health facility. None of the practitioners are designated to work strictly with survivors, and not see other patients. Thus, when a survivor comes in, they receive services from the practitioner who just happens to be available at the time. The practitioners repeatedly remarked that, due to the large number of patients that they have to see, their workload is high. If a clinical officer is available to examine a survivor, the survivor is sent to them, but this is often not the case. Many practitioners talked about the high numbers of patients that they see on an average day. One shared:

This facility is very busy. There are days we can see over 200 out-patient cases, yeah. The work-load can be that high, and especially when we didn't have the clinical officers, you can imagine you are the nurse, you are the doctor, you are giving all those services so you can imagine, yeah. (Female Nurse).

Another talked about feeling overwhelmed. He shared that as a result of the current working conditions, it is often not feasible to provide the expected level of

comprehensive services that survivors deserve and are expected to receive. He expressed the following:

We have a number of challenges, because the facility, like this facility, we see around 150 outpatient cases and you might find only one clinician and with that work-load. The normal patients in a day and with that work load you find the clinician is sometimes overwhelmed, they are overworked and I am not saying he may not do the necessary [following treatment protocol], but with those constraints you, you find it's not easy with such working conditions. (Male Clinical Officer)

One practitioner provided another perspective on why their workload was high. He noted that because the health facility was located near a large slum, the facility served a large catchment area. He shared:

The other challenge is workload. It's quite a lot because we are not seeing GBV [gender based violence] only, I'm seeing other patients. And you can attest to that 'cause I am busy, busy, busy. So the workload is quite high, even understanding our catchment area, the workload is quite high. (Male Nurse)

Survivors are supposed to be given priority when they report to the health facility.

This means that, even in cases where there is a long line of patients waiting to be seen, the survivor is moved to the head of the waiting line. But when there is only one staff member available, and he or she is with another patient, then there is no one to attend to the survivor. Many interviewees felt that the only solution was to get more practitioners:

Sometimes you'll find that it is one staff [practitioner]. When she has her things [work] to attend to, there will be nobody to attend to those people [survivors]. That is the challenge. And therefore we hope and believe that workload will reduce. We cannot do anything about it because for workload the only solution is to get more staffs. (Male Nurse)

Another practitioner shared the impact that the high workload has on a survivor reporting to the health facility:

Yeah, the workload is a challenge. Maybe you have a lot of clients you're dealing with and when the survivor comes, he or she can stay for so long before, before they are seen. (Female Clinical Officer)

One practitioner shared that, due to the high caseload of patients, survivors get lost in the mix. He spoke about the dehumanization that results when survivors are treated hastily, which happens all too often. He shared:

The clinician may have a lot of clients to attend to and then the people from the triaging, from the registration, may not be so friendly. Because a client, if you're so attentive and so maybe sharp, you'll be able to realize that this person is a survivor. There are times you can get a survivor who is so emotional, who is so stressed and it might even, she might even go home. (Male Clinical Officer)

In this context, it is important to remember that time is of the essence particularly when it comes to pregnancy prevention as well as reducing the chances of STD/STI infections.

Similarly, another practitioner said that he gets exhausted, implying that it must affect the quality of his work. He shared:

So sometimes the workload really presses us down 'cause the survivor may come in the afternoon, in the morning I was here, I'm really exhausted. (Male Clinical Officer)

The high workload not only impacts the practitioners' experience of providing the service but also the survivors. The survivors are met with exhausted practitioners who view them requiring two-to-three times as much work as they anticipate that it will take to attend to their needs.

Due to the number of clients, practitioners expressed feelings of being overwhelmed, to the point that they feel like they want nothing more to do with the work at hand. One expressed:

We have a heavy flow of clients. Sometimes you see a client and you just want to go out, walk up and down and count the vehicles that are flowing in the traffic. Yeah and then just come back; pick your bag and leave. Yeah, it's that bad. (Female Trauma Counselor)

High workload due to the number of patients that a health facility provides services to on any given day results in significant time constraints.

Time constraints: Practitioners talked about time constraints when working with survivors of sexual violence. Survivors are not the only patients that they see in the facilities, and if they do all that is required of them, it is a long process. One nurse shared his experience with the process of conducting the medical examination, which includes systematic head to toe physical and genito-anal examinations according to the guidelines.

He shared:

It's tedious! The first thing after you have taken the history [medical history], you have given the start dose of PEP [post-exposure prophylaxis] and all that, do an examination, which will take a while, because you need to take urine sample, you need to do a high vaginal swab to make sure that, to see whether you are going to get some semen. It's really a process because you have to send the patient to lab, they have to wait for it and it will not come within 10 minutes. But you would say that the time a patient takes maybe will be between 1hour and 1hour 30 minutes, that's the time that I'll stay with the patient from the time that they come in, they go for their, they are tested HIV. Then from there the process of history taking, examination and going to the lab and all that and still I'm handling the other patients. So when I get these patients after I'm done with the counseling, history taking, I send them to the VCT [Voluntary Counseling and Testing] for HIV testing, I will not to do it, because of the workload, of course. (Male Nurse)

Another practitioner shared her frustration with the lengthy exam, particularly because there are so few practitioners even while knowing that one must not rush the process with a survivor. She was well aware of the pressure generated by time constraints because the longer the exam takes, the more the work backs up:

It's a bit detailed. It takes time because you have to take time with the patient [survivor] so sometimes if, like, you are the one [practitioner] seeing patients alone, it becomes a bit difficult. Ok you get your, your workload is too much accumulated because you know you can't rush these patients. (Female Clinical Officer)

Another practitioner expressed a similar frustration with the medical management piece. The word ‘challenging’ seemed to sum up this practitioner’s experience with survivors:

The medical management piece has been a challenge because you can spend with a client like an hour or so, and that will, that is a challenge, especially when a client has come late in the day. So you have to go through those procedures one by one, of which is a bit challenging, yeah, so basically it’s about an hour. (Male Clinical Officer)

Another practitioner shared that he has even had to tell survivors to come back the following day. As time is of the essence when working with a survivor, telling them to return the next day is a serious disservice. Having a survivor sent home jeopardizes whether they will return for treatment. This particular practitioner bases his decision on a rough calculation of the time that it will take. The practitioner, in the hopes of not having to rush the survivor through the process, opts to have them return the following day. He shared:

Time is beyond us. So it is still work because I expect a raped person can take more than an hour, more than an hour to disclose. When a raped person tells you [discloses], the first thing, you don’t insist [force them to tell] what happened to them, to rush them, you are trying to create a rapport with this person. Sometimes you tell them to come tomorrow. (Male Nurse)

This practitioner’s assessment of his experience is that the work with a survivor requires patience as it is time-consuming. While he acknowledges that patience is required, he also acknowledges that he often tends to rush the survivor in order to attend to the other patients waiting:

My experience I can say that it needs, this work needs a lot of patience because it’s time-consuming, a lot of patience, you have to be patient. And having the workload which we have, you have to share the cases maybe to consider other people. The queue is usually long, and other patients are waiting to be seen so you tend to rush the survivor. (Male Clinical Officer)

Multi-tasking: In this analysis, multitasking is defined as practitioners taking on another role that was not their primary role. For example, a clinical officer's primary role while treating a survivor is medical management, not psycho-social support, which includes counseling. Multi-tasking arises as a consequence of the low numbers of medical practitioners in a given health facility. There are many different aspects of the strains produced by multi-tasking, including insufficient training to provide non-medical, psychosocial counseling, juggling the needs of the survivors with the various concerns of family members in attendance, and additional requirements for informed consent.

One question posed to the practitioners asked about the capacity in which they work with survivors of sexual violence. The practitioners talked of their primary designation at the health facility, but then they talked about having to manage multiple tasks concurrently, which made it difficult for them to do any one task well. They also mentioned that, with multi-tasking, they were often called upon to perform duties that they are not adequately trained to perform. In particular, practitioners conveyed feelings of inadequacy when it came to providing counseling. Due to staff shortages, they sometimes have to conduct counseling sessions with clients, even though they may not be properly trained to do so. One practitioner expressed that she felt she had shortchanged the survivor. She could tell that the survivor was traumatized, but she had not been adequately trained to assist the survivor in the way that she would have wanted:

Ok, maybe if I had gotten like counseling skills, nice good counseling skills because that was a traumatized lady. Maybe, I would have had a good session of doing proper counseling because I used the basic one. So, maybe, if I had that proper training for that specific person and maybe I had experienced how those training are yeah? Such sessions, of people being counseled, maybe it would have helped me with that lady. (Female Clinical Officer)

The feeling of incompetence was one that the practitioners detested. When they had to take on another role for which they lacked proper training in, they are not able to provide the type of service a survivor may require. Another practitioner shared the following:

There is someone who does the counseling. We usually send those ones [survivors], who really need counseling; we send them to, eh, one of our clinical officer who is trained in that. Sometimes because he is not here, you do the counseling but she [survivor] might need too [more] detailed counseling. (Female Clinical Officer)

This practitioner raised the complexity of working with a survivor. Many survivors, particularly victims who are still children, do not come to the facility on their own. In cases where a family member accompanies the survivor, the practitioner has to tend to the survivor and often has to answer concerns raised by the accompanying party. Juggling attention between the survivor and her family members was another challenge:

You know this increases my work load because I am not dealing with one person remember. I am dealing with relatives. I will deal with the immediate patient, with the survivor, but I will also have a word, I must start working with the family so then I am not just working with one person, I am working with the family and that is challenging because it requires a lot of time and a lot of patience. (Female Trauma Counselor)

As a result of these severe resource constraints, the practitioners stated that they had great difficulty in coping with the high level of demands on them as individual service providers, which led to high levels of stress and burnout among the staff, and to other strategies for coping with these pressures, for example, by redefining what they considered the appropriate scope of work for themselves (regardless of whatever the national guidelines may say).

Burnout: As a result of the low number of practitioners and high demands of the position, another salient aspect of the practitioners' experience was burnout. Feelings of being overtaxed stemmed from dealing with both the volume of the work, as well as the

content of the work. It is worth noting is that the majority of the practitioners who brought up the issue of burnout were female.

Burn-out is very high with me and most of my colleagues. (Female Trauma Counselor)

Another practitioner talked about giving up and not caring if she lost her job. This particular practitioner talked about reaching her wits end. Of concern here is how it affects her work with survivors. She expressed the following:

I was almost like giving up. I actually told my supervisor once that I don't really care whether I lose my job or not. I didn't care. It had reached that level I didn't really care at all. Yeah 'cause I think of what I was feeling on the inside. (Female Social Worker)

This practitioner referred to experiencing burnout as a result of the trauma-filled work that it involves:

There's a lot of burn-out, yeah, because hearing the same trauma related cases is really hectic sometimes, yeah. You take it in, sometimes you take it in deeply and it's also traumatizing on our end. (Female Trauma Counselor)

Some practitioners resorted to cutting the services they offered to survivors as a way to deal with the numbers as will be described below.

Cuts in services: To try to avoid burning out, others talked about various surreptitious strategies that they use to keep going. One common device was to take it upon themselves to rationalize their own redefinition of the appropriate scope of services, which basically meant that they did not provide all of the services to the survivors that are mandated by law. In this way, the practitioners are agentically working with what they're given—quite literally.

Many practitioners said that their responsibility of working with survivors as one of managing physical injuries, preventing sexually transmitted infections and pregnancy,

but not the emotional state of the survivor, even though counseling is specified in the national guidelines. This is particularly evident in the lack of referrals for psychological support to the facility's counseling practitioners; many practitioners did not see this as an integral part of their role. Some practitioners mentioned modifying and deviating from the services outlined in the guidelines. They shared:

Not all the survivors need counseling. Some, after they receive treatment, you see that they are smiling and they are ready to home. (Male Clinical Officer)

After seeing the clients and then they have gone through the services, then they tend to just to become normal as if they were not raped, so they usually don't need further counseling. (Female Nurse)

One practitioner expressed frustration with the number of steps that the guidelines recommend and instead just did his single part of the larger treatment plan. The guidelines are clear on the importance of obtaining consent. The guidelines state that results of a medical examination conducted without consent cannot be used in legal proceedings. Making matters worse, the practitioner who examines a survivor without consent could potentially be charged with the offense of assault and trespassing of the survivor's privacy. This practitioner shared the following:

There are some flowcharts and things we are supposed to do. The poster [guideline flowchart] was put somewhere I will not cheat [lie] to you, most of the clients I've worked with, I don't think I've ever asked their consent. They are too many forms; I just do the medical part. I may be wrong but no one has ever come back and complained. (Male Clinical Officer)

Obtaining consent is vital in working with survivors, but can easily be forgotten in the midst of the many demands of service provision. Unfortunately, as a result, some health practitioners developed negative attitudes about providing services to survivors as will be described below.

Negative attitudes: Practitioners often developed negative attitudes towards their client from dealing with the content, as well as the volume of the work. One practitioner shared the devastating impact that having a negative attitude had to a survivor. The negative attitude was as a result of the practitioner being exhausted and passed this sense of anger and frustration on to the survivor. He shared:

I remember a client was mishandled, was mishandled in a way. That particular time, unfortunately the clinician who was the first contact person to this particular client, was not really, I think was a bit maybe exhausted or had a different attitude. Yeah, didn't portray a good attitude to the client. Yeah, the client went and then came back the following day. Yeah, got frustrated came back the following day when time had really gone. Yeah, the 72-hour threshold had closed in; the gap had really closed in. The time they come in it is past three days. As an adherence counselor, I had that fear that even the PEP that we're going to give might possibly not work. (Male Trauma Counselor)

Another talked about how the workload drains one's capacity for maintaining a positive attitude when working with survivors. He mentioned that it affects the quality of services offered:

It may be attached to workload and attitude of the health care workers. Yes, a not positive attitude. Sometimes you know when somebody works so much, you get burn out. When I'm stressed or somebody has done something bad to me, I'm very sure I cannot offer the best to you. I need to be in my right mind to give you the best because I need to be jovial. I need to show you that you are at home [at ease]. (Male Nurse)

The negative attitudes of the practitioners in turn affect the survivors seeking services as will be discussed later.

Interpersonal Level

The interpersonal level involves the practitioner-survivor interactions. I identified three groups of factors in the practitioner- survivor interaction. The main factors were: emotional toll; service related concerns including client issues and coping strategies. Many practitioners mentioned that there are many rewards ("the little things") that come

from the job, but much more often, the practitioners are feeling overwhelmed and drained emotionally from interacting with clients.

The most salient experience at the interpersonal level is the emotional toll that treating survivors day-in and day-out is taking on the practitioners. First, the practitioners mentioned feeling uncomfortable talking to the survivors about this highly traumatic experience, mainly because they feel like they have not been adequately trained. This is especially true for taking histories from young girls, and from survivors who are older than them. A second category of factors that contributes to the emotional toll is the discontinuation of services by survivors. A third category that adds to the emotional toll centers on issues that have to do with the clients, and the two main factors here are the question of 'genuine clients' and the fact that the crime is often committed by a family member (which, is, in many respects, more disturbing than the rape being committed by some stranger). Because of the heavy emotional toll interacting with and that treating rape survivors entails, practitioners have then developed a number of 'mental health' strategies to help them cope, such as singing, debriefing with colleagues, praying, etc. For heuristic purposes the factors identified at this level of analysis can be depicted thus:

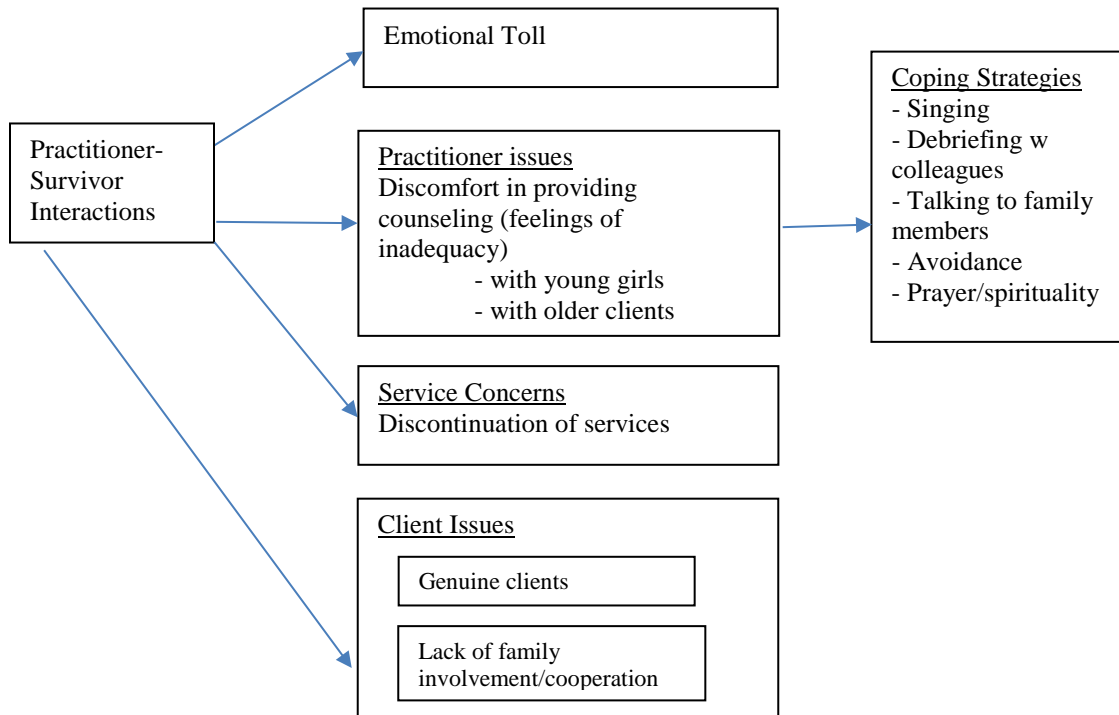


Figure 5.2: Interpersonal Level Factors

It is important to begin the discussion of practitioner-survivor interactions by noting that, despite the high demands placed on practitioners, many stated that they found the work satisfying to some degree. The practitioners mentioned that it was the little rewards that they felt when working with survivors that kept them going and able to continue working with survivors. Several mentioned that seeing the survivors testing negative for HIV was deeply rewarding. They felt that they were helping the survivors to have better outcomes, as can be seen in the following excerpts.

When you see them healing and they gain back the self. Especially for children, they come here when they're sometimes they're admitted and some are teenagers so you know what will happen to them after that trauma. When I hear they're even performing well in school again, I'm just happy. (Female Trauma Counselor)

Yeah, there are rewarding aspects and I would say the patient turning out to be HIV negative is a rewarding aspect to me, the patient not getting pregnant is a rewarding aspect to me, the patient not getting an STI is a rewarding aspect to me. And also at the end of everything, the patient being able to cope with the trauma is a rewarding aspect to me. (Male Clinical Officer)

Providing this at the post rape care service? Ah, it has been good because to me I think that I am doing something, I am preventing these people from getting the HIV virus, because when we give them the PEP, most... in fact the six...most of the clients we get, if you test them, most of them are negative. Ideally, I am yet to meet one who is HIV positive. (Female Nurse)

It gives me satisfaction that I give them, that I did the best for them even if they never took the perpetrators to court, but it gives me satisfaction that I did not fail on my part. Because if I fail on my part, then I have failed them, so that is, I draw my satisfaction from that. Yeah like the one who told me that they, she wants to retain the baby, and I see her coming to the clinic, it encourages me. Yeah because she wanted to abort and now that child is going to survive, yes that really gives me satisfaction that I saved a life. (Female Clinical Officer)

Similarly, receiving feedback from survivors was one rewarding aspect of the practitioners experience in providing these services. Several shared:

Those [survivors] who, sometimes those who bring back feedback. That, basically, just say that I went through this [treatment] successfully and I'm I can say that I have gone through it, the person; the culprit was arrested and was prosecuted. Some bring feedback and tell you, "Hey that person [perpetrator] was prosecuted and I'm happy, I'm feeling happy about it." The client feels, says "I'm feeling happy about it, I'm happy that now it will never happen again. It's going to never happen to anybody else." (Male Trauma Counselor)

How they respond, how they come back and say, "thank you, you've helped me a lot, I didn't know what to do but now I'm ok." Others they can even call me and tell me, "You have supported me a lot." (Male Trauma Counselor)

One of the rewarding, one of the rewards is when you see somebody who came, they were so devastated, some of them they didn't know whether they were going to make it again in life. You see them later doing well, or after you come for re-testing they are HIV negative, it's quite nice. It's true they went through trauma, but then they are negative, that is very important. (Male Nurse)

Moreover, not only was the work sometimes rewarding, a few practitioners indicated that the experience made them better people. They felt like they are stronger emotionally as a result of working with survivors, as expressed by this practitioner:

I can say I am much stronger now. I am very strong emotionally compared to how I was before I came here. Yes I can't even compare. Yes, I have really grown, I have really grown emotionally, I have really, really tremendously. I even say there is a reason I came to work here. (Female Social Worker)

Another practitioner expressed similar sentiments:

After experiencing such issues I also, they also strengthen me, they also give me the strength to want to help more and more because it gives me opportunity to understand the world more. (Male VCT counselor)

However, although many practitioners mentioned the rewards of their work, the majority voiced concerns about the tremendous toll that the work was taking on their emotional health. Two major factors contributing to the emotional toll were related to problems with the health care system, and two other major contributing factors were related to issues with the clients themselves. The two system-related issues were: (1) the discontinuation of services and resultant lack of follow up with survivors, most often attributed by the practitioners to the difficult logistics of obtaining services over a prolonged period of time (weeks or months), and (2) the practitioners' sense of discomfort or unease in obtaining information on the assault, especially when very young girls were involved, which they attributed to insufficient training. Regarding the survivors' role in this interaction, two factors generating stress were: (1) doubts about "genuine" survivors, where the practitioners often felt that some women might be claiming to have been raped as a ruse so that they could obtain services, especially post-exposure prophylaxis to prevent HIV transmission or other STIs, and (2) cover-ups of the role of family members – typically fathers or uncles – in perpetrating the crime.

Emotional toll on practitioners: The practitioners talked about the emotional toll that providing services to survivors has on them: The emotional toll is sometimes due to the shortcomings of the practitioner (they do not take enough time, they have negative attitudes or do not treat the survivors well); sometimes it is due problems with the system (the problem of referrals); and sometimes it is due to issues that have to do with the client (e.g., the family wants to cover up the involvement of a family members in perpetrating the crime). Providing services to survivors of trauma not only has an effect on the survivor but wears on the health practitioner as well as.

It has been actually a very demanding thing 'cause sometimes like now I'm here, my partner is not there. Sometimes we have volunteers who come for some hours, then they leave [for some] other option. I do my best, the best I can to help and maybe if I feel I cannot finish the, I do what is necessary at that point. And then I refer in the morning, the following day. I don't know how other people feel but it is really a demanding, we also sometimes we are also affected, we are also pained by the issues that we deal with. (Female Trauma Counselor)

One practitioner narrated the effect that the experience has had on her life. This practitioner has been in practice for seven years and talked about the ways in which her life has changed. She talked about her experience of being attacked and almost raped and how that has changed the way that she sees survivors. She also talked about her thoughts on future motherhood and the fear that comes from seeing child survivors. Fear was the salient emotion for this practitioner as she relayed the toll that this work has had on her:

This experience here has been quite, personally it's been, totally changed my life, totally changed my life. Again you tend to have a lot of fear. For me I am a single person. First of all I look at, I am thinking of my kids tomorrow and I'm thinking okay, 'cause I've seen the kids here and I'm thinking okay, yeah. And again you reach a time you just, like the beginning of this year I was attacked by thugs, yeah. They tried to rape me, and you know after that I was like okay, when I go back to the office and somebody walks in, like my life changed, like this person who is seated there, I can actually understand. (Female Counseling Psychologist)

Another practitioner talked about how draining the work is. She talked about feeling both physically and mentally tired. She summarized her experience as follows:

Providing these services is draining. It makes someone not to be, you just feel like not doing it anymore, yeah. You do it until you feel like you are just tired, yeah. The whole process; the nature of the stories, the examination, everything, yeah. (Female Clinical Officer)

Another provider shared:

Getting over, sometimes I think I have gotten over the situations, but you know anytime a similar case comes, it then triggers all those episodes that you know I had seen. All those episodes I thought I had forgotten, then they come back and then they start haunting me and those kinds of things, so that's it. (Male Clinical Officer)

Practitioners also talked about the emotional impact that providing the services has on their home life.

Yeah, 'cause this is, it's too much, too much. Yeah, it's not normal, yeah. For this to be a daily, yeah, and it happens. The kind of information you ingest on a daily basis, it's just too much. Sometimes you have no one to talk to here, you go home talk to the people there and one day my husband just told me, "Please shut up." Not in a bad way, but even [with] him I was projecting the trauma to him, yeah. So it's not a, it's a nasty experience. (Female Trauma Counselor)

Another one shared the effect that working with survivors has on her sex life:

Ofcourse, like I said emotionally you're left drained, sometimes very drained. You're left drained and sometimes you don't trust anyone. It's very difficult to trust and then you become oversensitive even to your children. You tell them that when you go somewhere don't be greeted by anyone. If you're not very careful sometimes you find yourself taking these cases home. So even for your husband, you kind of, sometimes you're not even able to, to meet his needs sexually sometimes. (Female Trauma Counselor)

Another practitioner shared the effect that this work has on their personality. She talked about not feeling safe in public transportation, and another mentioned not feeling safe even in her own house:

I'm dealing with traumatized people and so that makes me become more traumatized. Sometimes you don't know when you're becoming traumatized until

you start doing some things like you go to on public means [public transportation], and you doubt everyone. Sometimes you go to your house, ok, personally I'm a mother and dealing with boys. Not once or twice I've broken down seeing my boy and thinking. So you start like hallucinating without knowing. You become so sensitive to issues such that even people around you are thinking you're getting matters out of your hand. But it is I think and basically it's because of those things that you hear every day and see every day. (Female Trauma Counselor)

Two practitioners shared that they would check their children's reproductive organs daily to ensure that no one had violated them. This would cause their spouses to wonder why they did not trust them with their children. The practitioners attributed this behavior to dealing with survivors of sexual violence on a regular basis.

I have really changed a lot, my personality, I don't think I'm the woman I was three years ago, 'cause I've been here for three years. My temperaments maybe have gone high, mood swings, yeah, paranoia. Sometimes, I feel like I'm not safe anymore, yeah. Even in my own house, I have to make sure I lock. My hubby would not even care about whether the locks, for him it's normal but I have to go check. Yeah, I have to check my child's--both the penis and the anus. Guys will be wondering, "What is happening"? You don't trust us in the house or what?" So yeah, I don't think I'm the same. (Female Trauma Counselor)

I have a colleague who told her child that anytime the father comes home, she runs, the girl, the small girl runs. When she goes to the bathroom, she closes the door completely. After bathing, she ties herself completely so that her daddy shouldn't see her. The father was like what are you teaching the child? But you know, the father is not a medic, I'm a medic. You can't just relax and say that I'm different; my husband is different from the ones who commit that, yeah. (Female Nurse)

Practitioners also mentioned not being able to control their emotions in sessions with their clients, thus causing them to compromise their professional boundaries:

Yeah, sometimes you find yourself crying when they share the stories. Yeah. Some of the stories are very, very traumatizing, very traumatizing, yeah. (Female Trauma Counselor)

One, we're emotional beings so sometimes you'll break down in front of a client. When that happens, I wake up and I just request the client, just give me a minute, I pick something. I go and compose myself and come back (Female Trauma Counselor).

Discomfort in questioning: Practitioners also mentioned concerns about not feeling comfortable in getting the necessary information from the survivors. Practitioners are tasked with obtaining a thorough medical history, which is then documented in the PRC form. The gaining a thorough medical history was particularly a problem depending on the age of the survivor, where some practitioners did not feel comfortable questioning children about the details of the sexual assault.

I need information about working with children, to get them to open up. Sometimes they are able to talk and say what happened and other times they just sit there. (Male Trauma Counselor)

Age was also a factor when the survivor was older than the practitioner. One male practitioner talked about feeling uncomfortable with asking details of the sexual assault. He mentioned being particularly uncomfortable questioning older female survivors. This may likely have to do with cultural norms around respect for elders. As obtaining a survivors medical history is a major part of the medical management, it is an uncomfortable experience for this practitioner. He shared:

Yeah, there are instances I find quite uncomfortable, especially when it comes to where you have to get the details of the actual event how it happened. Like if its rape, there are some details you have to get, whether it was a vaginal penetration, anal penetration or oral. You know, those kinds of questions, I find them uncomfortable, especially when I get a client who is like older than me. That's uncomfortable, so you are looking like; she's old enough to be my mother, so you don't feel comfortable. I have to ask, but to me it's uncomfortable. (Male Clinical Officer)

One practitioner talked about her discomfort in working with couples. Survivors are allowed to have someone in their room if they wish and this causes discomfort for the practitioner. This also connects to discomfort over gender expectations—men being strong. She shared:

I usually have issues with couples when they are together. For example, thugs attacked a woman in the house, they raped my wife and now you are listening to the case the wife is there, the husband is there. So you can see that the husband is traumatized and you just don't want to tell him go out first. So when they are together I am not able to ask some questions. But when the man goes, the guy is out, I am able to talk to the lady. (Female Social Worker)

Another factor that contributes to the emotional toll is the discontinuation of services by the survivors.

Survivors discontinuing services: Practitioners talked about their frustrations with clients who discontinue services after one or two visits. To recall, the medical management of survivors of sexual violence includes clinical care and treatment for injuries; examination and documentation for legal purposes; post-exposure prophylaxis (PEP) to prevent HIV infection; pregnancy prevention services; as well as psycho-social support in form of counseling services. The PEP is administered within 72 hours of the assault and requires a blood-monitoring test at two weeks. Depending on the HIV test results, the survivor is referred to HIV care for ongoing medical care or given PEP with a two-week follow-up appointment. Emergency contraception is administered up to 120 hours post assault and a six-week follow up is required for a pregnancy test. The guidelines also recommend a five-session minimum of trauma counseling sessions. As the medical management of sexual violence is multi-faceted and cannot be completed in one appointment, it is necessary for the survivor to return for follow-up treatment in order to provide high quality care. The guidelines note that, to provide comprehensive care, all of the service enumerated above should be provided to the survivor. But in the practitioners' experience, it is often difficult to do so.

My experience, I can say it's a real challenge, 'cause sometimes you find that they don't cooperate, whereby someone can come to one or two sessions and they

withdraw, Yeah. And you might even find that some they don't want to take action. (Female Social Worker)

This practitioner alluded to survivors not seeing the importance of getting psycho-social support. In this practitioner's experience, most of the survivors do not return to the health facility after the initial medical examination. He shared:

Most of them don't come. But here in Nairobi is where I've not seen them coming back. When they've received the medical, most of them think it is finished. (Male VCT Counselor)

Similar sentiments were echoed by this practitioner who seemed to expect only one treatment session with survivors as they usually do not return for other appointments:

The problem actually that we've been having here is that, when the survivors go, there are some people who just go, they don't come back. They don't come back. Like you treated one, yes and they aren't coming back and they won't come back. So they are outside there. (Female Counseling Psychologist)

We need to do follow up of Post Exposure Prophylaxis that we give them for HIV; they need to be followed up. So it is like a must. They have to come back for a follow up, but some don't come back. (Female Clinical Officer)

Practitioners in this study mentioned that the fear of contracting HIV/AIDS was the most important motivation for the survivors seeking medical treatment and particularly in order to receive, if necessary, the Post Exposure prophylaxis.

Another practitioner mentioned the lack of continuity with a single provider as a possible reason why the survivors do not return to the health facilities. He shared:

Some don't return because you know they do not want their, their case to be known by everybody. You may not want your case to be known by everybody. So that survivor would want to deal with one person continuously, which may not be possible in our public hospital. Some even give up. They would tend to give up and they would not come again. They, you know, they feel they're traumatized. (Male Trauma Counselor)

Another practitioner brought up an issue specific to child survivors. As children are brought to health facilities by a guardian or parent, returning for more treatment is not

up to them. She deduced that part of the reason may be that the perpetrator was known to the child, maybe even a family member.

I've noticed, I've not done a formal research, but it's something I note, because we note them. So in that we've noticed some children, they're brought to the hospital for the first time and because they know the perpetrators they don't come back for more treatment. (Female Trauma Counselor)

Genuine clients: Another major issue that came up in the interviews was that several practitioners mentioned the issue of genuine clients. (As I learned, individuals may feign rape in hopes of getting needed medical attention, most commonly to obtain PEP ARVs.) Practitioners were convinced that not all of the patients who came in purporting to be survivors of sexual violence were genuine, especially when the survivors did not display the typical behavior of a victim. They felt that it was a challenge balancing the feeling of going through the procedures required with a patient when they thought the patient was not genuine. One practitioner explained the way that he is seemingly able to determine whether a survivor was genuine or not:

So you also need to know that it is not everybody who comes who says I was raped is genuine. That is the challenge now, though with probing and taking time with them, you will be able to assess. You may not tell her, but you'll have known that this is not a genuine client. Because of course ah, non-genuine one will be very confident, will be very confident to say that I was raped. And they pretend a lot, eh? But those who are genuine will find it hard to express, themselves, yeah. (Male Nurse)

Another shared:

Ok now for that one particular person [survivor], I thought maybe it was someone, you know, you can read, you can know them [commercial sex worker], some psychological thing [uneasiness] on a person eh? Not every client is genuine. Someone [a survivor] will find something happens [unprotected sex] and because now they are scared of the consequences [pregnancy] they will tend to create a story. (Female Clinical Officer)

Another practitioner was convinced that the client couldn't have been a survivor because she refused examination. He shared:

I had an experience where a young girl came in. She alleged she had been a survivor, eh, sexually assaulted. She was about, between 16, 17. When I told her we wanted to examine her, she declined. It was then that I realized that, it's like it was not a true case. Because, she was also very reluctant to be examined by a female nurse; she said she was not comfortable. (Male Clinical Officer)

Another practitioner also shared his thoughts on the "inconsistent story":

If somebody [survivor] tells you its rape, but denies any action that could relate to penetration, yeah. Now if you [the practitioner] ask her what happened, and she said she was taken to a room by 4 men who grabbed and then she found herself, woke up there, and she doesn't remember the story well. She has already bathed. So some cases that come in as rape are not really rape. Ah, those are challenges. (Male Clinical Officer)

Some practitioner shared their experience of trying to keep the judgment that they had of a survivor to themselves:

Of course, we have cases that are not genuine. You'll get them through the cases that are real. And if you're on top of the game you can see we're going there, then from north we have gone west. I'm required not to be judgmental and remember I'm a human being. And she comes and the stories you're giving me are not, this is completely a lie and you triggered it. So yeah, they're there but you fight. As much as you're crying, you're telling me your life is at stake because you don't, I cannot be able to; my hands are tied to help you. So we have cases that are very, very untrue, there're not genuine. (Female Trauma Counselor)

Yeah, so she said when was in that taxi she reported [claimed] to have been attacked by some thieves. Ok, so, but you never know that kind of story. Ok, it is too unbelievable! Because the story was not like coming up [adding up] just like, at one point she was telling me she was with a boyfriend at another point she was telling me she was with friends. You see that story was not adding up. But, anyway that is not important. I had to treat her like a client. (Female Nurse)

Several practitioners brought up the notion that the survivors that fell into the non-genuine category often did so to get the free ARV medication:

Not every case is genuine, yeah. I've met several cases which are not genuine, and maybe like we have had issues of people that sell ARVs, so they come purporting

to having been raped, so by the end of the day if you do not take good history to know this one is not a genuine case. Others will just come and tell you I was raped so they cannot show, even after examination there is nothing to show that they were raped. So in such cases we need to be sure that this is a genuine case of rape or we are not just getting imposters who are purporting to be raped. (Male Nurse)

One comes and tells even that she doesn't want the husband to know that she was raped. I think it's cheating [lying]; it's not true that she was raped. So she takes PEP silently. (Male Clinical Officer)

So we have cases that are very, very untrue. They are people who know how to stick to their lie. You have to keep exploring. You have to let the client go another journey. They [survivors] are usually aware that these services are free. (Female Trauma Counselor)

Ok people are not being truthful; others know that you provide services for free. These services are for free and so you find someone who knows that very well. Like for example they were not raped but they come up with [make-up] this story. They come and tell you and you believe. I have been a victim of, of lies a few times and so when you discover that someone lied to you, you feel very bad. You feel very bad. According to their[survivor's] story she was out in a party, then she was drugged, then but they are a commercial sex worker whose condom burst or something happened they didn't use protection, I feel very bad. Because does that mean you [survivor] didn't trust me, didn't tell me the truth or something. (Female Social Worker)

Not really a rape. It was a case, I cannot understand. But it was not a rape case. They say burst condom so that they can get the medication. So those cases are not rape. Or they come in saying they've been raped so that they can get the medication. Because, even I was telling somebody this PEP idea, of giving people, now has become a fashion. Yeah, it is something that people now are misusing it. (Male Nurse)

Lack of family cooperation: Another factor contributing to the emotional toll that the work was taking on the practitioners was that many times clients would not be forthcoming about what had actually happened because they were trying to protect a member of the family. While working with survivors, sometimes their family members were more of a hindrance than a support system. For example:

You advise them that at least, do 1, 2, 3 but they [survivors] don't want. Reason, you might find some have been raped by the relatives. Now they want to hide, [they say that] I don't want my family to know this, how will they take it? They

will not understand me. So you find that it's about something that it's a challenging to us. Yeah, because of they don't want to cooperate and they don't want to take the justice part. Cause what we normally [usually] say [to the survivors] if in case this person comes again and rape you, what will you say? And you know if this person will come and rape you again, it will be now, it's like a game. And because you did not say it at the first time, the second time you can't say. (Male Social Worker)

And sometimes it's the father. The father talks with the mother and they decide to come back together. I have so many cases of that not only here, even in the other branches. But unfortunately, the mother really swears she's not going back but again she comes to you and says that he is the provider, what do I do? To be frank as a counselor, you can't save all of them. You try to empower them but I think because of the level of education and poverty, they prefer to keep silent. (Female Trauma Counselor)

I can remember there's one case, which I handled sometimes back and the lady was raped by a cousin. The mother decided that they were not even going to report and that they would settle it locally. They don't want to break that relationship between family members. (Male Trauma Counselor)

A lack of family cooperation was cited by practitioners as a major hindrance to the survivors pursuing legal action.

The other challenge is there are cases like the case I got recently whereby there was this lady who had come to Nairobi to visit her aunt and the aunt had another relative in the house. The aunt left the girl with this man and this man raped the girl. So it was so traumatizing, we did not know where the girl comes from and tells the aunt, the aunt is not cooperating and the whole issue becomes complicated because it's like family. Following it up ah it was very hard because the aunt was not supportive. Even when we gave her the PEP the aunt went and threw them away, you see. She didn't want to hear about it, she just wants to hide it. It's quite a challenge, it's traumatizing also to you as a [health] provider. (Male Nurse)

A woman comes in and is like my child was raped by the dad but at the same time they don't want to get out of the marriage, at the same time they still want to get out of it. Even they accuse the children, "what did you do to make your Dad do this [rape]", you know? (Counseling Psychologist)

They [survivors of sexual violence] tend to hide it. Culturally, you may find there are some cultures whereby they tend to see it [rape] as if it is something that is a legitimate thing. Somehow it is legitimate. Yeah, and then they tend to stereotype it a bit, they say that it's because the wife is not playing her part, has not played her part to take care of the children or to satisfy sexually the husband. So hence

the husband or the family member could be an uncle, can even take over. Can take, you know, can do whatever he wants. (Male Trauma Counselor)

You can imagine we can have a survivor lady who was raped for example by an uncle. And you know for her to say going for legal, it's like you're telling me we are going to have a family meeting here, or a family conflict here. So I'd rather keep quiet than have this family issue. That is the reason why we allow them to make that decision for legal, yeah. (Female Counseling Psychologist)

Practitioners found ways to deal with the effects of the content of their work by finding ways to cope.

Coping Strategies: Because of the heavy emotional toll that treating rape survivors takes, practitioners have developed a number of 'mental health' strategies to help them cope, in addition to cutting back on the scope of services they provide, as noted above. Their coping strategies ranged from singing, to debriefing with colleagues, to avoidance.

One of the coping mechanisms is to sing. Yeah, it's a therapy, yeah. You sing, then you pray also. God also intervenes and you'll be ok, yeah. (Male Trauma counselor)

I just remind myself that I'm a therapist and this is what I need to be able to do, help this client. This is what I love doing. Self-talk, I can do this and I take my time, we have paper works we can do, so when we sit down properly, only sometimes I can tell them just give me a minute I will walk out go to the bathroom, breathe in out, breathe in out, actually that is what I can do the rest I am back. I am like, now I can be able to be able to listen, yeah. (Counseling Psychologist)

When I go home I just write about what happened, I have a journal. I just write my daily [thoughts] and the striking [tough] case and I write, you know some nonsense there and I say this is critical. I just journal, but I use to nag people and I could see people are not getting what I'm saying. (Female Trauma Counselor)

Several practitioners mentioned debriefing with colleagues to help relieve what they were feeling. They recounted:

I usually share with my colleague. I could tell her how I felt and she could also tell me. She encourages, she usually encourages me by telling me if you don't do

this work and you refuse to attend to them, who shall help them? Who shall help them? So you have to keep on doing it, doing this work. (Female Clinical Officer)

Let me say once you encounter a rape case, it's not a good experience also to you as a health practitioner, and sometimes we end up, and you are not supposed to discuss patients, but you end up talking about it so much with your colleagues 'cause it also affects you. (Female Nurse).

Another practitioner talked about sharing her experiences with relatives and friends (and in doing so violating the survivor's confidentiality). She shared:

And I think it is from getting to share my experience with other people, like my fellow doctors, my relatives, you know, my friends, I get to like console myself. (Female Clinical Officer)

Some practitioners cope by using avoidance strategies.

I'll say, I'm fine and then I'll avoid more communication. I'll not ask, "How are you coping?" Despite, [instead] I'll assume I know nothing. And even if the client [returns to the facility] would ask "Don't you remember me?" I'll tell her "I don't remember. I may have attended to you but I don't remember." I say that to avoid remembering. So those are some of the key things that maybe personally I'm using. (Male Nurse)

I just cut off everything and, yeah, pretend to be as fresh as possible for the other case. But sometimes, deep down, it's not the case. Sometimes I'll even forget that I saw a client. Like a client will come in three or four days' time and they'll be like, "You saw me just the other day, you can't remember?" I'm like, "No, I can't," because I really don't want to remember. (Female Trauma Counselor)

Yes I think it became so much part of me, I choose to forget and I truly forget. I don't remember, I don't remember stuff. I don't know how, but it just became part of me. I don't remember cases. I handle it here and we are done here, we are done. But if you come tomorrow, we have a bit of recap, then we continue. But I think, what is it called? Is it intentional? I think it's something about forgetting things intentionally. (Female Social Worker)

Another mechanism that the participants use to cope with the emotional stress of their work is employing spirituality. In talking with practitioners, some use it as a coping mechanism and others use it as a counseling tactic.

Yeah, I pray and I move on with life. But I've never got that trauma whereby it has put me down, that I can't even handle another one...And I read the Bible.

Yeah. So before, when I enter here, before I start my work, I have to pray. Yeah? I pray for the day, I pray for everything. (Female Social Worker)

Yeah, spiritually. Now that, that is personal. But of course when it gets too much into you, go back home and pray. Sometimes you know there are things, you see fine, you know like death, it happens and that, this is supposed to happen, but there are those that really affect you. So you pray and tell God to help you accept that. That [incident] was a timing of that particular person no matter what you would have done. (Female Clinical Officer)

Spiritually it really affects, but it's like, it brings me closer to my spiritual, to God. Because if I really come across some things, they really brings me nearer to God, because if such a things can happen and I don't know how I can explain, I can express this to you because it brings me closer to my God. Because I ask myself so many questions [like] "Why does this happen?" "How can this be done better?" "How can...?" I ask so many questions and out of those questions, which are not answered, it brings me closer to God because I leave them to God. (Male VCT Counselor)

Institutional Level

Factors at the institutional levels revolve around capacity building. This refers to aspects of service provision that need to be overhauled to improve the systems that provide services to survivors. There are two major institutional systems that have responsibility for responding to the needs of rape victims: the health care system, and the criminal justice system. Both were perceived to have serious shortcomings.

With respect to the health care system, practitioners talked about scaling up efforts to provide better services to survivors by improving their skills and by strengthening the systems where they work. The treatment of survivors of sexual violence is more complex than that of routine patients due to the combination of severe negative mental and physical health effects associated with this form of violence. Because of this, it is imperative that health practitioners not only minimize the impact that the violence has on the survivor, but also ensure that they are not further contributing to the survivor's trauma. The practitioners mentioned several issues with respect to the health care system

that needed capacity building efforts: the lack of privacy; the fragmentation of services; building practitioners' capacity for better forensic management; building better referral systems and linkages; and, building the practitioner's capacity to improve their counseling skills. A diagram of the factors identified is shown in the chart below.

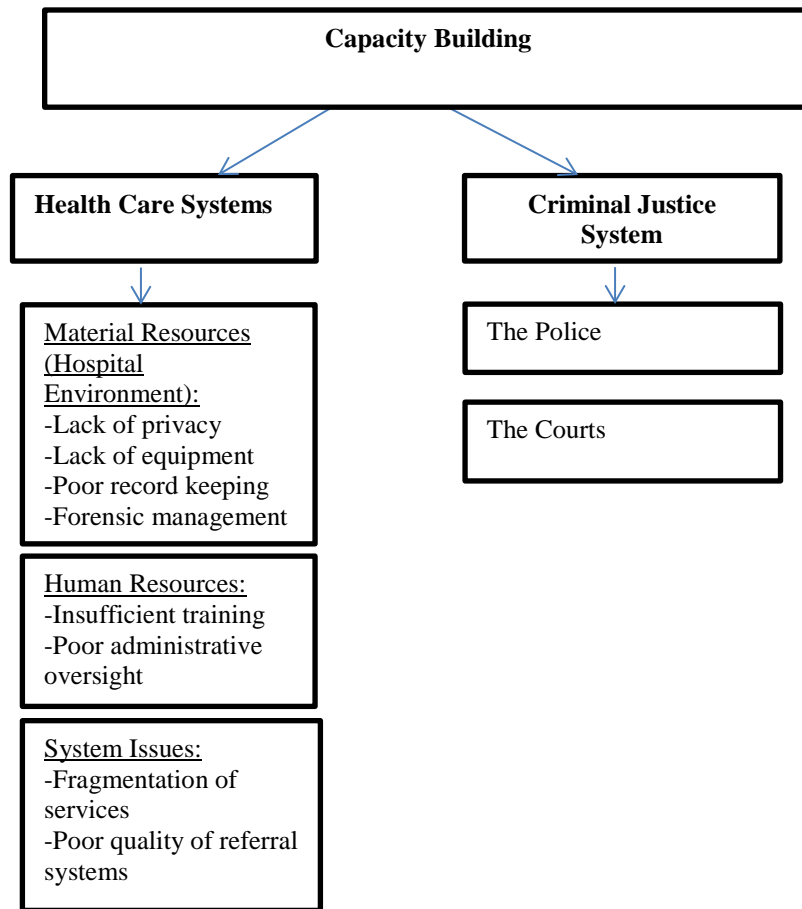


Figure 5.3: Institutional Level Factors

Material Resources (Hospital Environment): The research study also revealed other deficiencies in the health-service environment that affect the quality of services provided to rape victims in Kenya. The inadequate hospital setting was a major concern raised by the practitioners as a hindrance to their providing quality services. Practitioners

mentioned the lack of privacy, lack of equipment, poor record keeping and; poor forensic management in the health facility as major hindrances to their providing quality services.

Lack of privacy: The lack of privacy was an issue that practitioners raised as a critical problem in their work with survivors. They mentioned other patients being able to hear the conversations taking place in the room making it difficult to maintain a survivor's confidentiality. Practitioners mentioned being frequently interrupted while conducting exams due to the doors not latching properly. In addition, the lack ease of service for a survivor was mentioned. The guidelines talk about privacy and stress the importance of unauthorized people not being able to view or hear any aspects of the consultation. This, however, was not the experience of many practitioners. For example:

Sometimes, it's the environment of the hospital, like now, we are sitting here, and right outside there is a patient. Someone, not usually even patient, they will just keep opening the doors and also you know that patient [survivor] has to feel like the information will not be heard by anyone else. So if there was some place a bit secluded that you could take the client to, a covered [private] place, then I think they will even open up more. But now they know just outside [the medical exam room], they are not even sure that the walls can leak the information. (Female Clinical Officer)

While conducting an interview for this research in one of the examining rooms, the issue of privacy became really apparent. During the interview, patients kept opening the door to see if there was a practitioner who could see them. He shared the following:

You need a bit of, a bit of privacy. Like now you see people keep opening this door. Imagine now I have a rape case and people keep opening the door like they are doing now. We need a lot of privacy. (Male Clinical Officer)

The survivors needed to go to different places within the health facility for their medical examination, pick up their results from the laboratory and for counseling etc., which can be particularly distressing for a person experiencing trauma. Several practitioners

suggested having a designated private room to provide services survivors so as to avoid interruptions and maintain confidentiality.

Lack of equipment: The lack of equipment – both quality and quantity - to do the required tasks was also mentioned. These shortages caused frustration for the practitioners as they were not able to provide comprehensive services to the survivors. In most cases, they have the know-how and are willing to provide the services, but due to the lack of equipment, they are not able to do so. The practitioner expressed his frustration thus:

The one challenge would be you don't have maybe like the things that you require, like test kits, they may not be there. The other thing might be the drugs; the STI pack and of course the HIV and retroviral drugs. And then the most challenging part of it is though we came to learn of the forensic investigation through the samplings, the packaging of those, the packages are not always available. (Male Nurse)

Another practitioner expressed his frustration with not being able to complete the treatment with a survivor because of the lack of materials, saying:

Well what I would say, the challenges, is like the, the high vaginal swabs eh, the specimen sticks, some of them expired. So it forces me now to refer them somewhere else and I don't complete what I started, that's a frustration. (Female Clinical Officer)

Another practitioner also talked about the interruption in service provision when either a piece of equipment was missing or was shared with other wards in the facility:

Another challenge is also the equipment, like speculum, the equipment that we need to have at eh my place, yeah the swabs, most of the time we run short of them. So when I have a survivor here, I have to get them. Sometimes I run to the maternity [ward] so that I can get a speculum, run to the laboratory to get a swab, and if we don't have them at our facility, we request for the patient to be taken to the nearest clinic so that a swab can be done. (Male Clinical Officer)

Some practitioners talked about the limited services that they are able to provide for the survivors at their facilities. This practitioner talked about the particular problem of

not being able to treat children properly, due to the lack of equipment as well as other issues. This practitioner was older and likely had children of his own, which undoubtedly made the experience even more difficult for him. He shared the following:

There are cases that I'm not able to handle are like children. And generally a child for examination, you need to examine under anesthesia which we do not have here. So you have to send that child to a hospital whereby examination shall be done under anesthesia. It's so traumatizing that you cannot begin doing examination on a baby, they are already traumatized. (Male Nurse)

It is interesting to note his use of the word traumatizing, which he used to express what he felt as well as what the child was experiencing.

Another practitioner talked about having never actually seen the equipment with which they were supposed to collect the evidence. She talked about seeing it at other hospitals and wanting to be able to provide those same services at her current facility:

The complete kit, I don't know. I have not seen it. I have never seen it, the one you have to, this is one you pick, I just saw it on video. So I know what you are supposed to pick but I have never seen the actual kit. So if I would have maybe, you know even the ones that you go to the hospital where something is being done and you see it being done. I would really appreciate that. (Female Clinical Officer)

Poor record keeping: Another point of frustration was the poor quality of record keeping. One practitioner talked specifically about how the record keeping system at the institution made it harder to follow up with clients:

Like our filing system is not the best. Our record keeping is not the best. I think basically the whole administration is not the best. You know the filing, how we follow our clients, yeah. It's not really the best. Basically we don't have our own filing system. So the whole record keeping is in the hospital. So, you know even in terms of confidentiality, there's no confidentiality. But I want to imagine that's the challenge with multi-disciplinary institutions. (Female Trauma Counselor)

This practitioner also raised the concern of the lack of confidentiality due to the poor record keeping. She alluded to practitioners that work with survivors not having their

own filing system to record information pertinent to just survivors. This means that the survivor's record could be accessed by other hospital personnel not working directly with the survivor which may violate their privacy.

Forensic management: Practitioners cited the lack of adequate hospital facilities for the collection of evidence. Government hospitals are the first point of contact for many survivors of sexual violence in Kenya. Several practitioners lamented the low rate of prosecution and conviction versus the number of rape cases that came through their facility. Poor evidence collection and documentation are likely factors contributing to this gap. This discouraged them because they often felt like that they did not do all they could for the survivor. One major problem had to do with their inability to collect forensic evidence. Several practitioners relayed their frustrations with this aspect of their work provision.

One practitioner wondered whether there was any benefit to the services that they provide to survivors if they are not able to do the DNA tests that are essential for linking the perpetrator to the crime. She shared the following:

You see for the DNA? We haven't done. The DNA, we didn't do any DNA to the clients who came. We did DNA to one patient only one who was raped by a guard, only one, and the others, there was no DNA. Now you wonder if there is anything that you can do, there is no equipment. (Female Clinical Officer)

Another practitioner added her frustrating with lacking the evidence preservation equipment.

I would like to mention is that we do not have a supply of the equipment that we need in order to preserve the evidence like if the client has come and they have not bathed, we need to keep those clothing that she has on for evidence. But we normally we don't have the brown paper, yeah. So you find some of them they carry in this polythene paper and even in our facility we don't have the brown

paper which is recommended to preserve evidence. That is one area that has been frustrating. (Female Clinical Officer)

Having complete rape kits is, of course, the optimal solution because they contain all the required items to ensure a thorough and accurate collection of forensic evidence. One practitioner recalled receiving training on evidence collection using the rape kit, but the training has been rendered useless by the lack of kits of at the facility.

There are these kits that we were taught during the training on the collection of evidence, that there is a special kit whereby you have to, yeah the rape kit. It has to be handled in a manner whereby we reduce contamination, yeah. We don't, in our facility right now we don't have such kits. So what we do is just to, we refer the patient, yeah we refer for forensic evidence to other hospitals. (Male Clinical Officer)

I also think if we're able to have the required instruments or equipment, so that we're able to help these clients, it would be much better. Because sometimes we're tied, in that, you are supposed to do to this client a certain test, but this and this is not available and you know very well if you get this test you're able to capture the assailant, the person who did it. That in fact is a disturbing thing 'cause you know very well that I did not do this so I may set the assailant scotch free by not getting the evidence. So I think that if we get those things that would enable us to do everything and I mean everything, instead of referring people maybe to Nairobi hospital. That would surely make us, you know feel good. (Male Clinical Officer)

One practitioner talked about feeling embarrassed about not knowing how to collect the evidence. The practitioner took pride in her role as a nurse, but in examining a survivor, she did not know how to collect forensic evidence:

You see you cannot, for example, you want to examine the client and you don't know to collect the specimens. It is really embarrassing so you feel like, you just want to refer her to another facility. (Female Nurse)

Another aspect of the problem with the collection of forensic evidence is the limited lab hours. The lab hours and personnel are only available during weekdays, making it harder for those practitioners working on weekends to collect any forensic evidence, as can be seen in the following excerpt:

One of the challenges is that most of them will come when they have already changed, they've taken a shower they've changed everything. So for the forensic evidence it's a bit difficult to obtain. Okay, one of the reasons they usually say that maybe it was over the weekend and the lab is closed so they will have to wait until Monday. That is very crucial evidence, which you don't want to miss, but most of the time, you end up missing, so it's a challenge.
(Male Clinical Officer)

The guidelines are thorough in detailing the procedures for forensic management, including: how to avoid contamination, the time within which to collect evidence, proper handling of the evidence, the labeling of the evidence as well as the security and recording of the evidence. Having detailed procedure is useless if the tools required for the practitioners to carry the task are available at the health facility.

Human Resources: Another issue regarding the health systems was that of human resources. Specifically, the practitioners identified the lack of training and poor and administrative oversight as major challenges in their providing quality services.

Insufficient training: Interviews with practitioners revealed variable knowledge of the national guidelines on the management of sexual violence. Some practitioners had no knowledge of these guidelines, while others knew the guidelines well (or fairly well). However, due to the health facilities' limitations, they were not able to follow them properly. While the health sector plays a significant role in the multi-sector effort to prevent sexual violence, its main role is at the secondary and tertiary prevention levels. As the national's guidelines are the standards of care for working with survivors, it is imperative that all practitioners working with survivors be adequately trained on these guidelines. Having all practitioners trained will help ensure uniformity of services to survivors of sexual violence. Having standardized guidelines is essential for improving the quality of care for survivors, providing healthcare practitioners with a sound protocol,

carefully constructed for their work. Some practitioners were unaware that there were guidelines for the management of sexual violence and called for the creation of guidelines. They shared:

I normally go back to and sometimes from the Internet but you see that is not sufficient. We need guidelines, like you could find guidelines on my table here. Yeah when I get a client, people, we are human beings. We are bound to forget you can skip some steps yeah? But if you have guideline like this is what you are supposed to do? You refer [to them] when you feel like something is not very clear, you refer. That would be a step forward. They should design a guideline and ensure that every clinician who is seeing those survivors has that guideline. People are not perfect that they can put their knowledge here and they can produce it whenever it is needed, it's not possible. (Female Clinical Officer)

I think there are guidelines, there are guidelines, I don't know, I'm not very sure. I heard this during our training. (Female Nurse)

I realized in the last training that I have some knowledge gap. We don't have guidelines; Like you see for treating Malaria. No, I've never heard about the guidelines of GBV [gender-based violence]. (Female Clinical Officer)

We were trained on the guidelines, I think, when it started. Was it? It was in 2007 or 2008 at Globe Cinema. But since then I have not revived any updates. (Female Nurse)

Another point of frustration expressed by the practitioners interviewed for my study was the feeling of incompetency. Many of them cited little to no training when it came to medical management of rape and sexual violence. Most of them relied on their professional training, which did not cover sexual assault treatment. While some health workers have been trained through short courses, numerous challenges impacted service at the district and primary level health facilities. There are a limited number of trained staff members, who are already overburdened with heavy patient loads, as well as limited infrastructural resources. Several practitioners also mentioned seeking information from the Internet as a means to augment their professional training.

I think the challenges are more information about or more training about the proper care for those clients, we need more. Because even in college, I don't think people were taught much, unless now they started. Now it was never much, we also need to know about the legal aspect. It was touched there when we had that training, but I think we need to be more updated. Because like now for example, you don't know where to start when you get this client. Do you go to the police? After the police then what? Where is the case taken? (Female Nurse)

Several practitioners cited little to no training when it came to medical management of rape and sexual violence. They talked about favoritism in the health facilities and how that played into which practitioner was chosen to go for training sessions. Practitioners raised concerns about who got to go to the training and what would happen when those trained were on their day off.

We were only two clinicians who went for that seminar, and when this week I'm in, maybe next week I won't be there, maybe tomorrow I won't be there. We come in duties [shifts]. What if that client finds someone who wasn't trained? Would she be taken care of well? You don't know how this book is filled out, you don't know. Because even those books, it needs you to be trained on how to fill it out, yeah. The importance of that book, the importance of documentation, yeah, updates. Sometimes you are not given the updates at that time. Like the anti-retrovirals (ARVs). You only hear, "no, that one [medication] was changed and you didn't even know." (Female Clinical Officer)

One practitioner talked about the missed opportunity to provide proper services to survivors due to lack of training. She shared:

So if you are not trained on post-rape care, and you get a client at night and you are, you are two [practitioners] who are not trained, you see? You just tell the client that let me prescribe for you this ibuprofen or another and then come back tomorrow you see? And then you have missed an opportunity, yet this client came, this client came knowing that, that, she came to doctors and she'll be attended to well and later go home you see? So you give the medication and you don't know if they will return, you see? So they should come and give us more training. (Female Nurse)

Many practitioners voiced concerns about their overall level of competency:

I am not competent, but as I said there before, it's a challenge. It's a challenge, I encourage myself and I serve the survivor to my best level I can. So at the end of the day I go back to the books and see, that in case next time such a case happens.

I have to go back to the books and review where you did well, and where I did bad, then I correct myself so that next time I get another case I'll be competent to attend to. (Female Nurse).

Yeah to see more about counseling, other parts, like medical and the other and also legal part of it. The legal part of it is also very, very key. I don't know how the, how it can be expanded to the community to maybe the police. I don't know whether police would, police need to be sensitized on this. (Male Clinical Officer)

Concerns about not feeling competent were even more acute when working with children and the need for more specific training on that. One social worker shared:

Topics I feel will be beneficial to learn about in, in sexual violence are more about children, how can you get information from children. Sometimes it is very challenging getting to know. Children have low concentration. You are talking to them, and they are looking outside, they have forgotten what you are telling them, it becomes difficult, so you end up not getting the information that you need. (Female Social Worker)

Poor administrative oversight: Lack of administrative support and requisite oversight was another sub-theme identified here. Included in this was the lack of supervision, which was a source of frustration for the practitioners I interviewed. They felt that some of the problematic issues they encountered on a daily basis could be mitigated by effective supervision. The national guidelines on the management of sexual violence tout the importance of supervision. It states:

Supervision is important for preventing “burnout” of the counselors and for maintaining high quality communications between the counselors and the survivors. Supervision provides an opportunity for counselors to come together with other professional counseling providers and at least one trained supervisor, to discuss and process issues that arise during the counseling of survivors of sexual violence and to monitor the quality of their own service provision over time (Ministry of Public Health and Sanitation & Ministry of Medical Services, 2009, p.24) .On the ground, supervision

looks very different from what the guidelines recommend. In some facilities, supervision consisted of merely going to the facility in charge's office and collecting data on the number of cases that the facility had received. Several practitioners talked about needing follow up support supervision so that they are able to express their frustration and discuss issues that arise when working with survivors.

Supervision? In terms of supervision, we don't get the supervision from anyone else. It is just us, it's just me, let's say not us, it's just me who maybe goes out there to my friends and talks to them and you know and tells them. But there's no supervision. (Male Clinical Officer)

One practitioner shared their reasons for wanting supervision. He said:

So as a human being also I'm sometimes overwhelmed, yeah. So there are those cases that touch me, and that's why we say sometimes we need supervision. (Male Trauma Counselor)

Practitioners questioned the idea that supervision entailed only collection of the data on survivors from the facility. Supervision in this context appeared to be mere paper-shuffling administration, rather than someone who could provide advice about improving the quality of care based on their own extensive on-the-ground work experience with survivors. This practitioner expressed her thoughts on the problem of ineffective supervision, due to the fact that the administrators do not treat survivors and therefore cannot provide adequate supervision.

But even the supervision itself, they were going to the office. And whoever is in the office is not the one who treats the patient. So I believe instruction should be coming to people who are actually, people who are actually dealing with the clients, so that you can see what I'm doing so that you'll correct it. I believe that is what supervision is all about. Now when they come and go to the office, what are they doing there? (Female Nurse)

Another practitioner called supervision non-existent. While he was trained, there was no follow up supervision to see how the training translated to the everyday service provision. He shared the following:

There are those promises that were made that they would make a follow up, support supervision, they never did. Up to this time I have never seen, they have not come to the ground to see what I am practicing after they have trained me.
(Male Clinical Officer)

This practitioner shared the importance of supervision, a sentiment echoed in the guidelines. She talked about being frustrated with the lack of regard shown for the work that they do and the consequent effect on her attitude. It is clear from her response that she is interested in doing good work and would like supervision that involves feedback.

That support of supervision is very important. Because then they would see my areas of weaknesses and strengths and help me to move forward because you know like it's human nature after you have done something and then you don't see things going the right way, it's human nature. You also start feeling like, I mean it's like the people who are supposed to give us support or supervision, they are not serious. It starts changing the attitude. Yes they should make frequent follow-ups. Do we have the materials? Are we doing the right things? Do we have the tools? Yes, they have never come on the grounds and I will like to say this. When support supervisors come, they shouldn't go to the office because that is not the person on the ground. Some of those support supervisions really frustrate me, when I hear someone went to the in-charges office, gathers some information there. They have not come to the ground, yeah so things continue as usual.
(Female Clinical Officer)

System Issues: Fragmentation of services and poor referral systems were the system related issues identified by the practitioners in this study.

Fragmentation of services: The survivors usually must go to different places in the health facility for their medical examination and counseling. One practitioner talked about the fragmented care and limited collaboration across units and agencies

Sometimes when there is no team work, there is no proper coordination; it is a challenge to attend to this client. Basically you'd expect to work with lab closely

CCC (Comprehensive Care Center) or VCT (Voluntary Counseling and Testing), and maybe the pharmacist. But it's a challenge. (Male Nurse)

Poor referral systems: Practitioners also expressed concerns about the limited referral system and the scarcity of external support services locally. Relatedly, the lack of available transportation was another issue raised by practitioners. This was an issue especially when they were referring clients to other health facilities for services that they could not perform at their facility. For cases that need referral, the lack of functioning ambulances to take survivors to the other health facility was another problem.

Practitioners mentioned that the burden fell on the survivors to secure and pay for a taxi for transport to the hospital to which they were referred. One important reason that they would like to have a functioning referral system is to facilitate continuity of care for survivors. Having a system in place that enables better movement between health facilities is needed:

Sometimes you don't have an ambulance and we have stated that we should get an ambulance for every facility so that in case of any emergency like that one they can just go. Sometimes the ambulance has been broken down and you are telling the clients to look for other means. And we are not sure whether they would go and they don't have money. (Female Nurse).

It's hard, it's really challenging 'cause for example if there is no transport. The community we are serving, most of them, they have financial problems and maybe you don't have an ambulance to take them to the next level or to the other facility to be served the services that we do not provide in our facility. (Female Nurse)

When you refer the patient to another facility, she will say that she doesn't have the money to go, money for transportation to go to Nairobi Women's for treatment. (Female Clinical Officer)

When practitioners had to refer survivors to receive additional services at another facility, they were uncomfortable with the feeling. One practitioner talked about the reality of the survivors' circumstances. One particular facility was located next to a large slum area,

where most of their patients live. He shared his apprehension about having to refer survivors to another facility, which would require them to pay for transportation cost, money that he knows they most likely do not have:

When I have to refer, I don't feel fine. I feel bad, I feel bad, knowing very well that this person I'm referring, she may not even go there and maybe it's a person who is less privileged. We usually see people from many slums and maybe she can't even make it there. (Male Clinical Officer)

This practitioner talked about having to rely on other partners to assist with transporting a survivor when they are referred to another facility:

Secondly, we don't have the, a good referral system, because we rely on other partners, like here, we don't have our own ambulance. Then you also find that this, like now the ambulance we called was not for our facility because we don't have one for the city council. We don't have one. And the one like we have is for the whole district. At times we can call and find the ambulance has taken a patient to another hospital for referral. So the patient, the client becomes so impatient and you wish if everything could just be done under one roof. (Female Nurse)

At other times, practitioners mentioned having to use their own resources to help survivors. When the practitioners were not able to provide the services to the survivors and had to refer, they sometimes gave them money to ensure that they would get to the other health facility. While they did what they could in the moment, they acknowledged that it only a temporary solution for one appointment:

Sometimes we have even done it through our pocket and told the client to use this as fare and go where they are supposed to go. But you see, you can only, I may only provide for one day fare and that client may need a follow up appointment. (Male Nurse)

Similarly, another practitioner mentioned using his money to buy phone credit in order to follow up with clients:

And also the challenge, another challenge is maybe the air time [phone credit] for calling them. I'm not being given. I use my own money to call them, my own airtime to call them for follow up. (Male Trauma Counselor)

One practitioner took it upon himself to solicit his colleagues for funds for a particular survivor in order for her to attend all her sessions. As selfless as that was, he did not stop there, but also sought funds to get her back home:

I used to have to solicit for funds from the health workers here in the facility to take her to for counseling until now she healed for all those sessions and then I had to look for fare [bus fare] to give her transport back home to her rural home. (Male Social Worker)

Due to ill equipped facilities, practitioners are often unable to provide all the necessary services to a survivor. As a result, practitioners have to refer the patient to another facility for further treatment making having working hospital transportation necessary.

Criminal justice system: Lack of police cooperation was often cited as another deeply frustrating aspect of the work for practitioners. Several practitioners mentioned police apathy when dealing with survivors.

The Police: Many practitioners questioned the value of referring survivors based on their experiences with other survivors. Practitioners also mentioned that survivors reported harassment and that perpetrators are often able to bribe the police.

There are those perpetrators who are arrested and they go, they give, they bribe the police, so they will be released. (Male Social Worker)

There was one that defiled 4, or was it 5, primary school kids; one perpetrator who used to entice them with some sweet, sweet, things to visit him in the house. So he defiled them, all of them. I followed this case up to the police station. I talked to the OCS [Officer Commanding Police Station] and the gender-based violence person in the police department and this person was released and he ran away. He was arrested but after sometime, this case got lost just like, like that, yeah, by bribing the police very disgusting. (Male Social Worker)

One practitioner talked about the nasty experience that one woman had when she was trying to report her daughter's case. She recounted:

There was this mother came with that, with her girl in Kamukunji. She had gone to another hospital that sent her to Buruburu police station then when she came to the police station, you can imagine police officer beats the lady, she slapped her, the officer accused the woman of using her child to make money. You know? Without even getting history from this mother, she gets slapped. She came with this small girl and started to explain how the police beat her. This mother was fighting for the right of this girl and the person who raped the girl is the girl's teacher. Mama has gone extra mile, going to the police and when she went there, the police officer, a lady, a lady to make matters worse is the one who slapped her. (Female Nurse)

This sentiment was echoed by another practitioner who said:

Then the other thing is our police force, which we would expect to help these survivors, may not be very much, they may not be very much helpful to this survivor. What they do best is to add more trauma to this client. It could be either through failure to provide the help, the necessary help that is needed or rather continuing to rape the client.[traumatize the survivor] (Male Nurse)

Practitioners expressed the fact that they were leery of the police due to the stories that survivors told them about the treatment at the police stations. The experience of harassment was a recurring theme. Another shared:

But now the challenge, one of the challenges that has come out very strongly from a number of ladies is that some police officers, especially maybe male and a few female, tend to harass the ladies. They tend to blame the survivor when they're reporting. They say things like "It's because you had dressed badly, indecently, that's why it happened." "Where were you going at such a time of the night?" "It seems you are a prostitute" and such kind of things. (Male Trauma Counselor)

Some survivors told the practitioners that, when they report their cases, they are told to bring back the perpetrator. Due to this, practitioners felt it useless to encourage reporting of the incidents to law enforcement. One practitioner recounted:

When we try to encourage them [survivors] to go to the police, that is where we get lost. After that they just, we went, we were told to come back with that person who raped them or anything. Some of them [perpetrators] cannot be found. Some of them [perpetrators] they are their [survivors'] relatives and they fear. So the cases just disappear like that. (Female Clinical Officer)

Some practitioners recounted the victimization that the survivors faced when they went to the police.

Like one lady who told me that the police woman and even the police man was actually kind of, how can I say, ridiculous? Can I say ridiculous? I don't know if that is the proper one. They were making fun, I don't know, something like that. They were trying to make fun of the whole thing and it was so hurting to her. They were asking [questions like] "Where were you?" And "what is that odor?" (Female Clinical Officer)

One practitioner talked specifically about policemen doubting the story of the survivor.

She shared:

No, many don't report 'cause the legal is more, it's not working for them. It's not and even they know that, so they don't even waste their time. Because they have been there before and they have seen what has happened and the language being used by the police so you don't even want to go through that after what you have gone through already. Ah bad language, being asked "How can your husband force you to have sex?" or "Hey, that is why you have been beaten cause you refused." You know, they are using bad [insensitive] language, not like the way we are talking, they are using, they are talking bad, and you know you [the survivor] are already traumatized. That is not what you need now. You need someone who can listen to you and help you, not someone who can talk the way they are talking. (Female Social Worker)

Practitioners also brought up the fact that it was a well-known fact that survivors would not have legal recourse when it came to their case and so they did not even bother. One shared:

Let me be very sincere. Even if you take this client, because majority of them I take them up to the department that is claiming to handle gender-based violence cases in the Police Station, nothing is done. Not much is done. And also there is some harassment within the police department. So this person will give up. (Male Social Worker)

The issue of corruption is also one that came up often during the interviews with the practitioners. One practitioner shared:

What I would say is on the issues of justice for sexual violence survivors. I can say that most of them don't report. They pursue, but they get tired with the corruption with the police force. Yeah, the case doesn't go anywhere. Because this person who defiled my child or who defiled me is rich or he has more money or he is a man and the case is being handled by a man so they are understanding each other at some level. So there is nowhere my case is going. You know justice

it is part of the healing process and we have a long way to go. (Female Social Worker)

The Courts: Practitioners also talked about what happens when survivors take the issue to court. The practitioner expressed frustration with the corrupt system. She recounted:

When they go to the court, there is a lot of bribery and then this woman walks out knowing this person raped her but is not getting, he's been released. That is something that is a challenge, even when there was evidence. (Female Counseling Psychologist)

Community/ Cultural Level

Kenya has a largely traditional patriarchal culture (which is now undergoing tremendous stresses due to the press of modernity, globalization, westernization, equality, women's rights, etc.). This patriarchal value system is most evident in the widely prevalent attitudes that still blame women for causing their own rape. It is also a poor country, where women still have few options but to be supported by a male wage earner, which then leads to cover-ups, retractions of statements, and out of court settlements, because women have nowhere else to turn. Finally, there is the influence of religion, which reinforces the subordinate status of women, and influences how the practitioners counsel the survivors (e.g., telling them that abortion is a sin).

At a broader level, practitioners identified the dominant cultural values and social practices that impact the perceptions of women who have been raped, and the services that survivors are able to receive. Some practitioners expressed their frustration with cultural practices as seen below:

Yeah, there are times, Ok, there are things I think triggers, though I may not support that so much. I believe in our African culture, ladies are not known to, mini-skirts are not accepted. Sometimes they may lead somebody to be raped, eh? Exposure of part of the breast is not acceptable. Culturally in Africa it is not

acceptable. They may go that, they may wear that, but the African culture, it's a no, and it goes across the tribes. (Male Nurse)

And this one, I experienced, I experienced this one here not in Nairobi, but in Nyanza, yeah, in the Nyanza region of Kenya. Also one also, one area that also is still has issues is to do with inheritance, wife inheritance. You find a woman if she refuses to be inherited, she's assaulted sexually. Yeah. She's assaulted sexually, and the community allows that. (Male Trauma Counselor)

Yeah, because as I told you this morning as I was talking to the parents I told them, specifically the mothers, that we the mothers make our girls also to be raped. This is because of the way even we dress our daughters. Because if we dress our daughters in a manner less way, halfway naked, they are walking with skin tights, and these men are seeing halfway naked and around the chest, the men are seeing daily, you see. (Female Nurse)

Practitioners talked about the behavior of the survivors and attributed the blame for the sexual assault to their behavior. Some of the practitioners' responses are below:

That one can, it can, like walking outside at night that is another behavior, why do you walk at 3am? Where do you? Like here, we get clients at 3am with a cough, a lady you ask why do you walk at this time? I stay near here. You ask the victim, do you know the dangers of walking around at night? So why should a client walk with, a girl to walk around dressed in short clothes. Such behaviors will lead to rape! (Female Nurse)

So in such a case that is a person who was drunk, they were raped because they were drunk. So she doesn't know even who raped her yeah. (Male Nurse)

You shouldn't have maybe, that's what I'm saying, you shouldn't have gone to drink with people you don't know and then they put, they add some more drugs in your drink and then they end up now being raped. Or even the way they dress, it provokes people. Like this lady, you see now she took even the risk of sleeping in a room that maybe it could have contributed, because if she never went to that room alone, she could not have ended up in that mess you don't go to a place you don't know, and then you are told go and sleep there in the house, and you just go and sleep, you see. (Female Nurse)

It was only one case I felt the client was responsible. The girl went out. She was in her early 20's. She went out with her friends and I think they had a party. She told me they were drinking. They went only girls but in that party there were boys and girls. So, in between when she was taking her drinks, she got intoxicated and she could not remember anything about the actual event in the particular place. So she got hooked to another guy who she did not know and one thing led to the other. I remember her telling me she got raped. But I don't know, I thought maybe

she consented to having sex with the boy. The reason why I thought she was at fault was because it was the second time it was happening. (Male Nurse)

For example now the lady is walking alone and is putting on those tight clothes, maybe a mini skirt you know, it makes the boys eh, they tend to be moved, aroused and may be raped. (Male Clinical Officer)

The HIV/AIDS aspect was also brought up in relation to a reason for perpetration of sexual violence. One practitioner talked about the misconceptions in the community that still needed to be addressed:

There are misconceptions in the community with regard to HIV. There is always that misconception that having sex with a virgin and for that matter, or a child one would be healed of HIV. It's very outdated and very bad misconception leading to rape. (Male Trauma Counselor)

Family settlement/out of court settlement: Some practitioners mentioned the notion of families accepting reparations for the survivor's rape as a frustrating aspect to working with survivors. Formal charges were never filed and reparation for the crime was sometimes settled in exchange for money or cattle.

That is one area that has been frustrating eh and also after the initial contact with the client, later on like there is one particular case that really saddened me. These, the perpetrator went and they agreed with the other villagers to settle that matter at home so this lady was suddenly becoming uncooperative. Yes they said it was a rape and then later on now she is turning the story it is not a rape. (Female Clinical Officer)

Some of them they entice the survivors with some things. Giving them maybe cash, some food stuffs. (Male VCT Counselor)

Most of the clients the ones, like the ones I had gone through the five sessions, they never reported their cases. Their cases, they settled them outside the court. They didn't share but they ok, the way they shared, they said they had a meeting with the elders. (Male VCT Counselor)

Similarly, there are times when the community thinks that it can handle the problem better than the formal criminal justice system:

I'm dealing with communities, like some communities that want to deal with issue in a community way, not pursuing legal. So they [guardians] think if we bring, we take that child to counseling, we will force them to pursue legal choice. We don't force them. So they better deal with it at home or from the clan's way. That's the problem I'm dealing with it here. (Female Trauma Counselor)

Several practitioners interviewed felt that the socio-economic status of the family played a major role in their decision to settle the matter out of court. Sometimes when the perpetrator was a member of the family, the threat of losing the primary wage earner made them refrain. One practitioner shared:

Sometimes it is the father of the child. That's why the mother cannot report because maybe the father is the breadwinner. If she reports and then that's the end of the relationship, so they fear. (Male Trauma Counselor)

Other practitioners echoed this sentiment:

Yeah, I had a case where a stepchild was violated, and then this man threatened to divorce this woman if she took him to court. Now in order to preserve her marriage, so she just had to drop it, and it was frustrating. After we had collected the evidence and then now she just comes and says "no, I don't want this thing to continue, I want you to change." So I said, "I can't change what I wrote so if you are going to change things somewhere else you can but not me changing what I have written." And I felt frustrated cause that's not the first case. (Female Clinical Officer)

And when you sometimes you talk with parents when they come, you realize they were given money by perpetrators to keep silent. We have cases where we've seen parents being given money, and they don't mind their children even going back again. It's like a way of business; I have some cases that I can say, these two, three I'm very sure of this. (Female Trauma Counselor)

For example like in my experience like we work with some survivors from the [located removed] for example, yeah. For them they believe if this thing happens, I'll give you some cattle, I'll give you some camels, and it's gone. You being able to go through and help this person understand, it is very okay to go for the legal, they are not, they don't understand that word at all. So it reaches a time you just, you just make sure she is safe medically and all that and be able to talk through all that. But you as a counselor, you are sitting behind thinking she is seeing the perpetrator every day, she is seeing the perpetrator every day or she is sitting with parents who sat down and agreed to be paid cattle. It's not a good thing, but again we try to help where we can help. In this gender-based violence issue culture

comes in, exposure comes in; a lot of things come in, yeah. (Female Counseling Psychologist)

I know most people are doing this thing out of poverty because there is one who told me who had a four-year old daughter, and she was given 30,000KSH by the perpetrator. Remember this is a single mother staying alone and perhaps she has never seen 30,000KSH in her life so when she was given that one she opted to throw out the case. Yeah, so poverty plays a very big role in this. (Female Clinical Officer)

Yeah, there're many times when parents are not involved, and they're [survivors] brought by even good Samaritans. Even like right now, here I have a child that I'm dealing with who was brought by the teacher and guess who was the perpetrator? The father! Because he [the father] is divorced with the mother, unfortunately, the child had been exposed to, you know, money. So whenever the father comes and you know the level of poverty of this area, comes with, let me use things like chips. To that child, that is an achievement, and so the child would give in [to sexual abuse] and never report until she could not walk and so the teacher had to take the initiative. (Female Trauma Counselor)

The practitioners not only brought up what they felt were risk factors for female survivors but also what they felt contributed to the perpetration of sexual violence.

Influence of religion: Of particular concern was the seeming tendency by practitioners to use counseling sessions as a forum to proselytize their own spiritual views. Practitioners talked about counseling women who ended up pregnant, as a result rape, out of getting abortions, citing it as a sin. In one case, the practitioner enforced her own religious values on the survivor. One practitioner talked specifically about using religious beliefs to help a survivor make a decision, which, in this case, was advice to keep the baby that resulted from rape. She recounted:

She was not infected with HIV, but she was pregnant. And then now she was telling me after that rape, she was attempting to tell the husband to lay with her so that she could cover [up the rape]. But somehow it did not happen. And even if it happened the timing would be wrong, the husband will definitely know that it is not his pregnancy. So I had to take her through that trauma counseling and even introduce a religious aspect into it. She told me she was Christian; then I tactfully introduced that aspect of religion. Then after having introduced that aspect of religion, we discussed on it, that it would be unfair to terminate [the pregnancy]

on religious grounds, to terminate the life of this unborn child. It had a right to, to, to live also. Then she just said that she would want to keep the baby and then at that point I also let her know that there are other counselors, but she didn't terminate that pregnancy. (Female Clinical Officer)

For the record, according to the Sexual Offense Act of 2006, pregnancies may be terminated in cases of rape. While abortion is illegal in Kenya, the Sexual Offenses of 2006 act states that the termination of pregnancy may be allowed after rape. Should the survivor decide to opt for termination, she should be treated with compassion and referred appropriately as per the guidelines. The onus is on the practitioner to inform the survivor of their options and not impose their own religious ideals on them. This statement signals a lack of caring on the part of the practitioner, the dehumanization of the survivors. The practitioner was more concerned about her religious beliefs than the psychological state of the survivor.

Practitioner Recommendations

The practitioners had many suggestions for improving the quality of services provided to survivors of sexual violence. Beyond the critical need for more trained professionals, most voiced the need for more and better trainings. After that, recommendations included: Setting up support group; personal therapy sessions; self-defense classes; shelters for survivors; and increased community awareness.

One practitioner brought up that one way to share the workload was to have everyone trained on working with survivors. In this particular facility, only clinical officers tended to survivors.

What we are requesting is that everyone, nurses, clinical officer, medical officers should be trained, so that all of us should be able to treat survivors. Yeah, that will ease our work, and then it will help even the survivors (Female Clinical Officers).

How to deal with cultural influences was another aspect of training that practitioner mentioned:

How to address the cultural issues, those taboos, and the issue of how to deal with the corruption part of it. (Male Trauma Counselor)

Some practitioners talked about doing their own research on the internet to keep abreast with information so as to do this work. One of them shared

Sometimes I do some research on the internet about this so that I can have more information to give for my clients because that is the only way they can be empowered to protect themselves. (Female Clinical Officer)

Support group: This study highlighted the need for support programs for practitioners.

I think there should be an organization where those ones, they get maybe a free time, maybe like 3 months or 4 months or 6 months, they get like a support group or a meeting somewhere. Those people who care for those people so that they can discuss their issues, they share my experience, you say yours like that, you talk and then you get a counselor who will spend a day or two, outside your workplace. (Female Nurse)

Personal therapy sessions: Having therapy sessions for the practitioners was a suggestion that some practitioners brought up in order for them to have somewhere to unload their emotional burden.

If at all we could have a counselor, once or twice in a month that comes and you go and talk to her what you have. I think it could be better. Because it can pile in your head; pile, pile, pile, until you start losing it and start yelling. Sometimes you can, actually tell them “Stop disturbing me!” “I don’t want to hear!” You’re overwhelmed, yeah. (Female Clinical Officer)

I wouldn’t say it doesn’t have an impact, it has and basically we have a problem in our country because I think time after time staff should undergo counseling sessions. A continuous, it should be a continuous, eh? That after three months somebody should go for counseling session. Three months may be more but at least it would be better than none. (Male Nurse)

Psychologically, I can be affected but since we are in the profession we can go to let's say if I get burned out I should go for counseling also. (Female Clinical Officer)

No, actually we used to think it will be nice to have a counselor. We always used to discuss that but you know you cannot. I know they are trained people who have counseling skills in the facility but there is no way my colleague will counsel me. So we were thinking it will be good if there was a counselor maybe then even, even though it is not best in one facility, like best in like a district. It will be helpful that you can go to and have that emotional thing sorted out. (Female Clinical Officer)

You know sometimes because you're all colleagues. There're things you're not going to say, you will hide, you know? Uh, but when you go for personal therapy, it's easy now to talk about it. And so, you will journey with the therapist. (Female Trauma Counselor)

Yeah, of course like I said personal therapy. It should be the key but it seems like not only here, I've talked to so many counselors working with trauma. I think institutions don't understand how personal therapy is important to a counselor. And then things like debriefing, debriefing, supervision, you know. Just a place to go to get that outburst. It's very key, taking care of the counselor, I think it's very important. (Female Trauma Counselor)

When you talk with another counselor about this frustration then you also get support counseling then it becomes lighter. (Female Clinical Officer)

Self-protection classes: Practitioners also mentioned the need to help women to create a plan for protecting themselves from future sexual violence. These tactics ranged from taking self-defense classes to refraining from drinking alcohol, to wearing extra clothing. One practitioner said:

And also like empowering these women, like when they are traveling at night they can put on shorts, something even that the perpetrator has fight with, to struggle with you before. Yeah, they don't put on trousers or shorts from inside and so they should be empowered. Not necessarily revealing but which are too easy to undo. They should just put on clothes that are difficult to undo, like you put a short inside what I normally tell them with a belt and if possible you put another one so by the time the perpetrator removes all those one to get into you and then you scream. (Female Clinical Officer)

This sentiment was echoed by another practitioner:

I told them there is a group in Mathare whereby women are being empowered to defend themselves at night. Key, defense keys [strategies], you can join them there. Learn a few taekwondo, you can hit that man before he comes from the ground, you have made more steps than he would have made unless this person has a gun. (Female Clinical Officer)

Shelters: Having shelters, particularly for children who were sexually abused in the home, was another suggestion that several practitioners articulated as a way to reduce further perpetration.

I am not accusing it, it's my government and I am part of my government. What I am saying is this when such a case has been reported there should be good system to take up the matter and to handle it and the survivors to be given, what can I say, security. They should be removed from the source of this violation, from that home. They should be completely removed from there because now this is the perpetrator. Yes, a shelter, they should be sheltered somewhere else. Because now she is going back to the same perpetrator, this person has made it a practice. It would not stop, it will continue, so there should be a system and the systems should be firm and corruptions to be out of this matter. (Female Clinical Officer)

Community awareness: Practitioners mentioned that the low numbers of survivors that come for treatment is due to lack of awareness of the services available to them. Some suggested having a better referral system with community health workers. Other mentioned having posters in public transit vehicles, similar to the HIV/AIDS posters, that provide information on what to do if one is assaulted. One practitioner suggested:

Like in Matatus [public buses], I see that they say that you open the windows. There is a poster from the Ministry, department of TB in the mathree [slang for public buses]. I haven't seen any [posters] for the rape and yet there are people that get raped in those public transit vehicles. (Female Clinical Officer)

Other practitioners suggested promoting community awareness:

We have cases that may not come to the facility because of the stigma. But most of them are women and owing to the fact that mostly the people who are survivors are raped by people who are known to them. They avoid reporting because they don't want to, maybe it is a father, it is an uncle, so we don't get those cases. And I think this one is attributed to no awareness, there in the community. The

awareness is low. Maybe people don't know their rights. I think that is the reason I believe at least on a daily basis we are having maybe a person who is raped or two or even three and our records do not feature that. (Male Nurse)

Yeah, I think also the campaign because I know there are a lot of cases happening but they are not reported. So the campaign is supposed to be done to the community also so that they may know that after rape, what am I supposed to do. Because I know they're so many cases which are not being reported. I know this because I'm not staying very far. I stay within the community. (Male Trauma Counselor)

The recommendations above seemed to follow directly from how the practitioners I interviewed perceived and defined the issue of service provision.

Reflections on the Interview Process

While conducting interviews, I had check in conversations with a member of my committee about the data collection process. One observation that I noted was the reaction of the practitioners after sharing their experiences. Almost all the practitioners shared that they appreciated being able to reflect on their experiences of working with survivors of sexual violence. I felt that many of them used the interview process as a personal therapy session. At least four of the practitioners broke down in tears and found the interview process to be cathartic for them. I also got the sense that reflecting on the work that they did with survivors was not something that they did often. At the beginning of the interviews, some practitioners needed prompts for the first couple of questions and were then able to talk about their experience without prompting. The interviews gave the practitioners a chance to reflect on the meaning they attach to working with survivors. During the interview, several practitioners talked about resorting to a mechanical approach to their work due to the high workload and emotional toll. The mechanical approach served as a coping mechanism for them. This highlights the neoliberal, bean

counting, dehumanizing approach. As many of them did not have an outlet for sharing their feelings, they decided not to dwell on them. At the conclusion of the interviews, most of them commented on, not realizing that significant time had passed as they had a lot to say. When talking about the challenges they faced, most reflected on particular cases they handled where they wished they could have done more for the survivor. It was interesting that almost all of them had a survivor in mind when they reflected on their experiences of service provision. Practitioners noted the high volume of survivors they see, most of whom they would not remember. It was evident that there was something different about serving survivors. They could recall exact details of services provided, things they would do differently and challenges faced.

Another observation noted was gender differences in responding. At the beginning of the interviews, I noticed that most of the male practitioners had a harder time reflecting on the experiences and opening up. Their initial answers were brief, and they talked about their work in a very mechanical, monotone detached manner and needed prompting. Over the course of the interview, they eventually became comfortable with sharing and talking openly about their experiences providing services. One explanation may be the fact that I was woman asking them about their experiences in providing services to female survivors of sexual violence which may have been uncomfortable for them. Another observation was that the male practitioners needed additional prompting when speaking about the challenges they faced in doing this work. I felt as though they perceived the question as me challenging their professional competency. This could also have been as a result of the gender dynamic.

In summary, the three most significant findings my research are: a) the survivor care system is completely overwhelmed, and under-resourced, leading to degrees of secondary victimization as the providers get burned out and begin to resent the amount of time and demands that caring for survivors takes; b) the issue of "genuine" clients, presenting at health facilities and c) the issue of family cover-up. While these are three seemingly very different problems, I contend that the roots can, in fact, all be traced back to problems in the political economy of health and the forces of globalization as well as the social construction of violence, which I will discuss in the next chapter.

CHAPTER VI

DISCUSSION

This study examined the experiences of practitioners facing the challenges of providing services to female survivors of sexual violence. This final chapter starts by describing and characterizing the current status of services, and then goes on to present an analysis and explanation for its now dismal state. The chapter concludes with recommendations for improving the quality of services, both long-term structural changes that need to occur to improve the experience of survivors, and more immediate short-term fixes, which can be implemented without major infusions of new resources. The primary goal of this research is to identify steps that can be taken to minimize the secondary victimization of rape survivors, and better yet, to provide high-quality therapeutic services that can genuinely alleviate the pain of survivors and improve their condition.

In reviewing the many findings uncovered in this research, three key results stand out, one largely expected and two more surprising. The first and most salient result identified here is the severe shortages of personnel, equipment, and competency in delivering services to survivors. Hospitals with designated counseling service units typically have no more than one practitioner with any training on call at any given time. These practitioners are required to see the same number of patients on an average day as the rest of the staff who do not have such training. As a result, significant and widespread problems with the current service delivery system include:

- Lengthy delays in being seen by an appropriately trained and qualified practitioner
- Significantly curtailed exam times, in response to high patient load

- Severe shortages in proper examination equipment and supplies
- Fragmentation of services and the lack of continuity in case management
- Shortcuts and the omission of key steps in recommended guidelines for care
- High rates of turnover and low morale
- Extremely poor forensic management, from lack of proper supplies (rape kits) to collect evidence, to lack of proper storage facilities, to botched handling such that crucial evidence is frequently lost
- Missing or misplaced Post Rape Care registers (required by the national guidelines for proper documentation of services)
- Favoritism in the selection of candidates for training
- Insufficient training to provide competent, professional counseling to rape survivors (to the point that many practitioners felt that they may be doing more harm than good).
- A complete lack of training on the special needs of children and the elderly who were raped
- A corrupt criminal justice system, where bribes frequently lead the police to ignore the case, and bribes are necessary to get the police to act.
- The development of burnout and victim-blaming attitudes towards survivors

Due to the acute shortages in personnel and equipment, many practitioners worried that they were feeling burned out; some had developed bitter attitudes towards survivors, blaming them for their high case load. They were distressed that there was virtually no administrative support for them to process the emotional toll that this type of work would take on anyone, even under the most ideal conditions, and consequently, they were forced

to improvise with various *ad hoc* strategies such as singing, taking unauthorized breaks from work, or ventilating at spouses (which was both damaging their marriages and in violation of the survivors confidentiality).

In addition, there were two other major findings that I did not anticipate based on my review of the literature and previous experience in the field: first, the added emotional drain on the providers due to pernicious doubts about whether the woman presenting in their clinic was a “genuine” rape victim, or rather, someone so desperate to obtain ARVs to prevent or control HIV infection that they made the false claim -- despite the enormous social stigma attached to being identified as a woman who had been raped. The second significant unanticipated finding was the great pressure exerted on survivors not to report or to follow-up on cases when the perpetrator was a family member. It was surprising mainly because the experience was less often voiced as feelings of shame about the act of incest, but more often expressed as the fear of financial ruin for the family if the male breadwinner were sent to jail. As the analysis and discussion that follow suggests, an explanation for the occurrence of these three seemingly disparate results points to common origins in social structural inequities driven by the global political economic policies that set the terms for North-South relations that perpetuates poverty and dependency throughout Africa and the developing world.

To explain the current state of affairs, it is important to set accounts of the experiences provided about individual doctor-patient encounters in a broader context. In chapter 3, I discussed the potential relevance of theories of the global political economy of health and the social construction of reality for analyzing problems in the delivery of health services in Kenya today. It is to these frameworks that we must turn to identify and

understand the most significant factors affecting the quality of services provided to rape survivors and how they press towards secondary victimization.

The discussion that follows examines the results of the study in relation to the original research objectives. It assesses the degree to which the key research questions have been answered: What are the main factors affecting the quality of services provided to survivors, and what needs to be done to improve those services? Finally, the implications of the study findings for future research will be discussed.

The Political Economy of Health in Kenya

The quality of services provided in the individual interactions between practitioner and survivor is powerfully shaped by macro-level factors that determine the level of resources available to the health care system in Kenya. Currently, the public health sector provides approximately half of all health care services in Kenya (Chankova, Muchiri, Kombe, 2009). However, research indicates that Kenya is far below the recommended WHO doctor-patient ratio of 1 physician to 1000 population (Kinfu, Dal Poz, Mercer, Evans, 2009; Mwenda, 2012). The results of a study by Kinfu et al (2009), in fact, found that, as of 2009, there were approximately 8,000 doctors practicing in Kenya, which is roughly 32,000 doctors short of the WHO recommendation for Kenya's population. The shocking shortage of physicians is made even worse by the fact that only 30% of them practice in the public health sector, while the remainder work in the private fee-for-service system.

The primary causes of the crisis in human resources for health in Kenya have been well characterized:

“inadequate and inequitable distribution of health workers; high staff turnover; weak development, planning and management of the health workforce; deficient

information systems; high migration and high vacancy rates; insufficient education capacity to supply the desired levels of health workers needed by the market; inadequate wages and working conditions to attract and retain people into health work, particularly in rural underserved areas” (Kiambati, Kiio & Toweett, 2013).

Currently, 80% of government spending on health is allocated to personnel compensation, thus leaving only a small fraction of funding for essential medical equipment, materials and supplies (Kiambati, Kiio & Toweett, 2013).

Key reasons for the shortages in healthcare personnel in the country point directly to restrictions imposed by the IMF on government spending and the unwillingness of the IMF and the World Bank to provide adequate levels of financial assistance to Kenya to support even a modestly decent health care system (Kinyanjui, 2008). Kenya’s healthcare system was hit hard by the structural adjustments policies that the IMF and World Bank required the government to make in order to qualify for future loans from the IMF. These policies dictated cutting government expenditures, in particular, “discretionary” (in contrast to “mandatory” loan repayment provisions) funds for health, education and social services. As a result, local dispensaries and health care clinics have faced drastic cuts in supplies of medicine and other medical materials (Kinyanjui, 2008). The IMF imposed a further restriction, prohibiting the Kenyan government from using any loan funds allocated for health care to cover the costs of salaries. This restriction subsequently led to drastic declines in the number of doctors willing to work in the public sector in Kenya (Ambrose, 2006). In 2006, the Kenya Health Minister, Charity Ngilu, accused the World Bank and IMF of undermining the country’s ability to tackle the significant health problems facing the country. Civil organizations in Kenya have expressed similar outrage. Since then, however, the contribution of these international institutions to

support Kenya's health sector has remained paltry. The high bar that these two institutions have set for borrowing has made it impossible for domestic governments in Kenya and elsewhere to address the needs of their people.

Outside of Nairobi, especially in remote rural areas, there are even fewer personnel in the health care sector, which means that victims of rape almost never see an appropriately trained health care provider. To understand why survivors are prone to be treated in ways that lead to secondary victimization, it is important to see that the problem starts with IMF policies, which are designed to protect the financial assets of its member lending institutions, and from which, a direct line can be traced to the length of time that it takes for a rape survivor to be seen by a health care provider, and the length of time the provider has to care for her patient. Policies dictated by the neo-liberal capitalist political economy also affect the quality of service provided to rape survivors in Kenya indirectly, by limiting the resources available to treat other medical conditions.

One of the most disturbing findings to emerge in this research was the issue of "genuine" rape survivors. On top of the already terribly trying circumstances with which the practitioners interviewed for this research have to contend, they also revealed that they had encountered situations where the person presenting claimed to have been raped, but the circumstances were suspicious and they eventually came to doubt the woman's story. Eventually, they explained to me that they find themselves faced with patients who have not, in fact, been raped, but claim to have been, so that they can obtain PEP medications free of charge. Thus, on top of the already heavy emotional toll, the practitioners must also struggle with the additional burden of doubts and suspicions about whether the ordeal being related actually happened. Again, it is important to be clear that

women are driven to these horrible lengths – making up stories about their own rapes – because they cannot get medications that should be provided by a national health care system. This situation is directly attributable to the austerity measures imposed on the Kenyan government in order to ensure that they are able to make the next interest payment on their outstanding IMF loans.

Finally, the study found that rape survivors in Kenya are not receiving justice, among other reasons, because going forward with the prosecution of the perpetrator threatens to cut off the primary source of income for the family, in cases where the father committed the crime. I also heard reports that families would pressure their daughter not to report the crime in exchange for cash settlements, to be negotiated with the culprits, again a turn of events that can be explained only by the desperate financial straits of the families so affected.

Within its severely limited resources, the Kenyan government and the Kenyan people still must make choices and set priorities about the use of their modest reserves. The extent to which women, in general, the health care needs of women as a whole, and then, the needs of rape survivors *per se* are seen to be deserving of an equitable share of these scarce resources is largely determined by social perceptions of the recipients, and whether they are considered deserving of a fair and equitable share of health services. The perceived value and role of women in society are socially constructed phenomena, yet ones with tremendous implications for the quality of care that rape survivors receive.

How Perceptions of the Need for Services are Socially Constructed

Sexual violence is frequently maintained and perpetuated by cultural norms and practices (Banyard, Plante & Moynihan, 2004). Prevailing social norms in communities,

particularly those that passively accept, acquiesce, or fail to denounce acts of violence against women, serve to perpetuate the violence (Jewkes, 2002; Maseno & Kilonzo, 2011). In this research, a few practitioners went so far to talk about the notion of “legitimate” rape, with regards to situations where a wife was alleged to be insufficiently sexually satisfying her husband. It seems as though there is a cultural perception that women exist mainly and most importantly to serve men. In a glaring example that illustrates the prevailing patriarchal view, during the 2006 debates of the sexual offenses bill, a member of Parliament stated: “Mr. Speaker Sir, African women are very shy and do not make advances and therefore criminalizing making advances would be tantamount to outlawing marriage . . . African women will not say yes to sexual advances and many a times their ‘No’ might actually mean ‘Yes’ ” (*The East African Standard*, 2006). Statements like this -- made by elected members of the Kenyan parliament -- demonstrate the calloused attitude towards sexual violence now prevalent in Kenya and many parts of the world. Such attitudes play a major role in both individual and institutional responses to violence against women (Flood & Pease, 2009). Although such perceptions were long understood to be a part of the “natural,” “God-given” order of the universe and went unquestioned and unchallenged for many millennia, feminists have pointed out that there is nothing “natural” about such social constructions, and demanded that the yoke of oppression be thrown off so that women can assume their right to equal dignity and respect. Cultural values, norms, attitudes and practices are not absolute, and must be changed to reflect more enlightened understandings of how people should treat one another.

Practitioners mentioned key underlying cultural and social factors that impact the quality of services that survivors receive. Family interference was a challenge brought up by several practitioners. They noted that the community frequently hindered work with survivors by interfering with cases on the community level. Women often feel pressure from their families and communities to keep their sexual abuse experience within the family, rather than reporting it to “outsiders” (WHO, 2010). There is a culture of silence in Kenya surrounding gender violence (KDHS, 2004). Several practitioners noted that, after survivors had sought medical care, many did not return to the clinic, usually because their families stepped in and tried to reconcile with family members in order to avoid legal proceedings. Other survivors would not return because the perpetrator was known to them, too often a family member, fearing that they would be pressured by the hospital staff to report the sexual assault. For some survivors, it was the stigma attached to being rape survivors and the notion that they must have loose morals that hindered their ability to receive a full course of treatment. For other survivors, the economic status of their family was a major factor in decisions to accept bribes from perpetrators in lieu of prosecution and continuing care. The issues revolving around the stigma of rape and the lack of reporting are not mutually exclusive and independent influences. This situation is directly attributable to the global political economy, which has resulted in more people living in absolute poverty, and to deep cultural factors.

Patriarchal cultures, as in Kenya, provide the social context for sexual violence as they encourage, support and reinforce women’s subordination. For example, one practitioner talked about acceptable and unacceptable ways for women to dress and used it to blame victims for the violence that they experienced. Wearing miniskirts or showing

cleavage is unacceptable in African culture, according to this practitioner, and hence, women who do so are responsible for inciting the violence that may ensue. According to these practitioners, the onus of prevention is on women. They must remain constantly vigilant and “pad themselves” (literally through clothing as well as through their behaviors) to keep men from acting on their apparently uncontrollable urges.

Victim blaming attitudes were common in my study. Victim blaming by legal and medical personnel appears to be largely attributable to acceptance of various rape myths, such as believing that women lie about the occurrence and/or provoke rape (Campbell & Johnson, 1997). The results of my study are similar to those of a study conducted by Kim et al. (2009) in South Africa. These authors also found that many healthcare workers held beliefs that attributed the blame for sexual violence on the woman’s behavior. In my study, practitioners blamed alcohol and drug use by the survivors as the reason that the violence took place. Understanding the dual roles of practitioners -- as members of the community and as health professionals -- helps to explain their perceptions. While the practitioners strive to act on their training and professional code of conduct, it is impossible for them to divorce themselves from their cultural upbringing and beliefs. Health practitioners are socialized into the same cultural norms and practices as the surrounding community, including the prevailing, socially-constructed gender roles (Colombini, et al. 2013). The practitioners in my study saw -- and, consciously or unconsciously, passed along this message -- that the onus for preventing sexual assault was on women, in general, and the survivors, in particular. When rape survivors are exposed to such victim blaming attitudes, they experience secondary victimization (Aherns, 2006).

Institutional Pressures

In spite of the recent policy measures enacted to address sexual violence in Kenya, communities in the country have yet to stamp out or reduce such cases. The overwhelming majority of victims of this criminal act in Kenya, like all other nations in the world, are women. The low priority of women's issues extends to the allocation of funds to post-rape services. The public health sector, supported by public financing, bears the brunt of the economic costs generated by the violence in the country. Serious stresses on the health care system documented in this study include shortage in human resources, supplies and materials, and administrative deficiencies.

An often repeated topic of frustration for the practitioners was the forensic management of cases. The low ratio of successful prosecutions and convictions relative to the number of rape cases that came through their facility was frequently lamented. Forensic management is the principal link between the health care system and the criminal justice system: it provides the key material evidence that an act of sexual violence did indeed occur. Poor evidence collection and documentation are critical factors contributing to the low rates of convictions, and resource constraints hamper the maintenance and transfer of solid forensic evidence. Key findings of a study by Ajema et al., (2011) identified numerous challenges experienced by service providers in providing post rape care services, such as lack of knowledge of forensic evidence collection and storage, attending to child and male survivors of sexual violence, and proper documentation of cases, following the procedures described in the Sexual Offences Act. The Ajema study found that the preservation of forensic evidence was also impeded by inadequate storage facilities (e.g., refrigeration units). The practitioners in my study

echoed similar sentiments. Practitioners talked about the need to have the rape kits available at their facilities in order to reduce contamination of evidence. My study also found that a lack of basic knowledge on forensic management was a common problem in the clinics. Many of the nurses and clinical officers that I interviewed did not know how to collect basic essential forensic evidence.

Previous research has found that health care workers who provide services to survivors of sexual violence often lack appropriate training (Jewkes, Sen, & Garcia-Moreno, 2002). When probed on topics for which they would like additional training, counseling skills was the leading topic of choice, especially with regards to working with children, older women and male survivors. Practitioners voiced frustration with the low numbers of practitioners trained to provide sensitive, high quality rape counseling services. Further compounding this problem, when short courses were made available, only a few practitioners were able to attend the training and the selection process seemed biased in favor of the friends and cronies of the hospital director, rather than those who might have the most to offer future clients. While they understood that not all practitioners could be trained at one time, they mentioned the need for a systematic and transparent way to ensure that they all receive the necessary training.

The practitioners expressed concern about the low reporting of assaults, both in presenting at health centers or reporting the assaults to the police. Many practitioners lived in the same geographic areas where they worked and they were convinced that the numbers of survivors who came to the facility did not truly reflect the number of rape cases in their respective communities. One major reason was the fear of consequences to the survivor if she reported the crime, especially if the perpetrator was a family member.

Another reason that the practitioners gave for the low reporting rates was due to the stigma in the community associated with rape. The low economic status of the woman evidently plays a major part in her decision to report, particularly if it is the husband or a family member who committed the rape or defiled their children. Practitioners mentioned that, when dealing with a case where a family member was the perpetrator, the fear of losing the main source of income to a possible jail sentence weighed heavily on their decision.

Institutional factors affect the quality of services for rape victims, especially in the criminal justice system. The practitioners in this study spoke at length about the ordeals that victims have to undergo to gain justice. Practitioners expressed their frustration with the police releasing the perpetrators after being bribed. In police stations, victims are subjected to unnecessary questions, even to the point of having to respond to allegations that the victims must have agreed to the act. In many cases, the police make it clear that they must be bribed before they would be willing to make any effort to follow-up on the case. Not only is this a direct instance of secondary victimization, but indirectly, this makes other and future victims leery about reporting the crime, denying them justice and adding another layer to their victimization.

The practitioners also mentioned that the survivors reported being harassed by the police. Some survivor's relayed instances where police officers would ask them to bring the perpetrator with them, accuse them of prostituting their children, question the legitimacy of their rape, ask if they enjoyed their assault, or even physically assault them. Experiences like this make it harder for the practitioners to convince the survivors to pursue criminal charges against the perpetrator.

Based on the accounts of the practitioners, it seems clear that the majority of the victims of sexual assault never report the crime to the police. The reluctance comes as a result of the poor response of the security systems, which in many cases are openly hostile towards the victims. Without reports, it is impossible to hold the perpetrators accountable.

One-on-One: The Experience of the Encounter

The goal of this research is to figure out ways to minimize the secondary victimization of rape survivors. The practitioners interviewed for my study cited the victim blaming attitudes of the police as a major reason why survivors do not report their sexual assault cases. Still, the practitioners themselves also tended to blame the survivors, although they generally did not express this directly to survivors, as they said the police did. The high workload demands stress the frontline practitioners out, which inevitably leads to a degree of backlash and resentment towards those people who seem to make their jobs even more difficult.

Canfield (2005) found secondary traumatic stress as the result of hearing emotionally shocking material from patients by those who work with traumatized patients. Practitioners, in taking a survivor's history, relive the rape along with the survivor as they recount the assault. The coarsening of attitudes towards survivors sets the stage for the secondary victimization of survivors, as my study has shown. A study conducted by Goldblatt (2009) on caring for abused women revealed that some degree of emotional involvement is necessary to provide care to such women. Goldblatt's findings also uncovered the internal dissonance that the health workers face in balancing their work and home lives. The nurses interviewed in that study said that they tried to block

out the impact that working with the domestic violence survivors had on their family lives, but typically found it impossible. In one example of the many potential sequelae, research indicates that counselors experiencing vicarious trauma may become excessively vigilant regarding their children (Trippany, Kress & Wilcoxon, 2004). One practitioner talked about not trusting her husband around her daughter. Working with survivors may also elicit worry by practitioners as well as fear of the occurrence of a similar traumatic experience (Goldblatt, 2009). Several practitioners brought up the problem of sorting out clients who had been genuinely raped from those who were making false reports for ulterior purposes, and the added stress that this set of circumstances placed on an already terribly difficult job. The perception of people posing as survivors was recently corroborated in local news reports. A recent newspaper article reported that commercial sex workers in Kenya reported lying about having been raped in order to receive free HIV medication. The sex workers would forgo the use of condoms in order to earn more money and visit a clinic the next morning to get emergency anti-retrovirals, or post-exposure prophylaxis (Murenga & Faife, 2014). Making matters even more complicated, it is important to point out that sex workers are also often victims of rape and may genuinely be going to the health facilities for treatment related to the assault, a notion that is not widely acknowledged in Kenya or elsewhere.

The Lived Experience of the Individual Provider

In listening to the individual practitioner's experience, the study results spotlight the need to increase both the quantity and quality of human resources for health provided to rape survivors in Kenya. Having a high patient load results in providing insufficient time, attention and care to highly traumatized victims, and cumulatively, the experience

day-in and day-out leads to burnout, and victim-blaming attitudes, a situation in which secondary victimization becomes almost inevitable (Campbell et al., 2001; Kadambi & Truscott, 2004). Although the practitioners generally did not express their irritation directly to the survivors, the frustrations that they expressed to me indicate that they see survivors mainly as adding major burdens to their already high workload, and only secondarily as victims in need of care, compassion, time and attention. In this type of situation, survivors all-too-readily come to be viewed as a bothersome irritant. The practitioners experienced burnout as a result of both the content and volume of the work they do. As a result, many indicated that they had developed cold, disapproving and spiteful attitudes towards survivors, which unfortunately was inevitably conveyed – usually subtly, rarely blatantly -- when working with them. The practitioners mentioned being highly stressed, and passing on their frustrations to survivors. These results are similar to a study conducted by Schauben and Frazier (1995), which looked at the effects on female counselors working with sexual violence survivors. They found that counselors with higher caseloads of survivors of sexual violence reported more vicarious trauma, disordered beliefs about themselves and others, and more PTSD than those with lower caseloads.

My study found that practitioners often deviated from the guidelines when providing services to survivors of sexual violence due to the lack of available resources and consequent need to improvise and make quick-and-dirty assessments of how much the survivor “really” needed all of the recommended services. Having standardized guidelines is essential for providing healthcare practitioners with a clear protocol for their work and meeting minimal standards for quality of care. However, studies have found

that health care practitioners frequently deviate from the standardized protocol depending on the particular case (Ajema et al., 2011). The practitioners in my study, for example, mentioned that, many times, they felt that it was not necessary to refer them for counseling after clinical care, as required by the guidelines. They claimed that they were able to make responsible judgments about the level of trauma based on a survivor's presentation, and thus, determine whether or not they needed counseling, but this sort of *ad hoc* decision-making is precisely what the national guidelines are intended to prevent. In trying to cope with the conflicting pressures, while practitioners generally acknowledged the usefulness of the guidelines, most felt that their practical application was near impossible in the real world of day-to-day operations. Many practitioners felt that providing comprehensive services was not practical given the high volume of patients, pressing time constraints and common lack of proper supplies, materials and equipment. In such circumstances, the practitioners tended to concentrate on clinical management, ensuring the survivor got the first dose of their PEP, and then send them on their way.

My respondents also experienced compassion fatigue and counter-transference (Kadambi & Truscott, 2004). Some practitioners said they were seriously looking at alternative career paths, as they could not see themselves working with survivors long-term due to their sense of impending burnout. Many times, burnout translates to high turnover and low morale (Wanjau, Muiruri & Ayodo, 2012). A study conducted by Ajema et al. (2012) found high rates of turnover at health facilities, which invariably reduces the quality of care to survivors.

Based on reports from the practitioners, it was also clear that the quality of care depended on the health facility at which the survivor sought medical attention. The facilities where I interviewed practitioners are touted as having functional PRC services, but this was often not the case. Many of the clinical officers and nurses that I interviewed were trained only in taking the survivor's medical history, conducting the physical examination, and managing physical injuries. A situational analysis of post rape care services conducted in Kenya found that counseling for survivors of sexual violence is often conducted by HIV/AIDS VCT counselors (Kilonzo et al., 2003). These counselors' primary training is in HIV counseling, not the critical post rape trauma concerns that a survivor may be experiencing.

Recommendations

The results of this study have several implications for future service provision by practitioners in order to improve the experiences of both the practitioners and the survivors. For the quality of services to survivors to improve and the incidents of sexual violence to decrease, changes are needed at the different system levels. I will start with the big picture changes that need to occur in the global political economy pertaining to health financing. I will then talk about my recommendations for the changes that need to occur in the way sexual violence is socially constructed. I will then conclude with the short-term recommendations that the practitioners in this study proposed. .

To improve the quality of services provided to rape survivors in Kenya, it is essential that the IMF and World Bank eliminate borrowing ceilings that impede the development of a sound health care infrastructure. After securing minimally adequate financial resources, the Ministry of Health needs to increase the quantity and quality of

human resources for health, paying particular attention to their recruitment and retention. Kenyans will continue to experience inadequate and poor quality health services until these severe deficits in the healthcare workforce are addressed (Digolo, Karuga, Nduta & Kilonzo, 2010). Improving the quantity, quality and distribution of the health workforce in Kenya is the only way to enable the country to achieve its health goals.

The public also has a role to play in preventing sexual violence since survivors and perpetrators inhabit the same cultural milieu. The continuation of traditional gender norms related to male entitlement, such as sexual intercourse as a man's right in marriage, or that women and girls are responsible for keeping men's sexual urges in check by not dressing provocatively, need to be challenged and changed. Culture is not static, and a goal of violence prevention is to aid in dismantling the elements of cultural norms that oppress women whilst preserving what is good. Progress on women's issues suffered a notable setback when the president signed Kenya's Marriage Bill 2014, which permits men to be polygamous without consulting their first wives. Laws should act as stimulants of change in society, rather than perpetuating women's subjugation, which regressive laws like this do. Sexual violence prevention programs have increased and have become more progressive in tackling attitudes and beliefs that support rape in their communities (Casey & Lindhorst, 2009). Community programs that involve community education that aim to promote positive change in societal attitudes and values need to be greatly expanded as this form of violence does not occur in a vacuum. Programs that engage men are critical in sending the message that sexual violence is not just a women's issue, but rather, a community issue.

The concerns related to the current shortage of medical practitioners in Kenya are unlikely to be resolved in the foreseeable future. In the meantime, the practitioners suggested a number of recommendations such as setting up support groups; providing personal therapy sessions; and better referral systems for survivors seeking treatment. The needs for support groups and therapy sessions are supported by the literature (Van Der Wath et al., 2013) and are recommended by the national guidelines, as essential for practitioners to cope with the emotional burden and their own traumatization.

Some practitioners suggested that the low numbers of survivors who come for treatment is due to a lack of awareness of the services available to them. They proposed the idea of having posters in public transit vehicles, similar to the existing HIV/AIDS awareness posters, which could provide information on what a victim can do if they are assaulted. Others suggested setting up a better referral system, which could involve the use of voluntary community health workers who live in the communities they serve.

The PRC guidelines were created without regard for the day-to-day operations and the varying administrative and operational environments in which care is now delivered. The focus of the Ministry of Health needs to shift its priority from promulgating (unrealistic) standards of care to focusing on overall the deficiencies in the health facilities in which care is provided. Proper training for practitioners, the availability of proper equipment and supplies, and functioning linkages between medical and legal services would benefit survivors. Lack of training results into poor quality of services for the survivor and may play a role in a survivor's decision to discontinue receiving services, an issue raised by the practitioners. Practitioners interviewed noted many gaps in their training that need to be addressed as well as the need to provide

booster or refresher courses. Having all practitioners trained will help ensure uniformity of services to survivors of sexual violence. Merely saying that practitioners should not blame their victims is not effective, as my results indicate. It would be helpful to have an evaluation of the services post treatment by the survivors. Having survivors fill out satisfaction surveys regarding the care received is a tangible way practitioners can receive feedback from a survivor's perspective.

Due to the limited resources, health systems need to figure out the most cost effective way to deliver services. Different strategies need to be employed to ease the workload of these service providers. An array of services are provided in a health facility. Some medical services require highly trained personnel, others do not, and for those services, it is important to utilize, lesser trained, less expensive health care workers. One potentially valuable strategy is the use of the community health workers. As one practitioner suggested, training community health workers on particular procedures in the overall service provision process would enable significant reductions in the practitioner's current workload. Reducing caseloads for those working with survivors of sexual violence can be another way to tackle the problem. An alternative solution could be shifting the rotation schedules of the practitioners who would see a survivor. This way, one practitioner would not be responsible for treating all the survivors who may present at a facility in a given time frame.

Practitioners in this study mentioned introducing joint training programs with police and medical practitioners. They felt that having front line legal and medical personnel who interact with the survivors participate in this training would facilitate a better referral system and would be beneficial for the survivor's continuity of care. This

is an important aspect to consider in training sessions tailored for service provision when it comes to survivors of sexual violence. A joint training will allow health and law enforcement personnel to interact and find ways to support these survivors.

Limitations and Strengths

The limitations of this study are similar to other qualitative studies that are conducted in one geographical region. This study sample was limited to a small geographical area in Kenya, mainly the capital city. Health practitioners who serve survivors living in different geographical areas of the country may have different experiences that shape their understanding of the problem. The relatively small area from which the respondents were recruited likely biased my results in two ways: 1) there are more resources (both human and material) in Nairobi than anywhere else in the country, and 2) peoples' attitudes in the capital city are likely to be more liberal or cosmopolitan than one would expect to find in rural areas, which are generally more conservative.

This study had multiple strengths. My bilingual background was a major strength for enhancing quality of this inquiry. While the interviews were conducted in English, the practitioners were able to express themselves in Kiswahili whenever they wanted. I conducted interviews and the data analysis without language barriers between inquirer and participants. In so doing, I was able to minimize the potential discrepancies inherent in studies that depend on translation services.

While all study participants were chosen based on their direct contact with survivors of sexual violence seeking services, the length of time and the extent of their contact with survivors on a day-to-day basis varied according to location, enabling me to observe how perceptions may change over time, as the practitioners saw more and more

survivors. The practitioners interviewed also had different job functions and brought different perspectives about the experience of providing services to survivors based on their job designations. I also had a good balance of both male and female practitioners with varying levels of work experience and medical backgrounds. Practitioners had varying medical training ranging from a 2 year medical diploma to post graduate training. This likely influenced their approach in service provision and influenced the way they perceive their work. Additionally, the medical practitioners interviewed were from both public and private health facilities, further enriching the range of views gathered in this research.

Future Research

The influence of the cultural value system was part of the fabric of every interview. One major finding from my study was the common practice of resorting to out of family /out of court settlement. The family's decision to take money from a perpetrator speaks to a more profound issue. The practitioners believed that the victims were generally not in agreement with accepting financial reparations and that this practice caused victims to lose their voice and aggravated the healing process. Whether the victim is typically in agreement with the family's decision to accept this reparation, or not, is currently unknown. While this practice is one that the practitioners viewed with dismay, it begs the deeper question of why this practice is still pervasive. To learn more about family perceptions concerning the decision to settle out of court, research comparing the experiences of survivors who pursued legal recourse with those who opted for an out of court settlement is urgently needed. Identifying factors that influence the decisions of women who pursue formal legal recourse would be helpful in strengthening the support

available to survivors. For women who settle out of court, I am interested in understanding the needs that are being served by this practice. Identifying the factors that lead to reporting versus not reporting may help the practitioners come up with strategies to get the survivors to reconsider the decision to accept an out of court settlement. While the economic status of the family was a key factor driving women not to report, the survivor's perspective on the decision to accept financial reparations is critically important for understanding this common cultural practice. Finding strategies to combat this practice would also reduce the likelihood of repeat offenses.

The practitioners interviewed in my study pointed fingers at the members of law enforcement, railing about their incompetence, lack of sympathy and their corruption. As the prevention of and response to sexual violence requires coordinated action from actors from many sectors, further research into the experiences of law enforcement in working with survivors of sexual violence is clearly important too.

After the survivors completed their 28 day regimen and first HIV test, many survivors who tested negative for HIV at that point did not return for follow up. As contracting HIV/AIDS is only one of the potential harms caused by sexual violence, I would also like to pursue research on the barriers to follow up testing and to conduct research on possible interventions that can be developed to motivate survivors to return for psycho-social and other necessary support. Studies with survivors on reasons for discontinuing free treatment would provide much needed insight into this issue.

Understanding the experiences of practitioners in environments that differ in resources, such as rural versus urban areas, is another important dimension to consider in understanding the barriers that practitioners face.

Conclusion

This study examined factors affecting the quality of health services provided to rape victims in Kenya. This research is important because the existing research on sexual violence in Kenya has not examined practitioners' experiences with service provision. It is important for health administrators at large to understand that, in order for practitioners to address the needs of survivors of sexual violence adequately, their day-to-day experiences on the ground need to be taken into account. Their stresses and frustrations need to be seen in the larger context of the geo-political forces that drive the distribution of poverty globally. Merely having guidelines does not ensure that survivors receive quality services. It is also critically important to recognize and address the dual roles of practitioners as members of the community and as health practitioners. Training curricula need to address the cultural context in which the practitioners' values, norms, attitudes and practices are formed.

My plan is to use this research to identify ways to improve services to survivors of sexual violence, given the identified challenges faced by these practitioners. The results from this study expand the knowledge base on factors affecting the quality of services and thus contribute to the development of better programs and intervention strategies.

By providing insight into the care of survivors from the perspective of health care providers, this study addresses an important knowledge gap outlined in Kenya's research agenda on sexual violence. The results of this research will be helpful in identifying innovative ways to improve access, increase uptake and deliver quality sexual violence

care, treatment and rehabilitation services for Kenyan women post sexual assault (Maternowska, Keesbury & Kilonzo, 2009).

To reduce violence against women in Kenya, empowering women is crucial. There is a need for more involvement of civil society organizations such as FIDA and other like-minded organizations in implementing community consciousness raising programs. Currently, these organizations are raising concerns about the criminal justice system and demanding justice for the victims. While this is important and necessary, it does not address the more fundamental forces that drive the perpetuation of rape and the subordination of women. These organizations have the capacity to take a leadership role in promoting community awareness, as they did in advocating for the successful passage of the Sexual Offenses Act.

Sexual violence against women in Kenya is still pervasive, but there are now glimmers of hope. Two recent stories captured national attention and spurred activism. The first case is of 16-year-old girl who was gang-raped and beaten unconscious by 6 men, who she was later able to identify. When she reported the case to the police, the officers sent her home to clean up, and told the perpetrators that, for their offense, they had to cut the grass in front of the police station. The perpetrators were not arrested and still do not face criminal charges. This led to protests at police headquarters demanding justice.

The second case occurred in November 2014, an event that spurred the “My dress, my choice” campaign by women organizations. The campaign arose in support a woman who was assaulted and stripped in public by a mob of men who claimed she was dressed indecently. The act was caught on camera by a passerby who uploaded it online.

Cases like this are sadly pervasive and show the denigration of women in Kenya. For any lasting change, it will take more and greater mobilizations of this kind at the grassroots level to force against perpetrators which will help curb the crime. While the two recent cases cast a gloomy picture the state of women's issues, Kenyan women are responding to the call to stand together against sexual violence. The protests that resulted from these cases were largely organized by women yet showed some signs of male support, including a public statement from the President. Kenyan women are increasingly challenging the cultural conditions that have maintained and perpetuated violence against women.

Conducting research to identify more effective ways to reduce and ultimately eliminate the incidence of sexual violence is an important career goal for me. This study makes an important contribution to addressing the limited literature on health care provider perspectives on factors affecting the quality of services provided to survivors of sexual violence. While my research study was small, it touched on various aspects on violence prevention research, victimization, perpetration, the criminal justice system, cultural and religious moral codes. Further research is needed in order to come to an understanding of the myriad factors that influence behavior of the survivors, their families and service providers.

The findings of this research will be used to provide feedback to key stakeholders in Kenya such as the Ministry of Public Health and Sanitation and the Ministry of Medical Services division of Reproductive Health. This is the division responsible for the development of the national guidelines on the management of sexual violence. One of the knowledge gaps outlined in Kenya's research agenda on sexual violence identifies the

need for research on innovative ways to improve access to, uptake and delivery of quality sexual violence care, treatment and rehabilitation services for Kenyan women and men post sexual assault. There is limited information on the factors that will strengthen the delivery of quality service in Kenya (Wanjau, Muiruri & Ayodo, 2012). Improving the quality of services, including post rape care services in health facilities, requires information on day to day operations. This study examined the care of survivors from the perspective of health care providers, which resulted in a number of major recommendations for improving the quality of care and preventing the secondary victimization of rape survivors in Kenya.

APPENDICES

APPENDIX A

CONSENT FORM

Consent Form for Participation in a Research Study
University of Massachusetts Amherst

Researcher:	Leso Munala, PhD candidate
Study Title:	The experiences and needs of health care practitioners providing services to female survivors of sexual violence in Nairobi, Kenya: A phenomenological investigation

1. WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision about participation in this research. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to know to participate and any known risks, inconveniences or discomforts that you may have while participating. If you decide to participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?

The health practitioners eligible for the study will be all male and female health practitioners in the health facility that are in direct contact with female survivors of sexual violence who are also not in supervisory roles in their respective facility. The practitioners will be medical doctors, nurses, clinical officers and trauma counselors who have worked in that particular site for at least 6 months. You must be at least 18 years old to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this research study is to gain knowledge on the daily experiences of health practitioners that work with female survivors of sexual violence. The study seeks to understand and identify the knowledge, attitudes and delivery of services among health service that work with survivors of sexual violence. Additionally, the study seeks to explore factors that influence the delivery of services to survivors of sexual violence that alleviate the impact that the violence has on the survivors. Finally, the study seeks to explore different approaches and methods in effective dissemination of information to service practitioners and enhance critical components to be included in relevant Continuing Medical Training (CME) training or educational curriculums to service practitioners in the country.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?

The interviews will take place in a private office at your health facility. The time allotted for the interview is an hour to an hour and a half.

5. WHAT WILL I BE ASKED TO DO?

If you agree to take part in this study, you will be asked to participate in a 1 to 1 1/2 hour long interview. The nature of the questions will focus on your daily experiences and needs as you serve survivors of sexual violence. You will be debriefed at the conclusion of the interview to provide an opportunity for you to reflect on the interview and add information that the interview questions may not have covered adequately.

6. WHAT ARE MY BENEFITS OF BEING IN THIS STUDY?

There are no immediate benefits for your participation in this study. However, you may benefit from the study through self-reflection on your work with survivors. I hope this research will contribute to the limited literature about your needs and perspectives on treating survivors of sexual violence and add to the body knowledge on current gaps in service provision.

7. WHAT ARE MY RISKS OF BEING IN THIS STUDY?

I believe there are no known risks associated with this research study; however, a possible inconvenience may be the time it takes to complete the study. The possible psychological risks related to this study are fatigue and/or emotional distress as you share your experiences in serving survivors of sexual violence. You are free to refuse to respond to any question that may result in psychological disturbance. Additionally you can withdraw from the study with no consequences.

8. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?

You will be assigned pseudonyms to prevent identification. The pseudonyms will be kept in a separate password protected file server from the digital files and will be deleted once the data is transcribed. The researchers will keep all study records, including any codes to your data, in a secure location. Identifiable information will not be recorded on the digital files or the transcripts. The master key and digital files will be destroyed 3 years after the close of the study. All electronic files containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Only the principal investigator will have access to the passwords.

9. WILL I RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?

You will receive KES. 1,000 as compensation for participating in the study.

10. WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision. I will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact me at 0786970730 or by email:

lmunala@schoolph.umass.edu. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at humansubjects@ora.umass.edu.

11. CAN I STOP BEING IN THE STUDY?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

12. SUBJECT STATEMENT OF VOLUNTARY CONSENT

When signing this form I am agreeing to voluntarily enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw at any time. A copy of this signed Informed Consent Form has been given to me.

Participant Signature: Print Name: Date:

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document and has been given a copy.

Signature of Person Obtaining Consent Print Name: Date:

APPENDIX B

INTERVIEW PROTOCOL

Introductory Script:

Thank you for agreeing to take part in this study. My name is Leso Munala and I would like to talk to you about your experience providing services to female survivors of sexual violence. The interview should take about an hour to an hour and a half. I will be digitally recording this interview and writing a few notes so that I can be sure that I am getting everything you say accurately. All your answers are completely confidential and your name or the name of this facility will not be shared in presenting these results. All narratives will be assigned a pseudonym and be combined with other narratives that I gather from across the city. All interviews will be transcribed and all proper names and places will be coded to protect your identity and privacy. Remember that you do not have to talk about anything that you do not want to and that you may end the interview at any time. I hope that you will benefit from the study through self-reflection on your work with survivors. I hope this research will contribute to the limited literature about health care practitioner's needs and perspectives on treating survivors of sexual violence and add to the body knowledge on current gaps in service provision. Are there any questions about what I have just explained?

1. Please describe to me your role in this health facility. What is your designation?
2. Please describe the capacity in which you work with survivors of sexual violence in this facility. Approximately how many female survivors of sexual violence have you attended to in the past six months?
3. Can you describe, in as much detail as possible, what your experience of providing services to a survivor of sexual violence been like for you?
4. Please describe how disclosures of sexual assault tend to occur? How do you typically respond to the survivor's disclosure?
Probe: How do you work on establishing trust with the survivor? Do you experience any discomfort in asking the survivors about their sexual violence case?

5. In thinking the survivors you have encountered, are there times in your opinion when a survivor's behavior causes the rape?

Probe: If yes, what are these behaviors (drinking alcohol, wearing revealing clothing, going out alone at night, etc.)

6. Describe the impact that providing these services to survivors has on you emotionally? Psychologically? Spiritually?

Probe: How are you able to keep emotional boundaries between you and the survivor?

7. Describe any coping mechanisms/strategies that you use to deal with your feelings following working with survivors of sexual violence?

8. What are the rewarding aspects of providing services to survivors? What are the challenges/difficulties?

9. How often do you attend trainings related to working with survivors of sexual violence? Do you feel they meet your needs as a health practitioner? Is there any specific topic you would add to the training?

10. Can you describe what, in your opinion if afforded to you in your daily work, can assist you in providing more effective services to survivors of sexual violence in the future?

Probe: What form of support can facilitate your better providing services to survivors of sexual violence in the future?

Is there anything more about your experience you would like to share at this time that we may not have touched on?

THANK YOU FOR YOUR TIME.

Demographics

Gender: Male ___
Female ___

Professional Degree: Medicine ___
Nursing ___
Social Work ___
Counseling ___
Other ___

Years in Practice: 0-5 ___
5-10 ___
10-15 ___
15-20 ___
20+ ___

Months in in Facility: 6-12 ___
12-24 ___
24-36 ___
36-48 ___
48+ ___

Facility type: Private ___
Public ___

Program setting: Hospital ___
Clinic: ___
Community-based organization: ___
Other: _____

APPENDIX C

LETTER OF AGREEMENT

Leso Munala, a doctoral candidate in the school of Public Health and Health Sciences at the University of Massachusetts, Amherst, will be working with health practitioners of Health facilities connected with LVCT in Nairobi, Kenya. The purpose of the project is to research the experiences and needs of health care practitioners providing services to female survivors of sexual violence in Nairobi, Kenya. For this study, I will be interviewing approximately 30 health practitioners that interact and provide to female survivors of sexual violence. Both participant names and name of the health facility site will not be included in the final product, which will be my dissertation. The data collection will last from June 2013 through August 2013. I, Leso Munala agree to do my best and adhere to the deadlines set forth in this agreement.

Leso Munala Agrees to:

1. Assume full responsibility for the design, implementation, analyses, and publication of this research.
2. Acknowledge LVCT for their participation whenever any findings are presented whether verbally or in writing.
3. Adhere to University and KEMRI procedures for ensuring the confidentiality of information from participants in the study.
4. Adhere to University and KEMRI procedures to maximize the safety of those participating in this research.
5. Compensate study participants with KES. 1,000 for their time invested in this research.
6. Provide LVCT with a written report of the results of this research when the work is completed.

LVCT Agrees to:

1. Facilitate access to PRC sites they support within Nairobi in order to reach health practitioners so that participation can be explained to them and they may make a decision of whether or not to participate.

2. Allow researcher to interview health practitioners working in LVCT supported PRC sites that agree to participate in the study

This letter confirms the working agreement between health facility LVCT and Leso Munala.

Researcher name (printed) _____

Researcher signature _____

LVCT (printed) _____

Contact signature _____

Date _____

APPENDIX D

TRANSCRIPTION CONFIDENTIALITY SHEET

I, _____, the transcriptionist, agree to maintain full confidentiality in regards to any and all digital recordings and documentation received from Leso Munala related to her doctoral study on health care practitioners needs and experiences in providing services to female survivors of sexual violence in Nairobi Kenya: A Phenomenological Investigation. Additionally, I agree:

1. To hold in strictest confidence the identification of any individual that may be unintentionally revealed during the transcription of digitally recorded interviews.
2. To not make copies of any digital recordings or MP3 files of the transcribed interview texts, unless specifically requested to do so by Leso Munala.
3. To store all study-related digital recordings in a safe, secure location as long as they are in my possession;
4. To return all digital recordings and study-related documents to Leso Munala in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices upon completion of study.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the digital recordings/ files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

APPENDIX F

UMASS IRB APPROVAL



University of Massachusetts Amherst
108 Research Administration Bldg.
70 Buttrickfield Terrace
Amherst, MA 01003-9242

Research Compliance
Human Research Protection Office (HRPO)
Telephone: (413) 545-3428
FAX: (413) 577-1728

Certification of Human Subjects Approval

Date: May 16, 2013
To: Leso Munala, Public Health
Other Investigator: Tameka Gilum, Public Health
From: Anne Herrington, Chair, UMASS IRB

Protocol Title: The experiences and needs of health care practitioners providing services to female survivors of sexual violence in Nairobi, Kenya:
A Phenomenological Investigation
Protocol ID: 2013-1653
Review Type: EXPEDITED - NEW
Paragraph ID: 7
Approval Date: 05/16/2013
Expiration Date: 05/15/2014
OGCA #:

This study has been reviewed and approved by the University of Massachusetts Amherst IRB, Federal Wide Assurance # 00003909. Approval is granted with the understanding that investigator(s) are responsible for.

Modifications - All changes to the study (e.g. protocol, recruitment materials, consent form, additional key personnel), must be submitted for approval in e-protocol before instituting the changes. New personnel must have completed CITI training.

Consent forms - A copy of the approved, validated, consent form (with the IRB stamp) must be used to consent each subject. Investigators must retain copies of signed consent documents for six (6) years after close of the grant, or three (3) years if unfunded.

Adverse Event Reporting - Adverse events occurring in the course of the protocol must be reported in e-protocol as soon as possible, but no later than five (5) working days.

Continuing Review - Studies that received Full Board or Expedited approval must be reviewed three weeks prior to expiration, or six weeks for Full Board. Renewal Reports are submitted through e-protocol.

Completion Reports - Notify the IRB when your study is complete by submitting a Final Report Form in e-protocol.

Consent form (when applicable) will be stamped and sent in a separate e-mail. Use only IRB approved copies of the consent forms, questionnaires, letters, advertisements etc. in your research.

Please contact the Human Research Protection Office if you have any further questions. Best wishes for a successful project.

APPENDIX G

KEMRI IRB APPROVAL



KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54843-00200 NAIROBI, Kenya
Tel: (254) (020) 2722541, 2743349, 0772-205501, 0733-400003; Fax: (254) (020) 2720030
E-mail: director@kemri.org info@kemri.org Website: www.kemri.org

KEMRI/RES/7/3/1

June 30, 2013

TO: **LESO MUNALA,
PHD CANDIDATE,
COMMUNITY HEALTH EDUCATION,
SCHOOL OF PUBLIC HEALTH AND HEALTH SCIENCES,
UNIVERSITY OF MASSACHUSETTS, AMHERST
PRINCIPAL INVESTIGATOR**

Dear Madam,

RE: **NON-SSC PROTOCOL NO. 396 (INITIAL SUBMISSION): THE
EXPERIENCES AND NEEDS OF HEALTH CARE PRACTITIONERS
PROVIDING SERVICES TO FEMALE SURVIVORS OF SEXUAL
VIOLENCE IN NAIROBI, KENYA: A PHENOMENOLOGICAL
INVESTIGATION**

This is to inform you that during the 216th meeting of the KEMRI/ERC held on 20th June 2013, the above referenced study was reviewed.

The Committee notes that the above referenced study aims to understand and explore the lived experiences of health care practitioners providing services to female survivors of sexual violence in Nairobi.

Due consideration has been given to ethical issues and the study is hereby **granted approval** for implementation effective this **20th day of June 2013**, for a period of twelve (12) months.

Please note that authorization to conduct this study will automatically expire on **19th June 2014**. If you plan to continue with data collection or analysis beyond this date, please submit an application for continuing approval to the ERC Secretariat by **9th May 2014**.

You are required to submit any amendments to this protocol and other information pertinent to human participation in this study to the ERC prior to initiation. You may embark on the study.

Yours faithfully,

**DR. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI/ETHICS REVIEW COMMITTEE**

APPENDIX H

RESEARCH PERMIT

REPUBLIC OF KENYA



NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telephone: 254-020-2213471, 2241349, 254-020-2673550
Mobile: 0713 788 787 , 0735 404 245
Fax: 254-020-2213215
When replying please quote
secretary@ncst.go.ke

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref:

NCSTI/P/13/5072/31

Date:

12th July, 2013

Leso Munala
University of Massachusetts
P.O.Box 3443 – 01004
Amherst.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“The experiences and needs of health care practitioners providing services to female survivors of sexual violence in Nairobi, Kenya: A phenomenological investigation,”* I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **31st August, 2013**.

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. M. K. RUGUTT, PhD, HSC.
DEPUTY COUNCIL SECRETARY

Copy to:

The County Commissioner
The County Director of Education
Nairobi County.



APPENDIX I

MINISTRY OF HEALTH CLEARANCE LETTER



MINISTRY OF HEALTH

Telegrams: "FAMHEALTH", Nairobi
Telephone: Nairobi 725105/6/7/8
All correspondence should be addressed
to the Head.
When replying please quote

DIVISION OF REPRODUCTIVE HEALTH
MBAGATHI ROAD (OLD)
P. O. Box 43319
NAIROBI.

REF:DRH/GHR/32/VOL.II

22nd July 2013

Health Facility In charges

- ✓ **Kenyatta National Hospital, GBVRC**
- ✓ **Kayole Health Centre**
- ✓ **Jericho Health Centre**
- ✓ **Riruta Health Centre**
- ✓ **Lunga Lunga Health Centre**

**REF: Permission to Conduct Research on SGBV with Health Care Providers at
your Health Facility**

The Division of Reproductive Health, Ministry of Health has granted permission to Miss Leso Munala to conduct a qualitative research at your health facility. Leso is a doctoral student at the School of Public Health and Health Sciences at the University of Massachusetts, Amherst. She also holds a Masters degree in Social Work from the University of Chicago and a Bachelor's Degree in Psychology from The Ohio State University. She obtained ethical approval to conduct the study from the University of Massachusetts-Amherst Institutional Review Board and the Kenya Medical Research Institute Ethics Review Committee.

Leso has previously participated in two research internships with Liverpool VCT in the years 2011 and 2012. She will be receiving Technical support from Dr Kilonzo, Executive Director of LVCT, during the data collection period.

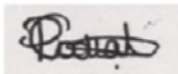
The purpose of this study is to understand and explore the lived experiences of health care practitioners providing services to female survivors of sexual violence in Nairobi, Kenya. The research questions this study is responding to include the following:

1. What is the health practitioner's lived experience of providing direct services to female survivors of sexual violence?
2. What circumstances and contexts influence the lived experience of providing services to female survivors of sexual violence?
3. What is the lived experience of training for sexual assault service providers in Kenya?

Leso will conduct this study in five health facilities in Nairobi namely: Kayole health centre, Jericho health centre, Riruta Health centre, Lunga Lunga health centre and KNH, GBVRC. These are sites that receive technical and infrastructural support from Liverpool VCT through close collaboration with the Division of Reproductive Health. The data will be collected between 15th July 2013 to 9th August 2013

Please accord Leso the necessary support

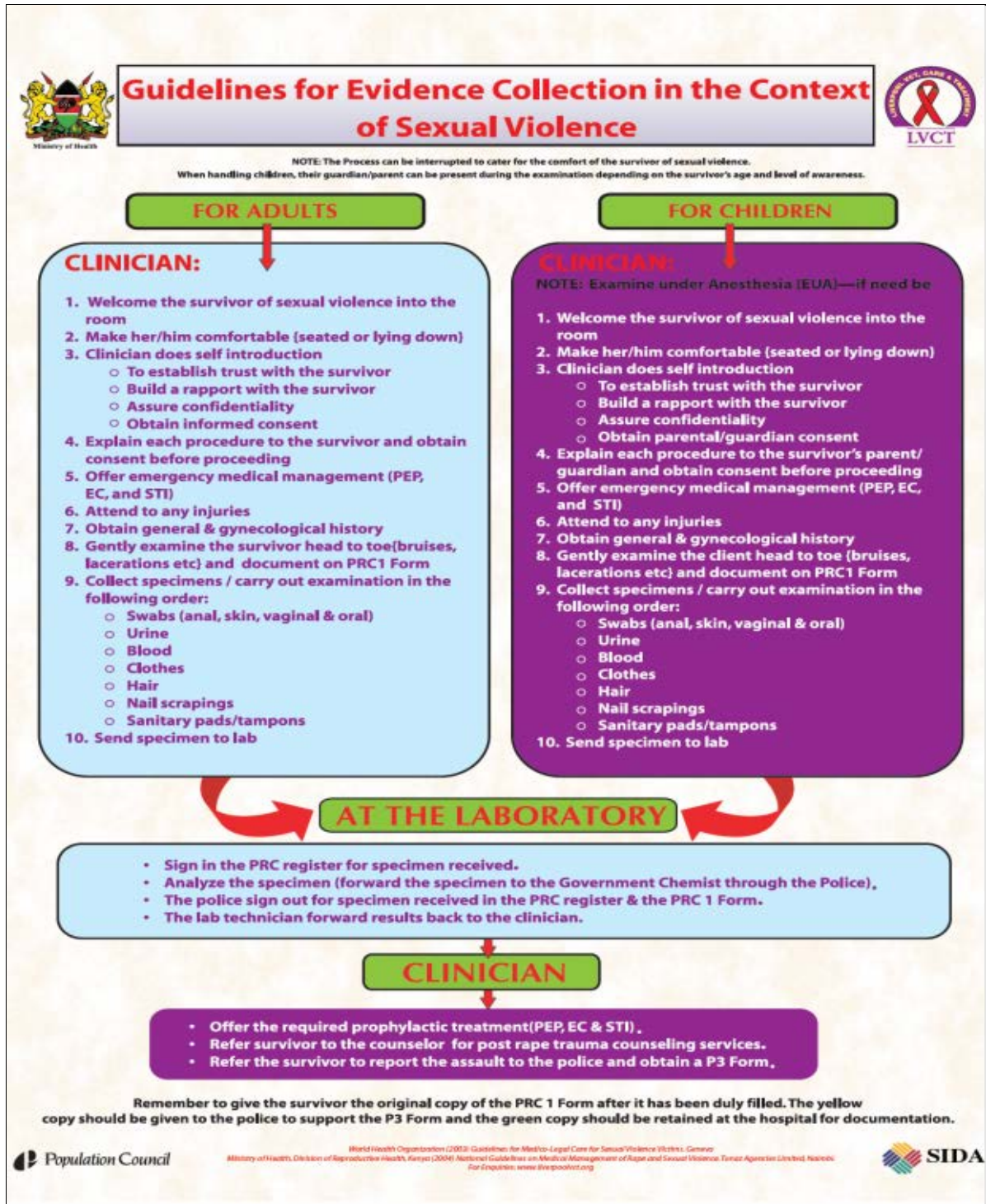
Yours,



Dr Pamela Godia
Program Manager, Research, Gender and Reproductive Health Rights
Division of Reproductive Health
Ministry of Health

APPENDIX J

GUIDELINES FOR EVIDENCE COLLECTION



APPENDIX K

POST RAPE CARE (PRC) FORM

Day	Month	Year	Province Code	District Code	OP / IP No.	
Last Name			First Name	Date of birth	Male	
				Date	Female	
				Month		
				Year		
Contacts (Physical Address and Phone number)						
Date and time of Examination			Date and Time of Assault		No. of Assaultants	
Alleged Assaultants (Indicate relation to victim)			Unknown		Known	
Place Assault Occurred						
Chief complaints / Presenting Symptoms						
Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Presence of struggle?)						
Type pf Assault	Use of condom?	Incident already reported to police?				
Oral	Yes	Yes (indicate which station and when)				
Vaginal	No	No				
Anal	Attended a health facility before this one?	Where you treated?		Were you given any notes?		
Other sex	No	Yes		Yes		
	Yes (indicate which one and when)	No		No		
Comments						
Significant medical and/or surgical history						
OBS /GYN History	Pati ty	Contraception type	LMP	Known Pregnancy?		Date of last consensual sexual intercourse
				Yes	No	
General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm or not)	

Psychological Assessment (Should be done by: -Psychiatrists, Medical Doctors, Psychologists, Psychiatry-trained nurses, Psychiatry social workers or Counseling psychologists of repute)

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PREMORBID HISTORY (state the mental condition of survivor prior to assault)

Mental Status Evaluation (*Tick as appropriate*)

- **Appearance** (kempt, unkempt, other)(specify)_____

- **Behaviour** (appropriate, restless, calm, absent mindedness, other) (specify)_____

- **Mood** (low, excited, depressed, tense, irritable, tearful, anxious, angry, other)_____

- **Speech** (flow, tone, amount)(specify)_____

–

- **Perception** (hallucinations, illusions, derealization, depersonalization, dissociation, other) (specify) (specify)_____

- **Thought** (Preoccupation, Stream of thought, suicidal thoughts, helplessness, hopelessness, worthlessness, odd beliefs, flashbacks, specific fears e.g. of open places, enclosed spaces, men, women, adults, strangers, other) (specify)_____

Diminished capacity to enjoy life_____

- **Cognitive Disturbance** (Orientation in time, place, person, Level of attention, Concentration (use serial seven subtractions

Memory: short term _____, long term _____

Judgement_____

Insight – does the survivor understand what happened to her/him, possible consequences, any legal implications, any wishes of the survivor?

Diagnosis:

FOR CHILD SURVIVORS:

Evaluate behaviour, mood and speech as above but use the following to evaluate thought:-

- Drawing – allow child to draw (e.g..) family members and let her/him comment on the drawing. report verbatim.

- Play – by use of toys and dolls allow child to give comments on the play and report verbatim.

- Assess the unconscious world of the child by asking about:

- Feelings e.g. ask the child to report the feeling that h/she commonly experiences and ask what makes him/her feel that way.

- Wishes (let child state her/his wishes)

Diagnosis

Forensic

Did the survivor change clothes?		State of clothes (stains, tears, colour, etc)			
Yes	No				
Were the clothes put in a non-plastic paper bag?		Were the clothes given to the police?		Did the police sign the rape register at the health facility?	
Yes	No	Yes	No	Yes	No
Did the survivor have a bath?		Did the survivor go to the toilet?			
Yes	No	Long call?		Short call?	

Comments:

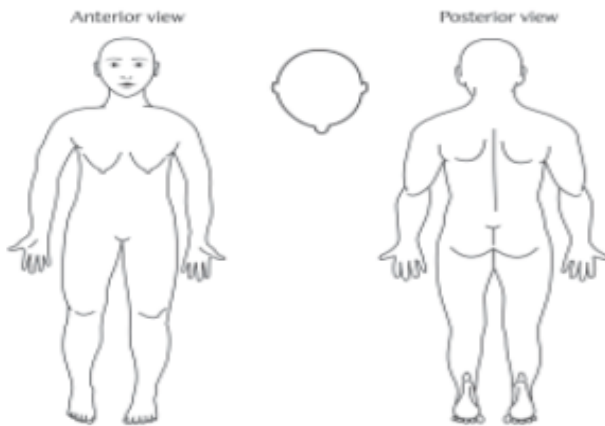
Does the survivor have any details on the assailant? Is the assailant known, is there any relation? Did the survivor leave any marks on the assailant?	Yes
	No

General Examination

Describe in detail the physical status
 Physical injuries (sign in the body map)
 Outer genitalia
 Vagina/hymen
 Anus
 Other significant orifices

Physical examination [indicates sites and nature of injuries, bruises and marks outside the genitalia]
 Please use the sketches below to indicate injuries, inflammations, marks on various body parts of the survivor

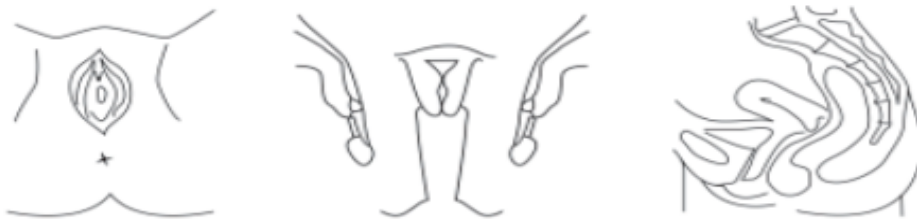
Sketch of person



Comments



Female Genitalia



Male Genitalia



Other Comments from the examination									
Diagnosis/impression									
Immediate Management	PEP 1 doses		EC given		Stitching /surgical toilet done		STI treatment given		
	No	Yes	No	Yes	No	Yes	No	Yes	
	No. of tablets		which EC		Comment			Comment	
Any other treatment / Medication given /management?									
Referrals to	Police Station								
	VCT/DTC								
	Laboratory								
	OPD/CCC/HIV clinic								
	Trauma counselor?								
	Other (specify)								
Name of Examining Medical/clinical/Nursing Officer					Signature of Examining Medical/clinical/Nursing Officer			Date	
Laboratory	Sample Type	Test	Please tick as is applicable		Comments				
			National government Lab	Health Facility Lab					
	Genital - Anal - Skin - Oral swabs Specify	Sperm							
		DNA							
		Culture and sensitivity							
	High vaginal swab	Sperm							
	Urine	Pregnancy Test							
		Microscopy							
		Drugs and alcohol							
		Other							

b o r a t o r y s a m p l e s	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies				
Other (specify)					
Chain of custody					
These /All / Some of the samples packed and issued (please specify)					
To	Police Officer's Name	signature	Date		
By	Medical/clinical/Nursing Officer's Name	signature	Date		

APPENDIX L

P3 FORM

This P3 Form is free of charge

THE KENYA POLICE P3
MEDICAL EXAMINATION REPORT

PART 1-(To be completed by the Police Officer Requesting Examination)

From _____ Ref _____
_____ Date _____

To the _____ Hospital/Dispensary

I have to request the favour of your examination of:-
Name _____ Age _____ (If known)
Address _____

Date and time of the alleged offence _____

Sent to you/Hospital on the _____ 20 _____

Under escort of _____

and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.

Date and time report to police _____

Brief details of the alleged offence

Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS - (To be completed by Medical Officer or Practitioner carrying out examination)

*(Please type **four** copies from the original manuscript)*

SECTION "A"-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref. No. _____

1. State of clothing including presence of tears, stains (wet or dry) blood, etc.

2. General medical history (including details relevant to offence)

3. General physical examination (including general appearance, use of drugs or Alcohol and demeanour)

This P3 Form is free of charge

SECTION "B"- TO BE COMPLETED IN ALL CASES OF ASSAULT INCLUDING SEXUAL ASSAULTS

COMPLETION OF SECTION "A"

1. Details of site, situation, shape and depth of injuries sustained:-

a) Head and neck

b) Thorax and Abdomen.

c) Upper limbs

d) Lower limbs

2.	Approximate age of injuries (hours, days, weeks)
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3.	Probable type of weapon(s) causing injury
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4.	Treatment, if any, received prior to examination
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5.	What were the immediate clinical results of the injury sustained and the assessed degree, i.e. 'harm', or 'grievous harm'.*
DEFINITIONS:-	
"Harm" Means any bodily hurt, disease or disorder whether permanent or temporary.	
"Maim" means the destruction or permanent disabling of any external or organ, member or sense	
"Grievous Harm" Means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.	
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Name & Signature of Medical Officer/Practitioner _____	
Date _____	

SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES

AFTER THE COMPLETION OF SECTIONS "A" AND "B"

1. Nature of offence _____ Estimated age of person
examined _____

2. FEMALE COMPLAINANT

a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia
majora, labia minora, vagina, cervix and conclusion

b) Note presence of discharge, blood or venereal infection, from genitalia or on body externally

3. MALE COMPLAINANT

b) Describe in detail the physical state of and any injuries to genitalia

c) Describe in detail injuries to anus

d) Note presence of discharge around anus, or/ on thighs, etc.; whether recent or of long standing.

This P3 Form is free of charge

SECTION "D"

4. MALE ACCUSED OF ANY SEXUAL OFFENCE

a) Describe in detail the physical state of and any injuries to genitalia especially penis

b) Describe in detail any injuries around anus and whether recent or of long standing

5. Details of specimens or smears collected in examinations 2,3 or 4 of section "C" including pubic hairs and vaginal hairs

6. Any additional remarks by the doctor

Name & Signature of Medical Officer/Practitioner _____

Date _____

Government of Kenya, Ministry of Public Health and Sanitation

APPENDIX M

RAPE TRAUMA COUNSELING FORM

RAPE TRAUMA COUNSELING DATA FORM					
Sex		Has the client reported to the police?		0 No	1 Yes
1 Male	2 Female			If not, name reason(s)	
Age (years)		0 No	1 Yes		
		If not, name reason(s)		2nd Visit	
Education		a) Is the client willing to report to the police?		a) Disclosure of SV	
0 None		0 No	1 Yes		
1 Primary		If not, name reason(s)		b) Disclosure HIV results	
2 Secondary		Client referred from?		0 No	1 Yes
3 Post Secondary/Technical		1 VCT services	2 Police stations		
Marital Status		3 Health Facilities		9 Other	
0 Never		Was the 1st dose of PEP administered?		If not, name reason(s)	
1 Married		0 No	1 Yes		
2 widowed		If not, name reason(s)		d) Still taking PEP	
3 Separated/Divorced		Type of assault		0 No	1 Yes
1 Penile anal rape		1 Presented after 72 hours		3rd Visit	
2 Penile vaginal rape		2 Client declined		Is disclosure done so far?	
3 Use of objects in vagina		9 Other		0 No	
4 Use of objects in arms		Was EC administered?		1 Yes	
9 Other		0 No	1 Yes	2 N/A	
Client seen		If not, name reason(s)		4th Visit	
1 Individual		Did client know HIV status before the assault?		Comments	
2 With partner		0 No		5th Visit	
3 With guardian/parent		1 Yes		HIV Test done	
4 With friend/relative		If Yes,		0 Negative	
9 Other		0 Negative		1 Positive	
Services required by client		0 Negative		1 Positive	
Was the PRC 1 form filled?		0 No		1 Yes	
0 No		1st Visit		Disclosure of SV	
1 Yes		a) HIV test done		0 No	
If not, name reason(s)		0 No	1 Yes	2 Declined	
		If Yes,		0 Negative	
		0 Negative		1 Positive	
Who is the assailant?		b) Pregnancy Test done		Pregnancy Test done	
0 No		0 No		1 Yes	
1 Unknown		1 Yes		2 N/A	
Results		0 Negative		1 Positive	
0 Known		c) Disclosed SV		Comments	
1 Unknown		0 No		1 Yes	
If known, specify relationship		1 Yes			

Government of Kenya, Ministry of Public Health and Sanitation

APPENDIX N

PRC-REGISTER

Date	Time	Name	Age	Sex	Date and Time of alleged assault		Seen by (CO)	P3 filled	Police officer Signature	Forensic Examination Assaunt type (insert card no.)	Given 1 st dose of		VCT / DCT	PEP Follow up	STI	LAB	Signature of person filling the form	Comments
					EC	PEP												

Government of Kenya, Ministry of Public Health and Sanitation

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