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"She Is NOT a Genuine Client": Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya

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Abstract

Sexual violence is one of the most common forms of violence against women in Kenya. Recognizing this, the Kenyan government introduced health care sector guidelines for survivors of sexual violence. This study explores the care of rape survivors from the perspective of health-care practitioners and identifies a number of recommendations for improving the quality of care. Qualitative interviews were conducted with 28 health practitioners from eight post-rape care facilities located in Nairobi, Kenya. Data were analyzed using the Colaizzi's 1978 analytical model. The study uncovered a troubling tendency of health practitioners questioning the authenticity of a woman's claim, deeming some not to be *genuine* rape survivors. Doubts about the veracity of the client's story led to additional emotional drain on health practitioners. This judgment negatively impacted the quality of care for rape survivors and in some cases, leading practitioners to deny services and exposing survivors to secondary victimization.

Keywords

rape survivors, health practitioners, sexual violence, victim blaming, commercial sex workers, guidelines

Introduction

Sexual violence is a major public health and human rights concern worldwide and in Kenya.[1–3] Sexual violence is different from other aggressive behaviors in that it is often covert and encompasses power differentials.[4,5] It has both short- and long-term negative consequences to the physical, social, and psychological well-being of survivors and their families.[4–6]

Rape is one of the most prevalent violent crimes committed in Kenya.[4] Research has found that between 40% and 50% of women in Kenya have been subjected to some form of violence in their lifetime, with a nationwide study showing that 25% of women aged between 12 and 24 years reported having lost their virginity due to forceful or coercive sex.[4,7,8] The latest Kenya Demographic and Health Survey[9] corroborates these findings, reporting that 47% of women aged 15 to 49 years experienced some form of physical or sexual violence. The likelihood of experiencing some form of violence was reported as increasing with age, with 54% of women aged 40 to 49 years reporting violence compared with 35% of women aged 15 to 19 years. In addition, 14% of ever-married women reported suffering some form of sexual violence by their spouse.[9] One study reported that one in every four separated, divorced, or married women had experienced sexual violence by their most recent or current husband, with 16% reported as having been violated sexually by other persons in the community.[10]

The true prevalence of sexual violence in Kenya is unknown, as survivors may not report due to shame, stigma, and the perceived lack of adequate services, among other reasons.[11] 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.[10] The reluctance to report cases of sexual violence is linked to the fact that it is a sensitive issue surrounded by traumatic, often victim blaming experiences. Rape is also increasingly recognized as a significant risk factor for acquiring HIV/AIDS, especially for women.[4]

Health Sector Response and Challenges

Sexual violence, particularly rape, is serious and requires a range of services to ensure the effective management of the

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physical and psychosocial health consequences.[12] In 2004, the Government of Kenya, in collaboration with other stakeholders, developed the National Guidelines on the Management of Sexual Violence.[13]

The guidelines outline the procedures relating to the 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 that health practitioners in every facility need to know about post-rape care (PRC). In addition, the guidelines also 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. National law mandates that the service package as defined in the National Guidelines on the Management of Sexual Violence are to be provided free of charge to survivors of sexual violence at all government health institutions.[14]

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 2 weeks. Depending on the HIV test results, the survivor is referred to HIV care for ongoing medical care or given PEP with a 2-week follow-up appointment. Emergency contraception is administered up to 120 hours post assault and a 6-week follow-up is required for a pregnancy test. The guidelines also recommend a five-session minimum of trauma counseling sessions. The guidelines note that, to provide comprehensive care, all of the services enumerated earlier should be provided to the survivor. The guidelines are comprehensive but to assure the quality of care, they must be appropriately applied and implemented in contexts where providers are sensitive and empathetic to clients when providing care. To date, this program has not been subject to a comprehensive evaluation.

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.[15,16] It is an indirect method of assault that occurs through insensitive treatment of victims by individuals and institutions.[15–17] Research reveals that rape victims often experience secondary victimization in courtrooms and medical settings.[16,17] Secondary victimization can occur in medical settings during the practitioner–survivor interaction when seeking treatment.[17] Victim blaming attitudes as well as the acceptance of rape myths by the health practitioner can cause further harm and traumatization. Research suggests, however, that most of this secondary victimization can be reduced and minimized by assuring proper counseling and treatment by trained professionals.[17]

Experiencing physical or sexual violence is associated with poor health seeking behavior due to fear of stigma and discrimination.[18,19] Research has shown that accessing health-care services is particularly daunting for commercial sex workers (CSWs), especially in countries where commercial sex work is criminalized.[20–22] Health workers have been described as hostile, abusive, or disrespectful and have outright denied treatment to CSWs (or women perceived by health practitioners to be sex workers).[21,23] Similar attitudes may be extended to women who are not CSWs but who are perceived as immoral or otherwise to blame for their assault. This means that, in addition to the documented mistreatment of CSWs seeking care, health practitioners may be commonly mistreating and retraumatizing a large portion of rape survivors seeking care.

One of the major knowledge gaps outlined in Kenya's research agenda on sexual violence centers on 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.[24] There is limited information on the factors that will strengthen the delivery of quality rape services in Kenya.[25] This study sought to address this gap in part by examining 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. Research informed by practitioner perspectives on survivor recovery and on what improves quality of life, promotes healing for survivors, and the challenges that practitioners face in service delivery is urgently needed.

Methods

The Ecological Model was used to provide a framework for organizing the numerous factors related to sexual violence. Framing sexual violence in an ecological model makes it possible to explore the interactions between variables as well as different levels of influence. Moreover, the model is instructive in informing intervention development, implementation, and evaluation.[4,26]

Sample and Data Collection

Health-care practitioners were recruited from health facilities in Nairobi that have functional PRC services. To be eligible, the health-care practitioners had to have worked at the facility for a minimum of 6 months. 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 managing sexual violence and they also do not work directly with survivors. In total, 28 participants were interviewed for this study, 16 female and 12 male, from eight PRC facilities, four public and four private, in Nairobi, Kenya. Their years of medical practice ranged from 2 years to

30 years. Ethical approval to conduct this study was obtained from the University of Massachusetts, Amherst Institutional Review Board (IRB) and the Kenya Medical Research Institute (KEMRI) ethics review committee.

Questions for the interview protocol were generated based on a review of the literature on service provision to survivors of sexual violence.[11,16,27–31] 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 finally, recommendations to improve the quality of care provided to these women.

Data Analysis

Data analysis followed Colaizzi's (1978) approach to analysis.[33–37] The analysis of the transcripts was initiated as soon as the transcript of each interview was completed, toward the aim of incorporating insights from earlier interviews into the ongoing data collection. The principal investigator 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 the depth and meaning of each interview was fully understood. During this stage, thoughts and ideas from the lead investigator's previous knowledge of sexual violence service provision were noted along with any biases and suppositions. The first and second readers then looked for key emerging words, phrases, and significant statements. For example, key words were "frustration," "challenging," and so forth. They 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. Then, they formulated meanings from significant statements that appeared in the transcripts. Next, they grouped the formulated meanings into clusters of themes. Clusters of themes that reflected a specific idea around service provision to survivors were incorporated together to form a distinctive domain. The themes were then merged into an exhaustive description of the factors affecting the quality of services to female survivors in Nairobi, Kenya.

Results

One key finding in this research was the issue of *genuine* rape survivors. Practitioners in the study sample perceived that some women seeking the PRC service package were not true survivors of sexual violence. In describing their perceptions that some women were not genuine clients, practitioners often shared their assumptions and theories as to why women were falsely presenting as rape victims and how they identify clients who are not genuine. In some cases, they also described their feelings of frustration or even spite toward these clients. Practitioners explained that some individuals may feign rape in hopes of getting needed medical attention free of charge, most commonly to obtain Antiretroviral (ARVs) drugs for PEP. When the survivors did not display behaviors that practitioners considered to be typical of a rape victim or when the practitioner suspected the woman of being a CSW, they tended to conclude that these were not genuine rape victims. In some situations, practitioners judged that the client was a CSW and therefore could not possibly be a true victim of rape.

One practitioner explained how 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 practitioner stated how she would know that the woman was not genuine:

> 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 could not have been a survivor because she refused medical 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, so was she really raped? (Male Clinical Officer)

Another practitioner also shared his thoughts on the *inconsistent story*, which for him meant that the rape survivors could not possibly have been raped:

> If somebody [survivor] tells you it's 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 her and then she found herself, woke up there, and she doesn't remember the story well. Sometimes she has already bathed. So some cases that come in as rape are not really rape. Ah, those are challenges. (Male Clinical Officer)

Some practitioners 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 [vigilant] 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 it. 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)

A nurse recalls how she put her judgment aside even though she thought that story was too unbelievable to be that of a genuine rape case:

> Yeah, so she said, when she was in that taxi, she reported [her account] 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 [square] 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. As per the guidelines, I am supposed 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)

A clinical officer describes a situation:

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

Another employee stated:

> 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)

Finally, a social worker shared her opinion on a survivor's truthfulness:

> Ok people are not being truthful; others know that you provide [PRC] 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 this [made-up] story. They come and tell you and you believe. I have been a victim of, of these 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 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)

Many indicated that they had developed cold, disapproving, and resentful attitudes toward survivors, which unfortunately was inevitably conveyed—usually subtly, rarely blatantly—when working with them.

> 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 PrEP idea, of giving people, now has become a fashion [trendy]. Yeah, it is something that people now are misusing it. (Male Nurse)

Compounding doubts about the veracity of the client's story added to the emotional drain on the practitioners.

Discussion

The tendency of health practitioners to doubt the clients' accounts of rape and the legitimacy of their request for services must be assessed in the context of the social construction of rape and the harsh economic realities of the Kenyan health system. Sexual violence is frequently maintained and perpetuated by cultural norms and practices.[38] 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.[2,39] In this study, a few practitioners went so far to talk about the notion of *legitimate* rape, with regard 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 and their sexual needs.

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. While this study focused on health practitioner experiences, we are also able to explore some of the impacts that these pernicious doubts about whether the women presenting in their facility were *genuinely raped* on the survivors. The study found that these doubts negatively affected the quality of care by exposing rape survivors to secondary victimization and by driving inconsistent implementation of the National Guidelines.

Finally, Kenya's health system suffers from chronic underfinancing, which has driven health workforce and medical supplies shortages for decades. Due to the acute shortages in personnel and equipment, many practitioners worried that they were feeling burned out; some had developed bitter attitudes toward survivors, blaming them for their high case load. Within its severely limited resources, the Ministry of Health must make choices and set priorities about the use of their modest reserves. The extent to which the health care needs of women in general and the needs of rape survivors in particular are seen to be deserving of an equitable share of these scarce resources is largely determined by social perceptions of the recipients. The study found that health providers believe that some women falsely claim rape despite the enormous social stigma attached to being identified as a woman who had been raped. In several cases, practitioners suspected women of presenting disingenuously as rape victims in order to avoid paying out-of-pocket for services and for ARV medications in particular. The finding that practitioners sometimes conclude that clients are not genuine victims of sexual violence has serious implications for the experiences of both health workers and clients and for the quality of care.

Practitioner Impact

Canfield[40] 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 toward survivors sets the stage for the secondary victimization of survivors, as the results of this study indicate. A study conducted by Goldblatt[15] on caring for abused women revealed that some degree of emotional involvement is necessary to provide care to such women. 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 difficult job.

Practitioners were clearly frustrated at the perceived exploitation of scarce facility resources including health workers' time and ARV medications. Health workers also described feelings of frustration and inadequacy in response to the fact that they believed the client felt the need to lie to them. Thus, on top of the already heavy emotional toll practitioners report due to institutional and individual capacity constraints, they felt betrayed and exploited by the women who they believe to be lying. The double bind thus exacerbates conditions that lead to burn out and poor quality of service delivery.

The added emotional toll aggravates frustrations at their lack of training and inability to respond adequately to the needs of sexual violence survivors. This emotional toll likely contributes to feelings of burn-out, and hence, the loss of trained and experienced health-care providers to facilities that are already critically understaffed and in a health sector setting where there is already a documented lack of health workers.

Completeness and Consistency of Service Delivery

This study found that practitioners often deviated from the National 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 health-care practitioners with a clear protocol for their work and meeting minimal standards for the quality of care. However, research have found that health-care practitioners frequently deviate from the standardized protocol depending on the particular case.[41] The practitioners in this 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 proscribe. In trying to cope with the conflicting pressures, while practitioners generally acknowledged the usefulness of the guidelines, most felt that their application was practically impossible in the real world of day-to-day operations. Many practitioners felt that providing comprehensive services was not possible given the high volume of patients, pressing time constraints and the 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.

Victim Blaming

Victim blaming attitudes were common in this 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.[16] The results of this study are similar to those of a study conducted by Kim et al.[42] in South Africa. Those authors also

found that many health-care workers held beliefs that attributed blame for sexual violence on the woman's behavior. In this 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.[42] Health practitioners are socialized into the same cultural norms and practices as the surrounding community, including the prevailing, socially constructed gender roles.[43]

Similarly, the notion of people posing as rape survivors has been picked up and reinforced by local news reports. A newspaper article reported that CSWs in Kenya reported lying about having been raped in order to receive free HIV medication.[44] Sex workers report that they would forgo the use of condoms in order to earn more money and visit a clinic the next morning to get emergency ARVs for post-exposure prophylaxis.[45] Making matters even more complicated, it is important to point out that CSWs 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 by practitioners.[21]

The practitioners in this study saw—and, consciously or unconsciously, passed along this message—that the onus for preventing sexual violence was on women, in general, and the survivors, in particular. When rape survivors are exposed to such victim blaming attitudes, they experience secondary victimization.[45]

Several practitioners interviewed for this 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 frontline practitioners out, which inevitably leads to a degree of backlash and resentment toward those people who seem to make their jobs even more difficult.

In situations where the practitioners assumed a client was a CSW, their calloused judgment was heightened. Practitioners might make a decision about whether the client is a genuine client, meaning that they have to determine whether they were truly raped, or not. Since CSWs are sometimes raped on the job, it makes the decision difficult and stressful for practitioners. As seen in their personal statements, decisions about whether the presenting patient deserves the services is challenging for the practitioners to make in the moment. Practitioners must try to determine if the rape was real based on how the presumed CSW presents at the facility. However, not every rape victim is going to present in the same way. This means that the decision whether or not to treat the women, whether they are sex workers or not, should not be at the discretion of the practitioners.

Conclusion

The issue of genuine rape survivors was among the most disconcerting findings to emerge in this study. On top of the emotionally draining and operationally challenging circumstances with which the practitioners interviewed for this research have to contend, the practitioners felt burdened by playing detective when circumstances surrounding the woman's presentation seemed suspicious. This doubt stemmed from the health workers' perceptions of acceptable female sexuality and behaviors (e.g., clothing choices) and their anxiety over the need to allocate scarce resources to care for sexual violence survivors. The practitioners' judgment, in turn, often contributed to the secondary victimization of the women seeking care and, in some cases, led them to curtail services, or to haphazard implementation of the guidelines, further reducing the quality of care.

Several recommendations with the potential to address these challenges were identified during this research. Practitioners need to be better prepared to anticipate and cope with the emotional toll of working with rape survivors. Training curricula require revision to include sufficient focus on trauma and secondary trauma as they relate to both victim and practitioner experiences. Training and reference materials should include focus on coping mechanisms, with emphasis on realistic and effective coping strategies in low-income countries with resource-constrained environments. This approach is already recommended in the National Guidelines but its implementation should be prioritized and better supported since there is obviously unmet need.

Capacity building and ongoing supportive supervision for practitioners could improve quality and consistency of care. This ongoing support through retrainings and facility visits should emphasize that it is not the practitioner's role to judge or to screen out clients, but to provide services in keeping with the National Guidelines. There should be more supportive and constructive messages, rather than chastising, to encourage practitioners to focus on the good they are doing by providing full services without discrimination. For example, for those clients whom they mistrust or perceive to be CSWs, training and supervision messaging should focus on the power that practitioners have to ensure that no opportunity to prevent HIV infection is missed. Ongoing capacity building and supervision approaches should target facility operations, in addition to individual practitioners, and aim to address deficiencies in the care environment, such as whether proper equipment and supplies are available.

Clearly, there are also major implications for Kenya's efforts to control the HIV epidemic if women who were exposed to HIV through rape are discouraged from seeking prevention and treatment services.

The short-term recommendations presented here can contribute to improved attitudes and practices at care facilities, but it will take a broader and more ambitious response to have a significant impact on the problem. More specifically,

there needs to be a coordinated response among African nations to secure debt relief to counter the austerity measures imposed by international institutions such as the International Monetary Fund and World Bank to redress the chronic shortages of trained health personnel and medical supplies at the local level.

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