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“If You Report Your Dad, How are You Going to Survive”: Health Practitioner Perspectives on Quality of Care for Survivors of Sexual Violence and the Challenge of Family Interference

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Abstract

This study examined the experiences and perspectives of health practitioners facing the challenges of providing services to female survivors of sexual violence. 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 analysis of the results was guided by four domains of the ecological framework: individual, interpersonal, community/cultural, and public policy. The study documented a myriad of detail about the challenges faced by women before reporting the crime as well as the actual process of reporting. One key finding from this study was that health practitioners perceived family interference as a barrier

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to reporting, access to care, and to the pursuit of justice for survivors, particularly if the perpetrator was a relative. Family interference was also identified as a factor with implications for health practitioners' ability to ensure quality of care as it resulted in patients loss to follow-up and added to the negative emotional toll on health practitioners providing post-rape care. Three main themes emerged in practitioner responses related to this issue: (a) fear of consequences of reporting and care seeking, including economic vulnerability, family conflict, and retaliation such as divorce or further violence, (b) the trend toward out-of-court settlements rather than intervention through formal health and criminal justice sector challenges, and (c) attitudes toward sexual violence and survivors, normalization of rape, and victim-blaming attitudes. The study adds to our understanding of the obstacles faced by health practitioners providing post-rape care and provides a unique set of insights from the front lines on underlying factors contributing to these challenges.

Keywords

sexual violence, reporting, support seeking, child abuse, cultural contexts

Introduction

Sexual violence is associated with devastating health outcomes across the lifespan, affecting women and children's physical, emotional, and social health (Classen et al., 2005; Humphrey & White, 2000; Mekuria et al., 2015; Penn & Nardos, 2003; Olatunya et al., 2013; Penn & Nardos, 2003; Sinclair et al., 2013). The health risks include HIV and STIs (Sinclair et al., 2013; Penn & Nardos, 2003), pain and injuries (Olatunya et al., 2013), unwanted pregnancy (Breiding et al., 2017; Penn & Nardos 2003, sexual dysfunction, unsafe abortions (Penn & Nardos, 2003), and death (Olatunya et al., 2013). Mental health consequences include depression, anxiety, substance abuse, suicidal ideation (Mekuria et al., 2015; Penn & Nardos, 2003), and an increased risk of sexual revictimization in adulthood (Classen et al., 2005; Humphrey & White, 2000).

Background

The overall prevalence of child sexual abuse of all forms was greater than 25% (UNICEF, 2012). According to the survey, 10.7% of female participants aged 13–17 years reported experiencing some form of sexual violence in the prior 12 months, including unwanted sexual touching, unwanted attempted

sexual intercourse, pressured sex, and physically forced sex (UNICEF, 2012). Among 18–24-year-old females, 31.9% reported some form of sexual violence prior to age 18. A boyfriend or romantic partner was the perpetrator of violence in most cases reported among all females. Among female respondents aged 18–24 years who experienced sexual violence before the age of 18, the perpetrator of their first incident was 10 or more years older. Family members were reported as the perpetrators of sexual violence among 15.3% of female respondents. The true prevalence of sexual violence in Kenya is unknown as survivors may not report due to shame, stigma, lack of economic resources, and the perceived lack of adequate services, among other reasons (Bhana et al., 2009; Kilonzo et al., 2008; Mekuria et al., 2015; Muganyizi et al., 2011; Postmus et al., 2015; Shackel & Fiske, 2016; Weaver, 2017).

Kenya has demonstrated commitment to preventing sexual violence against women and children and addressing the needs of survivors by developing national laws, policies, and guidelines (WHO, 2014). The Sexual Offenses Act was established in 2006 and national guidelines for the health sector prevention and care response were released in 2004. However, the implementation and enforcement of these national guidelines is inconsistent or limited and their true impact is unclear (Maternowska et al., 2009; WHO, 2014). The Children Act of 2010 and revised in 2012 adds protection from child abuse and bans sex for those under the age of 18 (Children Act, 2012). Even though laws exist to protect children, child sexual abuse is still prevalent in Kenya (Wangamati, 2019). In Kenya, acts of sexual violence against women and children continue to go underreported, even though policy and legal frameworks are now in place (Children Act, 2012). Research is needed to determine the effectiveness of these national policies and other initiatives to prevent and mitigate the negative impact of sexual violence (Maternowska et al., 2009).

The negative health impacts of sexual violence can be mitigated through effective post-rape care (Murray & Burnham, 2009). Comprehensive post-rape care packages are comprised of clinical and psychosocial treatment, forensic examination, and sexual and reproductive health services including emergency contraception, abortion services, HIV and STI counseling, and testing (Munala et al., 2018; Wangamati et al., 2017). Access to quality, comprehensive post-rape care is a basic right of survivors, including children whose ability to access services is largely determined by parents or guardians (Wangamati, 2019).

It is critical to understand factors affecting access to post-rape services, quality of care, and risk factors for sexual violence against girls and women. Health practitioners are often the first or only point of contact for survivors of sexual violence (Krolikowski & Koyfmann, 2012). Their experience working

with survivors of all ages provides critical insights on issues that affect post-rape care services in quality, effectiveness, and accessibility. In previous studies among health practitioners caring for rape survivors, health sector challenges have been the primary focus (Wangamati et al., 2017). In this study, health sector challenges were explored, but efforts were also made to obtain health practitioners' perspectives on other aspects of their experience caring for rape survivors and factors affecting access and quality of care for rape survivors.

This study focused on the experience and perspectives of health practitioners on the factors affecting quality of care and access to services for survivors of sexual violence. The research analysis was guided by four domains of the ecological framework: individual, interpersonal, community/cultural, and public policy. Among the challenges reflected in the complete set of findings were health worker burnout, high emotional toll of caring for survivors, individual and institutional capacity gaps, and patient loss to follow-up.

The focus of this article is to explore a key finding that emerged from the study. The key finding from this research is that health workers perceived family interference as a barrier to reporting, access to care, and to the pursuit of justice for survivors. This family interference was also identified as a factor with implications for health workers' ability to ensure quality of care as it was an important contributor to health workers' experiences of secondary trauma, frustration and burnout. Health practitioners in this study frequently reported observations of care being prevented or interrupted by the survivor's family, with the family preferring to cover up the incident, especially where the perpetrator was a family member. Health worker observations were shared in relation to female survivors of various ages, spanning children, adolescents, and adult women. There are unique challenges and perspectives for these diverse age groups that merit individual attention. The majority of health practitioner observations in this study related to child and adolescent victims of sexual violence, but there were also instances in which adult female survivors were the object of practitioner comments. In cases where the survivor was a child and the offender a male relative, family cover-up was perceived by health practitioners to be motivated by factors other than shame at the act of incest.

Cultural Attitudes and Beliefs

Sexual violence is a complex problem that is influenced by myriad structural, environmental, social, and cultural factors. Authors Shackel and Fiske describe the intersectional influence of variables on outcomes for women, stating that "poverty, health, and education needs interact in mutually reinforcing ways,

with disadvantage on one axis creating or compounding disadvantage on the other axes” (Shackel & Fiske, 2016, p. 75). The willingness or ability to report sexual violence is similarly affected by a multitude of factors (Bamiwuye & Odimegwu, 2014; Barnett et al., 2016; Chen & Ullman, 2010; Okenwa et al., 2009; WHO, 2014). Among children survivors who reported experiencing sexual violence in the previous 12 months, only 8% accessed post-rape care services (UNICEF, 2012). In the Kenyan setting, key considerations include cultural acceptability/normalization of rape, fear of victim blaming (Munala et al., 2018), retaliation or other consequences, concerns around economic survival and maintenance of family, and the lack of trust or confidence in the police and criminal justice system (Simister & Mehta, 2010).

Traditional patriarchal norms and beliefs are predominant in Kenyan society. As but one indicator of its patriarchal culture, the majority of Kenyan families prefer male children, to the detriment of female children (Kiriti & Tisdell, 2005). 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. Patriarchal and traditional values foster norms and behaviors that lead to sexual violence against women and girls. The low status of women and girls in a patriarchal society puts them at a high risk for rape as people expect women to be subservient in relationships (Moore, 2008).

Studies suggest that community beliefs about sexual violence against women and even girls are that they are a consistent and unchangeable aspect of local culture (Hatcher et al., 2013). This same sociocultural context presents obstacles that prevent survivors from seeking and receiving the necessary health care and criminal justice services to which they have a right. In this context, cultural acceptance of sexual violence against women creates conditions in which women are blamed for their own rape and subsequently denied protection and justice (Barnett et al., 2016; Kimuna & Djamba, 2008; Tavrow et al., 2013). This contributes to the problem of low reporting rates for sexual violence, especially in cases where the perpetrator is known to or an intimate partner to the woman (Chen & Ullman, 2010; Mugoya et al., 2015). In addition, marital privacy is highly valued in this traditional cultural context, leading families and even survivors themselves to maintain their

silence to maintain the external view of familial and marital harmony (Barnett et al., 2016). These attitudes and practices can be seen as means of social control for the preservation of the traditional family and moral order (Barnett et al., 2016).

Economic Factors

Economic factors are also associated with sexual violence and present barriers to post-rape care. Both household poverty and women's individual economic inequality and dependence are associated with higher rates of interpersonal violence, including sexual violence (Bamiwuye & Odimegwu 2014; Breiding et al., 2017; Kishor & Johnson, 2005; Ribeiro et al., 2017). Recent data from Kenya shows that women from poor households are more likely than those from non-poor households to have experienced some form of spousal violence (physical, sexual or emotional); however, it is notable that spousal violence is experienced across all household economic quintiles (Bamiwuye & Odimegwu, 2014; KDHS, 2015). Poverty results in the denial of choices and provision for basic commodities needed to live, provide for children, and maintain social networks (Barnett et al., 2016; Simister & Mehta, 2010). In a recent qualitative study, economic survival was found to be paramount and that other notable variables such as community networks were seen primarily through the lens of facilitating access to financial and other assets (Barnett et al., 2016). Clearly, the diverse variables that contribute to women's risk of violence and prevent them from seeking care, justice and safety from their perpetrators require further study, with close attention to the intersectional nature of these variables.

Methods

Sexual violence against women is complex and the ecological model has been used to conceptualize it (Sallis et al., 2008). The ecological model was used to provide a framework for organizing the numerous factors related to sexual violence. 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. Importantly, it addresses the structural factors that promote sexual violence, rather than just focusing on the individual's behaviors. 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, and particularly policy

level interventions (Reproductive Health Response in Crises Consortium, 2004; Sallis et al., 2008).

Sample and Data Collection

Nairobi is the capital city of Kenya with a population of 4.39 million (Kenya National Bureau of Statistics [KNBS], 2019). Nairobi contains a mixture of high-income, low-density residential areas as well as low-income densely populated areas (Kenya National Bureau of Statistics [KNBS] & ICF Macro, 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. Health care practitioners were from health facilities in Nairobi that have functional post-rape care services. To be eligible to participate in the study, the health practitioners had to have worked at the facility for a minimum of six 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 8 post-rape care facilities, 4 public and 4 private, in Nairobi, Kenya. 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 counselor. Their years of medical practice ranged from 2 years to 30 years. The purpose of interviewing many different health practitioners was to better understand the vast care for a post-rape victim and to gather a variety of perspectives. 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 6 months to 48 months. In Kenya, practitioners are often transferred to different health facilities.

Ethical approval to conduct this study was obtained from university 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).

The in-depth interviews followed a semi-structured interview protocol format. Questions for the interview protocol were generated based on a

review of the literature on service provision to survivors of sexual violence (Campbell & Johnson, 1997; Campbell et al., 2001; Christofides & Silo, 2005; Keesbury & Thompson, 2010; Kelleher & McGilloway, 2009; Kilonzo et al., 2008; Martsof et al., 2010). 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.

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. 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. 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. To protect the confidentiality of the participants, all interviewees were assigned a pseudonym post interview. All interviews were digitally recorded with the permission of the study participants and transcribed verbatim by professional transcriptionists who had prior research experience.

Data Analysis

Data analysis technique followed was Colaizzi's (1978) approach to analysis (Alexis & Shillingford, 2012; Arthur et al., 2006; Martins, 2008; Saghafi et al., 2012; Scannell-Desch & Doherty, 2010). The steps are: (a) reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account, (b) extracting significant statements that pertain directly to the phenomenon, (c) formulating meanings for these significant statements, (d) categorizing the formulated meanings into clusters of themes that are common to all participants, (e) integrating the findings into exhaustive description of the phenomenon being studied, and (f) incorporating any changes offered by the participants into the final description of the essence of the phenomenon (Martins, 2008; Taylor et al., 2001; Wojnar & Swanson, 2007).

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. This allowed the principle investigator to adapt questions as needed to gather more relevant information. 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. 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 research team then looked for key emerging words, phrases, and significant statements. For example, key words were "frustration", "challenging", and so forth. Using an inductive thematic approach, 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. The groups of clusters of themes that reflected a specific idea around service provision to survivors were incorporated together to form a distinctive theme. The themes were then merged into an exhaustive description of the factors affecting the quality of services to female survivors in Nairobi, Kenya.

Results

Three main themes were identified related to family interference using the ecological framework: (a) individual and interpersonal: fear of consequences of reporting and care seeking, including economic vulnerability, family conflict, and retaliation such as divorce or further violence, (b) organizational and community: the trend toward out-of-court settlements rather than intervention through formal health and criminal justice sector challenges, and (c) community and public policy: attitudes toward sexual violence and survivors, normalization of rape and victim blaming attitudes.

Individual and Interpersonal

At the individual level the most salient felt experience is the fear of reporting.

Fear of consequences of reporting and follow-up with health and justice sector systems.

A number of practitioners interviewed felt that the economic implications for the family played a major role in decisions not to report rape and to discontinue post-rape care. Sometimes when the perpetrator was a member of the

family, the threat of divorce and losing the primary wage earner made them refrain. One practitioner shared:

Ok. So eh.. yeah yeah I think ok those clients, those survivors it is hard to come and report the person you know. Maybe... maybe let me say it is your father, your uncle... maybe your guardian. Most of them I think they fear to report because after all if you report your dad, how are you going to survive? Yeah. Yeah. (Female Nurse)

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, then that's the end of the relationship, so they fear. (Male Trauma Counselor)

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)

Practitioners reported that some clients would not be forthcoming about what had actually happened, would vehemently deny that rape had been committed or would change their story due to pressures from the family and community. The consequences of reporting and seeking care for survivors may include divorce and family conflict. The fear of such consequences and their long-term negative impacts may be seen as unacceptable or untenable to survivors or their parent. Thus, preservation of the marriage and avoidance of family conflict appear to take priority over care and support for survivors or child protection:

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 (reporting), 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)

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)

In one case, the practitioner recounted an experience with a client and her family in which the interruption of care was driven by the desire to hide the issue and avoid family strife to the extent that the survivor’s aunt went so far as to throw away the valuable antiretroviral medications the girl had already been provided:

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)

Organizational and Community

Kenya is 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.

Out-of-court settlement and trend toward use of informal community channels, rather than formal health and justice sector channels.

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. In these examples, survivors or their guardians accepted out-of-court settlement through informal village and tribal channels, rather than formal criminal justice sector channels.

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)

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)

One practitioner expressed concern that survivors had to endure the presence of their attacker in their daily life after the matter was settled out of court. Critically, such are reparations paid to survivors and their families in lieu of justice for survivors. The implication is that payment will make the issue disappear, and thus there will be no further follow-up with health or justice sector services. This approach clearly ignores the trauma experienced by survivors, neglects their health care needs, and results in an ultimate violation of survivors' right to receive quality post-rape care and children's right to protection.

For example, like in my experience like we work with some survivors from the (location 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 or 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'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)

In another statement, the intersection of cultural and economic factors is important to understand for the issue of informal reparations and out-of-court settlements:

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)

Community and Public Policy

Kenya has a largely traditional patriarchal culture. This patriarchal value system is most evident in the widely prevalent attitudes that still blame women for causing their own rape.

Cultural attitudes and practices; Normalization of sexual violence and victim blaming. Some practitioners posited that cultural attitudes normalize rape and place the onus on women to prevent sexual violence or bear the consequences, including placing the burden on mothers to prevent their husbands and other male relatives from abusing their children. These patriarchal norms and behaviors result in a tendency to blame the survivor for her own rape, even by a male family member. One counselor stated:

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)

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)

As a whole, the study findings illustrate a tendency to relegate the rights of women and girls to the lowest priority level and to uphold traditional cultural and family norms and practices at the expense of survivors. These results highlight the challenge of protecting the rights of survivors and ensuring their access to quality post-rape care services in traditional patriarchal cultural contexts where the survivors may be seen as property belonging to the male family member or where the authority and satisfaction of males takes precedence. In keeping with prior research and global analyses, these findings highlight gender inequity as a driver of power imbalances that facilitate violence against women and exploitation.

Discussion

In a key finding from this study, health workers reported that family members can often create barriers to survivors seeking post-rape care and pursuing legal action, in particular when the perpetrator is a family member. In the

context of this study, the practitioners reported these challenges as contributors to their feelings of frustration and ultimate burnout. The lived experience of health practitioners and personal consequences such as burnout and accumulative frustration with clients have negative implications for practitioners' ability to ensure quality of care. By narrowing focus to this specific finding, the intent is to explore the potential various drivers of family interference in post-rape care as perceived by health practitioners. These results reflect practitioner views and not the views or experiences of survivors. Practitioner views are grounded not only in experiences as post-rape care providers but also reflect their perspectives as individuals and community members, including their personal assumptions, prejudices, and theories as to why care was interrupted.

In describing their experiences of a lack of family cooperation in the care process as a challenge, practitioners suggested that family interference was driven by factors spanning institutional, community/cultural, and structural domains. Practitioners mentioned key underlying cultural and social factors that impact the quality of services that survivors receive. 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, 2014). There is a culture of silence in Kenya surrounding gender violence (KDHS, 2003). 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. Some 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 and suffer negative consequences from family and community. 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.

Practitioners also indicated a lack of follow-up care. Temmerman et al. (2019) studied follow-up for psychological care for victims of sexual violence. Only 19% of survivors returned to their first counseling visit. Several practitioners interviewed discussed that many survivors only returned to receive PEP follow-up. Practitioners noted that there is a lack of continuity of care, having to travel to different facilities, or parents not bringing child survivors back to the facility, all deterring survivors to return for care.

In the following discussion the results are considered in the context of their classification according to structural, cultural, and institutional ecological domains.

Structural Factors

For many survivors, the economic consequences for the woman and family were a driving factor in decisions to stay in the marriage after sexual abuse by her husband and to accept bribes from perpetrators in lieu of prosecution and continuing care. At the structural level, this situation may be partially attributable to widespread poverty in Kenya, unequal access to economic resources along gender lines, and to the global political economy, which has resulted in more people living in absolute poverty (Chuma & Maina, 2012). In this economic context, sociocultural factors become important drivers of resource allocation and prioritization of individual and community needs. 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 (Muchoki & Wandibba, 2009).

Addressing women's economic empowerment may address these challenges to an extent, but will not be sufficient to remove barriers to post-rape assistance and ultimately break the cycle of sexual violence that causes so much destruction (Sarnquist et al., 2018). Social support is important for women's economic survival and as a resource for survivors in their own right (Bourey et al., 2015; Sarnquist et al., 2018).

Community and Cultural Factors

The study findings suggest a widespread belief that the preservation of family, marriage, and traditional community and cultural institutions should be the highest priority, above the health and rights of women and children survivors of sexual violence. From a community and cultural perspective, the preservation of the family is critical for the maintenance of traditional norms and values. The subjugation of women and, more specifically, the normalization of sexual violence against wives and even children function allows communities and

institutions to devalue the experiences and needs of survivors. Viewing rape as an accepted male retaliation for denial by women of their rights and authority leads to victim blaming and ultimately discourages survivors from seeking help or even believing this is a possibility (Tavrow et al., 2013). Furthermore, survivors who report their assault or assault against their children and pursue legal action against the family perpetrator, including criminal prosecution and divorce, may be seen as responsible for breaking up the marriage. The survivors in this context bear the double burden of responsibility for their own assault and for destroying the family for perceived self-indulgent reasons. According to a recent survey in Kenya, this patriarchal belief that women should tolerate and bear the consequences of sexual violence is pervasive (UNICEF, 2012). Between three and four out of every ten women aged 18–24 years in the study reported feeling that women should tolerate sexual violence to keep the family together. From the survivors' perspective, the family conflict and judgement they face if they report their attack may translate into social isolation and a loss of social support that is essential not only for recovery but also for daily life (Barnett et al., 2016). In the absence of alternative housing and economic support it would be difficult to leave the perpetrator's household. Other research supports this observation; Muganyizi et al. describe the economic and social inequality that define survivors' experiences working with police and the health system, their decision-making and the ultimate course of action. Inadequate services, the realization "that it is all about money", and an assessment that survivors are caught up in a dysfunctional system comprised barriers to care which characterize survivors' experiences "managing in the contemporary world" (Muganyizi et al., 2011, p. 3197).

Institutional Factors

Finally, institutional factors also come to bear on the issues associated with family interference in post-rape care. In particular, the trend toward use of informal community, village or tribal mechanisms to settle allegations of sexual violence incidents suggests a sociocultural objective to preserve and uphold these traditional structures and a widespread mistrust of police and criminal justice mechanisms. The issue of out-of-court settlement provides a prime example of the intersectionality of factors influencing family interference and other issues impacting quality of post-rape care. Women experiencing sexual violence by their spouse often decline formal options available through the health and justice sectors in favor of informal community or interpersonal level settlement options. This choice may result from community and family pressures that serve to uphold traditional patriarchal norms. At the same time, survivors and families may also be driven by a lack of trust in

criminal justice institutions. They may perceive a high level of risk with the pursuit of criminal justice sector channels due to bureaucratic processes, time burden, and victim-blaming attitudes that may intimidate survivors and discourage their efforts. Legal action, financial settlement, and accountability may come only after a lengthy and onerous follow-up period, if they come at all. Legal sector outcomes may ultimately prove unsatisfactory or even damaging to survivors if the perpetrator influences the outcome through bribes, the penalties are insufficient to deter future violence or provide or if the survivor risks economic and familial alienation. With respect to the structural issue of poverty, there is no guarantee that the economic outcome of formal criminal justice action will be satisfactory. On the other hand, community settlements may be quickly negotiated and come with a certainty and simplicity that may be perceived as advantageous under many circumstances. Unfortunately, these channels neglect the needs of survivors and lead to violations of the fundamental right of survivors to quality post-rape care including the pursuit of justice and the right of children survivors to protection from harm.

Limitations

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. In consideration of the Kenyan context, the relatively small area from which the respondents were recruited likely biased the results in two ways: (a) there are more resources (both human and material) in Nairobi than anywhere else in the country and (b) 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 and may reflect distinct cultural attitudes that affect understandings and experiences of sexual violence. The literature review draws on studies from settings outside of Kenya and East Africa, demonstrating the global challenge of violence and exploitation of women. The issues of stigma, economic dependence, and gender inequality, among others, are prominent in existing research from diverse settings around the world. However, caution should be taken when extrapolating these findings to other settings. Further research exploring the diversity of these issues is needed.

Conclusions

The current study provides new insight into health practitioners' experiences providing care for rape survivors and the phenomenon of family and

community interruption of health care and criminal justice processes. One major finding was that health providers observed family interference as an important issue that contributed to their feelings of frustration and burnout. Practitioners reported survivors or the parental guardians of child survivors resorting to out-of-court settlement instead of pursuing care and reparations through formal health and justice system channels. 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 survivors and caretakers of child survivors who settle out of court, there is a critical need for a better understanding of the aims 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. Addressing women's economic empowerment can address these challenges to an extent but may not be sufficient to prevent sexual violence and remove barriers to post-rape assistance (Sarnquist et al., 2018). Finding strategies to combat this practice would also reduce the likelihood of repeat offenses.

Cultural, institutional, and structural variables must be taken into account in research and evaluation efforts. This qualitative research was conducted to explore the perspectives of health workers based on their experience caring for survivors of sexual violence. Sexual violence against women and children, attitudes toward reporting, community and cultural attitudes and practices, and institutional trust and capacity should be further explored from the perspectives of survivors. 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.

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