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The Impact of Macroeconomic Policies on Healthcare Delivery in Kenya: An Analysis of the National Sexual Violence Prevention and Care Response

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Abstract

Sexual violence is one of the most common forms of violence against women in Kenya. This study documents the care of sexual violence survivors from the perspective of health care practitioners based on an analytic framework developed in studies of the political-economy of health to examine the effects of International Financial Institutions' conditionalities on the allocation of national fiscal resources. The study documented the working conditions of practitioners and myriad challenges that they experience in providing quality services to sexual violence survivors. The issues reflected in the results are grounded in social structural inequities driven by the global political economic policies that perpetuate poverty and dependency throughout Africa and the developing world. Macro-level variables associated with health care provision are assessed with a focus on global macroeconomic policies established by the International Monetary Fund and World Bank, their impact on Kenya's health economy and their ultimate impact on the capacity of the health system to meet the complex needs of survivors of sexual violence. In this paper, study results are analysed within the context of these macroeconomic policies and their legacy.

Keywords

post-rape care, sexual violence, structural adjustment policies, health systems, quality of care

Rape is one of the most prevalent violent crimes committed in Kenya.¹ It is estimated that one in every four women has experienced sexual violence in their lifetime: constituting nearly 22-million women worldwide.² Research shows 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 virginities due to forceful or coercive sex.¹ The overwhelming majority of victims of this criminal act in Kenya, like all other nations in the world, are women.³

The Kenyan government has demonstrated a will to address this problem through the development of national legislation and programs to support prevention efforts and to facilitate access to comprehensive care for victims of sexual violence. The national response to address sexual violence has included the introduction of the Sexual Offenses Act and the National Guidelines for the Management of Sexual Violence, among other initiatives. In particular, the

National guidelines on the medical management of sexual violence, first produced and disseminated in 2004,⁴ aim to improve health providers' knowledge about the delivery of Post Rape Care (PRC) services.

The guidelines list specific services that are provided free of charge to survivors of sexual violence at all government health institutions. These include: clinical care and treatment for injuries; examination and documentation for legal

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purposes; post-exposure prophylaxis (PEP) to prevent HIV infection; pregnancy prevention services; and psycho-social support in form of counselling services. However, there is a dearth of research assessing the challenges of adhering to these national guidelines for the management of sexual violence in public health care settings in Kenya.

The Kenyan Health Care System: Current Challenges

Generating adequate resources to finance the health care sector is a major problem in Kenya. The Kenyan healthcare system relies heavily on user fees, which present a significant barrier to utilizing of health care services in the country.^{5,6} Health care expenditure remains abysmal, failing to meet minimum thresholds set by the Abuja Declaration and the WHO.⁷⁻⁹ The ongoing exodus of medical professionals from rural to urban settings, public sector to private practice or to developed countries creates additional challenges.^{10,11} Most of the challenges faced by the Kenyan health system can be traced back to the impact of the IMF and World Bank Structural Adjustment Policies (SAP) on the development of poor nations in the early 1980s.

SAP and Healthcare Systems. SAPs are a wide range of policy reforms aimed at overhauling the structure of a country's economy to become more market oriented.¹⁵⁻¹⁷ Developing countries are required to meet a set of conditions stipulated by IFIs such as the International Monetary Fund (IMF) and the World Bank (WB) in order to receive loans and other forms of financial aid from these institutions.^{16,17} These conditions include the implementation of austerity measures to reduce the size of the public workforce, privatization of public enterprises, cuts in public sector budgets, devaluation of local currency, weaken government regulations, deregulation of fiscal policy.¹⁷ To reduce budgetary deficits, governments were forced to cut national programs designed to alleviate the effects of poverty such as health and education programs, increasing poverty, income inequality and decreasing access to healthcare and other social services.^{18,19} In the healthcare sector, user fees were introduced as a cost-recovery mechanism for previously free services²⁰ and public health services were contracted in favour of private sector priorities of profit maximization.²¹

Available research show that cuts in government expenditure resulted in poorly resourced health systems,¹² increases in infant and child mortality,²² higher maternal mortality rates,²³ increased workload for health providers and poor work conditions,²⁴ poor quality of services and long wait lines,²⁵ reductions in access to healthcare services.²⁶

Using the conceptual framework proposed by Kentikelenis,²⁷ the impact of SAP on health care systems can be categorized as direct and indirect effects (Figure 1 and Table 1). Direct effects of the implementation of austerity measures, for instance, led to workforce shortages in the healthcare system as hiring freezes and wage cuts encouraged

emigration of healthcare workers; reductions in government expenditure also affected the volume and quality of services provided. Indirect effects of fiscal consolidation, trade policies and financial liberalization have impeded access to imported medicines and equipment and undermined the government's ability to finance the healthcare system.

In Kenya, government expenditure of social services declined from 35% in 1975–1976, to 32.9% in 1990 – 1991 while expenditure on debt servicing increased from 8.3% to 31.8% in the same period.²⁸ This externally mandated shift of funds led to the shutdown of health facilities, while the few institutions that remained operational lacked basic equipment and supplies such as cotton wool, surgical gloves, etc.²⁹ Research shows that conditionalities imposed by the SAP placed caps on employment and salary increases for health workers, leading to low wages, poor working conditions, heavy workloads, migration of health professionals and reliance on inexperienced health providers, in developing countries (Table 2).^{30,31}

The detrimental impact of these reform policies is considered long lasting.^{19,32} In recent years, SAPs have been replaced by Poverty Reduction Strategy Papers (PRPS)' which focus national policies on poverty reduction measures.³³ However, these poverty reduction economic reforms have been criticized as macroeconomic policies similar to those of SAPs.^{27,34} Available research shows that participation in IMF poverty reduction programs increases rates of poverty in the long run in participating countries.¹⁸ Further, IMF conditionalities continue to undermine the healthcare system, particularly progress towards universal health coverage.¹²

Methods

The purpose of this study was to identify and analyse the factors that influence the quality of services provided to female survivors of sexual violence in Kenya from the perspective of health care providers in the country, using the conceptual framework proposed by Kentikelenis.¹⁵

Participants

Health care practitioners were recruited from eight functional Post Rape Care (PRC) services centres in Nairobi. 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, located 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 counsellors, three social workers, one clinical psychologist, one pharmacy technician, one reproductive health officer and one Voluntary Counseling and Testing (VCT) counselor. Their

Figure 1. Structural Adjustment and Health: Overview of Mechanisms. By Kentikelenis.¹⁵

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 a Level 5 hospital

Data Collection

All interviews were conducted primarily in English. Both medical training and Continuing Medical Education (CME) in Kenya are 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. Ethical approval to conduct this study was obtained from University Institutional Review Board (IRB) and the Kenya Medical Research Institute (KEMRI) Ethics Review Committee. 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.

Results

A number of themes emerged concerning the health care providers' perspectives on the challenges of providing quality services to female survivors of sexual violence in Kenya. Themes are categorized and presented below as Health Workforce Shortages and Health System Deficiencies as direct and indirect effects of IFI conditionalities.

Direct Effects: Health Workforce Shortages

Practitioners identified a number of specific stresses that follow from the limited number of medical practitioners trained to provide post-rape care services. The shortage of trained personnel leads to main four problems: (1) high workload, (2) time constraints, (3) multi-tasking, and (4) burnout.

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. The practitioners repeatedly remarked that, due to the large number of patients that they have to see, their workload is high.

One practitioner provided further 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

Table 1. Direct and Indirect Effects of SAP policies on Health Care Systems.¹⁴

Direct Effects		
1	Stabilization component	Reduction in government public expenditure
2	Austerity measures	Hiring freezes and Wage cuts Medical brain drain
3	Revenue raising and Cost cutting elements	Introduction of user fees
4	Deregulation	Enhance private sector role but roll back of public provision of services
5	Health system decentralization	Inadequate health system coordination and budget execution problems
6	Priority spending floors	Accorded secondary importance in contrast to economic targets, targets often not met.
Indirect Effects		
1	Fiscal consolidation	Currency devaluation; weak currency impeding access to imported medicines and equipment
2	Trade and capital account liberalization	Removed tariffs, reducing trade tax revenues which undermine fiscal basis for health policy Impede government's ability to develop and stably finance health systems
3	Privatization	Withdrawal of benefits such as health coverage for former employees of state-owned enterprises
4	Austerity measures	Increased aid flows and donor intervention. Aid substituting rather than complementing government spending on health

Table 2. Challenges Faced by Kenyan Health Sector.

- **User fees:** heavy reliance on out-of-pocket expenditure (OOP). First dictated based on World Bank/IMF structural adjustment program in 1980s.¹²
- **Health sector expenditure:** Kenya spends just 4.8% of GDP on healthcare. As a proportion of total health expenditure, government expenditure accounts for 29%, households 36% and donors 30%.⁹
- **Inequitable distribution of resources:** health funding not distributed fairly across Kenya. Urban areas tended to receive much more per capita funding than rural areas despite greater unmet need in rural settings.¹³
- **Doctor/patient ratio:** Kenya's most recent doctor-patient ratio stands at 13 per 10 000,¹⁴ far below the WHO minimum of 23 doctors, nurses, and midwives per 10, 000 population.
- **Funding allocations:** 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.⁵
- **Exodus of health workers:** one in every five nurses trained in Kenya applies to emigrate, while about 30–40% of the medical doctors leave the country each year, on completion of their internship.¹⁰

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 practitioners 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)

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)

Other practitioners expressed feelings of exhaustion and being overwhelmed by the amount of work to be done and by the intensity of the tasks at hand and needs of patients. The high workload not only impacts the practitioners' experience of providing the service but also the survivors.

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 practitioner expressed frustration with the time involved in examination and the medical management tasks. 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, 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 grave 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)

Multi-Tasking. 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.

Practitioners conveyed feelings of inadequacy when it came to providing counselling. Due to staff shortages, they sometimes have to conduct counselling sessions with clients, even though they may not be properly trained to do so. One practitioner expressed that she felt she had short-changed 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 counselling skills, nice good counselling skills because that was a traumatized lady. Maybe, I would have had a good session of doing proper counselling 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 counselled, maybe it would have helped me with that lady. (Female Clinical Officer)

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 many 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. She expressed concern at 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 Counsellor)

Some practitioners resorted to coping mechanisms to address all of the above challenges. Among these, health workers often made the decision to alter the service package based on their available time, level of emotional and physical capacity (i.e. burnout), workload, and other drains on their time (i.e. multi-tasking). Additionally, practitioners described experiencing negative attitudes towards survivors due to all of the above described pressures and other cultural factors.

Indirect Effects: Health System Deficiencies

The practitioners mentioned several issues with respect to the health care system that affected their ability to provide the necessary services and ensure quality of care: (1) the lack of privacy; (2) lack of equipment; (3) poor record keeping; (4) forensic management challenges; (5) insufficient training; and (6) poor referral systems.

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.

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, as one provider shared:

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 readily 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, to pick up their results from the laboratory, for counselling 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 also came up often. 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. One 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 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 Counsellor)

This practitioner also raised concerns about 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 pertaining strictly to survivors. This means that the survivor's record could be accessed by other hospital personnel not working directly with the survivor, which would violate their privacy.

Forensic Management Challenges. Practitioners cited the lack of adequate hospital facilities for the collection of evidence. 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.

Several practitioners relayed frustrations at their inability to collect forensic evidence. 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)

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 had been rendered useless by the lack of kits at the facility.

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 tired, 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)

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 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)

Insufficient Training. Another issue regarding the health systems was that of human resources. Specifically, the practitioners

identified the lack of training and poor administrative oversight as major challenges in their providing quality services.

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

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)

Several practitioners cited little to no training when it came to medical management of rape and sexual violence. They talked about favouritism in the health facilities and how that played into which practitioner was chosen to go for training. 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)

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 Referral Systems. Practitioners also expressed concerns about the limited referral system and the scarcity of external support services. 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 indicated that they would like to have a functioning referral system 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 practitioners had to refer survivors to receive additional services at another facility, they were uncomfortable with the prospect. 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)

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)

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 for counselling until now. She healed [completed] from 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)

Discussion

Legacy of IMF and World Bank Lending Policies

Ultimately, these health workforce and health system challenges that negatively impact quality of care for survivors can be traced back to the macroeconomic policies that have led to significant under-resourcing of the national response to sexual violence and the health system more broadly.

Kenya's healthcare system was hit hard by the structural adjustment policies (SAP) mandated by the IMF as prerequisites for future loans. 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, many health service delivery points closed, and others have faced drastic cuts in supplies of medicine and other medical materials.²⁹ 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.³²

One major critique of the IMF and World Bank model is that it prioritizes the fiduciary concerns of the lender over the interests of poor people and health-seeking clients. The SAP model is based on the neoliberal capitalist assumption that economic growth is the most effective means of establishing a sound fiscal position and stable development trajectory.³⁶ These ideas have, at best, chequered 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).^{12,37}

IMF-dictated cuts in health spending have severely limited the ability of the health sector to address critical health challenges and provide a minimum service package. 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. Conditionalities of IMF lending continue to exacerbate health care system weaknesses and poor health outcomes in developing countries. For instance, the devastating effects of the HIV/AIDS pandemic³⁸ and the recent Ebola outbreak¹⁵ in Africa have been linked to IMF caps on public sector wage bills and constrained government expenditure on health care.

Healthcare requires continuing investments on the part of government officials, the private sector, and non-profit entities. Great expenses mount up because they have to spend money to purchase equipment and provide high-quality services to the entire population. As these investments do not directly produce measurable economic benefits, they are viewed as a drain on the economy. Unfortunately, IMF policy is guided by a limited economic view that fails to consider the long-term effect of these investments on individual health, which in turn increases productivity.^{39,40} Ironically, the IMF's neo-liberal mandates are forcing the Kenyan government to cut back on social spending and programs to alleviate poverty and this is having the unintended effect of exacerbating poverty in Kenya. This effect on poverty is compounded by the large number of loans to the Kenyan government and the high interest rates that result in increases in Kenya's debt burden over time.

This research revealed severe shortages of personnel, equipment and competency in delivering services to survivors, all of which can be traced to change in health and social spending dictated by IMF and World Bank lending policies. Practitioners often deviate from the National Guidelines due to a shortage of supplies and personnel, leading to a decrease in quality and continuity of care.⁴¹ 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.⁴² Improving the quantity, quality and distribution of the health workforce and health sector infrastructure in Kenya is the only way to enable the country to achieve its health goals.

Conclusion

For the Kenyan healthcare sector, the effects of the global political economy are evident in the lack of resources and financial support for social programs. Under the conditions of the loans, the IMF demands that recipient governments adhere to restrictive fiscal policies and practices, which

include making significant reductions to health and social spending. These cuts place additional constraints on the national budget, forcing the Kenyan government to allocate the limited resources that are available to a select few priority programs.

Beyond the detrimental effects to the health sector, there are impacts on other public sector services including the education sector.³⁰ Additional research is needed to explore these areas and factors affecting both the prevalence of sexual violence and service provision for survivors.

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