Is sexual abuse a part of war? A 4-year retrospective study on cases of sexual abuse at the Kenyatta National Hospital, Kenya

Mary W. Kuria,[1] Lilian Omondi,[2] Yvonne Olando,[3] Margaret Makenyengo,[4] David Bukusi[5]

[1]Department of Psychiatry, University of Nairobi; [2]School of Nursing Sciences, College of Health Science, University of Nairobi; [3]Psychologist, Private Practice; [4]Psychiatry Department, Kenyatta National Hospital; [5]Kenyatta National Hospital Youth Centre, VCT and HIV Prevention Unit, Kenya

Abstract

The harmful effects of sexual abuse are long lasting. Sexual abuse when associated with violence is likely to impact negatively on the life of the victim. Anecdotal reports indicate that there was an increase in the number of cases of sexual violence following the 2007 post election conflict and violence in Kenya. Although such increases in sexual abuse are common during war or conflict periods the above reports have not been confirmed through research evidence. The purpose of the current study is to establish the trend in numbers of reported cases of sexual abuse at Kenyatta National Hospital over a 4-year period (2006-2009). Data on sexually abused persons for the year 2006-2009 was retrieved from the hospitals record. A researcher designed questionnaire was used to collect relevant data from the completed Post Rape Care (PRC) form. The PRC-Ministry of Health no. 363 (MOH363) form is mandatorily completed by the physician attending the sexually abused patient. There was an increase in the number of cases of sexual abuse reported in 2007 election year in Kenya, with a statistically significant increase in the sexually abused male cases. Sexual crime is more prevalent when there is war or conflict.

Introduction

In Kenya's general elections of December 2007, there was a high political tension that culminated to post election violence, which extended to February 2008. Violence erupted in several parts of Kenya including the slums of Nairobi. Incidences of sexual abuse especially towards women, mainly gang rapes were reported to have increased.[1] The violence ended after the signing of the peace accord between warring parties on 8th February, 2008.[2] An increase in the number of cases of sexually abused women and children was reported following the December 2007 election and the subsequent post election violence that extended into the first 2 months of year 2008.[3] The number of sexually abused people attended at Kenyatta National Hospital (KNH) was reported to have gone up two months before the year 2007 December general elections and 2 months after. These attended cases were however said to be only 30 per cent of the actual figures with the majority going unreported.[4] These reports have not been confirmed through research-based evidence.

History of sexual abuse is common and greatly increases the risk of developing psychiatric illness as well as the risk of attempted suicide and drug abuse.[5-12] Additionally a history of sexual abuse is associated with poor physical health and the consequences may be long term.[3,13,14] In addition to physical and psychological trauma other complications of sexual abuse include; unwanted children, prolapsed uteruses, vagina fistulae and cervical cancer,[15] increase of suicide, AIDS, sexually transmitted infection.[16-19] Additionally many victims cannot afford the care they need, or do not have physical access to appropriate care needed.[20]

Though sexual abuse is common in African wars, the highest prevalence and the worst intensity of sexual abuse reported in the world currently is in Eastern Congo[21] where there are about 200,000 surviving rape victims today[20] with sexual abuse having been used as a weapon of war.[22]

Anecdotal reports indicated that sexual abuse was used as a weapon of war (terror, intimidation, punishment) in the 2007-2008-post election violence in Kenya.[23] Although generally many cases of rape go unreported, it is important to specifically consider the cases reported in the conflict period between December 2007 and May 2008 and compare them with both the preceding period and the period after the conflict. The year 2006 was a conflict free year for Kenya, while 2007 was an election campaign year characterized by uncertainty and mistrust. Like the year 2006, 2009 was a peaceful year with the majority people of Kenya returning to a fairly normal life.

Since the harmful effects of sexual abuse are long lasting and sometimes lifelong clinicians should be prepared to offer both physical and psychological help to victims of rape for as long as it is required.

Kenyatta National Hospital is the main referral hospital and has a gender violence recovery centre. It was expected that any increase in the number of victims of sexual abuse should be reflected in the records of patients seen at the hospital. Moreover, the Kibera informal settlement where the unrest was severe is located just about 2 km from KNH. Sexually abused patients are ordinarily attended to at the gender based violence recovery centre or in the Accident & Emergency (casualty) Department. Records of all patients seen are subsequently stored in the main hospital medical records department.

The current modern criminal justice system in many countries is more lenient to rape offenders and is largely considered as unfair to sexual assault victims.[8] The criminal proceeding of rape cases appears to put the victim and her behavior on trial rather than the defendant.[9] This may explain why most of the victims of sexual abuse do not report the incidences. Additionally, the perception that rape is unique to women and never occurs to men is outdated[10] and other laws have eliminated the term rape altogether.[11] Proper documentation of the sexual abuse in medical notes is important for criminal proceedings.

In Kenya the Ministry of Health has provided a structured format for guiding the physician on mandatory required information when evaluating victims of sexual abuse. This structured form is referred to as Post Rape Care Form 1-Ministry of Health no. 363 (PRC1-

Correspondence: Mary W. Kuria, Department of Psychiatry, University of Nairobi, P.O. Box 74846 code 00200, NBI, Kenya.
Tel. +254.0720.755681.
E-mail: mkuria@uonbi.ac.ke; wangari2@yahoo.com

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MOH363). This is an important document that is latter used to complement the police forms (P3) which is a legal document presented to court for prosecution of apprehended sexual abusers.

Materials and Methods

The study was conducted at Kenyatta National Hospital, which is Kenya's main referral hospital. After receiving ethical clearance by the KNH/University of Nairobi ethical review board, the principal investigator requested the KNH administration to avail records of patients treated for sexual abuse between the years 2006-2009. A researcher designed and administered questionnaire was used to extract necessary data from the patients file. The researcher completed a serialized questionnaire for each case. Required patient information on all patients treated for sexual abuse of any type including, rape and sexual defilement was obtained. Information obtained included: sex, age, residence, whether they were treated as outpatient or inpatient, management given and the month of the reported rape was obtained. All the completed questionnaires were given a serial and stored in a locked cabinet. The data was then entered in to a computer and analyses done.

Confidentiality was maintained and no name or identifying data was attached to the information obtained.

Eligibility criteria

All recorded cases of patients seen at KNH with diagnosis of sexual abuse of any nature in the year 2006 to 2009 were included in the study.

Instrument

A structured researcher designed questionnaire was used. Data was extracted from the completed PRC1-MOH363 form. This is a form that must be filled by the physician for every patient seen at all the ministry of health facilities for all sexual abuse victims. This form is provided by Ministry of Health and provides the national rape management guidelines for examination and documentation of all survivors of rape/sexual assault. Accurate completion of the PRC1-MOH363 is therefore very important.

Results

Socio demographic characteristics

The majority of the cases treated for sexual abuse between the years 2006-2009 were female 91.5%. There was a statistically significant increase (P value 0.12) in the number of males seen in the year 2007. The majority of abused persons were under 23years of age with no statistically significant difference in the patients over the 4 years (P value 0.144). The majority of the participants were of primary education level with was no statistically significant difference in the education level of the reported sexual abuse cases (P value 0.719). Much of the information was missing from the files especially that regarding, education, occupation, marital status and age.

Details of the socio-demographic characteristics of cases are shown in Table 1.

Reported cases of sexual abuse 2006-2009

The numbers of sexually abused persons treated at hospital increased in the years 2007 and 2009 as compared to the years 2006. A drop in the number of reported cases occurred in the year 2008. The results are shown in Table 2.

Post-HIV-exposure prophylaxis

Post-exposure prophylaxis (PEP) was given to 50.1% of the cases over the 4 years, 14.3% did not receive HIV PEP while for 34.9% the data on whether the victims received PEP was missing. The results are shown in Table 3.

Patients' records

The patient's clinical notes were poorly recorded, with information necessary for legal use missing. A total of 46 (16.9%) files had incomplete socio demographic information missing while 83.1% had the complete information recorded. Although the PRC1-MOH363 is a useful document that doctors attending to the sexual abuse victim must complete, only 9.9% were fully completed. Despite the PRC1-MOH363 been a useful document that doctors attending to the sexual abuse victim must complete, only 9.9% were fully completed. There was however a statistically significant improvement in the completeness of patients' demographic data records over the 4 years (P value 0.00).

Discussion

The majority of the persons allegedly abused sexually between the years 2006-2009 and attended to at KNH were female. There was however a statistically significant increase in the number of males abused in the year 2007. There was also an increase in the numbers of sexually abused persons in the same year as compared to the year 2006 and 2008. Sexual abuse to women has been reported to increase in times of war where men consider women humiliation as a sign of triumph.[6] The year 2007 was an election year with election campaign. The resulting post-election conflict may have provided an enabling environment for sexual offenders to perpetuate the crime; on the other hand, sexual abuse may have been

Table 1. Socio-demographic characteristics of the victims of sexual abuse.

Characteristics	Number	Percentage
Marital status		
Married	3	1.1
Single	90	33.1
Total	93	34.2
Missing data	179	65.8
Age		
<18	77	28.3
18-23	62	22.8
>40	13	4.8
24-40	56	20.6
Total	208	76.5
Missing data	64	23.5
Sex		
Male	22	8.1
Female	249	91.5
Total	271	99.6
Missing	1	0.4
Education level		
None	1	0.4
Primary	28	10.3
Secondary and above	3	1.1
Missing data	240	88.2
Total	272	100.0
Occupation		
Unemployed	11	4.0
Employed	1	0.4
Business	5	1.8
Student	28	10.3
Total	45	16.5
Missing data	227	83.5

Table 2. Number of sexually abused cases in a year.

Year	Frequency	Percentage
2006	62	22.8
2007	74	27.2
2008	62	22.8
2009	74	27.2
Total	272	100.0

Table 3. Post-exposure prophylaxis.

Administered	Frequency	Percentage
No	39	14.3
Yes	138	50.7
Total	177	65.1
Missing data	95	34.9
Total	272	100.0

used as a weapon by the warring ethnic groups to harm each other.

Sexual abuse victims are at risk of contacting sexually transmitted diseases and prevention of such diseases is of paramount importance. Only slightly above half of the cases (50.7%), had HIV post exposure prophylaxis, 14.3% did not receive HIV PEP while in 34.9% had information on whether they were given PEP or not missing. HIV been one of the dreadful consequences of rape should be prevented and doctors should give PEP and keep record of prophylactic measures taken to prevent the infection indicated and if not reasons should be recorded.

The study shows a statistically significant improvement in socio demographic data collection by the hospital staff over the 4 years with information about the education level, occupation and marital status missing in most of the cases. Possible reasons for such missing data may be due to three factors. Firstly the emergency nature of the patients' presentation may overwhelm the attending personnel, who may ignore certain information recording requirements. Secondly the attending doctor may emphasize the treatment aspects of management and ignore the importance of gathering complete patient information. Thirdly the patient may be too traumatized by the event and unable to provide the information. Irrespective of the reasons for the missing demographic data and other data, this is likely to result to poor criminal proceedings against accused offenders if brought to court for trial. Medical information on sexually abused cases is useful to the courts and inadequate information is likely to weaken the court cases against the perpetuators of the sexual crime if insufficient. Proper training of clerks and physicians on the need to collect and record detailed information from victims of sexual abuse is important.

Further training of medical professionals on importance of PEP will reduce the chances of developing HIV/AIDS, which is one of the worst consequences of sexual abuse. It is a responsibility of African leaders the need to avoid post-election conflicts in order to reduce the chances of their *armies* using sexual abuse as a weapon.

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