THE EXPERIENCES OF NICARAGUAN HEALTH CARE PROFESSIONALS’ ENCOUNTERS WITH VICTIMS OF SEXUAL VIOLENCE
ABSTRACT

Background

Sexual violence against women and adolescents is widespread in Nicaragua, a country which also has one of the highest rates of adolescent pregnancies in Latin America. Research shows that adolescent pregnancy is often in correlation with sexual violence. Health care services have an important role in the detection, prevention and treatment of victims of sexual violence. Yet research on Nicaraguan health care professionals’ views and practices regarding sexual violence is scarce.

Aim

The aim of this study was to explore how the Nicaraguan health care system approaches the issue of health care towards victims of sexual violence. What are Nicaraguan health care professionals’ views and practices regarding the health care towards victims of sexual violence? To what extent is the steering document La Norma being applied in the Nicaraguan health care system?

Methods

A qualitative interview study with six health care professionals was conducted and data was interpreted with a qualitative content analysis.

Findings

Health care workers express strong commitment for their professions and a willingness to attend to the victims of sexual violence. However, views and practices not in accordance with La Norma were found, such as gender stereotypes among health care professionals about adolescent girls becoming pregnant mainly due to recklessness on their side. This constitutes a barrier against regarding adolescent pregnancy as a possible indicator of sexual violence. There is a clear connection with gender as it is young women and girls that are affected. This attitude is negative for the detection and treatment of victims of sexual violence and consequently for the protection of these patients’ right to the highest attainable health.

Conclusion

Health care practices and views of health care professionals are often not consistent with the steering document La Norma. Increased resources including education and more time with patients would strengthen nurses’ work and improve the medical attendance to sexual violence victims, thus contributing to a rights-based approach to sexual and reproductive health. Implementation of steering documents regarding the attention to sexual violence in the health care services also needs to improve. Future studies should further examine the implementation and monitoring process of steering documents, including budget resources.

Key words

Sexual violence, health care, adolescent pregnancy, human rights, Nicaragua
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ABBREVIATIONS IN ALPHABETICAL ORDER

AIMNA = Atención Integral a la Mujer, Niñez y Adolescencia, which translates into “Integral Program of Attention for Women, Children and Adolescence”

AMNLAE = Asociación de Mujeres Nicaragüenses Luisa Amanda Espinoza, a Nicaraguan Women’s organisation

CAT = The Committee against Torture, a UN committee

CEDAW = The Committee on the Elimination of Discrimination against Women, a UN committee

ECLAC = United Nations Economic Commission for Latin America and the Caribbean

FSLN = Frente Sandinista de Liberación Nacional, a political party currently in office

HIV = Human immunodeficiency virus

ICN = International Council of Nurses

IPV = Intimate partner violence

MINSA = Ministerio de Salud, Nicaragua’s Health Department or Ministry of Health

NGO = Non-governmental organisation

OHCHR = Office of the High Commissioner for Human Rights

RBA = Rights-based approach

SILAIS = Sistema Local de Atención Integral en Salud, the local primary care division of The Health Department or Ministry of Health (MINSA)

SRHR = Sexual and reproductive health and rights

STD = Sexually Transmitted Diseases

UN = United Nations

UNICEF = United Nations Children’s Fund

UNFPA = United Nation’s People’s Fund

WHO = World Health Organisation
INTRODUCTION

*Health is not bought with a chemist’s pills
Nor saved by the surgeon’s knife
Health is not only the absence of ills
But the fight for the fullness of life*

Piet Hein, for the celebration of World Health Organisation’s (WHO) 40th anniversary in 1988.

Illustrated by the poem above, health is a subject that concerns not only the absence of ills or the effects of medicine, but in fact the fullness of our lives – and the fight for it. As a nurse in the making and a feminist, the relations between human rights and health, society and health care are vital parts of my understanding of the world. Since I have a long-standing interest for Latin America and for sexual and reproductive health and rights, I established contact with the Nicaraguan office of the Swedish non-governmental organization (NGO) Svalorna Latinamerika. This NGO is working with local organisations against sexual commercial exploitation of children and adolescents. Sexual violence is frequent in Nicaragua (Amnesty International, 2012; Ministry for Foreign Affairs, 2012), but research is scarce on Nicaraguan health care professionals’ approach to health care towards sexual violence. I could find only few studies that looked into the role of the health care system – a system that most victims come in contact with.

In 2005, Rodríguez-Bolaños, Márquez-Serrano and Kageyama-Escobar conducted a quantitative study to assess the knowledge and attitudes of Nicaraguan health care professionals (including nurses and doctors) towards the identification and referral of gender-based violence victims. Another aim was to assess the levels of knowledge about the practices and procedures issued by the Health Department on the issue of domestic violence. Results showed a generally positive attitude towards treating and referring victims of gender-based violence, but barriers to providing medical care to these victims were the lack of training on the subject, fear of getting involved in legal issues and the concept that violence is a private affair and a personal issue instead of a social one (Rodríguez-Bolaños et al, 2005).

The high prevalence of sexual violence in Nicaragua and globally (WHO, 2013a), makes this public health issue an important research topic for a nursing study. Therefore, I decided to explore the role of the health care system regarding sexual violence through qualitative interviews with health care professionals. I was curious to discover and explore patterns with the aim of understanding individuals’ experiences as well as their interpretations of these. This makes a qualitative method suitable (Polit & Beck, 2012).

BACKGROUND

**Sexual violence**

The definitions of sexual violence and what it consists of vary. Often the concept of sexual violence is used interchangeably with gendered or gender-based violence (violence with a gender and power aspect), usually referring to men’s violence against women and including psychological, physical and sexual violence (European Institute for Gender Equality, 2013).
In this study, I will use the definition of sexual violence presented by the WHO in their World report (2002) on violence and health:

"/.../ any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances /.../ against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work” (WHO, 2002, p. 149).

This definition of sexual violence includes rape, unwanted sexual advances or sexual harassment (including demanding sex in return for favours), sexual abuse of children, denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases (STD) and forced prostitution and trafficking of people for the purpose of sexual exploitation. The WHO report also states that the above used term coercion can be of various forms such as physical force, psychological intimidation, blackmail and other threats (WHO, 2002).

Violence against women is widespread globally (Watts & Zimmerman, 2002). One out of three women is subjected to physical or sexual violence by a partner, or sexual violence by a non-partner (WHO, 2013a). This highly contributes to women’s ill-health and according to WHO, this demands a public health response (WHO, 2005). Women who have been subjected to violence seek health care more than other women, also when not mentioning the violence and health care providers are often the first professionals to meet victims of intimate partner violence (IPV) (WHO, 2013a).

Sexual violence is a violation of the victim’s human rights and damaging to a person’s health (Campbell, Jones, Dienemann, Kub, Schollenberger, O’Campo, Gielen & Wynne, 2002). Sexual and reproductive health and rights (SRHR) is an umbrella term for people’s right to their own body, sexuality and reproduction, a right that is an absolute condition for health and well-being (Knöfel Magnusson, 2009). According to WHO, sexual health is a state of physical, mental, emotional and social well-being in relation to sexuality and not only the absence of dysfunction or disease. It is strongly linked to the extent to which human rights are respected, protected and fulfilled. Sexual rights are already expressed and recognised internationally in human rights documents, including the rights to social security and the highest attainable standard of health, the rights to be free from torture or cruel or degrading treatment or punishment and the right to decide the number and spacing of one’s children (WHO, 2013b).

**Gender analysis**

Being a woman or a man is a condition under constant construction, something one becomes rather than is. The concept of gender liberates the concepts of men and women from biology and can be used to describe social processes (Dahlborg-Lyckhage & Eriksson, 2010). However, gender is not to be considered a social response to a biological dichotomy and defined as the cultural roles of men and women, because cultural patterns do not simply reflect bodily differences. Gender rather regards the ways society deals with bodies and the consequences of those dealings on people’s lives, and is best understood with a focus on social relations involving a particular relationship with bodies (Connell, 2009). According to Connell (2009), gender can thus be described as “the structure of social relations that centers on the reproductive arena” (p. 11). It is crucial in the understanding of identity, social relations and culture. In practice, the dimension of gender involves individual and social
justice and even survival (Connell, 2009). Survival is at stake in the case with sexual violence, for example regarding the physical and mental health consequences of rape and abuse (WHO, 2013c).

Gender analysis is also a research tool, helpful to understand how people’s lives are defined and organised and consequently, the impact of this in different contexts (Dahlborg-Lyckhage & Eriksson, 2010). To understand health and ill health, vital for nursing research and practice, social determinants such as gender must be considered. Gender analysis examines the power relationship between women and men and its consequences in their lives, which is crucial to the understanding of sexual and reproductive health and rights including the issue of sexual violence. Gender analysis is useful to investigate how the social system, from public policies and health care to intimate relations, incorporates power inequality between women and men. Gender is a determinant of exposure to risk, access to health care, information and other resources as well as the realisation of a person’s human rights (Cottingham & Myntti, 2002).

A rights-based approach to health

Health policies, programmes and practices have an impact on human rights. Violations or lack of implementation of human rights have negative effects on physical and mental health as well as on social well-being. A rights-based approach (RBA) to development, where the concept originates from, is an approach to change the traditional paradigm of charity in development agencies and NGO’s, into a model founded on the international consensus on human rights. Suffering from poverty, hunger, discrimination and injustice is considered a violation of human rights – not a charitable cause for aid-givers. The RBA model aims to empower rights holders and strengthen the capacity of duty bearers, meaning the institutions and governments obligated to fulfill the citizens’ rights. The use of RBA gives the possibility to hold governments responsible for the fulfillment, or the failure to fulfil the human rights of their citizens (OHCHR, 2006).

According to WHO, a RBA to health means the integration of human rights principles in the design, implementation, monitoring and evaluation of health-related policies. Attention to the needs and rights of vulnerable groups, an emphasis on health systems being accessible to all and the principle of equality and freedom from discrimination, including on the basis of gender, is crucial for a rights-based approach to health (WHO, 2013c). It is the institutions of health care that must be held accountable, to prevent the responsibility being laid only upon the individual health care professional. For a true RBA to health, all policies and programmes must be consistent with human rights and there must be means to hold the state and its institutions accountable (London, 2008).

For both institutions and the individual health care professional, the transition to a RBA means moving beyond the paradigm of compassion, from a view of patients as beneficiaries to a perception of patients as rights-holders and the health care system as a duty-bearer (Yamin, 2008a). Although the RBA is now a popular and widespread paradigm also in health at least on a theoretical level, to truly implicate a human rights framework in health care research, advocacy and delivery of services has a radical potential (Yamin, 2008b). Regarding the role of the health care services and patients who are the victims of sexual violence, a RBA to health implies a focus on the duties of the health care services to respect the patients’ sexual and reproductive rights and not violate them further (WHO, 2013c). It furthermore implies that health care professionals are able to identify victims of sexual violence. This includes knowledge of the issue of sexual violence and the competence to perform a clinical
interview. An RBA to health also includes correctly referring these patients to specialist agencies when needed. Sufficient time for the encounter between patient and health care professional needs to be supplied by the health care institution and effective interventions for the patients must be available, as well as training programs for the health professionals (Yeung, Chowdhury, Malpass & Feder, 2012).

**Nicaragua**

**Political context**

Nicaragua is the largest country in Central America and has a population of six million people. It is the second poorest country in Latin America. The armed conflicts of the 20th century in Nicaragua with military dictatorships, guerrilla warfare and civil war still affect the country. Although it has been a relatively peaceful period since the start of the 1990’s, the end of war did not result in an improvement of the life conditions of the majority of the population (Utrikespolitiska Institutet [UI], 2010). The distribution of resources is uneven, although some progress has been made regarding the decrease of people living in absolute poverty and the decrease of malnourishment (Ministry for Foreign Affairs, 2010). The political party Frente Sandinista de Liberación Nacional (FSLN) won the elections for a second term in 2011 and the country’s president is Daniel Ortega. The government declares the will to improve the access to free education and health care, but although public expenses for health care have increased (for staff, medicine and infrastructure), the planning of the budget does not correspond with this statement. Health care is free since FSLN took office in 2007 but the resources given are not enough and quality cannot always be guaranteed (Ministry for Foreign Affairs, 2010).

Democracy, including civil and political rights, has been in decline during the last years. Since President Ortega took office in 2007, he has centralised the power to the government party and his own person, lashing out against oppositional media and forbidding various political parties. During the current government’s term of office it has shown authoritarian tendencies. Transparency has decreased and the borders between the government, the governing party and the presidential family have been blurred (Ministry for Foreign Affairs, 2012).

The extensive foreign aid from Venezuela is kept separate from the state budget and used without transparency (UI, 2010). Transparency Internationals’ corruption perceptions index in 2012 puts Nicaragua in place 130 of 174 countries (Transparency International, 2012). Particularly organisations working for women’s sexual and reproductive rights have been subjected to acts of reprisal. United Nations Committee Against Torture (CAT) has expressed concerns with the increase of threats and attacks against human rights’ defenders where those who work for women’s sexual and reproductive rights have been particularly exposed (CAT, 2009). Representatives for the defense of these rights and the right to medically motivated abortion have in some cases been denied access to space in media (Ministry for Foreign Affairs, 2012). Women are underrepresented politically in Nicaragua. They are also discriminated against in the labour market where there are discrepancies between women’s and men’s salaries (Ministry for Foreign Affairs, 2012).
Sexual and reproductive health and rights

Nicaragua has one of the highest rates of adolescent pregnancies in Latin America. Girls under the age of 19 stand for 27 percent of all pregnancies and girls between 10 and 14 for three percent (Ministry for Foreign Affairs, 2012). Adolescent pregnancies are more frequent among teenagers living in poverty (ECLAC & UNICEF, 2007). Adolescent pregnancies are risky pregnancies. Globally, 11 percent of births are by girls aged ten to nineteen but this age group accounts for 23 percent of the overall burden of disease due to pregnancy and childbirth. In Latin America specifically, pregnant girls under the age of 16 has a four times higher risk of dying as a result of pregnancy than pregnant women in their twenties (ibid.). Health problems such as anemia, HIV and other STD, postpartum hemorrhage and depression are also associated with adolescent pregnancy (WHO, 2013c).

Abuse and sexual violence against children are frequent in Nicaragua, particularly in the poorest regions of the country although the number of unrecorded cases is believed to be high (Amnesty International Sverige, 2011). United Nations Children’s Fund (UNICEF) has expressed concern regarding the large number of children who are subjected to violence, including sexual violence, within and outside the family. Child prostitution is an increasing problem. Trafficking, particularly with sexual purposes but also for forced labour, affects minors, especially young girls between 13 and 17 years old (Ministry for Foreign Affairs, 2012).

Since 2007 all forms of abortion are illegal, also when the mother’s life is at risk, a so called therapeutic abortion, and when the pregnancy results from rape or incest (UI, 2010). The punishment for having an abortion is four to ten years of prison. Doctors who perform abortions risk up to ten years of prison as well as the loss of their medical licences (Ministry for Foreign Affairs, 2012). Because of this, many women do not seek medical attendance during pregnancy problems which has led to an increased maternal mortality (ibid.). Together with Guatemala, Nicaragua has the highest rate of maternal and infant mortality in Central America (UI, 2010). Over ten percent of maternal mortality is estimated by women’s rights organisations to be the consequence of illegal abortions, but the number of unrecorded cases is believed to be high (Ministry for Foreign Affairs, 2012). The law has also resulted in women not receiving treatment when they do seek medical help for obstetric and gynecological troubles, non-related to abortion, because of doctors’ fear of legal reprisals. Organisations for women’s rights and human rights mean that the illegalisation of abortion is a crime against human rights and have appealed against the law (Amnesty International, 2009). UNICEF, The Committee against Torture (CAT) and The Committee on the Elimination of Discrimination against Women (CEDAW) are all UN Committees that have expressed concern over the legislation on abortion and how it affects young girls who get pregnant involuntarily (Ministry for Foreign Affairs, 2012).

Adolescents are particularly vulnerable to sexual violence and also have a high risk of becoming pregnant as a result of rape and incest (Amnesty International Sverige, 2011). In Nicaragua, the perpetrator of sexual violence is often a close relative to the child or adolescent, such as a father, brother or uncle (López Vigil, 2000). The new legislation on abortion is especially severe for adolescent girls as their pregnancies tend to be more dangerous than adult women’s pregnancies (WHO, 2013d). The earlier acceptance of the so called therapeutic abortion was a way of fulfilling adolescent girls’ rights and defending their health that is now lost to them (Amnesty International Sverige, 2011).
International research also shows a strong correlation between adolescent pregnancy and sexual violence (Silverman, Raj, Mucci & Hathaway, 2001; Saewyc, Magee & Pettingell, 2004; Baumgartner, Waszak Geary, Tucker and Wedderburn, 2009). According to The United Nation’s People’s Fund (UNFPA), in some Latin American and Caribbean countries between 15 and 40 percent of young women were coerced into their first sexual intercourse, thus both being subjected to sexual violence and not having the possibility of protection against disease and unwanted pregnancy (UNFPA, 2012). A report from Ipas Centroamérica and other NGO’s to the Inter-American Commission of Human Rights in 2011, expressed concerns that none of Nicaragua’s institutions responsible for attending to victims of sexual violence, kept a register or published statistics on the number of girls, adolescents and women who became pregnant after rape (Movimiento autónomo de mujeres, 2011).

The concept of machismo or “machoism” (often translated into (“[male] chauvinism”) may, though the use and usefulness of the term is sometimes disputed, need to be introduced in this study. It can be regarded as a belief in the supremacy of men over women and is a term sometimes used by Latin American feminists and scholars to describe the patriarchal structure of gendered relations in Latin America (Connell, 2005). Blandón and Castañeda (2012) recently presented a study about the decline of respect for women’s sexual and reproductive rights that has taken place during the current government’s passing of laws, such as the criminalization of abortion, as a result of the “ unholy” alliance between the government and the church. According to Amnesty International (2012), few cases of sexual violence are prosecuted. Violence against women including domestic violence, rape and abuse is widespread. The UN committee CAT also expresses its concern with the high rates of violence against women and girls, particularly domestic and sexual violence (CAT, 2009). The Committee also expresses concern regarding the victims’ insufficient access to the justice, confirmed by a Nicaraguan study (Centen, Matamoros & Pérez Herran, 2010).

Legislation on sexual violence

The Penal Code of Nicaragua defines all criminal acts and their due punishment. The current Penal Code including Law 641 came into force in 2008. This was the first time in Nicaraguan law that crimes of sexual violence are defined in detail and given their own chapter, Chapter II (AS, 2007:641, Ch. II).

When the victim of rape is younger than 14 and the other part is an adult, whether the minor gives consent or not it is considered rape of a minor (AS, 2007:641, Ch. II, article 168). Statutory rape is when an adult without violence or intimidation has “physical access” (this in practice means penetration) to a person older than 14 and younger than 16 (AS, 2007:641, Ch. II, article 170). This crime differs from the above mentioned article 168 about rape of a minor because of the age of the victim and also renders a lower punishment.

Law 779 (AS, 2012:779), the Comprehensive Law against Violence towards Women, came into force in 2012 as a means to confront the widespread violence against women in Nicaragua. It states that the violence against women is a public health problem as well as a threat to the security of the citizens and that is the duty of the Nicaraguan state to act to protect and defend women’s human rights, as expressed in ratified international agreements. It is the state’s duty to quickly react and intervene and the victim shall not be further violated by the authorities’ intervention. The government should guarantee the resources (financial, professional, technological and scientific) to the institutions of the state (AS, 2012:779, article
The persons who in accordance with legislation have the obligation to report these crimes should report them to the National Police or to the General Attorney’s Office within 48 hours, once having learnt that a woman, child or adolescent has been the victim of violence (AS, 2012:779, article 17). The failure to do so will be punished with a fine. Nevertheless, healthcare workers may be afraid to report sexual violence crimes to the authorities due to the specific choice of words having learnt of that seem to imply a certain level of certainty. An individual thus may abstain from reporting a crime merely on suspicion, out of fear for legal reprisals because of article 102 of the Penal Code about “calumnia”, meaning slander or defamation (AS, 2007:641, article 102).

However, article 49 in the Book of Laws regarding Children and Adolescents (AS, 1998:287, article 49) stipulates that the directors and staff of both public and private health care units where minors (children and adolescents) are brought to receive medical attendance, have the obligation to report any reasonable suspicion of bad treatment or abuse of these to the General Attorney’s Office (Ministerio Público). Article 49 leaves more space for reporting on suspicion, but the word “reasonable” may still constitute a barrier and this law only regards minors. With the further requirements from Law 779 (AS, 2012:779) and the steering document “La Norma” (both presented below) on the matter, the issue of when to report or not, and to whom, may be even more complicated for the health care professionals.

The health care system’s legal responsibilities

The book of laws regarding children and adolescents in Nicaragua (AS, 1998:287, article 33) recognises the right of all children and adolescents to enjoy the highest attainable level of physical and mental health. The state is obligated to provide medical attention to children and adolescents through its public health care system and guarantee the access to health promotion, health protection and recovery of good health (AS, 1998:287, article 40).

Law 779 (AS 2012:779) declares the explicit responsibility for governmental institutions such as the Health Department (Ministerio de Salud [MINSA]), the legal institutions and the special police stations for women and children ("Comisaría de la Mujer y la Niñez"), to coordinate themselves in order to protect women afflicted by violence. This responsibility also applies to the General Attorney’s Office, the Institute of Forensic Medicine and the Family Department (AS 2012:779).

The victims of violence shall be guaranteed the necessary medical, psychological and psychiatric attention. The state is to ensure prevention and provide medical attention to the victims of violence, thus guaranteeing the women full execution of their human rights. Medical attention by specialists, legal counselling and psychological treatment free of charge shall be placed to the victims’ disposal (AS, 2012:779, article 19). Women shall receive comprehensive health service to attend to diseases originating from gendered violence. Information shall be documented and given to the competent authority regarding the physical and psychological findings of violence, in patients who turn to public health services or to legal services, meaning that health care services are obligated to investigate, document and report these findings to the police. Victims shall be referred to the required health services or legal services without delay, including referral of patients to the forensic doctor when needed (AS, 2012:779, article 20). The national forensic system shall meet the necessary standards to
make comprehensive and interdisciplinary expert statements about the people affected by gendered violence. The access to legal, medical and psychological assistance free of charge for women facing violence is to be increased (AS, 2012:779, article 21).

La Norma – the steering document for health care services regarding sexual violence

In 2009, MINSA issued a document of guidance for health care institutions and health care professionals in order to help them prevent and detect sexual violence and attend to victims of sexual and domestic violence. I will refer to it as La Norma (“The practice”) which is how the title is often shortened. It is not per se a legal document but the most important steering document for the health care services regulating their work on sexual violence. La Norma deals with both sexual and domestic violence (now increasingly replaced with the term intimate-partner violence [IPV] internationally), because of how frequently they coincide in Nicaragua.

La Norma is founded on current legislation such as the General Health Law that states that it is "the responsibility of MINSA and society together" to contribute to the systematic decrease of the impact that violence has on health (AS, 2002:423, article 28). The aim of La Norma is to establish a basic outline for all suppliers of health care services who attend to cases of domestic and sexual violence and its application is mandatory for these suppliers, according to MINSA (2009). It consists of instructions on how to deal with victims of violence in the clinical practice. It describes the situation in Nicaragua today regarding sexual and domestic violence and also introduces and defines the key concepts to understand sexual violence against women, children and adolescents, such as gender and inequality. It presents different forms of sexual violence such as sexual abuse and a model to understand violence on different levels in society. La Norma also presents some of the laws that concern and regulate health care professionals’ work regarding sexual violence in a brief and introductory way (MINSA, 2009).

The desirable character of the services provided by the health care system and the necessary resources for this are presented. The material resources include specific interview forms to identify these types of violence, kits for sampling and storing forensic evidence and educational material to be spread among the population visiting the centre. The human resources concern which knowledge and skills are needed to attend to these patients at a health care unit and what tasks are compulsory for the employees to perform (MINSA, 2009). These include the use of a particular interview form: a screening instrument on sexual and domestic violence when it is suspected. La Norma also requests the registering and following-up of these patients as well as the reporting of the cases of these types of violence to MINSA. It is compulsory to report to the competent authorities when the patient/victim is under age when legislation so requires. The health care units are obligated to establish a referral system with other units to attend to people affected by these forms of violence (MINSA, 2009).

La Norma describes the principles for working with sexual violence such as accessibility meaning that the health services should guarantee conditions that promote people’s confidence in the services. Services should focus on certain areas such as equality between sexes and on identifying factors that contribute to inequality in society and families as well as develop strategies to dismantle myths and prejudice that justify violence against women, children and adolescents. Services should also focus on identifying the most vulnerable groups in society and design interventions to meet the needs and priorities of these. It contains detailed sections on how to attend to victims of sexual violence including the diagnosis of
adults, adolescents and children. La Norma presents an appendix of copy-and-use sheets with screening instruments for the detection of sexual violence such as interview forms for inquiring about experiences of sexual violence - one for adults, one for adolescents (MINSA, 2009).

La Norma contains descriptions of physical and emotional indicators of sexual violence and abuse for adults and children/adolescents respectively. Two or more indicators is declared as enough to raise suspicion and should according to La Norma lead to the application of the specific screening instrument for sexual violence. These indicators include “adolescent and pubescent” pregnancy (meaning pregnancy in girls 19 years old or younger). They also include other physical signs for both adults and minors such as contusions on the body, sexually transmitted infections, blood stains on underwear, pain, pruritus or infection anally or vaginally, vaginal discharge, pain when urinating or repeated urinary tract infections, as well as frequent medical consulted on these symptoms. Emotional indicators presented by La Norma include anxiety, isolation and fear, aggression, depression, repeated behavioural changes, that the patient easily and continuously cries, low self-esteem, poor school results, loss of appetite, constantly running away from home or school, lack of affection, self-inflicted injuries and nightmares. A guide on how to interview a person who has been sexually abused is presented as well as a guide on how to proceed with a forensic exam and the collection of forensic samples (which by Nicaraguan law, any practicing physician with sufficient competence may perform) and a consent form for the exam (MINSA, 2009).

AIM

The aim of this study was to explore how the Nicaraguan health care system approaches the issue of health care towards victims of sexual violence.

Research questions

What are Nicaraguan health care professionals’ views and practices regarding the health care towards victims of sexual violence?

To what extent is the steering document La Norma being applied in the Nicaraguan health care system?

METHODS

Study design

To discover and explore patterns with the aim of understanding individuals’ experiences as well as their interpretations of these, I applied a qualitative method, collecting data through qualitative interviews (Polit & Beck, 2012). The idea of the qualitative interview is simple: if you want to know something of how people perceive their world and their lives, why not ask them? Kvale and Brinkmann (2009) see this method as a social production of knowledge, where knowledge is produced through the relationship between the interviewer and the respondent and therefore contextual, narrative and pragmatic, which contrasts with a positivist idea of knowledge as given facts, ready to be quantified. To analyse data, I applied a qualitative data analysis. According to Trost (2010), the qualitative method is suitable for finding and understanding patterns, which is compatible with my research aims. According to
Polit & Beck, “the purpose of qualitative data analysis is to organise, provide structure to, and elicit meaning from data” (2012, p. 556).

**Study sample**

I conducted individual interviews with six health care professionals in one department (‘departamento’, which is a Nicaraguan term for a region of the country), of Nicaragua during March and April in 2013. The respondents were chosen for their various experiences from a number of fields within the health care sector. They were included for the purpose of exploring the issue of sexual violence in Nicaragua with relation to health care, from their different points of view.

The six respondents included a nurse and a doctor at a primary health care centre and a nurse at the emergency ward in the department’s hospital, all three in the public health care services. I also interviewed the department’s government-employed forensic doctor and a doctor at a maternal house (“casa materna”) run by a women’s organisation. I also interviewed a doctor working as a representative at the office for integral attention to women, children and adolescents (AIMNA) at the local primary care division (SIL AIS) of The Health Department (MINSA).

**Description of the respondents and their contexts**

I opted not to present “personal” demographic background of my respondents, such as age, gender, years in the profession etcetera, apart from that which transpires through the interpretation of the interviews. This was because I didn’t consider the gathered data enough to draw informed conclusions on patterns, differences and likenesses based on such information. Instead I describe what I perceive as relevant to the study, contextual background such as the respondents’ workplaces and the constitution of the Nicaraguan health care system.

**The nurse and the doctor at the public health care centre**

The health care centre is one of various health care centres in the city of the department, where I conducted the interviews. A health care centre is a primary care unit, where doctors and nurses can be expected to have specific experience of primary care. The centre can refer patients to the hospital when needed. The health care centre was very busy with a vaccination programme for children when I did my interviews. The nurse found a private room for the interview. The interview with the doctor however, was conducted in a room where colleagues walked in and out and talked with each other and sometimes consulted my respondent on clinical matters. At one point, another doctor intervened and answered one of my questions when the original respondent became silent. I considered her input valuable to the study and have included it in the findings, indicating clearly when it is another doctor speaking than the respondent.

**The emergency nurse at the hospital**

The Nicaraguan department where I conducted the interviews has one referral hospital. The emergency ward is one of the hospital’s many wards, such as wards for obstetrics and gynecology, pediatrics, orthopedics etcetera. According to the nurse, all referrals to the hospitals from the rest of the department, including from the health care centres, pass through
the emergency ward. The interview with the emergency nurse was conducted at the emergency room in a private space.

The doctor at the maternal house

This respondent works at an institution that is a specific Nicaraguan phenomenon, the maternal house (“casa materna”). A maternal house in Nicaragua is similar to a hostel, located in a city where there is a hospital with a maternity ward, where pregnant women from rural areas come to stay for a few days before delivery in order to have access to a hospital when giving birth. This is quite common in Nicaragua, where the population is mostly rural with no access to hospitals and assisted birth nearby, and became common in the eighties after the Sandinista revolution, in 1979, as an initiative to improve maternal health and decrease maternal and infant mortality. At this particular house, they have a unique aim to detect women who have been subjected to sexual violence. The doctor I interviewed had started the activities aimed at detecting and preventing sexual violence against the women who come to the maternal house and is currently working as a consultant there.

Nicaragua’s maternal houses are part of something called “Plan del parto” (plan for giving birth) which is a social strategy run by MINSA but organisationally and politically rather considered social work than health care. Maternal houses are only supposed to provide housing, alimentation and health education regarding reproductive health such as risk factors during pregnancy and pregnancy health problems. The maternal houses are not considered to be within the activity of the Health Department and thus they are not included by the MINSA’s 2009 steering document on the medical attendance to sexual violence, La Norma. However, the doctor thinks that MINSA still somehow considers the maternal houses to be under their reign, but that the houses run by MINSA tend to function less well than the NGO-run ones. This doctor thinks they are dirtier, the women are mostly left alone and that there are no nurses or activities.

The forensic doctor

The forensic doctor is the only forensic in this region, also called a department (“departamento”), which is a country-division of Nicaragua. The department is presently trying to recruit a second forensic to share the workload. The doctor handles a total of about 200 cases a month and out of these, 15-20 are sexual crimes. The majority of these are sexual abuse cases. In most of these the victim is ten to 16 years old. Collaborating with the forensic doctor is also a forensic psychologist, located next door. The forensic clinic is situated in the same building as the city’s custody and courthouse. The waiting room is in the yard, facing the rest of the building including the jailed men that are being held in custody in full view but behind bars. The interview took place in private in the doctor’s office.

The doctor working at AIMNA

The Health Department (MINSA) has a regional office for primary care in the department: the SILAIS. AIMNA (the “Integral Program of Attention for Women, Children and Adolescence”) is a part of the SILAIS and is located in the same building. One of AIMNA’s tasks is to implement the laws and MINSA’s steering documents regarding the medical attendance and health care towards victims of sexual violence, such as La Norma. According to the doctor, every local SILAIS has an AIMNA office and so does every health care unit, such as the health care centres. This I had not heard anything of during my interviews at the
health care centre. The AIMNA at this SILAIS consisted of a team of young healthcare workers, including a doctor, a nurse and a psychologist. The interview took place in an open office area.

Data collection

Respondents were found in various ways and the interviews took place in various settings. At the health care centre I walked in, presented myself and my study and asked for willing respondents, a nurse and a doctor showed interest. I performed the interview with the nurse in a private room, but during the interview with the doctor there were colleagues walking in and out of the room – with one of them, another doctor, actually intervening to answer a question in the interview at one point.

The interview with the emergency nurse was achieved by obtaining approval from the director and vice-director of the hospital, who told me to go through the wards and search for respondents during their work shifts. The interview with the emergency nurse was conducted at the emergency room in a private space.

With the forensic doctor and the doctor at the maternal house I established contact through a local NGO. I interviewed the doctors at their workplaces in private rooms.

With the doctor at AIMNA I established contact by simply entering the local SILAIS office. When I walked in, presented myself and asked if someone would have the possibility to answer some questions about the implementation of La Norma, I was directed to the office of AIMNA, (the “Integral Program of Attention for Women, Children and Adolescence”) that is located in the building. The interview took place there in an open office area.

I wished to let the respondents speak freely about their experiences and used a semi-structured interview guide to make the interviews comparable and to cover all matters of importance (appendix I, the guide in Spanish and appendix II, the guide in English). These provided a list of subjects to cover while allowing the respondents to speak as freely as possible on these subjects (Polit & Beck, 2012). I wished to cover matters such as how the respondents define and identify sexual violence, their clinical experiences of encountering these patients and how they regard their responsibilities and possibilities to act, as health care professionals.

During the interviews I aspired to confirm that I had understood the respondent properly by continually summarising the participants’ responses and asking if I had understood correctly. I sought clarification of answers when needed and asked follow-up questions to encourage the respondents to develop their thoughts, as recommended by Graneheim and Lundman (2004).

A pilot interview was conducted and included in the study as it responded well to the study’s aim.

Data analysis

All interviews were audio-recorded and transcribed by myself. I read all the interview transcriptions and my notes from the interviews, looking for information relevant to the study from the respondents’ different areas of experience, knowledge and opinions, trying to keep an open mind whilst keeping the aim of my study present. When reading the interview transcriptions over and over I found recurring meaning units. A meaning unit is described as “words, sentences or paragraphs containing aspects related to each other through their content
and context”, by Graneheim and Lundman (2004, p. 106). I condensed (shortened) the meaning units into codes and compared the codes regarding similarities and differences and subsequently grouped the codes together in preliminary categories and sub-categories as described by Graneheim and Lundman (2004). In the process of interpreting data, categories were changed, sometimes put together and sometimes divided into different categories as my understanding of data expanded. Simultaneously, a theme based on the categories, the interviews as a whole and my ongoing interpretation of the implicit meanings of data, started to develop. The five categories I found are presented as separate chapters, with their respective sub-categories presented under distinct subheadings. These categories are: Definition of sexual violence and methods of identifying victims, Medical attendance and health care towards sexual violence victims, Resources, Challenges and Education and empowerment. The common theme drawn from the five categories is Views and practices that contribute to or counteract the health care towards victims of sexual violence. The theme is discussed in the Discussion chapter.

Reliability

It is under debate whether reliability or related terms such as validity or rigor, associated with the positivist paradigm, are to be used at all in qualitative research or not (Polit & Beck, 2012; Kvale & Brinkmann, 2009). A too strong emphasis on reliability can counteract creativity (Kvale & Brinkmann, 2009). However, qualitative research must seek to accomplish trustworthiness (Polit & Beck, 2012). Kvale and Brinkmann’s take on the term reliability is that it refers to the consistency and trustworthiness of the research results (2009). They define this trustworthiness of results as a craftsman skill, which can be judged by the reader by considering the focus of the study, the methods of data collection and analysis and whether the report gives a valid account for the results found (2009). In the light of this, I aimed for a detailed description of the research methods and findings to enable the reader to judge the trustworthiness of the study. I also included only respondents who would suit the aim of the study and used the same interview guide for all interviews, as well as audio-recorded them.

Ethical considerations

All respondents were asked if they preferred confidentiality. As some respondents wanted this, all respondents are presented confidentially and so is the department where the study was conducted, as respondents could easier be identified by the use of its name. This confidentiality also has the unfortunate effect of not allowing the respondents who did not wish for anonymity, to be acknowledged as valuable resources of knowledge in the study (Kvale & Brinkmann, 2009). I presented myself, the focus of the study and for what purpose I would use the interviews. I then sought and obtained informed consent from all respondents individually as recommended by Henricson (2012).

In a post-colonial world I, the European researcher, travelled to a poor country in Latin America, to ask questions of my choice, interpret the answers myself and then produce knowledge that will be presented to other Europeans. Whose truth will be represented? What use will the results be of and to whom? This is highly problematical and discussed in for example feminist research theory (Naples, 2003). Aiming for objectivity is not a solution. I do not believe that objectivity should or can be achieved and that any aspiration towards a supposed objectivity would only conceal the producer of this knowledge: me, the researcher, as well as the power imbalance implied. In a positivist paradigm, the researcher tries to design the study to exclude all researcher subjectivity but as this can’t be achieved, the construction
only obscures the researcher’s role in the research instead of presenting it as a part of it (Naples, 2003). In qualitative research, this leads to a non-critical and consequently unethical research. My solution was to be as open and honest in the report as possible with being present in the study as the subject behind it, instead of aspiring to present an objective truth. This however did not solve the issue of power and representation and of the addition of yet another study to this long and problematic tradition.

FINDINGS

The findings will be presented in five chapters, corresponding with the five categories I found in my interpretation of data. These chapters are: Definition of sexual violence and methods of identifying victims, Medical attendance and health care towards sexual violence victims, Resources, Challenges and Education and empowerment. The subheadings in each chapter represent that category’s sub-categories. The theme that I interpreted as encompassing all five categories is Views and practices that contribute to or counteract the health care towards victims of sexual violence.

Definition of sexual violence and methods of identifying victims

The definition of sexual violence

The emergency nurse and the primary care nurse define sexual violence and give examples in accordance with national legislation such as sexual abuse and sexual harassment, without naming the offences and referring to it all as sexual abuse. The doctor mentions rape against children and adolescents. The emergency nurse is the only respondent to mention the subject of and explain statutory rape or rape of a minor.

Identification, indicators and risk factors

The two nurses mention that a child’s behaviour and way of speaking not adequate for its age may indicate that the child is a victim of sexual violence. The primary care nurse also mentions a child being depressive and crying easily, for example when the nurse mentions a family member who is the abuser. Other indicators are that the child does not want to be examined physically, is depressive, inhibited and reserved, or simply displays a changed behaviour. She also mentions vaginal discharge as a physical sign. The doctor at the health care centre remarks:

*There can be marks on the body of course, but sometimes there are only psychological marks such as aggression or trauma.*

Both nurses say it is very different to identify sexual violence in children from identification of adult victims. Many of the mentioned signs and indicators are in accordance with La Norma. However, in contrast to La Norma, the emergency nurse believes that as opposed to children, adults generally speak up about being the victims of abuse.

Both nurses say that the sexual abuser is most often a family member or someone close to the family such as a neighbour and both of them think that an abused child may seek medical attention for other reasons and then needs to be investigated further. The primary care nurse explains:
If a child is brought in for an aching stomach, after over 20 years working in health care I recognise the signs of sexual violence!

Some indicators that are not stated in La Norma are brought up by respondents, such as lack of affection in the mother’s attitude towards her child, according to the doctor at the health care centre.

**The use of screening instruments**

Regarding the screening instrument that La Norma requires health care staff to use when sexual violence is suspected, only the primary care doctor says there is one. She says it not there to show me however, but in another room. However, the nurse at the same centre says that there is only one sheet to fill in when seeing a patient, which is the medical record, the standard form of medical journal which is used for documentation of the patient’s health. This is a big sheet with a line for every patient that is filled out at every consultation during the day. The sheet has boxes to check for every line and patient and instead of moving on to a screening instrument, there is one box to fill in about violence, with an F for domestic violence - F for “familiar” (= family violence = domestic violence). According to the nurse, all patients who visit are being “reviewed” regarding subjection to violence and every member of staff knows how to fill in the box. She says:

*This doesn’t mean I always ask the patient – I am confident that I can spot a victim of abuse.*

At the emergency unit they also have a standard form to fill in for every patient and no screening instrument to follow if they see indicators of sexual violence. According to the emergency nurse, the nurses there have routines of how to proceed with patients with various ailments such as high blood pressure, but no procedure to follow for patients who show signs of having been sexually abused.

When the doctor at the maternal house started her work, the AMNLAE (a Nicaraguan Women’s organisation) network of maternal houses already had a certain entrance sheet in use, a form to be filled in by the staff in an interview with the pregnant girl or woman when she comes in. Here some indicators and risk factors for sexual violence are to be asked about such as the girl’s age. When applying the form the doctor often saw the need to conduct another interview with another form, the screening instrument designed to identify sexual and domestic violence in the health care system that was developed by MINSA. The doctor then introduced and started making use of this instrument (as presented by MINSA in La Norma of 2009). She says:

*All these young girls already came with one indicator according to La Norma: the adolescent pregnancy. If there is one more indicator, for example if you find a sexually transmitted infection while examining the girl, according to MINSA you should apply the screening instrument to investigate the girl for sexual violence. But in general, this isn’t being done in the health care system.*

A lot of the adolescent girls are referred to a maternal house because of a risky pregnancy. Adolescent pregnancies are risk pregnancies as the adolescent body is not ready for pregnancy and delivery and this is often how the adolescent pregnancies come to medical attention. According to the doctor at the maternal house, nowhere in the health care system on the girls’ way to the maternal house, are they examined for sexual violence, even though MINSA states
in its steering document La Norma, that adolescent pregnancy is to be regarded as an indicator for sexual violence (MINSA, 2009). The doctor has only seen two cases in four years where the referral from the health care system has mentioned violence, in all of the cases where she has detected it at the maternal house.

At the maternal house, two indicators or more of sexual violence in the entrance form leads to the use of the screening instrument as a part of the project the doctor launched for sexual and reproductive rights. This maternal house is the only one of all maternal houses in Nicaragua to work with this issue. The doctor says:

Before, they did work with violence here but in a very general matter, like ‘let’s prevent violence, let’s have a chat about it’, but not specific enough, attending to the problem we have here.

This maternal house actually collaborates with MINSA that occupies a part of the building and attends to the pregnant women’s medical needs. The staff at the maternal house fills in the entrance sheet with the pregnant girl or woman, and if there are two or more indicators of sexual violence she visits the MINSA doctor for an interview using the screening instrument for sexual violence.

Statutory rape and adolescent pregnancy

The forensic doctor reports seeing a lot of statutory rape, that is, a lot of young girls in sexual relationships with adult men:

She talks about her “hombrecito” ("little man", boyfriend) as the girl says, but really she is underage and does not have the legal capacity to consent according to Nicaraguan law.

The doctor at the maternal house came to this institution in 2008, four years ago. Since then she has kept statistics, and it caught her attention that every year, between 32 and 42 percent of the pregnant women were actually girls, between 12 and 19 years old, with the numbers rather increasing than decreasing during the four years she has been here. These young girls, at the age of 14 talked about their partner, who could be a man over 30 years old (21 is when a man is legally an adult in Nicaragua). The doctor says:

So I started to see the difference between the age of the young pregnant girl and her partner and with new eyes and new glasses I came to think that ‘whoa, there’s something going on here’. So when I saw these dynamics, this situation at the maternal house, I started to examine it a bit further.

Inside the public health care system, the important indicator of adolescent pregnancy was brought up only by the emergency nurse, mentioning statutory rape.

The doctor at the health care centre says that in this department is where adolescent pregnancy is the most common in the whole country and that teenage pregnancies, from the age of 13, constitute the majority of pregnancies there. According to the doctor, whether an adolescent pregnancy is an indicator of sexual violence or not depends. She does not investigate adolescent pregnancy further because:
Sometimes the girls get pregnant because they want to, or because they just don’t take care of themselves!

The doctor clarifies that by “taking care of themselves” she means contraceptives. The primary nurse expresses the same opinion and develops it like this:

Teenage girls get pregnant because they don’t protect themselves when they have sex as they, in the moment of emotion so to speak, they don’t think of pregnancy as a consequence of sex.

The doctor only asks if the pregnancy was planned or not. However, the nurse says that when documenting the medical history of a pregnant patient, a procedure is followed where the patient is asked also if the pregnancy is the product of rape, if she answers that it was not planned.

At the health care centre, they look into the pregnant patient’s age as it is required for the medical record, but they do not ask about the partner’s age. The primary care nurse says that almost always the girls have become pregnant by another adolescent and not an adult (although she does not inquire about the partner’s age). When asked if she sees adolescent pregnancy as a reason to investigate further whether the girl has been subjected to sexual violence, the nurse answers that she does not think that this is all that should be investigated when an adolescent becomes pregnant. She says that adolescent pregnancy is considered a problem in Nicaragua, and speaks of a strategy called “Cero Veinte” (Zero Twenty) to encourage youths to have “zero pregnancies before the age of twenty”. The nurse advocates abstinence from sex for youths under twenty, she says and adds:

Personally, I congratulate my daughter, who is eighteen now, of having preserved herself so far! But still, it’s my duty as a nurse to help girls who come to see me and wish to plan ahead.

Medical attendance and health care towards sexual violence victims

Referral to another health care level

The doctor at the health care centre says that when sexual violence is suspected at the centre, they call a psychologist to make an appointment for the patient at the hospital. The nurse at the centre says that a psychologist comes by the centre every day, but confirms that if she suspects sexual abuse, she contacts one of the two psychologists the municipality has. If the psychologist is not available they have the resident pediatrician with whom to form a team when needed. The nurse sometimes brings a patient to the doctor and they examine the patient together but she wouldn’t call it “referral” as it makes it seem as a more formal process than it is. The nurse explains that the technique of drawing a possibly abused child’s family together with the child to find out who might be the abuser is a strategy used by all staff but especially carried out by those who feel connected to the issue of sexual violence victims.

The nurse at the emergency ward says that the health care centres refer patients to the hospital when they need to be hospitalised to be examined for sexual abuse, which the centres do not have the capacity to do. This hospital is the referral hospital in the department for all of the municipalities and their cases of sexual abuse and all referred patients pass through the emergency unit first. He says that both a psychologist and a forensic doctor come to examine the patient at the hospital as well as the police, but not all at the same time. They have a psychologist at the hospital whom is called for when sexual abuse is suspected. In contrast,
the forensic doctor says that the patients that need a forensic examination always come to the forensic clinic, after coordination between MINSA and the police.

The emergency nurse states that the patient will not be admitted from the hospital until the case has been solved:

*If abuse is suspected, you can’t send the patient home knowing they might then continue to be abused. You have to protect them!*

**Reporting to the authorities**

When there is a suspicion of sexual violence they call the municipal psychologist to make an appointment for the patient at the hospital, the doctor at the health care centre says, and upon confirmation they call the police. The one to confirm is both the psychologist and clinically, the forensic doctor. When asked how they confirm it given that the psychologist does not come to the health care centre, the doctor now says that the psychologist does come right away to talk to the patient. It is then the psychologist who decides whether they should call the police or not. The doctor now says that they call the police also on suspicion of a crime and not only on confirmation. The answer from the nurse at the centre differs. The nurse says they do not call the police at all but call the Family Department instead when they have a problem. When specifically asked again if they do not call the police and the nurse says:

*We call the Family Department to let them know what is happening to the child and then they takes charge of what is to be done, legally and otherwise, in a comprehensive manner.*

The nurse at the emergency ward says that whenever they suspect an abuse case at the hospital, they call the special police for women and children (“Comisaría de la Mujer y la Niñez”). The nurse says:

*Even if the patient does not want to report it to the police, it is my obligation as a professional to report it. Not reporting this type of crime makes me an accomplice according to the law.*

The staff at the emergency ward does identify sexual violence according to the emergency nurse, but it is the psychologist and the forensic doctor who really does the interview with the patient and then the gynecologist report confirms or not. The forensic doctor has to regard both the psychological evaluation and the gynecologist’s clinical evaluation. If the psychologist and the doctor determine that there has been rape or abuse it is they who call the police.

The forensic doctor says that health care professionals are obliged by law to report these crimes to the police and then, according to protocol, the forensic doctor is requested by the police and not by the health care professionals with whom she does not have any direct contact.

The forensic doctor explains that in cases of sexual and domestic violence, this is handled by the special police for women and children. The doctor at the maternal house talks about these specialised police stations that have been set up in Nicaragua, the “Comisaria de la Mujer y la Niñez”, created to make it easier for women and children to report crimes that they are especially vulnerable to in Nicaraguan society. Her experiences of these are generally not positive. She says that the police at these stations have the information but lack the skills and
do not have the competence and experience to conduct interviews well. They inefficiently ask
the same questions over and over she says, thus hurting the woman who is reporting the crime
and further violating her. The doctor says:

*They do it mechanically. They say one thing, but their gestures and expressions give another
impression.*

The maternal house doctor furthermore observes:

*When the girls are accompanied by someone of us from the maternal house to health care
institutions and the police, they receive a more respectful treatment from the employees there.*

**Keeping register of sexual violence for public health statistics**

To keep register of sexual violence cases is required by La Norma. According to the doctor at
AIMNA, the follow up and supervision of the implementation of La Norma is being done by
analysing the statistics reports sent in to MINSA. According to the doctor, every smaller
health care station is connected to a bigger health care centre. Every health care station is to
send the report in every month to their bigger health care unit, whose AIMNA representative
sends it in to the SILAIS. These statistics should show the registered cases of sexual violence
and the registered cases of adolescents treated at the station. However, the forensic doctor
says:

*But in the municipalities, in the rural areas, where there are lots of these cases, many are not
reported so the statistics is actually lost.*

The forensic doctor’s report in each case is sent to the police and to the prosecutor who will
try the case in court. She does monthly statistics and sends them to the Institute of Forensic
Medicine in Managua. The forensic doctor says:

*Previously, there was no special box to tick for domestic violence in the statistics form but
now there is.*

The emergency nurse says that statistics are kept at the hospital in an epidemiology register in
which sexual abuse is documented by the doctors. The doctor at the health care centre says
that the number of cases every month and what happened are being registered at the centre
and that this information is sent to MINSA. In contrast, the nurse at the centre says that they
do not keep register at the centre and have no statistics on how many cases of sexual violence
they have. It may be so that the registering is being done by doctors only and therefore the
primary care nurse is unaware of the process. However, the nurse at the centre seems very
independent in her work with patients and has many more years of experience than the doctor.
Therefore, another possibility is that registers actually are not being kept at the health care
centre.

**Resources**

**Official local network**

According to the doctor at the maternal house, there is an official local network in the
department working together on the issue of sexual violence. The network works against
myths and stereotypes about sexual violence and to educate and empower people in society regarding sexual violence. They meet monthly and work with joint strategies and plans. The network includes the maternal house, the Attorney General’s Office, the Family Department, Ipas Central America (an NGO that works to make safe and effective sexual and reproductive health care available) and Intervida (a Spanish human development NGO) as well as a local NGO that works to promote the rights of children and adolescents. However, the doctor at the maternal house says:

*The NGO’s are a great resource but the government’s own departments tend not to show up at the meetings.*

The forensics doctor’s work and methods

According to the forensic doctor, the police and MINSA coordinate so that the patients that need her expertise come to the forensic clinic. The ideal is for the patient to be accompanied by someone from the police, but that is not always possible due to staff shortage. At the time of the interview, only one of the patients waiting seemed to be accompanied, actually by someone I recognised from the maternal house.

The majority of the victims of sexual violence that the forensic doctor examines do not display any physical injuries. It is more difficult to detect and prove sexual violence when a long time has passed, the forensic says, but there are efficient methods of interviewing children under the age of 12 about sexual violence. These interviews take a lot of time to perform but are the most efficient according to my respondent. She tries to coordinate so that the patient sees the forensic psychologist first, than the doctor reads the psychologist’s interview and if there is any information lacking that she needs, she asks the patient for only that information when they meet:

*It’s a strategy we have. We try not to violate the victims further by repeating the same questions over and over.*

The work to prevent and detect sexual violence at the maternal house

The doctor at the maternal house explains the history and current situation of the maternal house, which is run by and was started by AMNLAE (“Asociación de Mujeres Nicaragüenses Luisa Amanda Espinoza”), a Nicaraguan women’s organisation. Today, there are also maternal houses run by MINSA and religious movements. This maternal house is not financed by the government. Instead women and their families are asked to give what symbolic contributions they can and the rest is financed via AMNLAE by international NGO’s. The doctor explains that a possible way for a pregnant girl or woman in the department to arrive at the maternal house is by going to the small health care station (“puesto de salud”, the smallest, most basic primary care health centre in Nicaragua’s health care system) in the nearest village. If at the station they see a health risk, they refer her to a health care centre (“centro de salud”) or directly to the hospital. The hospital, if judging it necessary for her safety, sends her to a maternal house.

The doctor at this maternal house initiated her work with a study based on a “satisfaction questionnaire” that she had developed to evaluate how satisfied the pregnant women were with the service at the house. From this study she could see that the young girls, the children and adolescents, had other needs during their stay than the adult women.
The doctor explains that she has now been working with a Spanish NGO on a guide that has taken two years to develop and is to be presented in 2013, for other maternal houses on how to work with this issue. The guide aims to sensitisre the employees at maternal houses to the issue and empower them to work with it. The education that is given to the pregnant women in maternal houses, about infant care for instance, needs to be different for children and adolescent girls. It needs more focus on sexual and reproductive rights:

*Their education needs to focus on gender and sexuality and about seeing oneself as a person, a person with rights.*

In the activities for the pregnant adolescents, education and dialogue is primary. It is about strengthening the girls and their self-esteem, relaxation and opening up to see things differently. This is the first attention to the subject the girls who have been sexually abused have ever had, the doctor says, and is therefore much about putting words on experiences. It takes a lot of empathy to gain these girls’ confidence. She thinks they are often quite passive in their ways and that it is not easy to work with the issue. Once a week a psychologist from a health care centre comes to the house but the doctor thinks she is not sensitised to the matter of sexual violence. Another vital part of the activities at the maternal house is to promote the reporting of sexual violence to the police. The doctor explains that the task of the maternal house is to protect, inform and refer these women and girls to the right instance.

*Nursing as a resource for the health care towards victims of sexual violence*

The primary care nurse says the infrastructure of the centre has its limits when talking to a victim of sexual violence, trying not to be disturbed, but she says it is possible and adds:

*Sometimes infrastructure means nothing. You can stand beneath a mango tree or in the street, wherever, but if you know how to ask you will find your answer. But if you do not know how to ask you will not find it here either…*

At the health care centre they have a standard for how many patients they need to attend to: at least 16 patients in the morning and ten in the evening, for every nurse or doctor. But the nurse assures that colleagues will understand, also for cases of sexual violence if more time is needed for one patient.

*Even if you do not have time you have to make time; if you have a love for your profession. For example: if I’m going to heal your wound, I’m not going to heal it poorly because I just have a little amount of time. I either heal you well, or I do not heal you.*

The nurse in the emergency ward expresses a more troubled view:

*We are the ones close to the patient, continuously. We know the patient’s needs, they tell us. However, here at the emergency it’s too busy, we really do not have time to give every patient even ten minutes, and instead it’s all mechanical.*

He expresses that he suffers from this and thinks it is necessary to give the patients more time. According to the hospital’s service level agreement, he should attend to six to ten patients in his eight hour shift but sometimes has 25 to 30 patients. He thinks the desired standard of nursing, described in a protocol regarding quality attention to the patient, is not reached. Some
patients come to the emergency when it is a really busy ward, with 30 patients and one nurse and then the human contact is very difficult to establish. The nurse says that this is not the fault of the institution, but because of the very limited resources and that the resources for nursing are very, very small. The emergency nurse thinks the knowledge about sexual violence is good enough, but that time is lacking.

*We would like to talk to the patient, which would help them in recovering a better health, but we barely can... Sometimes, I walk up to the poor guy, give him a pill, fill in the form and bam! they give me another patient and I just leave the first one. We have to do it like that here but it makes us feel... Sometimes we talk to the patients like ‘what’s your name, what’s happened to you, how do you feel’... But very little.*

Regarding whether he has any strategies for his nursing in these circumstances, to give what he wants to give with such little time, the nurse says:

*Well, it’s always about showing these patients respect. It’s all really tragic and when a patient comes in it makes me feel so sad for them, so sad. So much that I do not even want to ask because I know the person’s pain is too big. And it hurts, or when someone dies, it hurts. And sometimes we do not find the words of comfort or the right words to give some satisfaction to the patient. Instead, we do the medically possible.*

The emergency nurse still thinks that the people who suffer from sexual abuse who visit the emergency ward almost always get satisfactory care as they get to stay until the police comes and take charge, so that the patients are protected against further abuse. They have protocols on how to receive the patient to try to satisfy the patients’ needs within the hospital. The nurses’ reception protocols are about making the patient feel comfortable and about filling in the forms and to do everything medically possible for the patient. He concludes that he believes that they do all they possibly can for all patients, victims of sexual violence or not, in the emergency ward.

**Challenges**

**Frustration with MINSA’s lack of work towards tackling sexual violence**

The doctor at the maternal house asks why, with so many laws, forensic doctors etcetera, are not all of these good things being implemented? There are financial resources she claims, coming from the World Bank etcetera. For example, Luxemburg has shown an interest in working with the concept of gender together with the SILAIS. She also believes that there are resources to work with this, but that other health issues are given priority by the authorities instead.

*The question to be asked is: how do they use the money? Are matters being worked properly? You need to look at the whole process, not only at the individual actions taken.*

She adds that maternal mortality is seen and worked with as an issue by MINSA, but not sexual violence although the problems coincide in an apparent way:

*To start talking about power in this chauvinist [“machista”] country is not one single step to take! They speak of maternal mortality but not of its cause when the cause is gender-related violence. There is a need to work with masculinity too.*
In fact, she sees MINSA itself as the biggest obstacle to a health care that reacts to and acts against the widespread sexual violence in Nicaragua, because of its lack of knowledge of and commitment to the matter. She believes that a lot of doctors do not think of violence as a question of health and stresses that sexual violence is a public health problem. She means that the patients and victims of sexual violence are being disrespected by the health care system and that health care workers claim not to have the time to work with it.

The doctor still thinks that MINSA has advanced lately, as there are now forensic doctors trained to examine victims of sexual violence. Still, she thinks that the new Law 779, against violence towards women, is mere political propaganda, passed by the National Assembly to make the country look good but with little actual effect on the matter of sexual violence.

Contrastingly positive views from within the public health care system

The emergency nurse reports seeing four to five cases of sexual violence a month, including referrals from the health care centres, but he thinks it is much more common in rural areas. He says that these signs and indicators are more likely to be identified at health care centres and at school than in the emergency unit, where patients come with more obvious physical injuries. The primary care nurse reports that she does not see much abuse at the health care centre either. In her opinion, this is because people already know where to go, to the Family Department or the police stations for children and adolescents. She explains this:

_The reason is that now with the new government, Nicaragua is becoming more aware and that these problems are decreasing compared to earlier years._

The forensic doctor is generally positive about the development in society and the current situation. She thinks that the legal system and court representatives are getting more and more sensitised on the matter of sexual violence and thinks the situation in the country regarding sexual violence is improving. She says that with the judges, there is no longer a problem. Her opinion is that the increased number of police reports on sexual violence is not a sign of increased violence but rather an indication of victims now daring to report these crimes. She says that this is because they see that more of these crimes are now being solved – since the new Law 779 came into force.

The doctor at AIMNA also reports seeing an improvement:

_We’re going in the right direction. That there are more reports to the police being made is a good sign of increasing awareness._

The nurse at the health care centre repeatedly refers to the government’s work for social improvement and how things are getting better since “the new government” took office. She refers to and presents to me a brochure on the government’s work on social issues in the community – with the picture of the president Ortega and his wife on it. The doctor at the expresses frustration when she explains:

_Yes, there is a lot of sexual violence in Nicaragua! But when the patients do not send out signals about being abused, you can’t verify it and the patient says no to being examined – what can you do as a physician?_
The doctor thinks that the problems with sexual and domestic violence are decreasing in Nicaragua and also explicitly attributes this to the FSLN government:

*Since the new government came to power in 2006, they work with it quite a lot compared to before. And the super important role of the nurses is also taken more into account these days.*

The emergency nurse at the hospital repeatedly presents his health care unit as well-functioning when it comes to dealing with patients who are the victims of sexual violence. Recurrently, when he mentions something that could be perceived as negative, he immediately emphasises that he thinks patients still get the best care possible.

**Sexual violence - a normalised phenomenon in society**

Sexual violence is so engrained in society, the doctor at the maternal house says, that doctors also tend to see it as something normal and unquestionable. The doctor at AIMNA remarks that an obstacle to successful empowerment of health care workers on the subject of sexual violence is the concept of “machismo”. To the AIMNA representative’s knowledge, they do not work with these issues at medical school. He says:

*Machismo is a problematic phenomenon all across Latin America. As health care workers are a part of this culture, the awareness of machismo, as both a part of themselves and an ideological problem that becomes a health problem, is not achieved in an instant.*

The doctor at the maternal house expresses a similar view:

*Professionals with public and legal duties to perform, such as nurses, doctors and police, are just as likely victims and abusers of sexual violence as the rest of society. And even when they’re not, they still have the same experiences and values as everyone else in this society, where sexual violence is so common.*

**Fear of reprisal**

According to the doctor and representative at AIMNA, the process of education and empowerment has not always been as successful as they wish. One reason for this is the fear of reprisal, expressed by some health care workers in the small health care stations in the municipalities, when registering these cases. There have actually been acts of reprisal, enough to create fear, says the interviewed doctor.

The doctor at the maternal house also thinks one reason as to why so few doctors at the municipal level diagnose sexual violence is because the doctors at these small rural health care stations fear reprisal. She explains that some rural victims of abuse are accompanied to the city to report abuse to the police by a member of a “defense network” of “parteras” (midwives with more or less formal training). Some of these accompanying midwives have received death threats.

Neither the two nurses nor the doctor at the health care centre bring up fear of reprisal as a barrier against attending to victims of sexual violence or reporting to the police.
Lack of continuity

The doctor at AIMNA explains that the fact that many of the doctors at the small health care stations are doing their social service, a two year period of medical duty after graduating, means that there is a lack of continuity in the health care service in the rural areas with a large staff turnover. After finishing their university studies, doctors have two years of “social service” ahead of them and nurses have one. This often means placement in one of the small health care stations in the rural municipalities. After a year or two, the health care staff in charge of the station who may have received education leave and new staff arrive, thus not allowing continuity in the work with sexual violence. During his social service, this doctor received a course on the matter by an NGO that now does not exist anymore.

The forensic doctor has participated in educating doctors in these municipalities on how to do forensic exams on victims of sexual violence and she has experienced this lack of continuity:

*It worked well for a while but often the person in charge is doing his or her social service as a doctor for a year or two, so he or she is only there temporarily.*

There has not been the coordination to ensure that the person who is going to stay there is the one to be educated, the forensic doctor says. Often, these doctors have been educated at her forensic clinic or with an NGO in the municipalities, but the issue of quick staff rotation is always the problem. This leads to that many of the victims of sexual violence who come to her clinic are patients from these municipalities as they do not have a doctor there who knows how to perform the forensic exam. These places are far off in the countryside, which makes it very difficult for the victim to come all the way to the city for a forensic exam.

The pregnant women and girls have an average stay of eight days at the maternal house. The doctor says that not as much as she would wish can be achieved during this time, but that it is a start. When the girls and women return home with their babies, there is not much follow-up that can be done by the maternal house. However, there is a “brigade” or network of protection consisting of health workers and “parteras” (midwives with more or less formal education) out in the municipalities. They are working to detect sexual violence and monitor the subjected girls and women, which is part of a partnership between the maternal house and Ipas. This means that some victims of abuse are accompanied to the city by a member of this defense network to report abuse to the police. The doctor at the casa maternal regrets that there is no shelter for abused women in the department.

Perceptions of responsibility in primary care

The doctor at the health care centre thinks sexual violence is a health issue rather than a social one. In her opinion, her task is to intervene psychologically where there is sexual or domestic violence in order to help the patient. Regarding whether the primary care nurse thinks it is her task and responsibility as a nurse to deal with sexual violence or not, she says that as a nurse at the health care centre she has a huge responsibility and that all medical staff is under the obligation to investigate if children are being sexually abused. She adds:

*But all health problems are social responsibilities and MINSA is actually very small for the size of the population.*
She sees sexual violence as a social problem and thinks it is a task for the families and the organisations of the community to educate their sons and daughters about values:

*It’s like... Like diarrhea! Diarrhea is not a problem for the Health Department! It’s a pathology that we at the Health Department have to attend to. But those who should prevent diarrhea are the people of a population, and this goes for domestic violence as well.*

Regarding whether the health care services can prevent sexual violence, the primary care nurse believes that they definitely can, but that it is in the home and in primary school that the prevention should be done.

*Your first health care centre is your house. If you breastfeed your child, you’re avoiding loads of diseases. If you talk to your child about violence, you can avoid violence. I think sexual violence starts at home and has its roots there.*

Simultaneously, the nurse at the health care centre links her nursing duties to her revolutionary duties:

*But as nurses, I believe that we have the obligation to investigate all children we see and work for them. Because they are not the future of this revolution, they are the present. We live in the present and we have to take care of the present; these children. As a revolutionary and a nurse I think I am obliged to give these children all attention possible and help their parents, guide them, reflecting with them, about how we can prevent sexual violence.*

**Education and empowerment**

**AIMNA and its structural work**

In the process of empowering health care workers, AIMNA prefers to come out to the health care units to make it possible for the staff at the small health care stations to participate. They find a place for 20 to 25 nurses and doctors at every occasion. This has been done annually for the last three years, the doctor explains.

The doctor at AIMNA thinks the issue of sexual violence needs intersectoral collaboration and says that they are working more and more in this way, together with for example the Education Department. Other partners for AIMNA have been UNFPA, WHO and Save the Children when working specifically with adolescents. They are also involved in local strategic projects with various partners such as civil society organisations. With reference to whether the collaboration ever includes health professionals talking about sexual violence in schools, the doctor at AIMNA says that this may happen, but the issue is so delicate that one has to tread lightly as there is a major resistance in the schools towards working with these issues. The AIMNA representative thinks that the faculties of medicine and nursing ought to teach about sexual violence in society and the health care workers’ role in it, but adds that it should be a part of every university education and that this is an issue for the National Council of Universities and not really up to MINSA.

**Knowledge of the document La Norma**

Regarding La Norma, the guiding document for health care workers on attending to victims of sexual violence that is described above in the background, views and practices among
respondents differ. The emergency nurse answers that he has never heard of La Norma. When asked about La Norma, the primary care nurse asks if I mean the protocol for domestic violence. She says she does not know it in detail but more or less what it is about, because when new practices are to be implemented, the staff is informed about them at the health care centre. The doctor at the centre says that she does not know any of the laws regulating how medical professionals are to attend to victims of sexual violence. When La Norma is further described to the doctor and to the question if she knows it, she does not answer. Another doctor, who is present in the room, takes over and says that the protocol was introduced and implemented at this and all other health care centres. This doctor explains that when new procedures or practices are to be implemented, the central MINSA in Managua has a reunion with all the SILAIS in Nicaragua. Then the local SILAIS comes to the health care centres and hospitals to inform about the new procedure. It is up to the institution itself to inform all doctors and nurses about the new procedure and how to implement it.

Learning more about sexual violence as a health care professional

The primary care nurse says that health care workers learn about issues relevant to their work, such as sexual violence and relevant legislation, through their own desire to learn. Desire is important because they have to be autodidacts:

*Employees shouldn’t consider it the institution’s obligation to empower [=capacitar] them! Everyone should empower themselves.*

She adds that when a new procedure is due to be implemented, the institution nonetheless makes it known to the employees.

The emergency nurse explains that at the moment they have about 14 members of the hospital staff taking a course about violence and gender. However, he considers 14 to be very few people. These courses last for long periods and it can take about five years to get a degree, as the employee continues to work whilst taking classes. The direction of the hospital decides who go to the courses, normally to a course fitting their professional profile such as gynecologists being sent to courses in gynecology and obstetrics. The nurse does not know how that process works regarding this particular course. At university, when he was a student in the nursing programme, the emergency nurse perceived that these topics were emphasised a lot. He adds:

*The issue of sexual violence is much emphasised in Nicaragua. But still, the nursing education is really more about counselling than about identifying... We learn more about respect for people’s rights.*

As a nursing student, he took a non-compulsory internet course at his university about violence, gender and sexuality, receiving a “small diploma” that he believes to have helped him somewhat in identifying people who have been subjected to sexual violence. He took the course out of interest and thinking it was good to know a bit about everything and that the obligation of a health care professional is to identify these things. He says that both by law and as a human being, he has to help these people.

In the empowerment process of the health care centres the doctor at the maternal house thinks it is actually best to start from the top, with the directors, and let them work their way down through the system when trying to accomplish this change, from the director to the sub-
director to the head of nursing etcetera. The goal must be to put La Norma and other steering documents to practice. There are two parts of the process she thinks: on one hand to sensitize, meaning giving information and knowledge as people need to know to be able to act, and on the other hand empowerment ("capacitación" is her Spanish word of choice), which is less about information and more about practice she says.

The need for research

The doctor at the maternal house says that a good start would be to make a comprehensive study to thoroughly map out the situation in the health care system, also in the municipalities and in the SILAIS (the local representation of MINSA). In her opinion it is necessary to “diagnose” before you initiate a process:

One needs to take a photo not only from above, but from underneath, to see the whole picture and what is actually being done.

The doctor at AIMNA comments that a study to map out the exact reasons for the lack of success of the implementation in the health care sector would be a good basis of information. He says that an investigation of the medical reports out in the rural areas, at the health stations, where general practitioners do the forensic work and learning about the difficulties they experience, would give a better understanding of the issue.

DISCUSSION

Discussion of research methods

The choice of methods was the qualitative interview study and the qualitative content analysis to interpret data. According to Kvale and Brinkmann, interviewing and the analysis of interviews are craftsman skills with few standard procedures of interviewing and interpretation, where the sensibility of the interviewer to the respondents, the dialogue and the data is what most constitutes reliability (2009). Hopefully, my interview and analysis skills have been satisfactory in this context. I have aimed at providing the reader with sufficient quotes and a description of data as rich as possible, to give the reader sufficient material to make informed assumptions on the reliability of the methods used.

Of all the potential respondents I asked to participate in the study, no one declined. Respondents participated willingly and generally showed much interest in talking about the topic. As to why that is, especially regarding the public health care professionals whom I could not expect to have a particular interest of the issue of sexual violence, I can only speculate. One possibility is a sense of national pride including that of the respondents’ workplace, the health care services, when interviewed by someone from another country. Another is a keen interest in one’s profession, and a willingness to share one’s experiences with another health care professional (a nursing student, in this case). Since almost all respondents seemed to answer freely and eloquently, it is probable that the presence of an audio-recorder did not bother them and likely did not influence the findings.

My choice of respondents however, was much up to chance and contacts, since respondents were found in various ways and in various settings. Hopefully this brought richness to the material. In interviewing both nurses and doctors, from primary care, hospital care, maternal care and including forensics and a representative of the Health Department (the doctor of
AIMNA), I hope to have achieved a representative selection of respondents from various contexts of health care that will add to the reliability of my findings. Yet, regarding whether the respondents in the study are representative of health care professionals in the public health care services in Nicaragua and the findings therefore transferable to other settings is difficult to say. I have tried to provide sufficient descriptive data in order for the reader to evaluate the transferability to other contexts.

The power aspect is central in research and not something that can be ignored when interpreting data and evaluating methods. This is always the case in research, where the researcher chooses the setting and focus and produces the research product according to her or his own interpretation, but particularly in a study like this. As Nicaragua is a “donor darling” (although recently less so), by doing research here I join a post-colonial heritage and a problematic tradition (Naples, 2002). To balance power somewhat and make my study more democratic I could have asked my respondents to read through my analysis before publishing it, adding their explanations to my interpretation (as described by Kvale & Brinkmann, 2009). As it was, I was lucky even to get the interviews I did and taking up these people’s time again did not seem like an option! As my analysis does not stem from consensus with my respondents, the research objects, I have tried to be honest about this aspect and my power of interpretation as much as possible in the study.

Discussion of findings

Findings have been presented in accordance with the five categories I found in my interpretation of data. I interpreted the theme Views and practices that contribute to or counteract the health care towards victims of sexual violence as encompassing all five categories. In this chapter I discuss relevant findings in the light of my aim and research questions and connect them to the theme.

AIMNA’s method of educating and empowering professionals of the health care system regarding how to attend to victims of sexual violence is, to give courses at the health care centres. The doctor at the maternal house means that this empowerment process needs to start “at the top” of the health care system and include both knowledge and more practical empowerment. Respondents express that comprehensive studies on the current methods and systems in the health care system, are desirable to map out why implementation of La Norma has been lacking in efficiency and before starting an empowerment process. The information and regulations, and even the document itself, of the steering document La Norma do not appear to be known by all health care professionals in the study. Although a willingness to attend to the victims and the opinion that this is important and a part of their responsibility, is generally expressed, the knowledge of and the use of La Norma seems to vary between every health care professional. However, professionals who do not use the Health Department’s stipulated Norma still try to detect and attend to victims of sexual violence. This is confirmed by a Nicaraguan study from 2010, where a respondent adds that even if steering documents are good in theory, they do not work in practice due to lack of infrastructure, materials or a professional who is specialised on the matter (Centen, Matamoros & Pérez Herran, 2010). Respondents in my study express the same view. This suggests that there is a willingness among health care professionals to attend to patients who are the victims of sexual violence, also where both human and material resources are scarce.

The respondents’ definitions of sexual violence are relatively consistent with La Norma’s description of sexual violence. However, definitions, indicators and risk factors relevant in the
Nicaraguan context such as statutory rape and teenage pregnancy are barely mentioned by the professionals in the public health care system. This is likely to be a consequence of the normalisation of adolescent pregnancy in Nicaraguan society.

The screening instrument that La Norma requires health care professionals to use when sexual violence is suspected, appears not to be in use either at the emergency ward or at the health care centre, though respondents’ replies are contradictory. At the emergency ward there is no standardised system known to the nurse on how to attend to victims of sexual violence, but at the health care centre, a certain though not complete level of method of investigation appears to be in place. At the maternal house, La Norma’s screening instrument is used together with other methods such as interviews to detect sexual violence and patient education on the subject. The doctor at the maternal house criticises the health care system for not applying the screening instrument regarding the patients they refer to the maternal house.

The establishment of a referral system between different levels of health care is required by La Norma, but respondents’ descriptions of the referral system varies, also at the same health care centre. How the referral system between primary care, the emergency ward at the hospital, psychologists and the forensic doctor function appears to be unclear. There is also uncertainty regarding the reporting of suspected crimes of sexual violence to the authorities, whether to call the police or the Family Department and if the authorities are to be alerted on mere suspicion or upon confirmation of a crime. La Norma also requires the keeping of registers on cases of sexual violence from health care system. Whether these registers are kept or not is unclear to me, as the health care professionals express different practices. Since these statistics form the basis for AIMNA’s evaluation of the system, these varying practices and the subsequent uncertainty seem problematic. None of the public health care respondents report fear of reprisals as a reason for not reporting to the police, something that is mentioned in previous research (Rodríguez-Bolaños et al, 2005) and by the doctor at the maternal house and the AIMNA representative.

In a Nicaraguan study on women’s insufficient access to justice when they are the victims of violence, the police are reported to take a woman’s reporting of a crime more seriously when a person from a human rights organization is accompanying her (Centeren, Matamoros & Pérez Herran, 2010). This is in accordance with the experiences the maternal house doctor describes, from both health care and police.

The findings suggest that there is room for improvement of the implementation of legislation and steering documents regarding sexual violence in the health care services. A full implementation of knowledge and application of La Norma would contribute to a rights-based approach to health. The AIMNA representative describes the monitoring of the health care centres’ implementation of La Norma as a self-reporting system. Through the reports on how many cases are being attended to, MINSA supposedly sees how frequent the detection of sexual violence is. But as the forensic doctor says, the self-reporting at health care stations is a problem in receiving correct statistics on sexual violence as the cases are not detected and then simply under-reported. La Norma was published partly to deal with this problem. To monitor the implementation of La Norma and receive correct statistics on sexual violence, the current self-reporting system does not seem efficient. That statistics on sexual and domestic violence is not made public by those in charge of attending to it, such as MINSA, is also put through in a report to the Inter-American Commission of Human Rights (Movimiento autonomo de mujeres, 2011).
On the subject of being obligated to report to the police or other authority (such as the Family Department or the Attorney General), legislation and steering documents may be confusing. Law 779 (against violence towards women) states that the persons who in accordance with legislation have the obligation to report these crimes should report them to the National Police or to the General Attorney’s Office within 48 hours, once having learnt that a woman, child or adolescent has been the victim of violence (AS, 2012:779, article 17). La Norma, the steering document that MINSA stipulates that its staff follows, states that professionals should report underage victims to the authorities when legislation so declares. That means that other legislation than Law 779 needs to be examined.

Article 49 in the Book of Laws regarding Children and Adolescents stipulates that staff of health care units have the obligation to report any reasonable suspicion of bad treatment or abuse of children and to the General Attorney’s Office (Ministerio Público) (AS, 1998:287, article 49). To my knowledge, there is no other legislation regarding health care professionals’ possible obligation to report crimes of sexual violence to the authorities, and therefore no law that stipulates that a nurse or doctor call the police when the victim is an adult, and no legislation regarding doing it against the victim’s will (as mentioned by the emergency nurse). However, WHO does not recommend reporting sexual violence against a woman’s will, but nonetheless offer it to her, in the WHO guidelines on responding to IPV and sexual violence against women (WHO, 2013a).

Furthermore, as discussed in the background, that this law’s choice of word is “reasonable” as well as “once having learnt that” in Law 779, may constitute a problem for health care professionals, who are required by law to make a quick decision when they are in fact neither forensics nor police.

According to laws and La Norma, it is the obligation of the units to coordinate themselves and establish a referral system in order to attend to the victims of sexual violence in the best, most comprehensive manner, but La Norma does not specify how. While the forensic doctor states that her services are always required by the police and not by health care professionals, the doctor at the health care centre articulates that it is in fact the forensic doctor that confirms a case of sexual violence and decides to call the police.

In fact, La Norma and the legislation it is founded upon may prove confusing regarding when and if a nurse or doctor is obliged to report a possible case of sexual violence and to which authority. How the referral system between the health care centres, psychologists, the hospital and the forensic doctor actually functions also seemed unclear to me when interviewing and comparing the interviews with professionals from different parts of the health care system, This is an issue that could be approached when it is time to publish an updated La Norma.

Respondents bring up the high frequency of young girls in relationships with adult men and the high frequency of adolescent pregnancies. The frequency of adolescent pregnancies is also confirmed by research, which also points to the correlation between adolescent pregnancy and sexual violence (Silverman, Raj, Mucci & Hathaway, 2001; Saewyc, Magee & Pettingell, 2004; Baumgartner, Waszak Geary, Tucker and Wedderburn, 2009). However, adolescent pregnancy is not investigated further at the health care centre as possibly indicating that the patient may be the victim of sexual violence. Instead, health care professionals express that adolescent pregnancy is the result of girls either wishing to get pregnant or being careless in taking preventive measures against it.
Both frustration with the lack of attention to the issue of sexual violence within the health care system and on the other hand, a positive view on how the issue is currently being approached, is expressed by respondents. By critiques, the lack of knowledge and commitment is mentioned as part of the problem. MINSA is criticised by the maternal house doctor for not working with sexual violence in a broader perspective: for example by when addressing maternal mortality, not acknowledging it as related to sexual violence which research confirms (Amnesty International Sverige, 2011; WHO 2005; Ministry for Foreign Affairs 2012; ECLAC & UNICEF, 2007). Findings suggest that those in Nicaraguan society who work for women’s rights and against sexual violence, such as the doctor and the nurse at the maternal house, share the views of local and national NGO’s that things are in fact neither good nor rapidly improving. This is in contrast with the unison views of the AIMNA representative, the government-appointed forensic doctor and the public health care professionals’ view, particularly those at the primary care centre. These latter respondents express that the legal system, the health care system and society in general is improving when it comes to the prevalence of sexual violence and how the victims are being attended to.

Health care professionals are very engaged in their work and profession and express dedication to social issues and responsibility for their patients. The nurses mention commitment to patients, the profession of nursing and a feeling of responsibility as resources for attending to victims of sexual violence. Challenges are described as the lack of time with patients to perform their profession as they wish. The primary care nurse links her obligation as a revolutionary with her obligation as a health care professional and tells me of her political engagement. Both she and the two doctors at the centre express how the problems with sexual violence are decreasing since the new government took office in 2006. This opinion is not shared with NGO’s who work for women’s sexual and reproductive rights (Movimiento autónomo de mujeres, 2011) nor the doctor at the maternal house, who also works specifically to detect and prevent sexual violence and who also keeps statistics of her patients. However, that the primary care nurse links her nursing practice to a revolutionary practice is an interesting way of perceiving nursing that I think is important.

Lack of continuity is also mentioned as a problem. This is perceived as due to the system of staffing rural health care stations for a year or two with of recently graduated doctors and nurses doing a period of “social service”. The professional that receives education on the issue is due to leave the post and be replaced by a health care professional without that knowledge of sexual violence. Another obstacle to the attendance to victims of sexual violence is the justifiable fear of reprisal from abusers that health care professionals may experience, according to literature (Rodríguez-Bolaños et al, 2005). and some respondents. But neither the nurse and the doctor at the health care centre nor the nurse in the emergency ward mention fear of reprisal as something they have experienced.

A conclusion I draw from the findings is that sexual violence can be perceived by health care professionals as both a public health issue and a social issue – the latter view may be a barrier against engaging in the health care towards victims in the health care system – but as long as health care professionals regard their professional responsibility as also a social one, neither view should constitute a barrier against the medical attendance and health care towards sexual violence victims.

A problem and a barrier against a successful health care towards victims of sexual violence is that sexual violence is a normalised phenomenon in Nicaraguan society, according to some respondents. The positive views that respondents’ express of Nicaragua’s development
regarding the attendance to sexual violence (and their eagerness to present them) may reflect a politicised society where the situation for civil and political rights as well as sexual and reproductive rights is negative. During the current government’s term of office it has shown authoritarian tendencies and the borders between the government, the governing party, the presidential family and the church have been blurred. While violence against women is widespread, few cases of sexual violence are prosecuted (Amnesty International, 2012). Meanwhile, Nicaragua has one of the highest rates of adolescent pregnancies in Latin America (Ministry for Foreign Affairs, 2012). The fact that that sexual violence is so frequent makes it likely not to be recognised as a violation of rights, if recognised as violence at all. This is made worse by the fact that most victims of sexual violence already belong to vulnerable groups who are already deprived of many rights, such as women and girls who live in poverty (ECLAC & UNICEF, 2007). Simultaneously, organisations working for women’s sexual and reproductive rights have been subjected to acts of reprisal and representatives for the defense of these rights have been denied access to space in media (Ministry for Foreign Affairs, 2012). This suggests that an accurate picture of the state of these rights does not reach the majority of the people – including health care professionals.

Findings also suggest that gender stereotypes among health care professionals may lead to the denial of human rights by the health care services. The idea that teenage girls become pregnant because they do not take precautions and do not take responsibility for their sexuality and protection - or get pregnant “because they want to anyway” - constitutes a barrier against regarding adolescent pregnancy as the indicator of sexual violence that it is. The attitudes towards teenage pregnancy that the nurse and doctor at the health care centre express are not in line with international studies on the connection between teenage pregnancy and sexual violence (Silverman, Raj, Mucci & Hathaway, 2001; Saewyc, Magee & Pettingell, 2004; Baumgartner, Waszak Geary, Tucker and Wedderburn, 2009). Simultaneously, the attitude that abstinence from sex is the best alternative for adolescent girls and young women sends a message to these patients that trying to protect oneself from pregnancy with contraceptives is bad. This may lead to these girls and women not using contraceptives and thus becoming pregnant involuntarily.

These gender-based views and consequent practices discriminate against pregnant adolescent girls and is a denial of the human rights of this group of rights-holders, by the duty-bearer that is the health care system. There is a clear connection with gender: it is women, particularly young women and girls that are affected (Amnesty International Sverige, 2011; UNFPA, 2012).

The normalisation of sexual violence in society as a whole and therefore also in the health care system among health care professionals, also reflects a patriarchal structure that respondents refer to as “machismo”. This patriarchal structure and the consequent normalisation of women not having the right to their own bodies (Knöfel Magnusson, 2009), can explain a lack of knowledge and commitment to the issue of sexual violence within MINSA. Some respondents refer MINSA’s lack of success to the shortage of resources, but the lack of willingness and commitment are likely to play a role when maternal mortality is discussed whereas the gendered violence coinciding with it is not, according to one respondent. This is consistent with the focus on teenage pregnancy as a problem per se as expressed by another respondent, and not as a problem connected to sexual violence.

Although a new law against violence towards women has recently been passed by the National Assembly (AS 2012:779), this will not be more than political propaganda if it has no
effect on the prevalence of sexual violence and if other health issues are constantly given priority.

Among respondents, there are different views on whether sexual violence is to be seen as a social or a health issue. Simultaneously, the health care system’s professionals are those of the state’s representatives that are most likely to come in contact with the victims of sexual violence. As sexual violence has serious negative effects not only socially but also on a person’s health (WHO, 2005), knowledge of and commitment to the issue, as well as views and practices in line with the steering document La Norma, among health care professionals would be preferable to strengthen patients’ right to the highest attainable standard of health.

Nicaragua is a country where the sexual and reproductive rights of women and girls are in decline. The result is that sexual and reproductive health deteriorates among those who are denied their rights, that is, women and girls. Thus, health and rights are intertwined and to achieve and maintain sexual health, a person’s sexual rights must be respected, protected and fulfilled (WHO, 2013a). This means that health care workers, such as nurses, need to integrate the respect for, knowledge of and practice of human rights into their health care work: a rights-based approach to health needs to be a part of nursing. This includes paying special attention to the needs and rights of vulnerable groups, in the case of sexual violence, women and girls. In order for nurses to sufficiently analyse these needs, an understanding of gender analysis is essential. This is something that La Norma to some extent offers (MINSA, 2009), although a more thorough take on gender would be preferable in the empowerment and education process that MINSA (for example through AIMNA) is responsible for. This opinion is based on the declination of women’s rights in Nicaragua and the normalisation of sexual and other gender-based violence in Nicaragua, suggesting that MINSA (and other authorities) have a lot of work to do. To include education on gender and a rights-based approach to health in nursing education could be a possible method. That one of the nurses in the study, working in primary care, verbally links her duty as a nurse to her duty as a revolutionary, can be a sign of the politicised Nicaraguan society I discuss above, but is also interesting as a nurse’s perception of nursing as a revolutionary social practice, that I would like to explore further.

Nursing is connected to the rights-based approach through the fact that people have the right to have their health needs attended to. This means that the concept of human rights can be understood as people having the right to receive good nursing. As health is crucial to nursing, the human right to the highest attainable standard of health becomes a central issue for nurses. This makes nursing a social practice. The preamble to the International Council of Nurses’ (ICN) Code of Ethics for Nurses actually states that the respect for human rights is inherent in nursing (ICN, 2006). The code also declares that a nurse together with society shares “responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations” (ICN, 2006, p. 2). A “vulnerable population” can definitely include women and children whose sexual and reproductive rights are being challenged.

Florence Nightingale (in Moberg, 2007), who wrote “Notes on nursing – what it is and what it is not” in 1860, is considered the founder of nursing as a profession and theory. Nightingale was an advocate and public debater for patients’ rights, good nursing and better health care in forms that are widely accepted today such as fresh air, clean water, sanitation, light and the importance of a beautiful and healing environment (Moberg, 2007). Nightingale was very much engaged in public health issues and for example voiced the importance of documentation and statistics (Olander, 2009). The understanding of the respondents views and
practices through a gender and rights perspective, may suggest that it is time for nursing theory to go back to the roots of Nightingale’s focus on public health, in order to provide nursing for people and society that fits their needs, with a rights-based approach to health as a fundamental part of nursing in both theory and practice.

**Conclusion**

Health care workers express strong commitment to their professions and a great willingness to attend to the victims of sexual violence. The steering document La Norma from The Health Department in 2009 can be a helpful instrument for a rights-based approach to health for health care professionals, but is not always known or in practice. Views and practices not in accordance with La Norma were found in the study, including gender stereotypes that constitute a barrier against regarding adolescent pregnancy as a possible indicator of sexual violence. There is a clear connection with gender as it is young women and girls that are affected. This gender-based attitude is negative for the detection and treatment of victims of sexual violence and consequently the protection of these patients’ right to the highest attainable standard of health. Such attitudes appear to be a normalised phenomenon in Nicaraguan society, which makes them difficult to challenge through only the health care system. Sexual violence can (and needs to) be understood as both a social and a medical issue in order to establish ways to eradicate it.

With increased resources, nurses’ work would be strengthened and consequently, the medical attendance to sexual violence victims would improve. These resources need to include both more time with patients and a more effective education and empowerment process on sexual violence, including a focus on tackling the lack of continuity in rural health care stations. This would contribute to a rights-based approach to sexual and reproductive health.

Implementation of steering documents regarding the attention to sexual violence in the health care services needs to improve if a rights-based approach to health is to be achieved.

**Future research**

Future studies should further examine the implementation and monitoring process of steering documents, including budget resources. La Norma contains a lot of information to take in, challenges established practices and presents a controversial discourse regarding for example adolescent pregnancy. How does AIMNA plan their methods of implementing La Norma and how is it received by the health care professionals? These are important questions and the answers I got from the professionals and AIMNA were not enough to fully comprehend it. Having obtained an understanding of this would have shed more light over the discrepancies between La Norma and health care practices and attitudes. As I within this limited study didn’t have the possibility to “go back and ask again” (do more interviews or obtain more data) this should be the pending issue for exploration in another study.

It has been almost years since the quantitative study on the matter was conducted by Rodríguez-Bolaños et al (2005) and by then the Penal Code from 2008 and Law 779 from 2012 did not exist. In fact, a greater study or a group of studies in a research project would be desirable to map out the whole area of health care and sexual violence. As the doctor at the maternal house says, the problem needs to be fully diagnosed to be confronted! The need for such a study was also expressed by the AIMNA representative.
This small study has given me knowledge and ideas on how to proceed with a larger study designed with local expertise and networks. In a future study it would be interesting to review the guide on how to work with detecting and attending to victims of sexual violence developed by the doctor at the maternal house. An interactive study could examine if it could also prove helpful to implement La Norma in the health care services and not only maternal houses and thus fulfill a rights-based approach to health by health care professionals and institutions. A study on the nursing education in Nicaragua and of attitudes among nursing students would also be of use for further knowledge on nursing in regard to sexual violence. Interviewing victims of sexual violence on their experiences of health care is a delicate matter but would definitely add the most important perspective on the matter.

The importance of the health care system for the victims of sexual violence cannot be exaggerated. Sexual violence is a big public health problem in Nicaragua and on a global scale and therefore an important topic for further study. A future research project could be of assistance to improve how the Health Department implements La Norma and monitors and evaluates the health care system’s practices and attitudes. These practices and attitudes are of great importance for the large number of patients that are victims of sexual violence and for the health care services’ important part in the fight to eradicate sexual violence.
REFERENCES


AS 2012:779. *Ley No. 779, Ley Integral Contra la Violencia hacia las Mujeres y de Reformas a la Ley No. 641 "Código Penal".*


APPENDIX I

Interview guide in Spanish

GUÍA DE ENTREVISTA

Situandose en el tema

1) La violencia sexual, qué significa para usted?
   - Podría darme ejemplos?

2) Significa lo mismo cuando un niña, niño o adolescente (NNA) sufre de la violencia sexual, como cuando un adulto sufre de la violencia sexual?
   - Si no, cual es la diferencia?
   - La violencia contra NNA incluye otras cosas?
   - Se nota otros signos o indicadores el en paciente menor de edad que en un adulto (físicos, psicológicos)?

3) Como se reconoce en un paciente menor de edad que puede haber sido víctima de violencia sexual?
   (Cuáles son los signos o indicadores?)

Planned prompt: Para el informante, qué es la violencia sexual contra adultos y contra NNA?

Experiencias

1) Usted ha visto estos signos o indicadores de violencia?
   - Cuáles?

2) Pasa frecuentemente?
   - Hace registro (estadísticas)? Adónde va esa información?

3) Se lo empieza a comunicar el paciente mismo?
   (Qué dicen los pacientes, por ejemplo?)

4) Si no, se pone usted a hablar con el paciente del tema?
   - Qué dice usted entonces?

5) Qué hace usted cuando sospecha o confirma que el paciente adulto o menor de edad ha sido víctima de la violencia sexual?

6) Si se sospecha o confirma que el paciente ha sido víctima de violencia sexual, sele indica que asista a ayuda profesional?
   ( - Cómo?
   - Dónde?)

7) Se denuncia a la policía?
   (- Cómo?)
- Porqué?
- Si no, porqué no?)

Planned prompt: ¿Qué hace el informante cuando pasa?

Capacitación

1) Siente usted que tiene suficiente conocimiento de la violencia sexual, particularmente contra NNA?
   - Sabe como actuar en estos casos?

2) Siente usted que tiene suficiente información de la legislación para saber como actuar en una situación en la que el paciente ha sufrido un crimen de violencia sexual?

3) Cómo se percibe la tarea y la responsabilidad de sí mismo como empleado en la institución, en el asunto de la violencia sexual?

4) Siente el apoyo de la propia institución para actuar?
   - Entonces, en qué forma está el apoyo?
   - Si no, qué tipo de apoyo le gustaría tener?

5) La institución les da información sobre el tema y cómo actuar, a los empleados?
   (O si se obtiene información de otra parte - de dónde?)

6) Cómo percibe usted la tarea y la responsabilidad de la misma institución sobre el tema de violencia sexual contra adultos y NNA?

7) Tiene recursos? Cuáles? Cuáles necesita? Cómo se puede trabajar el tema mejor?

Planned prompt: Siente que tiene la posibilidad y la responsabilidad de actuar?

Final

1) Hay algo que usted quiere añadir, o tiene algunas preguntas?

2) Puedo contactarle si hay algo que no entendí bien y necesito más explicación?
APPENDIX II

Interview guide in English (translation from Spanish)

INTERVIEW GUIDE

Defining and getting acquainted with the issue

1) What does sexual violence mean to you?
- Would you give me some examples?

2) Is it the same thing when a child or adolescent is subjected to sexual violence, as when an adult is?
- If not, what is the difference?
- Does violence against children and adolescents include other things?
- Can other signs or indicators be observed in underage patients than in adults (physical, psychological)?

3) How do you recognise in an underage patient that she or he may be the victim of sexual violence?
(Which are the signs or indicators?)

Planned prompt: What is sexual violence against adults and children and adolescents respectively, according to the respondent?

Experiences

1) Have you seen these signs or indicators of violence?
- Which ones?

2) Does it happen frequently?
- Do you keep register (statistics)? Where does that information go?

3) Does the patient bring it up?
(What do the patients say, for example?)

4) If not, do you start talking to the patient about it?
- What do you say then?

5) What do you do when you suspect or confirm that a patient (adult or minor) has been the victim of sexual violence?

6) If you suspect that the patient has been subjected to sexual violence, do you refer the patients to another health care level?
( - How? - Where?)

7) Do you report to the police?
(- How?
- Why?)
If not, why not?)

*Planned prompt: What does the respondent do when it happens?*

**Feeling able, empowered (“capacitación”)**

1) Do you feel that you have enough knowledge of sexual violence, particularly against children and adolescents?
   - Do you know how to act in these cases?

2) Do you feel that you have enough information of legislation to know how to act in a situation where the patient has been subject to a crime of sexual violence?

3) How do you perceive your task and your responsibility as a health care professional in this institution, regarding the matter of sexual violence?

4) Do you feel support from your institution to act in these matters?
   - If so, in what form is that support?
   - If not, what sort of support would you like to have?

5) Does the institution give you information about the issue and on how to act?
   (Or if you receive information from somewhere else – where from?)

6) How do you perceive the task and the responsibility of your institution regarding the issue of sexual violence against adults, children and adolescents?

7) Do you have resources? Which ones? Which ones do you need? How do you think the work on the issue could be improved?

*Planned prompt: Do you feel that you have the possibility and the responsibility to act?*

**Final**

1) Is there anything you would like to add or do you have any questions?

2) May I contact you if there is something I didn’t understand and I need more explication?