



# Obstacles to Nurses' Labor Militancy in Central America: Toward a Framework for Cross-National Comparison of Nurses' Collective Action

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Lisa Kowalchuk<sup>1</sup>

## Abstract

This paper seeks to understand the low level of nurses' labor militancy in El Salvador and Nicaragua compared with many other countries. Key to the analysis is the concept of oppositional consciousness, which was developed for the study of how oppressed groups convert anger over unjust treatment into vocal and even disruptive demands for change. I use data collected through interviews and focus groups to argue that while nurses in El Salvador and Nicaragua face many of the same hindrances to militancy seen elsewhere, they are more exposed to cultural and institutional forces that discourage a contestational stance. Chief among these are the influence of religion in nurses' schooling and socialization, and nurses' lack of experience with unions specific to their occupation. The latter owes, in turn, to particular historical and political factors in each country.

## Keywords

nurses, labor militancy, unions, Central America, gender

## Introduction

There has been a marked rise in labor militancy among registered nurses (RN) across several continents in the last quarter of the twentieth century, a global trend that can be better understood by looking at the counter case of Latin America in general, and Central America in particular. After decades of relative quiescence in response to their

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<sup>1</sup>University of Guelph, Guelph, ON, Canada

### Corresponding Author:

Lisa Kowalchuk, Department of Sociology and Anthropology, University of Guelph, 50 Stone Road East, Guelph, ON, Canada N1G 2W1.

Email: [lkowalch@uoguelph.ca](mailto:lkowalch@uoguelph.ca)

exploitation as taken-for-granted care workers, nurses around the world have increasingly embraced and engaged in labor strikes, stoppages, mass resignations, and related actions (Adams 2011; Apeso-Varano and Varano 2004; Briskin 2011, 2013b; Chadwick and Thompson 2000; Clark and Clark 2006; Coulter 1993; Fletcher 2000; Gray 1989; Henttonen et al. 2013; Jennings and Western 1997; Penney 2002; Wilson, Slatin, and O'Sullivan 2006). In so doing, they have overcome significant ideological and organizational constraints. Today, "the majority of nursing organizations throughout the world support the right of nurses to withdraw their labor" (Jennings and Western 1997, 277). While most scholarly attention to nurses' collective action has focused on the global North, several less-developed countries have also seen a recent rise in nurses' mobilizing for their own interests as workers, and around broader policies affecting their patients and the population (Abramovitz and Zelnick 2010; Pine 2013). On the organizational landscape, a related development has been the emergence of nurses' unions alongside much older professional associations. In Canada, and undoubtedly in other jurisdictions with socialized medicine, nurses have become a significant component of "the feminization of public sector militancy . . . union density . . . [and] union membership" (Briskin 2013a, 93). And nurses in the United States are now "one of the most activist occupational groups in the labor movement" (Ape-soa-Varano and Varano 2004, 77).

Exceptions to this overall trend, however, should caution against global generalizations. In Latin America, for example, while nurses tend to be the most highly organized and networked health-care workers, they are also the least militant (Malvárez and Castrillón Agudelo 2005). Within that region, El Salvador and Nicaragua are two countries where the level of nurses' collective action around working conditions, salary, and broader policy matters has been low compared with many other places in the world. It is safe to say that RNs in these two countries, taken together, have endured the same basic kinds of workplace strains and hardships as in the high-income countries—stagnating salaries, physical injury and mental strain caused by understaffing, unpaid overtime, precarity, underemployment, and labor wastage—and at a more severe level. But they generally do not exercise collective pressure on government or employers for improved treatment, recognition, or the conditions for providing quality care. At the same time, several parallel developments in these two countries' political and health-care policy trajectories make them important cases in which to examine nurses' responses to their conditions.

This paper attempts to understand nurses' relative lack of mobilization in El Salvador and Nicaragua based on data gathered through in-depth interviews, focus groups, and participant observation carried out between 2010 and 2013. Most of the scholarly literature on nurses' collective action consists of single-country studies. While these provide important clues as to why nurses mobilized at particular points in time, or why they unionized in some workplaces but not others (see, for example, Penney 2002), there is very little scholarship comparing nurses' mobilization across jurisdictions (Briskin 2011). Furthermore, most of the literature on nurses' labor movement participation focuses on affluent countries. This study can be a step toward addressing these gaps. I will argue that while nurses in El Salvador and Nicaragua face

many of the same hindrances to militancy seen historically elsewhere, they are more exposed to a set of interwoven cultural and institutional forces that dampen a contestational stance. Chief among these are the influence of religion in nurses' schooling and socialization, and nurses' lack of experience with unions specific to their occupation, owing in turn to particular historical and political factors in each country. The contrasting case of neighboring Honduras, where nurses became highly militant after the military coup in 2009, suggests that these kinds of impediments may be offset by events that drive cross-sectoral alliances in defense of basic rights, and that foment solidarity between RNs and the more working class-identified auxiliaries or nurses' aides (Pine 2013).

## **Background**

### *Regime Change, Health-Care Policies, and Nurses' Work Conditions in El Salvador and Nicaragua*

Several recent developments in the politics and health-care policies of El Salvador and Nicaragua generate both overlapping and distinct kinds of work-related strains for nurses. These characteristics make them important settings in which to examine the extent of nurses' labor militancy. The two countries are the clearest exemplars in Central America of the "pink tide," a term that refers to the ascendance of mostly moderate left parties to executive office throughout much of Latin America, starting in the late 1990s. Both the Sandinista National Liberation Front (FSLN), elected in 2006 in Nicaragua after sixteen years out of office, and the Farabundo Martí National Liberation Front (FMLN) that came to power for the first time in 2009 in El Salvador, campaigned on platforms that disavowed the previous decade and a half of neoliberal policies. Notwithstanding sharp differences in how they have enacted these stances in the health-care sector, neither government has been able to fully alleviate the hardships that those policies imposed on nurses. In the case of Nicaragua, the FSLN has actually made nurses' work conditions worse.

The regimes that the FSLN and FMLN defeated were ones whose policies generated similar kinds of deteriorations in nurses' work conditions, the effects of which were still being felt at the time of my research. In El Salvador, the National Republican Alliance (ARENA) began drastic cuts in social spending immediately after the twelve-year civil war that ended in 1992, paradoxically coinciding with an era of peace-building and postwar reconstruction. In Nicaragua, starting in 1990, three successive center-right governments enacted neoliberal restructuring that reversed eleven years of redistributive reforms by the FSLN government (1979-1990) in health, education, agriculture, and other sectors. The neoliberal regimes in both countries eliminated hundreds of full-time nursing positions in their Health Ministry facilities, largely through early retirement severance packages (Galdámez 2001; Huezo 2002; Rodríguez-Herrera 2006; Rossman and Valladares 2003). Nicaragua saw a 58 percent drop in the number of RNs in the ministry facilities between 1995 and 2001 (Pan-American Health Organization [PAHO] 2007). While there are no analogous data for El Salvador,

by the early 2010s, there were only 0.51 nurses per 1,000 population, far short of the World Health Organization's (WHO) critical threshold of 2.3 (Squires and Beltrán Sánchez 2013, 24). These data bear out in the narratives of participants in the present study, who told of hospital-wide nurse deficits (40% in one major specialist hospital, for example) and of shifts in which it was commonplace for one RN and two *auxiliares* to attend fifty patients. Worsening nurse-patient ratios have been a primary cause of workload intensification in both countries. Nurses' statements left no doubt about the physical toll of this on their bodies in fatigue, injury, and illness. Increased mental stress can also be inferred from unsolicited stories about preventable morbidity and mortality in their patients.

There are also variations in the types of work-related hardships that neoliberalism generated for nurses in the two countries, owing to differences in the specific measures enacted. Labor precarity became a particular problem for Salvadorean nurses owing greatly to the ARENA government's increased use of temporary contracts starting in the early 2000s (WHO 2013). Particular to neoliberal restructuring in Nicaragua was an increase in the number of private health-care facilities and services, due to privatization of the social security system (the INSS) in the 1990s, and the introduction of "differentiated services"—private-care areas within public hospitals for those who could afford it.<sup>1</sup> As my research participants explained, this effectively took nurses out of the public facilities and areas, imposing heavier workloads on those who remained. It also subjected those in the private facilities—all of which are nonunionized—to a set of contradictory conditions: a lighter patient load, but more demanding patients, and oftentimes more severe forms of employer surveillance.

Upon attaining power in 2006 and 2009, respectively, the FSLN and FMLN governments have differed considerably in the extent to which they have followed through on pledges to reverse neoliberalism in health care. In El Salvador, the FMLN enacted a major expansive reform of the public system with the aim of providing the full range of services to groups long deprived of access to care. This has meant the hiring of 845 more nurses and 517 more *auxiliares*<sup>2</sup> between 2009 and 2014 (Ministerio de Salud (El Salvador) [MINSAL] 2014) for the new community health teams and expanded community clinics. Under the FMLN, public-sector nurses in El Salvador also benefited from the gradual conversion of annual contracts into permanent positions (WHO 2013), and from a halt to the practice of hiring RNs into *auxiliar* positions, a cost-saving measure by the previous government that affected hundreds (Cáceres 2010). These employment opportunities and progressive labor policies have alleviated some of the strains imposed on nurses by the ARENA government's policies. But Salvadorean participants in the focus groups and interviews who worked in hospitals and clinics made clear that short-staffing and attendant problems of overwork, injury, and absenteeism have persisted under the FMLN. This is not surprising given that it is in the primary sector that new positions were opened.

In Nicaragua, the "second stage" Sandinista government (2006 to the present) has by all accounts made the situation of nurses worse than it was under the previous neoliberal administrations. With no expansive structural reform in health care similar to that of El Salvador, it has made no investment in the creation of new nursing positions.

This precludes a pathway through which nurses' excessive workloads could have been alleviated. Analyses in rural areas point to a persistent shortage of nursing personnel both in the primary-care sector and in hospitals (Kvernflaten 2013; Swedish International Development Agency [SIDA] 2009), findings that reflected the narratives of the Nicaraguan focus group and interview participants. Their observations suggest that workload has worsened since 2007, because while staffing levels have remained unchanged, patient demand has increased. This may owe partly to the abolition of cost-recovery user fees that were imposed by the previous regime (such fees were also enacted in El Salvador and removed by the FMLN). But, as well, nurses in my study pointed out that the FSLN government actively encourages citizens to assert their long-neglected right to free care, and to denounce any instance of care denial. As a result, threats of formal complaints and even malpractice lawsuits by patients' families had become a nightmare for nurses. Abusive treatment by patients and their families as an increasing and commonplace occurrence was a core finding of a survey-based study by the Asociación de Enfermeras/os Nicaraguenses (AEN 2012), which framed this as gender-based violence. This was also echoed by the nurses in my study, including those working in private-sector facilities. There, nurses reported that a "customer is always right" ethos is explicitly articulated by management. And while the FSLN eliminated the differentiated services from the public hospitals, it did not attempt to undo the privatization of INSS.

Finally, the FSLN government has allowed nurses' salaries to stagnate, continuing rather than reversing a trend that began under the neoliberal administrations. Even with the annual inflation adjustments made under the FSLN's minimum wage law of 2007, the base salary for nurses in 2012 was just \$140/month, the lowest in Central America, and probably in all of Latin America. In El Salvador, even with no new wage increase under the FMLN's health-care reform, RNs earn roughly \$525/month. That the salary in Nicaragua covers only about 37 percent of the urban basic market basket defined as food, clothing, and household essentials including fuel, electricity, water, and transportation (Instituto Nacional de Información de Desarrollo [INIDE] 2012)<sup>3</sup> explains why most nurses there juggle more than one full-time job, and why many seek work elsewhere in the region (Brenes 2008). These observations were echoed by participants in my study, some of whom had worked temporarily in Honduras. Nicaraguan doctors, meanwhile, have seen annual salary increases of about 30 percent since late 2006, under a law passed just before the FSLN was elected. This brings their monthly earnings somewhere between \$1,100 and \$1,600, depending on their level of specialization (Radio La Primerísima 2006).

### *Nurses' Organizational Vehicles: Professional Associations and Unions*

The most significant organizations for nurses in the two countries are the Asociación Nacional de Enfermeras de El Salvador (ANES), and the AEN, founded in 1934 and 1949, respectively. ANES's 3,400 affiliates as of 2011<sup>4</sup> represent about 80 percent of RNs in El Salvador's public and social security sectors combined (MINSAL 2014), while the AEN's 1,500 members encompass about 54 percent of those in Nicaragua's

public sector (Ministerio de Salud (Nicaragua) [MINSA], 2012).<sup>5</sup> Both organizations' activities have focused mainly on professional concerns, with occasional interventions to address labor-related crises or complaints of the members. In neither country have they engaged in collective bargaining nor fostered the creation of sub-units that act as unions. In the Health Ministry sector of both countries, and the Salvadorean Social Security Institute (ISSS) in El Salvador, mixed-occupation unions with no separate bargaining unit for nurses claim a minority of all RNs. In Nicaragua, most of these unions are members of the FSLN-linked Health Workers' Central (FETSALUD), a federation founded in 1974 with a presence in the public sector only. In El Salvador, there is a relatively new union specifically for RNs and other nursing staff. Formed in 2008, the Union of Nursing Professionals, Technicians and Nurses' Aides of El Salvador (SIGPTEES) was said to have affiliated 1,200 members by 2010. Although leaders asserted the 1,200 spanned all three health-care sectors—public, ISSS, and private—they admitted that recruitment efforts in the latter face formidable employer resistance (Interview, SIGPTEES leader, August 2010).<sup>6</sup>

Nurses in El Salvador and Nicaragua have been largely quiescent in the face of the work-related hardships described above. In both countries, it became clear in interviews and focus groups that nurses stayed largely on the sidelines of strikes pertaining to salary or broader health-care policies (such as the movement to prevent the privatization of the ISSS in El Salvador from 1999-2002). In Nicaragua, in fact, hospital nurses spoke proudly of not losing a single patient while they covered for doctors in all but the most advanced procedures during a whole year of the doctors' salary strike, presenting this as evidence of their competence and dedication. Many also darkly recalled the verbal abuse their nonparticipation elicited from doctors at that time. The picture may be starting to change in El Salvador. Although for the first seven years of its existence, SIGPTEES was largely silent on the grievances that motivated its formation, in 2015, it conducted a bold protest to demand ministry attention to low nurse-patient ratios and suppression of their union rights (Joma 2015; Morán 2015; Ramos 2015). The unfriendly press coverage of their action and its condemnation by ANES leaders, however, speak to the difficulty of scaling this up.

## **Theorizing Nurses' Collective Action**

### *Consciousness Transformation for Militancy and the Duality of Nursing Culture*

I take labor militancy to be collective action by workers that encompasses, but is not limited to, industrial action, defined in turn as “any noncooperation with management, such as strict ‘working to rule,’ refusal of certain duties, going slow, and ultimately withdrawal of labor” (Chadwick and Thompson 2000, 483). Analyses of nurses' labor militancy often focus on their values, self-image, and general mindset as hindrances to mobilization. But scholars must also pay attention to “the social psychological factors that contribute to the construction of identity, solidarity and consciousness” essential to their transition from inaction to militancy (Penney 2002, 20). In this regard,

valuable insights can be gleaned from scholarship on how groups subject to injustice move from passive resignation to indignation and action. A crucial aspect of this psychological transformation is the development of oppositional consciousness, defined by Morris and Braine (2001, 25) as “an empowering mental state that prepares members of an oppressed group to act to undermine, reform, or overthrow a system of human domination.”

Certainly, hardships and strain such as those experienced by Salvadorean and Nicaraguan nurses are a necessary condition for the development of an oppositional consciousness. In general, inequitably endured, undeserved hardships are what constitute exploitation and status inferiorization, and provide the motivation for collective action (Brockett 2005). But among oppressed people, Morris and Braine point out, critical understandings do not emerge automatically out of shared hardship. Even when people know that they are experiencing collective injustice, they are often immersed in a culture of subordination whereby they “devise survival strategies that enable them to cope” with the unfairness and pain of their reality. These strategies carry with them a “language of submission that permeates . . . [things like] their educational experiences” and that “decreases the possibility of large-scale mobilization” (Morris and Braine 2001, 22). Among nurses, this is well illustrated in their pervasive use of the term “vocation” in reference to what drives them—a quasi-religious calling to be of service to others. This helps them to cope with difficult or deteriorating conditions in their work, and also moderates their indignation at such conditions (McKay 1990).

In occupational groups composed overwhelmingly of women, gender ideology cannot be ignored as a basis of institutional and interpersonal oppression. That nurses more than any other type of health-care worker are considered “called” to their work can be traced partly to the religious roots of the occupation dating back to the nineteenth century, and even earlier. Nurses’ immediate predecessors were communities of “vowed” women who enacted their faith through attending to the sick, dedicating their entire lives to that role (Nelson 2001). Later on, the patriarchal beliefs and structures of the broader society layered onto Catholic and Protestant notions of God-fearing women as selfless caregivers. This ensured the subordination of nursing to male-dominated medicine (Ashley 1976; Ayala 2013; Malka 2007; Reverby 1987; Witz 1992). Inculcated in the first generations of nurses was an ethos of “altruism, sacrifice, and submission” (Reverby 1987, 8). Although there has been less attention to the origins of nursing in developing regions than in the global North, existing analysis points to similar forces at work in Latin America (Rios-Everardo 2001). In both El Salvador and Nicaragua, the first nurses were nuns of the St. Vincent de Paul society (ANES 2013; MINSa 2002).

Several scholars note a remarkable persistence of these early expectations of nurses (Adams 2011; Bessant 1992; Grinspun 2010) in spite of the advances they have generally attained in earnings, educational opportunities, professional recognition, association-building within and between countries, and so on. Several critical feminist analysts attribute this staying power to a particular conceptualization of care that has become predominant in recent decades. Transmitted through didactic nursing texts, and widely embraced by influential nurse leaders and educators (Grinspun 2010;

Malka 2007), this is an understanding of care as a moral imperative, an “emotional calling,” an inherent feeling toward others. Because care in this perspective is not seen as “a labor process influenced by institutional practices, power relations, and labor market contexts,” it generates “feelings of self-sacrifice and self-blame” (Grinspun 2010, 6-7) when work conditions constrain nurses’ performance. Inattention to the organizational dimension of caring makes nurses less likely to recognize the obligations of their employers and the health-care system for ensuring adequate conditions (Apesoa-Varano and Varano 2004; Grinspun 2010; Porter 1992; Selberg 2013). They will tend to “cover for the organization” (Selberg 2013, 28) rather than collectively demand changes.

Oppositional consciousness, however, is never completely absent in an oppressed group. Rather, it “is often present in the same cultural materials that promote submission. Rather than running along parallel tracks . . . [they] travel crisscrossing routes” (Morris and Braine 2001, 22). Members of oppressed groups “vacillate” between subordinated and oppositional cultures. Within nursing, the notion that two diametrically distinct mindsets coexist is borne out by the divisions over the appropriateness of labor militancy and in differing interpretations of professionalism (Adams 2011; Apesoa-Varano and Varano 2004; Bessant 1992; Briskin 2011; Strachan 1997; Wilson, Slatin, and O’Sullivan 2006). Across several national settings, two distinct overarching positions on these issues have been identified as traditional versus alternative professionalism.<sup>7</sup> Under the former, work stoppages are unacceptable for nurses as they are antithetical to selfless service. Studies of texts such as professional association newsletters reveal that the day-to-day concerns arising from this perspective center around research, publishing, education, scope of practice dilemmas, and defending and advancing the recognition of nurses’ expertise (Apesoa-Varano and Varano 2004; Wilson, Slatin, and O’Sullivan 2006). Absent from the agenda are hardships pertaining to job security, wages and work conditions, and health-care policy (Wilson, Slatin, and O’Sullivan 2006).

Conversely, alternative professionalism embraces nurses’ defense of their labor rights. Engagement in industrial action is viewed as something that enhances rather than erodes professional status. This is because such mobilization can and often does demand recognition for nursing-specific skills and/or conditions that improve services (Bessant 1992; Briskin 2013a, 2013b; Brown et al. 2006; Gordon 2009). This view of professionalism is compatible with what Briskin (2013a, 2013b) refers to as “the politicization of caring,” whereby nurses’ and patients’ well-being are seen as intertwined. Similarly, others contend that nurses’ care obligation entails a positive duty to demand the resources they need for high-quality service provision (Muyskens 1982).

### *Submission, Opposition, and Forces that Tip the Scale*

The tensions between the two “twin impulses” (Apesoa-Varano and Varano 2004) or “cultures” (Adams 2011) outlined above did not dissipate even after nurses began unionizing in the last quarter of the twentieth century. To date, there has been little systematic inquiry into the factors that have either suppressed, or “crystallize[d] and

elevate[d] the oppositional side of the equation” (Morris and Braine 2001, 22) among nurses. Given the Christian roots of nursing across so many countries, including in the global North (Nelson 2001, 2), an important question is the extent to which religiosity continues to affect nurse training and socialization. Although religion’s influence is a widespread historical commonality for nurses, this is likely more persistent in some countries or regions. Rios-Everardo (2001) argues that religion, as one of a number of cultural variables distinctive to Latin America, is heavily emphasized in nurses’ socialization. In Mexico this impedes being recognized as professionals (Squires 2007). Indeed, most countries in this region are considerably more religious than most affluent countries, with Cuba and the United States being outliers (Crabtree 2010; Pew Research Center 2014). But societal religiosity also varies considerably across the Latin American region, with higher levels found in the poorer countries of Central America—El Salvador, Nicaragua, Guatemala, and Honduras (Pew Research Center 2014). We might expect this to permeate nurses’ outlooks and to discourage assertion of workplace rights.

Resolving the tensions between submissive and critical orientations one way or the other also depends on class identification. Nurses share in common with all professions the fact of being “highly differentiated sub-communities loosely held together by a common occupational title” (Friedson 2001 cited in Adams 2011, 221-22). Fragmentation and hierarchy within professional nursing stems from, among other things, the managerial versus direct care divide, and stratification in educational attainment and specialization. The differences in the subjective sense of class belonging that this produces means that many eschew “‘blue collar or trade behaviors’ and industrial unionism” (Bessant 1992, 155), a stance that, significantly, is found among those who teach and socialize large numbers of new entrants (Gordon 2009). But class identification is not static. Particular events may work to disrupt nurses’ “adhesion to the oppressor” (Adams 2011), by generating solidary sentiment and action between, for example, professional nurses and the more proletarian-identified nurses’ aides. In Honduras, nurses’ militant protest against the 2009 coup regime arose out of coalition-building among their previously conservative professional association, the *auxiliares*’ union, and other social movement groups (Pine 2013). By dramatically imperiling the health of their patients and of nurses themselves, the coup led to a politicization of nurses’ care work.

Globally, in the organizational realm, the legalization of nurses’ and other health-care workers’ collective bargaining was often crucial to paving the way for nurses’ labor militancy. More permissive labor laws made professional associations rightly fearful of losing their membership to unions, leading them to modify their longstanding opposition to labor withdrawal. Some associations extended their role to encompass collective bargaining, or created union-like entities—professional unions—within the broader association structure (Goodman-Draper 1996, 8). In many jurisdictions, however, this was not sufficient to prevent nurses from joining or forming separate unions (Adams 2011; Coulter 1993; Jennings and Western 1997; Strachan 1997; Wilson, Slatin, and O’Sullivan 2006). Once nurses’ unions formed, early successful actions inspired subsequent militancy (Adams 2011; Wilson, Slatin, and O’Sullivan

2006). As well, a feminist oppositional consciousness—a recognition of nurses' exploitation as rooted in capitalism, neoliberalism, and patriarchy—can emerge in the midst of industrial actions, even if it is not fully articulated as such (Coulter 1993, 49).

Legislation that enables the unionization of nurses requires an amenable political environment. One might expect, then, to see cross-national variations in nurse militancy based on the level of political democracy. Regimes that suppress political participation and dissent are likely to prevent or shut down freedoms of association and expression. In many Latin American countries, labor autonomy—"the scope for unions to define a set of class-based interests, independently from the definition of interests imposed by their presumed political agents" (Stahler-Sholk 1995, 77)—has been limited by governments that use both "inducements and constraints" to exert corporatist control over civil society organizations (Collier and Collier 1979). Union leaders become less accountable to their membership, and more beholden to state officials (Levitsky and Mainwaring 2006). Some divergence from this pattern has been noted in recent years with the region's "new left" governments (Cook and Bazler 2013, 7). This makes El Salvador and Nicaragua interesting cases in which to examine autonomy for unions and other organizations representing nurses.

## Data and Method

The empirical data on nurses' collective action in the two countries were gathered primarily through in-depth interviews and focus groups carried out between May of 2010 and November 2013. This was supplemented by governmental and multilateral agency documents and field notes from participant observation of informational events and meetings convened by the professional associations. I chose to focus the study on professional nurses, not *auxiliares*. My recruitment targets for both the focus groups and interviews reflected a form of purposive (nonprobability) sampling known as nonproportional quota sampling, in which the goal is to include "a minimum number of cases belonging to the key categories" (Trochim 2008). I asked the assistants working with me in each country to ensure representation from the key types of health-care settings (hospitals of various levels of care complexity, urban and rural community clinics), as well as the main sectors of care—public, private, and social security. In both countries, there is a state-funded health-care system consisting of hospitals, clinics, and specialized facilities that are mostly under the auspices of their ministries of health. The population served by these facilities is largely of lower income. The social security systems—the ISSS in El Salvador and the Nicaraguan INSS—serve people insured through formal sector jobs. While in El Salvador, this is a parastatal sector of care, in that state funding supplements employer and employee contributions, in Nicaragua, this system was privatized in the early 1990s. This meant that, in Nicaragua, I sought participation from both the "traditional" private sector and the privatized INSS facilities called Medical Provider Businesses (*Empresas Medicas Previsionales*; EMPs).

There were four focus groups in Nicaragua and five in El Salvador, with thirty-one and thirty-two participants, respectively, for a total of sixty-three. One focus group in

each country was composed solely of students in their final year of the *licenciatura* (equivalent to the Bachelor of Science) nursing program, eight in Nicaragua and ten in El Salvador. The rest were nurses recruited and grouped partly based on their years of experience in the profession. This ranged from newly minted graduates to those with careers spanning three decades, with an average of about fifteen years. A similar experiential spread characterized the participants in the individual interviews, which numbered twenty-five in Nicaragua and thirty-seven in El Salvador. Some of these were directors of educational programs at both public and private institutions. Additional in-depth interviews were conducted with experts and key informants, seven in Nicaragua and ten in El Salvador. All participants signed informed consent forms. The project received approval from the University of Guelph Research Ethics Board.

For the focus groups, I raised the following main themes for participants to discuss: the stresses and rewards of their work, nurses' contributions to health care and to what extent this is recognized by others, and things that should change and how can nurses influence that. For this latter broad theme about agency, I also asked their opinion of specific kinds of collective actions, and the role played by the unions and their professional association. Although in interviews with the regular (nonexpert) nurses, I sought more specific biographical details, the same basic themes shaped those questions as well. The focus groups and interviews were audio-recorded and transcribed. For the data analysis, a handful of initial themes stemming from the literature expanded into several dozen arising from the data themselves. I used NVivo to sort most of this material.

Research on health-care systems in developing countries often entails working across a triple divide of linguistic, cultural, and occupational outsider status (Squires and Juárez 2012). With this in mind, even though I am fluent in Spanish, I drafted summary reports of my findings for several high-level nurses and key informants in both countries as a check on my understanding of the transcribed material. I also gave three formal presentations on the research to groups of nurses in El Salvador in 2013 and 2014.

## Findings

### *Ambivalent Views of Labor Militancy*

Participants were generally frank and unrestrained in pointing out multiple ways in which authorities, policy makers, and employers treated them unfairly. But on the role of nurses' own potential to transform their situation, and the appropriateness of labor militancy, the coexistence of two ambivalent mindsets became apparent. On the positive side, an idea voiced in both countries was that nurses have enormous leverage to paralyze the system through industrial action or the threat thereof. Many mused that it would take only half an hour for a work stoppage by nurses to achieve its objectives. One nurse in El Salvador described their workforce as a "sleeping tiger." In both countries as well, several nurses lamented that they had not exercised this potential.

In El Salvador, the most explicit approval of industrial action was found among nurses who belonged to the existing unions. For José, a union activist at a specialized state hospital, confrontation and bold action were necessary:

I have very clear in my mind the fact that everything that the worker has, all the benefits they have, it's not because the administration or the bourgeoisie has felt that they deserve it, but rather, they've attained it based on struggle. The *escalofón* [system of pay increases in the state sector] was based on struggle in 1995, more than a month of strikes, the sacrifice of many *compañeros* who were fired . . . So whoever doesn't struggle will never improve their condition. Those who say nothing will never improve. If people say nothing the government is going to keep adding to your workload as far as they can. (Interview, January 2012)<sup>8</sup>

This working class-identified statement sounds as if it could have been made by any health-care worker. Others, such as Jorge, a SIGPTEES leader and cofounder, spoke of nurse-specific needs and concerns that merited strong action, such as the government's ratification of the ILO 149 (the Convention on nurses' work conditions). He felt that the International Council of Nurses (ICN) conferred legitimacy on nurses' labor withdrawal by stipulating parameters for such action:

For example we will not block essential basic services like emergency, operation rooms, services that hugely affect patients. The ICN advises doing a reduction that does not paralyze the system. This is what we have clear. So the strike is an important tool. (Interview, August 2010)

Not surprisingly, Nicaraguan nurses who voiced a positive view of industrial action connected this with their abysmal salary. They also referenced several successful recent salary strikes, including one by Nicaraguan doctors and another by nurses in neighboring Honduras, as models for the appropriateness and feasibility of such action for themselves. One nurse remarked,

I'm in agreement with the doctors doing a strike because they raised their salary. They went to the National Assembly and it was a titanic struggle by the doctors . . . and they did it. I think that we nurses, who have been more submissive and timid, I believe that through the Association we have to look at this matter. (Nicaragua focus group, February 2011)

Another participant made this observation,

When I went to Honduras [to work], there was a general nurses' strike because they were fighting for a raise for both nurses and *auxiliares*. There, it's different. There is an organization of *auxiliares* and an organization of nurses. So the auxiliary staff went on strike and that greatly helped the nurses . . . Doing pressure with three days of strike activity! They are not going to fire 3,000 nurses [in Nicaragua] because where would they get replacements? (Nicaragua focus group, February 2011)<sup>9</sup>

Unlike in El Salvador and Nicaragua, auxiliary nurses in Honduras had their own association and identified with the working class. In Pine's (2013) analysis, this encouraged the RNs after the 2009 coup to become more politicized.

But discussions of labor militancy also elicited signs of a culture of subordination. In El Salvador, the rejection of militancy was explicit. Several who have held leadership positions in either the association or one of the unions, and who themselves wanted much more assertive action, reported a widespread passivity among their colleagues. A typical statement in this regard shows that this is difficult to disentangle from their views of unions:

The fundamental thing about unions, the bases on which a union is created, are very good. What happens is that along the way, people become distorted. I know of unions in the U.S. and they have nothing to do with the mentality of unions here. There, being in a union is even a privilege. Here, to be a union member is loud noise, the street, disorder. . . . That's not the way, to go around making noise in the street, doing strikes, doing marches, work stoppages. Although really, our governments have left us no options other than to apply pressure actions. (Focus group)

Similarly, another participant had no quarrel with nurses unionizing, but only if the unions refrain from doing anything disruptive.

The antipathy that many Salvadorean nurses expressed toward unions and health-worker militancy appeared rooted in classism. One nurse who was himself a union member spoke of unfortunate stereotypes many of his colleagues held about unionized workers, as “very conflictive, they’re people who clean, are lacking education, lacking their own brain, lazy, badly behaved and undisciplined.” These views are outdated, he feels, because now professionals are forming and joining unions. Similarly, SIGPTEES leader Jorge believed that Salvadorean nurses’ widespread contempt for unions reflected the fact that in the past, “they have defended the interests of people who don’t fulfill their work responsibilities, who don’t show up for work, who steal things from the hospitals, and who use drugs and drink within the hospital.” For additional insight on the ideologies reinforcing the rejection of militancy, we need to look at beliefs about their own role in health care.

### *Conceptualization of Nurses’ Caregiving*

Participants were asked to discuss the traits and motivations of the ideal nurse and what makes nurses’ contributions to health care distinctive from other occupations. Their responses provide a sense of their definition of care. The terms most commonly used were vocation, love, self-sacrifice (being *abnegada*), *mística*, and *humanismo*. *Mística* and vocation were used more or less synonymously to mean having an ingrained love of helping and serving others, and deriving intrinsic satisfaction from easing patient suffering. The terms were also interwoven with self-sacrifice. For example, a recently graduated nurse working in an EMP (private sector clinic for social security affiliates) in one of Nicaragua’s smaller cities talked about all the social rewards that nurses give up, and the hazards they willingly assume, as the counterpart of vocation. In addition to the forfeiting of better pay, which was mentioned by most who spoke on this topic, her list included the risk of contracting viral illnesses from patients or from needlestick injuries. She added,

We know what we are risking but we still feel satisfaction in being able to help others. . . . that's why we talk about love toward our career. Often, the patient doesn't thank us. Maybe we gave up our sleep taking care of them. Our time, our youth, went in taking care of them, helping them to recover, and we still keep going. (Interview, August 2011)

A Salvadorean focus group participant upheld this idea but lamented, "I believe that nursing has lost a lot of the *mística* . . . that they taught us in the school of Sor Evelia, that 'first the patient, second the patient, third the patient, and last the patient.'"<sup>10</sup> This statement also hints at the religious component of nurse training in these countries, to be elaborated below.

The desire to serve, one nurse stated, must be "born within" the person. A Nicaraguan nurse used a Christian metaphor on this point, "[Nursing] is an apostleship, a difficult apostleship." The related term "*humanismo*" means, as one Nicaraguan nurse explained, that "you have to be a person who likes to be near pain and to help fulfill the needs of another human being." In relation to love, a common reflection was that in treating any patient, nurses must "think that what one is doing to this patient is what one would want them to do to a loved one." For a number of Nicaraguan nurses, this way of thinking was infused with Christian faith, as exemplified in the following quotation:

Spirituality is the most important thing. It must be the nurse who sees in the patient the face of God. She should see the face of Jesus Christ. This is fundamental. . . . If I am imagining that that person with that terminal cancer is Jesus Christ himself, that it's God himself I'm attending, my care will be the best. (Focus group)

The adherence to these conceptualizations of care and nurses' role in caregiving mitigates an oppositional consciousness regarding industrial action, as some nurses themselves acknowledged. Asked if nurses in El Salvador are at the point of a crisis, several focus group participants answered affirmatively, with one adding,

We hang in, you could say. I mean, there are moments when it makes us want to explode, throw down everything and do a work stoppage, but . . . we told you at the beginning about the humanization of our career. That also acts to impede us from doing a stoppage, from throwing things down and leaving.

### *Persistent Religiosity*

The influence of religion, suggested in the above reference to the patient as Jesus, was a recurring theme in both countries. Some nurses explicitly linked their sense of vocation to their spirituality. A male nurse in the Salvadorean Maternity Hospital stated, "I am satisfied dedicating my work to God. It's a vocation, not a profession, and not for a salary. I dedicate my work in the name of God." In Nicaragua, many told of carrying their faith into their clinical interventions. This encompassed talking to patients explicitly about God's will, praying with a fearful patient, and giving religious counseling to

the terminally ill. Several described performing something like last rites on a dying patient while bathing them, praying for their sins to be pardoned. Others like this nurse spoke of nurses baptizing patients:

We are all authorized to baptize if someone is in danger of death . . . [even without holy water] you simply say, “in the name of the Father, the Son, and the Holy Spirit. Amen.” So that person actually then receives the holy water. That’s what health pastors are doing now, but we as nurses can also do it.

Another told of reciting the “Our Father” with a patient being prepared for surgery. Afterward, the man thanked her profusely, and admitted to her surprise that he was actually a priest. In El Salvador, one key informant was critical of his fellow nurses’ religiosity, noting that it sometimes interferes with ethical practice. Colleagues relying on their Christian faith, he observed, sometimes argue for continuing extraordinary interventions with dying patients even when the treatments are painful and there is no hope of recovery, because they consider withdrawal of such measures to be euthanasia.

These observations point to the persistent influence of religion in the nursing profession in both countries. Some additional, visible signs of this were staff prayer circles at the start of a hospital shift, which nurses reported in Nicaragua and which I directly observed in El Salvador, and the placement of Catholic iconography inside Health Ministry hospital wards—statues of saints, crucifixes, portraits of Jesus. While these emblems of religion in the workplace are clearly not confined to nurses, among health-care occupations, it is they who are most exposed to them.<sup>11</sup> Moreover, in Nicaragua, religion is institutionalized in nurses’ training, constituting an integral aspect of the curriculum in the largest private not-for-profit institution, the Polytechnical University (UPOLI). All nursing students at the UPOLI are expected to attend a weekly devotional service. The director of the school, which was historically a Baptist institution, explained, “From the time they start coming they are given these [theological] philosophical foundations because it’s really the school’s identity. Why? Because through this Christian service we cultivate values and principles, Christian principles, the ethics and morals of the students.”

### *The Legislative and Political Environment*

Legislative changes allowing health-care workers to unionize has been an enabling factor in nurses’ militancy in several countries. In El Salvador, the key change in this respect were the ratifications of ILO Conventions 151 and 135 in 2006, and C-87 and C-98 in 2009.<sup>12</sup> Crucial momentum for ratifying the key Conventions was pressure from the European Union, which required them as a condition for El Salvador to join the European Union–Central American Association Agreement (EU-CAAA) that was ultimately signed in 2012 (key informant interview August 2010). The advent of public-sector union legality led to a proliferation of new unions (Fundación de Estudios para la Aplicación del Derecho [FESPAD] 2015). But it also had the adverse effect of atomizing the sector, as no overarching bodies emerged to federate the increasing

number of workplace-specific unions. This generated a spate of work stoppages and disruptive protests by health-care workers in individual ministry hospitals (key informant interview, August 2010). The uncoordinated nature of these actions may help to explain the classist disdain that the Salvadorean participants observed or expressed toward disruptive militancy.

For the Salvadorean nurse's union, SIGPTEES, which emerged only in 2008, the finalization of C-87 and C-98 a year later helped their recruitment efforts (Interview, SIGPTEES leader, August 2010). But arguably, there had simply not been enough time for the union to inspire widespread militancy through successful pressure actions. One of SIGPTEES's challenges is an unfriendly relationship with the association. Tension became open conflict when union leaders were expelled from an ANES Assembly. Although nurses could be members of both organizations, the association probably saw SIGPTEES as a source of competition, especially given that at least some SIGPTEES leaders claimed that only the union had a legal basis to intervene in nurse-employer disputes. According to Strachan (1997), a hostile relation between unions and professional associations undermines nurses' overall capacity for collective action. It might also make it more difficult for SIGPTEES, as a relatively new entity with no external sources of funding, to counteract widespread disdain for unions.

In Nicaragua, ILO Conventions 87 and 98 were ratified in 1967, and C-135 in 1981. That no distinctive nurses' union has emerged here undoubtedly owes to the fact that the powerful federation FETSALUD simply opposes it. A FETSALUD executive member interviewed in 2010, referring to how tensions, trade-offs, and concessions between different types of workers are managed, stated, "No one acts on their own behalf. I can defend equally someone who cleans, as I can a nurse, or a doctor." Furthermore, FETSALUD amassed considerable power and advantages over other unions through its links to the governing Sandinistas during the 1980s (Stahler-Sholk 1995). This is a connection it retained through to the present day, as seen in the fact that FETSALUD President Gustavo Porras is a member of President Ortega's unofficial circle of advisors that is separate from Cabinet (Martí I Puig 2010). Thus, FETSALUD is amply empowered to preempt any initiative to form a separate nurses' union. And because the government is the employer of FETSALUD's members, it does not function as a countervailing power on behalf of these workers. One nurse critically observed, "Before, when FETSALUD would say 'we have to do something,' what would we do? A strike. Not anymore, because now we're all Sandinistas."

Many nurses in Nicaragua felt that as a mixed-occupation union, FETSALUD poorly represents nurses' needs and concerns. Participants in El Salvador had a similar evaluation of the Union of Workers of the Salvadorean Social Security Institute (STISSS). But Nicaragua stands apart by virtue of the FSLN government's well-documented abandonment of democracy in blocking all avenues for opposition to maintain President Ortega's hold on power.<sup>13</sup> The slide toward authoritarianism in Nicaragua (Colburn and Cruz 2012; Martí I Puig 2013) all but forecloses the prospects for the government-linked union to cultivate critical consciousness or active militancy. That the Sandinista government has its "own network of subordinated social movements" (Burrige 2016) is one manifestation of its authoritarianism. This stands in sharp

contrast with the situation in El Salvador, where the FMLN government has largely respected and even promoted civil society autonomy (Burrige 2016). My interviews suggest that FETSALUD, with its traditional links to the FSLN, is one of those subordinated organizations that forms part of a clientelistic machine. For example, a number of the narratives spoke of selective workplace rewards and punishments that FETSALUD disburses based on employees' affiliation with the union, in the form of special recognitions (such as being named the best nurse in the ward after three days of working there), promotions, and demotions.

The interviews also suggest that organizations that have traditionally been independent of the governing party, such as professional associations and research institutes, have come under increasing pressure to conform. This includes the AEN. An indication of this was seen in 2013, at a weekly meeting of its executive members in which for the first two hours, they provided me with feedback on my preliminary summary. Two or three of the leaders used this mainly as an opportunity to praise the current government's treatment of health-care workers and to blame its predecessors (the neoliberal regimes of 1990 through 2006) for problems such as the slowness in restoring staffing levels. In defense of current power-holders, a leader named Blanca criticized the report though she had not read it, and voiced praise for FETSALUD. Responding to a colleague's comment on Nicaraguan nurses' low salaries, she stated,

Our profession draws people who don't look to get rich. It's about vocation, dedication. The moral satisfaction is unpayable. This has nothing to do with government or policies. . . . Our movement is FETSALUD. It got us the collective agreement. We have paid time off, uniforms, really good things. That's our reward.

## Conclusion

Contradictory positions on the appropriateness of labor militancy are present among the study participants in both countries. Most were highly critical of the policies and authorities that oppressed them. But most also used a "language of submission" exemplified in terms like vocation and *mística*. While this is undoubtedly part of a strategy for coping with oppression, several participants themselves acknowledged it also dampened thoughts of militancy. The findings also point to a persistent hold of religion on the outlooks of many nurses, and suggest that this reinforces a culture of subordination. It is noteworthy that Honduras shares in common with El Salvador and Nicaragua a high level of societal religiosity, yet nurses there have been much more assertive and militant on several occasions over the past decade and a half, conducting strikes for higher salary in the early 2000s, and more recently, protesting around broader political and policy grievances. Without specific studies, we can only speculate on how generalized religiosity in Honduras affects nurse training and socialization, or how nurses reconcile religiosity with their willingness to defend their interests and oppose injustice. But from Pine's (2013) study, it appears that leading into the prolonged period of nurses' mobilization after the 2009 coup, dramatic events generated a sense of urgency and promoted unity with their main allied occupational group,

the *auxiliares*. Her work suggests that this overcame the default conservatism of the RNs, tipping the scale more toward oppositional consciousness and action, and politicizing their views of their care obligations.

An additional impediment to nurses' militancy in both countries is the lack of experience with unions specific to RNs. The multioccupational unions have inherent limits in attracting RNs, much less acting as vehicles for their demands, or working to cultivate oppositional consciousness. In Nicaragua, the political environment places further limits on the potential for health-care unions and the professional association to lead a transformation from resignation to resistance. While most of the Nicaraguan participants were harsh critics of government policy and of their superiors and employers, their space for criticism and collective action is highly constricted in the current climate. Although in Honduras, governmental intolerance of dissent was more severe and brutal, paradoxically, the political crisis generated multisectoral coalition-building that pulled in nurses. The fact that the *auxiliares* had their own association and identified more with the working class was an additional influence on the RNs when crisis struck.

More comparative scholarship is sorely needed on nurses' organizations and collective action in the global South. Central and Latin America are a good place to start given the core features these countries share in common, stemming from their colonial past. There is a need for studies that document more of the exceptional cases of nurse militancy in Latin America, and that analyze what disrupts or modifies the influence of religious indoctrination in nurses' training. Fruitful directions to explore in this regard would be the role of women's movements, given their influence on nurse intellectuals in the global North (Hoffman 1991; Malka 2007), and nursing associations' links with broader labor and social movements. Considering that adherents of evangelical Protestantism are more committed to their faith than most Catholics are, attention should also be paid to whether the growth of these denominations affects the religious views that nurses bring to their work. Last, taking lessons from the Honduran case, research should examine the role of political, economic, environmental, and other forms of crisis. In Nicaragua, a multisectoral resistance movement comprising feminist, environmental, peasant, and indigenous groups has been emerging in defiance of Sandinista authoritarianism (Burridge 2016). Whether Nicaraguan nurses join in such initiatives, perhaps through new, informal organizations, remains to be seen, but it may require a more politicized understanding of care.

## Acronyms

AEN—Nurses' Association of Nicaragua (*Asociación de Enfermeras/os Nicaraguenses*)

ANES—National Association of Salvadorean Nurses (*Asociación Nacional de Enfermeras de El Salvador*)

ARENA—National Republican Alliance (*Alianza Republicana Nacional*)

EMP—Medical Provider Business (*Empresa Médica Previsional*)

FETSALUD—Health Workers' Central (*Central de Trabajadores de Salud*)

FMLN—Farabundo Martí National Liberation Front (*Frente Farabundo Martí de la Liberación Nacional*)

FSLN—Sandinista National Liberation Front (*Frente Sandinista para la Liberación Nacional*)

ICN—International Council of Nurses

INSS—Nicaraguan Social Security Institute (*Instituto Nicaraguense de Seguro Social*)

ISSS—Salvadorean Social Security Institute (*Instituto Salvadoreño de Seguro Social*)

MINSAL—Health Ministry (Nicaragua) (*Ministerio de Salud*)

MINSAL—Health Ministry (El Salvador) (*Ministerio de Salud*)

SIGPTEES—Union of Nursing Professionals, Technicians and Nurses' Aides of El Salvador (*Sindicato Gremial de Profesionales, Técnicos, y Auxiliares de El Salvador*)

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## Notes

1. In El Salvador, National Republican Alliance's (ARENA) plans to follow health-care spending cuts with major restructuring through privatization were halted by strike action and social protest in 1999 and 2001-2002. In contrast, there was little social movement resistance to market-oriented reforms in health care in Nicaragua, which allowed the social security institute (INSS), covering about 24 percent of the population, to be largely privatized (Lesage Cruz 2001).
2. *Auxiliar* translates roughly as nurses' aide or nursing assistant.
3. Some sources refer to this as the "expanded" market basket (*canasta básica ampliada* in Latin America), restricting the "basic" basket to food expenses only.
4. Personal correspondence with key informant, October 2016.
5. Although accurate data on numbers of nurses working in the private sector do not seem to exist for either country, clearly the associations' share of all eligible nurses is smaller when they are factored in.
6. This would represent about 28 percent of El Salvador's 4,237 registered nurses (RN) in the two sectors (Ministry and ISSS) most promising for union recruitment. In Nicaragua, I was unable to obtain on the share of nurses among the 32,000 members of Health Workers' Central (FETSALUD) (El 19 Digital, May 2015), due at least in part to leaders' reticence.
7. Adams (2011) refers to these orientations as "professionalist" versus "unionist."
8. This and all translations from Spanish are mine.
9. In 2001, 5,000 public-sector nurses together with 5,000 paramedics from across Honduras went on strike to demand fulfillment of a salary agreement (Reuters 2001). Nurses conducted work stoppages again in 2006 to demand an increase in their monthly base salary from \$417 to \$548 (Associated Press 2006), a rate of pay considerably higher than in Nicaragua.

10. Sor Evelia was a nun credited with founding the profession in El Salvador, and also the name of the old state-funded school founded in 1950 and closed in the mid-1990s.
11. Notwithstanding the visibility of Catholicism, since the 1980s, the percentage of Salvadoreans and Nicaraguans belonging to Protestant Evangelical faiths has grown appreciably, reaching 36 percent and 40 percent, respectively (Pew Research Center 2014). Reflecting this diversification, several hospital nurses recounted efforts they made to link patients with the clergy of their faith preference.
12. ILO C-151, C-135, C-087, and C-098 are the Labor Relations Public Service Convention, the Workers' Representatives Convention; the Freedom of Association and Protection of the Right to Organise, and the Right to Organize and Collective Bargaining Convention. As explained by a Salvadorean labor law expert, the C-087 and C-098 faced delays due to aspects that were incompatible with the Constitution.
13. For an indication of how generalized the awareness of authoritarianism in Nicaragua has become, see <http://www.nytimes.com/2016/08/05/opinion/dynasty-the-nicaragua-version.html>.

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## Author Biography

**Lisa Kowalchuk** is a sociologist at the University of Guelph, Canada. Her research has encompassed social movements related to land reform and health-care policy in El Salvador, as well as the labor conditions of nurses in El Salvador and Nicaragua.