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FROM CONCEPTIONS TO CAPACITY

A PHENOMENOGRAPHIC STUDY OF HEALTH PERSONNEL AND THEIR CONCEPTIONS OF CHILD SEXUAL ABUSE AND HEALTH SERVICES IN ESTELÍ, NICARAGUA

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Abstract

Child sexual abuse (CSA) is a significant public health problem with serious consequences for human and socioeconomic development. In Nicaragua there is a dearth of information about CSA in relation to the health sector. The purpose of this study was to assess the Nicaraguan health sector's most fundamental capacity to respond to CSA, by way of investigating the conceptions constituted amongst health personnel in regards to CSA and CSA health services. The study was guided by phenomenography, a qualitative research approach used to reveal and describe conceptions from a second-order perspective. Twenty-three semi-structured interviews were conducted with governmental and non-governmental health personnel in the Nicaraguan city of Estelí. They revealed that interviewees conceptualized CSA as *Pathology, Crime* and *Devastation.* The same personnel conceptualized CSA services as *Extraneous specialty, Desired specialty, Professional duty* and *Human duty.* The interviewee sample was found to demonstrate desire and will to serve CSA survivors, although further training was required. The two sets of conceptions were consolidated to form a framework for understanding health personnel conceptions of CSA and CSA services. This framework should be useful for future health sector decisions, particularly regarding the promotion, design and evaluation of future CSA training for health personnel.

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Acronyms

CSA	Child sexual abuse
FGD	Focus group discussion
MINSA	Ministry of Health
NGO	Non-governmental organization
SILAIS	Local System for Integrated Health Attention
UNAN	National Autonomous University of Nicaragua
WHO	World Health Organization

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Chapter 1: Child sexual abuse in Nicaragua

Introduction

Child sexual abuse (CSA) is a significant health problem throughout the world. The most current figures estimate an international prevalence rate of five to ten percent in men, and 20 percent in women (García Moreno, et al., 2005; Heise, 1994; Runyan, et al., 2002:64). In fact, the Pan American Health Organization (2007:13) recently identified the abuse of children as a constraint on the achievement of the fourth Millennium Development Goal to reduce child mortality. High-income and low-income countries alike have struggled in the face of CSA. Yet poorer countries are limited by scarcity of resources and competing priorities. Prevalence investigations in Nicaragua, the second poorest nation of the Americas (World Bank, 2007) and the research setting of this study, have concluded that 20 to 32 percent of the studied population has suffered CSA (Contámelo, 2003; Olsson, et al., 2000).

Sexual violence is the only typology of violence that requires at least a perpetrator and a victim; it cannot be self-directed (Dahlberg & Krug, 2002). As such, CSA depends on power dynamics (Instituto Nicaragüense de la Mujer, 2001; López, 2005; Velázquez & Sequeira, 2000). It is most often – but not necessarily – characterized by disequilibrium of age between aggressor and victim. It is further defined by the sexual character of acts committed, absence of consent from the victim, and rupture with social norms. A recent publication of the World Health Organization (WHO) defines CSA as:

> …the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society (Butchart, et al., 2006:10).

However, it is worth highlighting that the definition of CSA does not exclude adolescents; both children and adolescents can be victims (Valladares & Peña, 2006).

The Nicaraguan Code of Children and Adolescents considers children to be those who have not yet reached 13 years of age, and adolescents to be between 13 and 17 years of age, inclusive (Consejo Nacional, 2006:6).

Sexual abuse of children and adolescents represents an important obstacle for health and development in Nicaragua, yet not all health personnel demonstrate that they are fully capable of addressing CSA survivors' needs (Expert Meetings, 2007; see Appendix C). The purpose of this thesis is to assess the health sector's capacity to respond to CSA. In a way that befits a low-income setting, the assessment concentrates on health personnel as the fundamental resource units of the health sector. Additionally, this thesis answers a call to know how health personnel understand CSA and CSA services. Very little, if any, other research in Nicaragua has focused on CSA and health personnel, let alone the health sector.

Seeking conceptions

The services that health personnel provide to their patients are unavoidably (and often unconsciously) informed by their personal ideas, experiences and bias (Helman, 2000; Svensson, 1997). In this way, health personnel's conceptions of CSA influence the services they provide to CSA survivors. Based on interviews with a sample of governmental and non-governmental health personnel in the northwestern Nicaraguan city of Estelí, this thesis seeks health personnel's conceptions of both CSA *and* the services they provide to CSA survivors. Thus, this study's research questions are as follows:

1) What conceptions of child sexual abuse appear amongst health personnel?

2) Given their conceptions of child sexual abuse, how do health personnel relate to the health services they provide to sexually abused children and adolescents? In other words, what are their conceptions of these services?

The answers to these questions should not only shed light on the degree of sensitivity to CSA within the Estelí health sector, but also identify areas for improvement of

health services and personnel training. It is one thing to be knowledgeable about the facts of CSA, and yet quite another to recognize when and how to apply that knowledge. For this reason, the second research question directly investigates into how health personnel understand their roles in the treatment of CSA survivors. As will be discussed, both detection and treatment of CSA within the health sector are essential.

This study is theoretically and methodologically underpinned by phenomenography, a qualitative research approach used to reveal and describe conceptions of phenomena. The implications of phenomenography will be explained at length in Chapter Two. But first, a more complete contextualization of the research problem under study is necessary.

Child sexual abuse, health and development

The health impact of CSA is well documented by predominantly American studies. Relationships have been found between CSA and the adoption of high-risk behaviours, such as smoking and poor diet, that lead to major adult non-communicable diseases such as heart disease, cancer and lung disease (Runyan, et al., 2002:69). Behavioural, psychological and physical problems include, among others: any behaviour peculiar to the child; depression; suicide; pregnancy; urinary tract infections; sexually transmitted infections; and migraines (Asociación, 2006:10; García Moreno et al., 2005:53; Rugada & Velásquez, 2000:60). A commonly accepted framework for understanding the trauma inflicted on CSA survivors identifies four core injuries of abuse: traumatic sexualization, betrayal, stigmatization and powerlessness (Finkelhor & Browne, 1985). This psychological distress, left untreated, tends to lead survivors to eventually abuse others (Strickland, 2008; Stordeur and Stille 1989 in Heise, 1994:28). Thankfully, commensurate health care is likely to prevent the abused from becoming the abuser. Thus, efficient and effective immediate and long-term health services contribute to the prevention of CSA before it occurs.

However, in Nicaragua, the problem of CSA has traditionally been shrouded in secrecy. Not until 1993 did a non-governmental organization (NGO) in the capital city, Managua, initiate the first project in the country to unearth the impact of sexual abuse of children (Expert Meetings, 2007). Sexual abuse researchers, psychologists and activists alike claim that because of CSA's sexual character, Nicaraguan society has been slow to accept it as a public issue (Expert Meetings, 2007). This is not uncommon – all societies have at one time closed their eyes to sexual violence against children, especially for its likeliness to occur within the family (Scutt, 1983). Meanwhile, abuse and violence exact heavy tolls on human and socioeconomic development, particularly when directed towards children (Dahlberg & Krug, 2002; Ellsberg & Clavel, 2001; Heise, 1994; Herman, 1992; Morrison & Orlando, 1997). Research shows that the earlier in life violence occurs, the more profound and persistent are its health consequences (Burnam, et al., 1988 in Heise, 1994:4).

Despite much CSA research in high-income countries, there is a dearth of literature dealing with poorer countries (Leventhal, 1998). Nonetheless, links have been drawn between the incidence of CSA and low-income settings characterized by financial insecurity, low levels of education, underemployment and socioeconomic deprivation (Butchart, et al., 2006; Farinatti, et al., 1990; Kotch, et al., 1995). David Finkelhor (1994), an internationally renowned expert in child abuse research, arranged CSA risk factors in two groups: those factors that lessen the quantity and quality of parental care; and those that produce susceptible, emotionally deprived children. Conditions in Nicaragua – extreme poverty, low levels of education, parents working abroad, a sizeable proportion of children and adolescents themselves working – are arguably conducive to CSA (MINSA, 2007a).

If figures from recent investigations were representative of the entire country population, well over one million Nicaraguans today would be survivors of CSA (Contámelo, 2003; Olsson, et al., 2000). A 2004 study in Somoto, a tranquil mountain town near the Honduran border, found that one-quarter of children and adults, and up to two-thirds of teachers, personally knew children or adolescents who had been sexually abused (Escobar, et al., 2004 in Valladares & Peña, 2006:14). Furthermore, a review of the client registry in the Estelí Forensic Clinic found that in 2007, in 87 percent of *rape, sexual offence* and *sexual abuse* cases attended, the victim was a

child or adolescent (Clínica forense Estelí, 2008). Not only does CSA affect one-fifth of the population, sexual violence disproportionately victimizes one of the most vulnerable groups in society.

A gradually increasing number of studies form an ever clearer image of the prevalence and incidence of CSA in Nicaragua, but little attention is paid to the health services needed by CSA survivors. UNICEF Nicaragua recently announced that more than 70 percent of new HIV cases detected in Nicaraguan adolescent women are due to sexual violence (La Prensa, 2007). Evidence also shows that CSA survivors experience more health problems, and visit health clinics and hospitals more frequently, than those who have not lived abuse (Dahlberg & Krug, 2002). In 1991, participants in a national conference for children identified physical and sexual abuse as the most important health issues facing Nicaraguan youth (Heise, 1994:11). Unfortunately, as Leventhal (1998) suggests, in poor countries such as Nicaragua, violence and abuse simply might not be viewed as important to the country's public health, relative to other issues.

A momentous role for health personnel

Health personnel are extremely well placed to detect and treat abuse. In particular where the family or guardian aims to conceal abuse and does not report it to the police, health personnel may be the only authorities to have contact with the victim (Heise, 1994:34). Thus, health personnel are in a position to play an extremely important role.

In Nicaragua, the bulk of responsibility for meeting CSA survivors' health needs has been assumed by NGOs (Castillo & Amador, 2001:30; Expert Meetings, 2007). A 2005 study on commercial sexual exploitation of children found that Estelí residents saw NGOs as much more capable in dealing with issues like CSA than were state institutions (Explotación Sexual Commercial, 2005). Another source goes further to say that of all public institutions, the Ministry of Health (MINSA) is seen by Nicaraguans to be the least involved in violence prevention and child protection (Antillón & Martínez, 2007:65). Even so, the ministry deserves credit for having

taken some significant steps in a fairly short time. In 1996, intrafamily violence was recognized as a public health concern by ministerial decree (MINSA, 2001). In 2001, MINSA adopted a protocol for attention to situations of intrafamily violence (MINSA, 2001). Unfortunately, these and similar other policies or protocols are not widely known by health personnel (Ellsberg & Clavel, 2001:17).

Five years ago, MINSA employees in Estelí were the first governmental health personnel to be trained in CSA services, albeit with emphasis on how to detect abuse rather than how to care for victims (Expert Meetings, 2007). Concurrently a protocol for attending to child abuse was elaborated and approved; but for unknown reasons, this protocol was never implemented (Expert Meetings, 2007; SILAIS, 2008). As well, Estelí is home to a health network against violence, composed of local state institutions and NGOs, and international organizations. Unfortunately, during field research for this study, the network lay dormant because no one was available to coordinate activities (SILAIS, 2008). This is despite increasing interest in CSA among the Nicaraguan public, stirred thanks to the initiative of groups such as the Managua-based Movement Against Sexual Abuse, which even has its own weekly column in *El Nuevo Diario,* a major newspaper.

Yet experts insist that the governmental health sector does not match NGOs in its provision of care to CSA survivors. Many even say that governmental health personnel lack knowledge and training, or are lazy (Expert Meetings, 2007). One activist – a CSA survivor – declared that she hoped this thesis would tell her what health personnel actually *think* when confronted with CSA. Consequently, this thesis examines an aspect heretofore neglected in Nicaraguan CSA research in spite of its paramount importance: the health sector and its personnel.

Thesis structure

The next chapter discusses the phenomenographic research process, including an explanation of phenomenography and its suitability to this study, as well as an outline of phenomenographic data collection methods and phenomenographic data analysis. Chapters Three and Four present the results to the first and second research questions,

respectively. Chapter Five links the two sets of conceptions as derived from the two research questions, and follows this with a discussion of the implications of research. Finally, recommendations and concluding remarks are given in Chapter Six.

Chapter 2: The Phenomenographic Research Process

The research questions of this study seek the conceptions of CSA and CSA health services that appear amongst health personnel. A qualitative strategy to answer these questions was chosen for its suitability to create an empirically grounded and theoretically informed reflection of research participants' reality, and to provide material for interpretation of phenomena and the external world (Brockington & Sullivan, 2003; Ragin, 1994).

Three qualitative methodologies were originally considered: grounded theory, phenomenology and phenomenography. Grounded theory was rejected first, on the basis that unlike the other two methodologies, it does not specifically aim to reveal human experience, and is therefore less in line with the study's questions. Phenomenology was rejected second. As their names suggest, phenomenology and phenomenography are similar in that they focus on the analysis of phenomena experienced by humans. However, they share theories and methods only to a limited extent – if at all (Hasselgren & Beach, 1996; Marton & Booth, 1997; Svensson, 1997). Phenomenology centers on pre-reflected cognizance while phenomenography explores conceptions, the reflected understanding of human experience, through a second-order perspective (Marton, 1981). While first-order perspectives, in which participants *describe* their experiences, are more common, a second-order orientation allows for description of participants' *reflected understanding* of the world, as seen through their eyes (Marton, 1981; Marton & Booth, 1997). Furthermore, phenomenological research collects a small number of individuals' conceptions of a phenomenon, whereas phenomenography is less concerned with individual experience than describing collective meaning (Barnard, McCosker & Gerber, 1999). As this thesis required the collection of a broad range of conceptions, phenomenography

became the approach of choice. As will be explained, phenomenography guided all theoretical and methodological thought during the design, data collection and analysis phases of this study.

Phenomenography

Origins and features

In the 1970's, in rupture with the dominant quantitative tradition of the time, a group of researchers at Gothenburg University in Sweden sought to qualitatively describe learning and knowledge in terms of the meaning that the individual student attributes to that knowledge (Svensson, 1997). Conceptions, or the internal relation between an individual (subject) and a given phenomenon (object), were central to their research as the main form of knowledge (Marton, 1994). The research group found that the number of qualitatively different ways in which a phenomenon could be conceptualized was limited, and that by describing these conceptions, meaning and knowledge could be empirically explored (Marton, 1981; Svensson, 1997). This was beneficial because teachers that knew the conceptions constituted amongst their students would be better prepared to change, modify or replace these conceptions (Marton, 1981). Thus, phenomenography was borne out of Educational Psychology.

Ference Marton (1981:180) was the first to use the term *phenomenography* in his proposal for a new empirical, theoretically deductive research specialization geared towards "experiential description," or descriptions of conceptions of the surrounding world. Phenomenography highlights the significance people ascribe to what they experience. Marton (1994:4424) describes phenomenography as "the empirical study of the differing ways in which people experience, perceive, apprehend, understand, conceptualize various phenomena in and aspects of the world around us." It is a non-dualistic approach according to which there is but one world understood in a variety of ways instead of two worlds: real and subjective (Marton, 1992 in McCosker, 1995). It studies the variation in ways of understanding and experiencing the same phenomenon, always via a second-order perspective that seeks to see the world

through the participants' eyes. In this second-order perspective, research subjects are encouraged to explore the meaning of their experiences, as an alternative to merely describing them (Marton & Booth, 1997).

Despite its invention in Sweden only three decades ago, phenomenography has since been applied in several locations including Australia, Hong Kong, Uruguay, Canada and the United States (Dall'Alba, 1996). The approach has also ventured outside the education realm and found a place in other fields, including domestic violence against women (McCosker, 1995) and nursing research (Sjöstrom & Dahlgren, 2002). Certainly, knowledge about the different ways health care is experienced and understood is key to improving services (Barnard, McCosker & Gerber, 1999; Sjöstrom & Dahlgren, 2002). Bowden (1996) has dubbed his own phenomenographic work "developmental phenomenography," for its ability to endow individuals with greater ability to change or learn. Phenomenographic results can be exploited in the design of learning experiences or training. Indeed, the results from this study should be used to inform future decisions related to sexual abuse and health services, in Nicaragua and elsewhere.

Criticisms

Hasselgren and Beach (1996) have faulted phenomenographers for their supposed lack of reflection over the relationship between data and the research participants' understandings and experiences. Säljö (1996, 1997), a staunch critic of phenomenography, depreciates the approach to a kind of discourse analysis; he asks how the conceptions of phenomenographic research represent actual experience, when talk about experiences is, simply, talk. Phenomenographers reject these critiques on the premise that talk is informed by the speaker's experience and internal relationships with the external world (Marton & Booth, 1997). In phenomenography's favour, Edwards (2006) found that her research subjects' conceptions easily matched their experiences.

Other criticisms of phenomenography concern the validity and reliability of the approach. Cope (2004) discusses this quite thoroughly and suggests that to increase

phenomenographic validity and reliability, research should be predicated on an analytical framework of the *structure of awareness.* In this study, the structure of awareness is incorporated into all aspects of research as a way to openly account for methods used, and to yield results as faithful as possible to the phenomena, data and research participants.

The structure of awareness

According to phenomenography, human awareness is structured and thematized. As an example, while a pediatrician in a health clinic attends a patient, the patient should be at the fore of the pediatrician's awareness and other things, such as the queue outside the pediatrician's office, should recede to the ground. The "fore" and "ground" of awareness are referred to as the *internal* and *external horizons,* respectively (Marton & Booth, 1997). The internal horizon is made up of the object of focal awareness – for example, the pathology of the child patient and the treatment being given. The external horizon contains all that which is related to or concurrent with the object of awareness, such as the medical history of the child, the queue outside, and the pediatrician's beliefs, values, morals and culture. While the internal horizon contains the discerned attributes of the object, the external horizon makes up the limits of understanding, or the pre-reflective aspects of the object (Bruce, 1992 in Barnard, McCosker & Gerber, 1999). In this example, the pediatrician's structure of awareness can be diagrammatically represented as below in Figure 1, where the encompassing oval is the external horizon, the inner oval is the internal horizon, and the small circles are dimensions of variation within the internal horizon (Cope, 2004; Marton & Booth, 1997).

Together, the internal and external horizons constitute the *structural* aspect of awareness. A proper description should also include its *referential* aspect, which is the intrinsic meaning of the structure (Cope, 2004; Marton & Booth, 1997). In the example above, the referential aspect might be "Pediatrician care under time pressure." Throughout this thesis, health personnel's conceptions will be represented and described according to the structural and referential aspects of a structure of awareness.

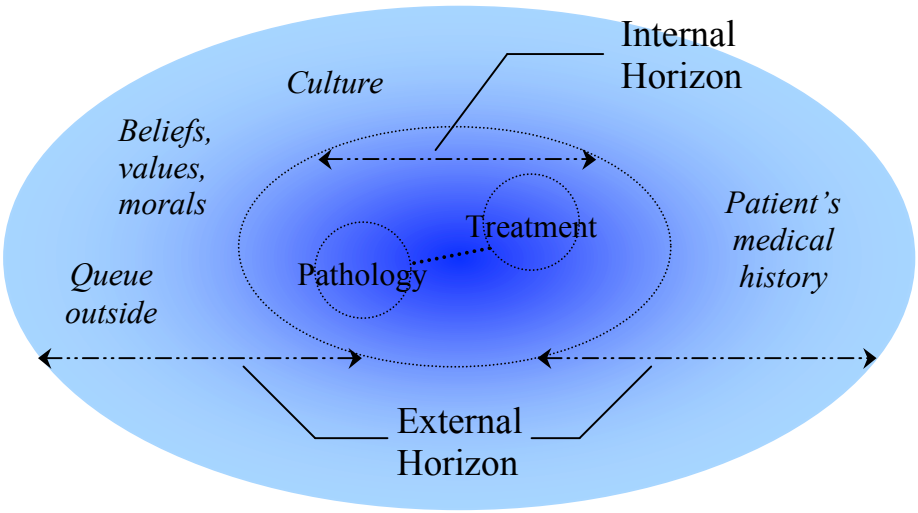

Figure 1: Structure of awareness – a hypothetical example
Source: *Adapted from Marton & Booth, 2007 and Cope, 2004*

Outcome

The outcome of phenomenographic research is description and comprehension (Cope, 2004). Results of analysis are presented as *categories of description* and *outcome space*. The categories of description aim to describe the elemental meaning of the phenomenon under study, but cannot be confused with the conceptions themselves; they are but attempts to express, as accurately as possible, the qualitatively different ways of conceptualizing the phenomenon (Bowden, 1996; Sandberg, 1996; Svensson, 1997). The outcome space arranges the categories of description in a sequential or hierarchical manner with respect to the relations between the revealed conceptions. As such, the outcome space displays the range of ways of experiencing or conceptualizing a phenomenon, and identifies the critical factors necessary to understand the phenomenon as a whole, and apply findings (Marton & Booth, 1997).

Summary

Phenomenography is a qualitative and empirical research approach underpinned by assumptions about the nature of conceptions; namely, that there are a finite number of qualitatively different conceptions of a given phenomenon, which are determined by the internal relation between the phenomenon (object) and the individual (subject). Phenomenography is thus suitable to produce rich data in response to this study's research questions, and discover not just what health personnel know about CSA but describe how they conceptualize CSA and CSA services.

Data collection

Estelí

All primary data were collected in Estelí, a municipality of more than 122,000 people, located approximately 150 kilometers north of Managua (MINSA, 2007a). Estelí is the capital of the department of the same name, and the administrative and commercial hub of northern Nicaragua (MINSA, 2007a). The third largest city in the country, Estelí comprises urban and rural areas, home to 79 and 21 percent of the population, respectively (MINSA, 2007a). According to many experts, the department of Estelí has led the country in efforts to raise population awareness of issues such as violence and abuse, and is, in fact, very likely one of the areas most sensitized and capacitated in regards to CSA (Expert Meetings, 2007; MAIS-UNICEF, 2007; SILAIS, 2008). Even so, Estelí data from 1995 – the most recent available – reveal that one out of every five children is born to an adolescent mother (MINSA, 2007a:20). Such figures point to abuse (MINSA, 2007a; Pan American Health Organization, 2007:411).

The Local System for Integrated Health Attention (SILAIS) is the local MINSA body that oversees all health services in Estelí. Governmental services consist of two main entities: Hospital San Juan de Dios, the regional hospital located within city limits that offers basic hospital services but lacks a psychology department; and Health Centre Leonel Rugama (henceforth the Centre), a primary attention clinic visibly

positioned on the Pan American highway that runs through the core of the city (MINSA, 2007a). The Centre, in turn, coordinates 15 smaller health posts – six in the urban sector and nine in rural areas – scattered throughout the municipality (MINSA, 2007a). These services are identified on the map in Figure 2.

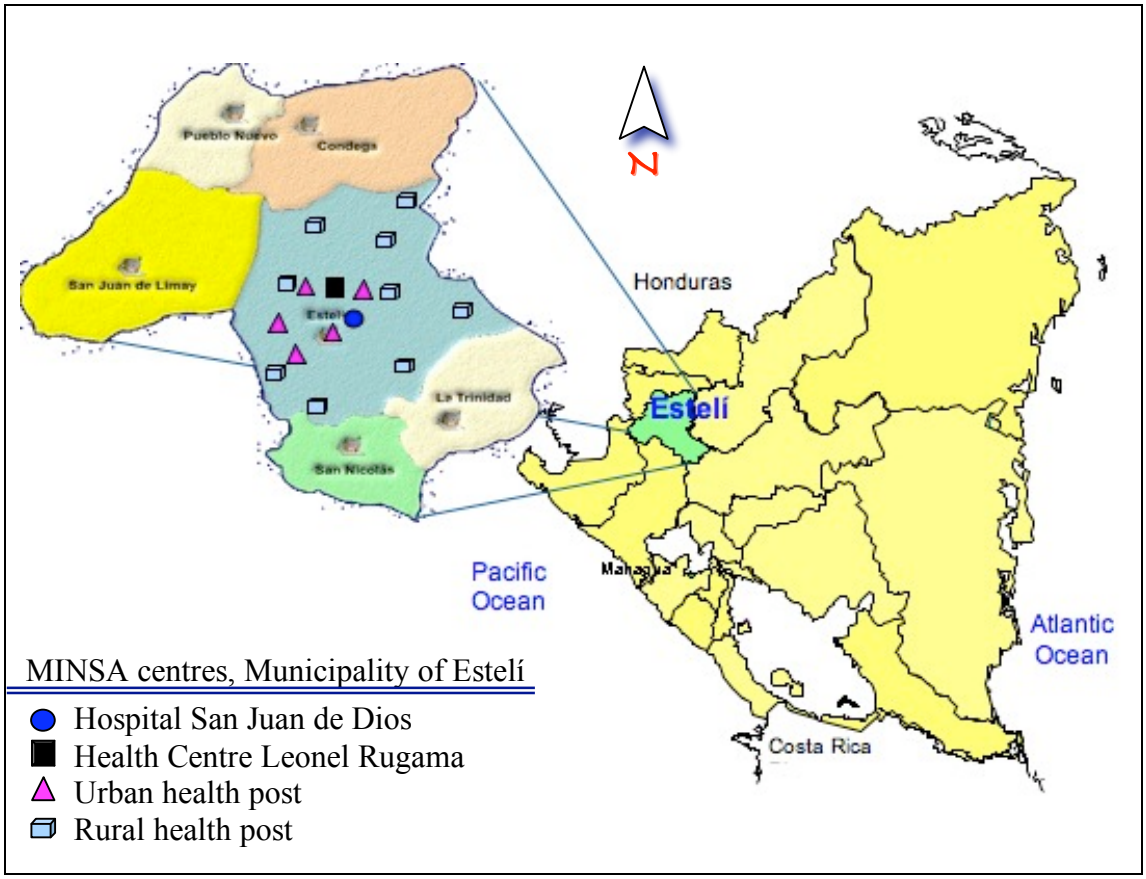

Figure 2: MINSA centres in the municipality of Estelí, Estelí department, Nicaragua
Source: *Adapted from MINSA, 2007b*

Estelí serves as a gateway to many smaller mountain towns in the northwest of Nicaragua; therefore there is an appreciable presence of international development agencies and other NGOs. SILAIS monitors the health services these groups provide as well, but more for purposes of collaboration than control (CARE, 2008).

Data collection was limited to the urban sector of Estelí. Although inclusion of rural areas might possibly have imparted interesting variation in the conceptions of health personnel, travel to and from these areas could not be arranged in the short time available for data collection.

The interview

Conceptions are the internal relations between a subject and an object, an individual and a phenomenon (Marton, 1994; Svensson, 1997). The interview was thus chosen as the principal method of data collection, for its ability to extract and illuminate research subjects' conceptions of CSA and the services they provide to CSA survivors (Barnard, McCosker & Gerber, 1999; Dahlgren, Emmelin & Winkvist, 2007; Kvale, 1996). Interviews are also a standard method in phenomenographic research, seen as a vehicle to incite reflection on experiences and reveal the relation between the interviewee and the phenomenon under study (Barnard, McCosker & Gerber, 1999; Francis, 1996).

Twenty-three audio recorded interviews with health personnel were completed. The average interview duration was 45 minutes. The researcher's level of fluency in Spanish was easily sufficient to engage interviewees in discussion, and not once was language thought to hinder the interviews. The aim of each interview was to delimit the two objects of CSA and CSA health services from their external horizons of awareness, and to reveal interviewees' conceptions of the phenomena (Svensson, 1997). Interviewees were oriented towards reflection on their experiences with CSA, and to thematize the different aspects of their conceptions. To quote Marton (1994:4427) once more:

> The experiences, understandings, are jointly constituted by interviewer and interviewee. These experiences, understandings, are neither there prior to the interview, ready to be "read off", nor are they only situational social constructions. They are aspects of the subject's awareness that change from being unreflected to being reflected.

In other words, the interviews took a second-order perspective. Rather than ask interviewees to describe their knowledge about CSA and their experiences providing services to CSA survivors, the goal was to maintain an exchange that would ultimately generate reflected understanding of CSA and CSA services – through the interviewees' eyes. Although at times a first-order perspective could not be altogether

avoided, the interviews did reach a second-order, reflected understanding. More than one interviewee expressed thanks for having been motivated to reflect in such a manner. Towards the end of an interview, one interviewee confided:

> It's almost never that someone comes to you to speak like this, that they ask you questions about this topic. This is the first time someone has come and asked me. Yes, we know there is a lot of child abuse, but for someone to come and interview you about it, in that moment it makes you think. (9.20)

Despite the specific aims of the interviews, no standardized interview structure was adopted. Holstein and Gubrium (1995) justify this decision in their description of an "active" interview that endeavours to gain from the process in which respondents bring together different horizons and aspects of meanings, inadvertently disclosing how they construct experiential meaning. A rigid interview structure would only hinder this process. Thus, as Kvale (1996) suggests, an exploratory type of semi-structured interview was employed.

Interviewees were encouraged to elaborate on their answers in a way that led to greater delimitation of the phenomena of discussion. In some cases, personnel spoke very readily, even without initial questioning. However, most interviews began with three hypothetical vignettes that described common situations of health service provision to sexually abused children or adolescents (see Appendix A). The personnel were asked to explain their reactions, actions and thoughts in each situation. The vignettes were designed after extensive review of available secondary data on CSA in Nicaragua, and were further informed through discussion with a number of Nicaraguan experts. The intent was not to delude the interviewees, but rather inspirit them to speak vividly about their understanding of CSA and health services. The choice to begin with vignettes was deliberate, so as not to pose a sensitive and abstract question that might cause unease, or result in an answer that was "clichéd and empty of grounded meaning" (Mason, 2002:228). Instead, the interviewees could determine the dimensions of their response and respond in a way that revealed their conceptions without risking direct moral exposure (Mason, 2002).

All interviewees were presented with the same three vignettes. A variety of prompt questions were then employed to investigate the characteristics of the phenomena (internal horizon) as well as their limits of understanding (external horizon) (Bruce, 1992 in Barnard, McCosker & Gerber, 1999). The most common prompt questions used are located in Appendix A, but it must be stressed that not all of these questions were used in every interview, nor were questions limited to those included in the guide. The prompts used, and their order, were entirely dependent on the particular interview situation and the degree to which the interviewee still needed to delimit his or her conceptions and reflect upon the meaning of experiences (Kvale, 1996; McCosker, 1995; Svensson, 1997). Many times, patience and silence – truly bestowing the interviewee with time to reflect – were the most effective ways of prompting (Kvale, 1996; van Manen, 1990).

In every interview, a "deliberate naïveté" was assumed (Kvale 1996:30). Phenomenography borrows a phenomenological term, *bracketing*, to describe the same action (Marton & Booth, 1997). This naïveté, or bracketing, involves disregarding one's own preconceptions during research. The researcher made a conscious effort to step back from her own experiences and see the world through the eyes of the interviewees, and to avoid inadvertently passing judgment on the interviewee during the exchange (Marton & Booth, 1997; Flick, 2006). Indeed, every attempt was made to ensure that interviews unfolded as relaxed, interpersonal, private conversations. Before the audio recorder was switched on, and after it was turned off, time was allotted to engage in light, sociable conversation. This set an amiable tone for the interview.

As Kvale (1996) further suggests, before and after the recorded interview, interviewees were briefed and debriefed. In the first interviews a one-page explanation of the study and the interview was read during briefing. This was useful to standardize the information given to interviewees as well as calm any nervousness in the researcher while interviewing in a second language (see Appendix A). However, after performing a few interviews, the researcher felt more confident and could improvise recounting the same information without difficulty. All interviewees were invited to ask questions or discuss any concerns – an opportunity seized only by

a few who feared knowing too little about CSA to be helpful to the study. Debriefing also took place following the interview.

Most interviews were scheduled in advance for a time convenient to the interviewee. A handful of personnel – generally those working in the non-governmental sector – preferred interviews on the spot, immediately after being approached and learning about the study. All interviews occurred in the interviewee's workplace. All but two interviews were conducted in a private area away from other personnel or patients. In these two cases there was a steady trickle of personnel in and out of the room, but because the interviewees insisted they were comfortable and appeared to be so, the surrounding noise was not enough to affect audio recording, and the situation appeared inescapable, the researcher allowed the interviews to proceed.

Sampling of interviewees

This study intends to explore and describe the variation in health personnel's conceptions of both CSA, and the health services they provide to CSA survivors. Consequently, interviewees had to be employed in the health sector.

A non-randomized, purposive sample of governmental and non-governmental health workers in Estelí was interviewed. This sample does not allow for statistically sound generalizations to a larger population, but, in the least, it combines a diversity of professions and workplaces to obtain maximum variation across experiences, and thus conceptions (Creswell, 2007; Willis, 2006). In fact, Creswell (2007:126) calls this a maximum variation sample. Before contact with the interviewees was made, a list was drawn of different health professions and places of employment, and then effort was made to form a sample that varied based on these criteria, as well as sex and years of experience.

Access to the non-governmental sector was straightforward. Health personnel were approached in their place of work and often agreed to a spontaneous interview. By contrast, the written approval of SILAIS, which itself was dependent on ethical approval of the study by the Bioethics Committee of the National Autonomous

University of Nicaragua (UNAN), was required before interviews with MINSA staff could proceed. Once ethical approval was granted, SILAIS speedily sanctioned the study and interviews were arranged. This was done with the aid of gatekeepers in the administrative offices of the hospital and the Centre. Based on the list drawn in advance, the gatekeepers arranged contact with potential interviewees.

Interviewee characteristics

Twenty-three health personnel were interviewed. Five interviewees were men and 18 were women, a sex ratio that reflects the balance of personnel in the Estelí health sector (Centro Leonel Rugama, 2007). Years of experience of the interviewees ranged from two years to more than 25 years.

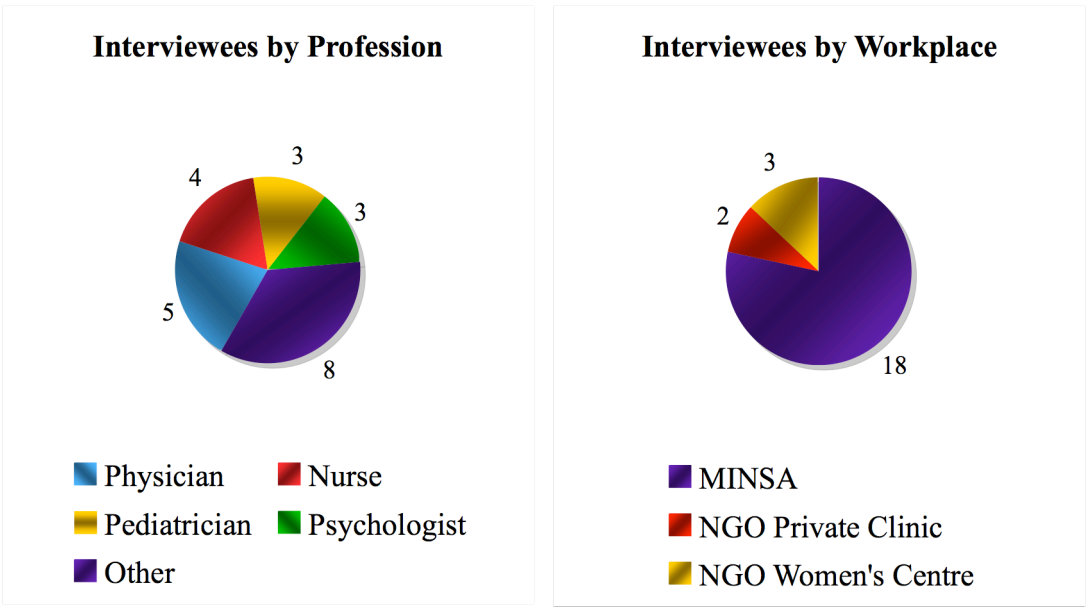

Figure 3: Interviewees by profession and workplace
Source: *Interviews, Estelí, 2007-2008*

The disciplines represented within this sample included general and forensic medicine; psychology; nursing; pediatrics; gynecology; gyneco-obstetrics; pathology; surgery; health education; statistics; and government administration. Figure 3 depicts the different professions and workplaces of the interviewees. Eighteen of the personnel were MINSA employees, three worked in non-governmental women's

centres that offer health services specifically for sexual abuse victims, and two worked in a private NGO clinic that offers a broader range of services. However, it must be noted that many of these personnel had double, or even triple roles. Many interviewees explained that they were employed in the governmental and non-governmental sectors, or even that they were forced to assume responsibilities from other medical specializations, due to scarcity of human resources in their workplaces.

Twenty of the personnel provided services directly to patients. Of these 20, only one claimed never to have provided services to a victim of CSA, alleging that CSA victims simply did not seek attention in her workplace. Of all 23 personnel interviewed, only eight attested to having been trained in attending to CSA victims.

Transcription

All interview audio recordings were passed to a hired Nicaraguan assistant for verbatim transcription in Spanish. The assistant had obtained an undergraduate degree in computer engineering the previous year, but was unemployed. The purpose of the study was explained and clear instructions to "transcribe every word!" were given to her before any transcriptions were begun (Kvale, 1996).

Before delving into analysis, all transcripts were proofread while listening to the audio recordings, ensuring that what had been converted to text retained what was felt to be the interviewee's original meaning. As Poland (2002) recommends, attempt was made to make certain no words were lost or mistaken, and that pauses, laughter and intonation – among other aspects – were presented in a way that the researcher could understand. The language of interviewees was not modified in any way in the transcripts, but selected statements were translated for presentation in this thesis.

Data analysis

Researcher background

Despite the best of intentions, no researcher can approach data analysis with an entirely open mind (Bryman, 2004). As part of a complete and open account of a study's method, phenomenographers have taken to acknowledging their backgrounds when writing about their research (Burns, 1994 in Cope, 2004).

Academically, the researcher is educated in the fields of international relations, international development and public health. Her studies are oriented towards issues of violence, specifically sexual violence. This academic interest stems from a year of employment as a Support Worker in a shelter for abused women and their children, in northern Canada. This experience is the context within which data analysis took place.

Several strategies were taken during analysis to continue to bracket own experiences (Marton & Booth, 1997), among them: audio recording and transcribing verbatim entire interviews to prevent pre-selection and unwitting exclusion of important data; meticulously proofing transcripts to ensure their highest quality; constant questioning and contrasting of interviewees' statements to unearth their truest meaning; and, perhaps most importantly, constant questioning of the researcher's own conceptions by keeping a journal of her assumptions and beliefs, and referring to this journal during data analysis – a practice suggested by Silverman (2005). Perhaps the most salient discovery made while writing this journal was that because of prior contact with Nicaraguan advocacy groups and a desire to help abuse victims, the researcher was subconsciously skeptical of governmental health services. Once aware of this bias, the researcher worked mindfully to bracket her experiences, which could otherwise have skewed data analysis. It is not believed that this bias tainted the interviews in any way.

Analysis of transcripts

Analysis began with the very first phenomenographic interview. Interviews are the first contact with the research subjects, hence the first opportunity to investigate their conceptions. Already in the interview, the researcher must attempt to see interviewees' experiences and understanding through their eyes.

Yet by far the most painstaking – and time-consuming – component of data analysis is transcript analysis. Phenomenographic analysis is defined in seven steps performed in an iterative, interactive manner, permitting movement back and forth between the different stages (Barnard, McCosker & Gerber, 1999).

The first two steps of phenomenographic analysis involve *familiarization* and *condensation*. Even though each of the transcripts had already been proofread for accuracy, they were all read again numerous times in order to gain familiarity of important themes, and to identify statements significant to the research questions.

These statements became the data to be analyzed. In a *comparison* stage, the variation in all the selected statements was noted. Bowden (1996:61) calls this a "cut-and-paste construction of the pool of meaning" when he points out that the isolation of statements risks a serious decontextualization through which meaning might be lost. Confessedly, a great deal of focus was placed on the selected statements in this study. Still, the full transcripts were referred to very regularly for context, so as not to render the analysis a purely abstract exercise (Säljö, 1996). Both Bowden (1996) and Säljö (1996) criticize phenomenographic researchers for giving disproportionate weight to statements extracted from their original milieu.

It is during statement (and transcript) comparison that the structure of awareness as an analytical framework might be most important. On Cope's (2004) suggestion, two fundamental questions were asked when trying to analyze how CSA and CSA services must be experienced in order for a quote to make sense to the speaker. The first question pertained to the external horizon: "how must CSA, or CSA services, be delimited from their context if this quote is to make sense?" The second concerned

the internal horizon: “what dimensions of variation must be discerned if this quote is to make sense?” Or in other words, “what aspects of CSA or CSA services are implied and what is the nature of the relationship between these aspects?” (Cope, 2004:14).

The final four steps of analysis – *grouping, articulating, labeling* and *contrasting* – relate to the formation of the categories of description. The selected statements were categorized according to the qualitatively different ways that CSA or CSA health services were conceptualized. These categories are distinct, logically related and collectively depict the similarities and differences in the participants’ conceptions (Marton & Booth, 1997). Each category was described, named, compared for similarities and differences, and then diagrammatically portrayed in an outcome space and in terms of the structure of awareness.

Focus group discussions as instruments for analysis

Following the completion of all phenomenographic interviews with health personnel and some preliminary transcript analysis, three focus group discussions (FGD) were conducted with three different groups: two self-help groups for women and girls who had been sexually abused, and one group of youth representatives from the Estelí Children’s Commission. Further information about the FGDs is located in Appendix B.

The FGDs were not meant to help answer this study’s research questions, but rather to generate data that would aid in the appraisal and discussion of the phenomenographic results. Especially considering that there is so little previous literature on this particular subject in Nicaragua, or even a low- or middle-income setting, the information gathered from the FGDs was invaluable. Also, as a foreign researcher, it felt imprudent to conduct such a study without also consulting with survivors of CSA, or even youth.

Expert interviews as instruments for analysis

In addition to FGDs, five expert interviews were conducted to aid in the evaluation of the study outcomes. The interviews were semi-structured, and informants were experts who were already familiar with this research. Further information about the Expert interviews is located in Appendix C.

A large part of these interviews focused on the discussion of anonymous statements selected from health personnel interviews. This discussion was important to determine whether the foreign researcher's understanding of the statement matched the understanding of the expert informants. One informant was able to review the statements beforehand and even loosely group them according to principles of phenomenographic analysis. It was shown that the informants and the researcher shared very similar interpretations of the meaning behind the statements, and potential categories of description.

Ethical considerations

CSA is a sensitive topic that presents several ethical hurdles. Research was designed and performed with respect to stringent ethical guidelines, as outlined in a research protocol submitted to the UNAN Bioethics Committee. This committee granted ethical approval of the study (see Appendix E).

Even though research participants were never directly questioned about personal experiences as *victims* of CSA, the first priority of research was their protection. The informed verbal consent of all participants was obtained and recorded before any research activities took place. A UNAN contact had advised not to seek written consent because asking participants to sign a form might be intimidating (Expert Meetings, 2007). All participants were fully briefed on the purpose and potential uses of research, the voluntary nature of their participation (and their freedom to withdraw at any time) and the measures to be taken to ensure confidentiality, anonymity, privacy and protection of materials.

Interview audio recordings and transcripts were shared only with the hired transcriber, who was never given information that could identify the participants. She was paid only after confirmation that all data still in her possession had been destroyed. All names were removed from transcripts, and all raw data is kept in password-protected files on the researcher's personal computer and external hard drive. In this thesis, only that information which cannot identify research participants is revealed.

Through the course of data collection, the researcher always carried information at hand about services for abuse victims, if ever it was necessary to refer a research subject to further professional support. This never occurred. Furthermore, a psychologist or physician was always present during each FGD. To the researcher's knowledge, no harm was caused to any research participant during research, such that professional support was needed.

The WHO (2001) states that researchers of violence against women have an ethical obligation to ensure their research is shared with relevant parties and put to effective use. The same tenet should be applied to research on violence against children. Following the presentation and defense of this thesis, a Spanish version will be written and shared with all participants, contacts and other interested parties in Nicaragua.

Trustworthiness of study

The outcome of any qualitative study depends on the relationships forged by the researcher with his or her research participants and data (Bryman, 2004). Also, given that the aims of phenomenography are conceptual rather than statistical, the concepts of validity and reliability are difficult to incorporate (Bryman, 2004; Sandberg, 1996). Therefore, efforts centered on achieving what Lincoln and Guba (1985, in Bryman, 2004:273) refer to as the *trustworthiness* of qualitative research.[1]

[1] Lincoln & Guba's (1985) terms of *credibility, transferability,* and *dependability* are used as explained in Bryman, 2004:273.

This study faced a number of limitations during the research process that may have impacted on the credibility and dependability of data. For example, reliance on gatekeepers to recruit a majority of the research participants risked creating a biased sample. To counteract this, firm requests were made for personnel of specific backgrounds and experience. Also, though it can be seen as a conception clarification process (McCosker, 1995:81), the interview is nonetheless a staged event that prohibits the collection of naturally occurring data (Silverman, 2005). Some interviewees could have deliberately concealed their full conceptions. Moreover, the researcher makes no claim to understand every nuance of the Spanish language, and while interviewing, the occasional opportunity to probe into interesting variation of experiences might have been missed.

This thesis espouses Sandberg's (1996) notion of *interpretive awareness*. The discovery and description of others' conceptions is not a task that anyone can guarantee to have fully achieved, but the reliability of research results can be bolstered through recognizing and dealing with subjectivity (Giorgi, 1988 in Sandberg, 1996). Effort to bracket one's own experiences, conceptions and biases – as attempted here – is one way to lend strength to research. As well, the structure of awareness as an analytical framework is used in this study to inform the reader in detail about how research was conducted. Even the results will be presented according to this framework, in a "manner which permits informed scrutiny" (Cope, 2004:15). Certainly, this thesis strives to rigorously account for each step of the study, which in turn should contribute to a high degree of intersubjectivity, and enhance the transferability of both method and outcome to other contexts.

Summary

Phenomenography forms the theoretical and methodological foundation of all aspects of this study. Twenty-three semi-structured interviews with health personnel in Estelí were performed, audio recorded and transcribed. The interview transcripts formed the main data for analysis, a meticulous and prolonged process of seven stages. The results of analysis will be presented in the next two chapters, wherein the structure of awareness will be used extensively as one means to increase intersubjectivity.

Chapter 3: Health personnel's conceptions of child sexual abuse

Inasmuch as the relational nature of conceptions means they are formed through thinking of external reality (Svensson, 1997), health personnel's conceptions of the services they provide to CSA survivors can be illuminated by knowledge about their conceptions of CSA itself – part of their external reality. In answer to this study's first research question, this chapter describes the conceptions of CSA amongst health personnel, as revealed through phenomenographic interviews and data analysis.

Three categories of description were found to describe the qualitatively different ways in which health personnel conceptualize CSA. Together, these categories represent a collective understanding of CSA amongst health personnel, not attributable to any one interviewee. Bowden (1996) has lamented that phenomenography is often criticized for denying voice to the individual, but as he justifies, this would be contrary to the phenomenographic aim: to discern the qualitatively different ways of experiencing a phenomenon. Even if a transcript is determined to portray a single category of description in particular, no assertion can be made that the individual is limited to this conception. All interviewees expressed more than one conception during the course of the interview.

Although the categories emerged from the transcript material quite plainly as commonalities of experience, they are not entirely uniform. The interviewees expressed conceptions in their own unique ways, hence some variation within the categories. This variation will be explored in complement to each category's internal cohesion, using selected interview statements as illustration. Every statement is followed by a code in parentheses that denotes its interview number and transcript page number.

Three categories of description were revealed:

Category One: Child sexual abuse is conceptualized as a significant *pathology*, particularly a mental pathology.

Category Two: Child sexual abuse is conceptualized as *devastation*.

Category Three: Child sexual abuse is conceptualized as a *crime*.

Each category aims to describe, as faithfully as possible, a qualitatively different way of conceptualizing the phenomenon of CSA. In simpler terms, each category attempts to describe a conception of CSA that appears amongst the interviewees. These conceptions are presented in the following sections, first in terms of the outcome space and then as each category of description in isolation.

The outcome space and conceptions of child sexual abuse

The outcome space can be likened to a map that portrays different groups of conceptions of a phenomenon and the structure that links them. This structure may be defined in terms of increasing complexity, or logical inclusiveness, in which one category of description is more complex and encompassing than the next (Cope, 2004; Marton & Booth, 1997). The categories "can even be seen as different layers of individual experiences" (Marton & Booth, 1997:125). These different experiences, in turn, have bearing on the way the phenomenon is conceptualized. Thus, the outcome space below confers a "complete" representation of the phenomenon of CSA: an amalgam of the aspects of pathology, devastation and crime (Marton, 1986 in McCosker, 1995; Marton & Booth, 1997).

Figure 4: Outcome space of health personnel conceptions of CSA
Source: *Author's interpretation of interviews, Estelí, 2007-2008*

The outcome space represented in Figure 4 is hierarchical. All interviewees shared the conception of CSA as a significant pathology, hence the placement of Category 1 at the foot, so to speak, of the hierarchy. But as will be explained, this category is also more simplistic than the others in terms of the number of dimensions of variation in its internal horizon. *Pathology* focuses on the health of the child, while *Devastation* and *Crime* each bring an additional focus – human development and justice, respectively – into the internal horizon of awareness. In this way the second and third categories are more complex and encompassing than the first. This increasing complexity is indicated with arrows in the figure above.

All interviewees bore at least the conception of CSA as pathology. In fact, several transcripts manifested all three conceptions. Moreover, in most cases where crime was a focus, *Devastation* accompanied *Crime* in the internal horizon, in the way that CSA was a crime *because of* the devastation it caused.

> *Sexual abusers, I think that they need to be punished. That they need to be punished, and pay for the damage they cause to children and youth. That it's great damage that morally, a child who was sexually abused… it's very difficult for this child to recover. It's a trauma that stays the rest of their life.* (13.5)

But not all interviewees associated crime and devastation in this way. Some transcripts revealed a strong conception of CSA as crime, with but minimal emphasis placed on the impact on the child. Rather, the crime was viewed as a callous violation of justice.

> *I consider it the most foul, the foulest because it has a lot to do with the principles that one learns at home. So this is what, to me, is negative here, that the laws don't do what they must do with these types of people* [abusers]. (10.5)

For this reason, there is also an arrow running from *Pathology* to *Crime.* There are not any arrows running to *Pathology* because the arrows denote increasing complexity of the categories.

Structurally, the categories of description are hierarchically related, *Pathology* being the simplest category and *Crime* being the most complex. In regards to its referential aspects, this outcome space shows that a "complete" health personnel experience of the phenomenon of CSA includes aspects of pathology, devastation and crime. A table representation of this outcome space, following a design recommended by Cope (2004), is also found in Appendix D.

The complexity and characteristics of each category of description will now be presented. To provide the reader with fuller understanding, the selected statements will be alternated with brief commentary and contextualization.

Category of Description One: Pathology

Referential Aspects

In this category, interviewees used pathological terms to describe their internal relations with the phenomenon of CSA, highlighting the adverse health impact of CSA on the child. All personnel interviewed attested to physical consequences – injury, pregnancy, sexually transmitted infections, among others – but placed greater emphasis on psychological trauma as the more prevalent, albeit hidden, pathology to be dealt with. Thus, their conceptions of CSA focused only on the poor health of the child, for which psychological treatment was paramount. Psychologists were seen as the most relevant health personnel in cases of CSA due to their faculty for treating and probing into the origin of mental pathology.

> *Every sexually abused adolescent has to go through therapy with the psychologist. All of them, independently whether their pregnancy is going fine. The pregnancy may be normal but the mind… her mind also needs to be "well," in quotation marks, to be able to face this.* (14.9)

> *Their psychological sphere is being affected and needs attention. Which is what maybe we don't provide. Rather, ours is something more immediate, something more prompt, and psychological attention has someone that will give not only one session but various sessions probably.* (5.8)

> *Simply, there is a cause, which is what psychology sees. Psychology sees the cause of the problem.* (1.10)

The hidden nature of sexual abuse was repeatedly brought to light, and in several instances CSA was branded as intrafamily violence. Positioning CSA within the family resulted in an even more invisible phenomenon, as understood by the interviewees. One interviewee explained that a "macro" perspective was, in fact, the official approach within the health sector:

> *The truth is that family violence, as we approach it, frames everything from verbal maltreatment, physical maltreatment to sexual abuse.* (21.4)

In other words, CSA was not frequently differentiated as a phenomenon on its own, but was rather seen to exist as a component part of intrafamily violence. In this light, psychologists were seen as even more necessary as the only personnel who had an inkling of a patient's home life. One interviewee remarked, "These types of pathologies are hidden by both the mother who brings the girl and by the girl herself." Then in reference to the hospital's need for a psychology department, he went on to say:

> *Because family violence in our country is everyday, just as we have surgeons to attend everyday appendicitis cases there should be a department for psychological care that would attend this type of patient and give much more attention.* (4.2)

Interviewees agreed that cases of CSA must be evaluated with care and with greater time allotted to a single patient. Interviewees called for a more profound and adequate care, something that psychologists were best able to provide.

Structural Aspects

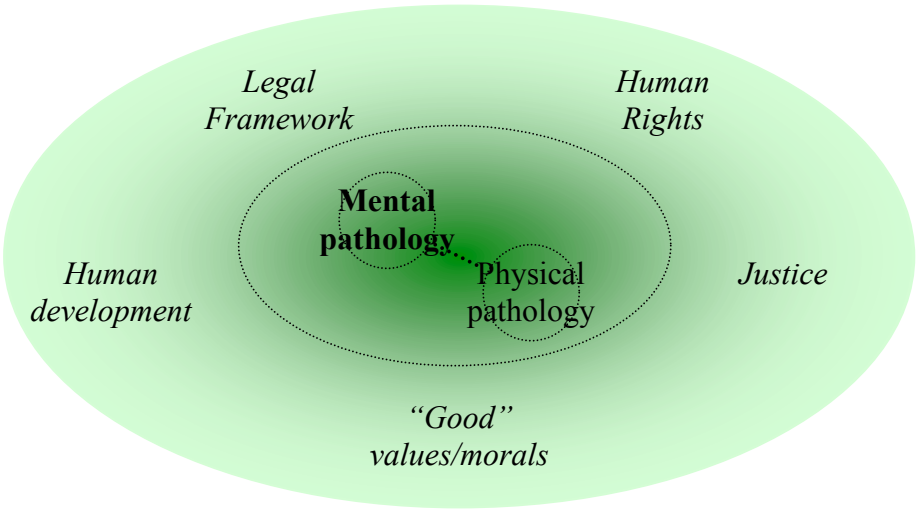

Figure 5: Structure of awareness - CSA as pathology
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

As shown in Figure 5, the external horizon delimits CSA to a significant pathology, particularly in terms of mental health. There are many features of the external horizon, notably human development and justice. Health is located in the internal horizon as a focus of awareness, represented by *Pathology*. The *Pathology* dimension of variation within the internal horizon has two values: *mental* and *physical*. The mental pathology is dominant.

Category of Description Two: Devastation

Referential Aspects

While acknowledging the physical and mental pathology present in a survivor of CSA, bearers of this conception assumed a more holistic stance in their understanding

of the phenomenon. They did not restrict CSA to a determinant of poor health, but gave it far greater meaning from a human development standpoint. Interviewees who took this view often commented they could not imagine the extent of the desolation experienced by the child. Yet they also saw the abuse as a sizeable impediment in the child's life.

> *This, psychologically, it is known that it affects the rest of your life. And even as the person grows up, it's a memory that stays in mind and it affects them up to adulthood and in their development.* (12.9)

> *She's a girl whose future, aspirations, hope have all been cut, and she's automatically converted into a girl mother, isn't that right?* (2.1)

> *Everything that goes against the will of a person. Everything. Not just to sexually abuse, but to sexually harass, to hurt constantly, limit their capacities, limit their skills, take away their capacity to act, to decide, to express opinion, to produce, to study, to go for a walk, to play sports….* (6.3)

Accordingly, in this category of description, CSA was conceptualized as a serious trauma, a sudden break between the victim and his or her life plans, or even constraints placed on the child and his or her skills, activities and self-expression. As a result, an indelible mark was left on the child and his or her personal development suffered. Clearly, the interviewees in this category saw this as a deplorable consequence. Many took this one step further, explaining that there were also devastating repercussions for society.

> *The victim is going to remain with psychological aftereffects the rest of their life. They are not going to be a good person in society, they will always have that trauma of what happened.* (19.3)

> *Even if the child leaves the abuse, it's a trauma and he or she is going to grow the rest of their life with that trauma. And so many abused*

children, well… we are going to have a society with a loss of values and self-esteem. Their future cannot be very good. (23.15)

Even so, most interviewees in this category stressed that despite such devastation, all was not lost. Comprehensive care could help the child recover.

At least life continues. She has no reason to carry that guilt all the time and she has to get help. Maybe we – I am not a psychologist to tackle the mental side – but yes, we can try to make her feel well. (18.9)

Health personnel that held the conception of CSA as devastation felt that the abuse amounted to more than just pathology, and that it significantly hindered the child's personal development. Moreover, repercussions were identified for society as well as for the child.

Structural aspects

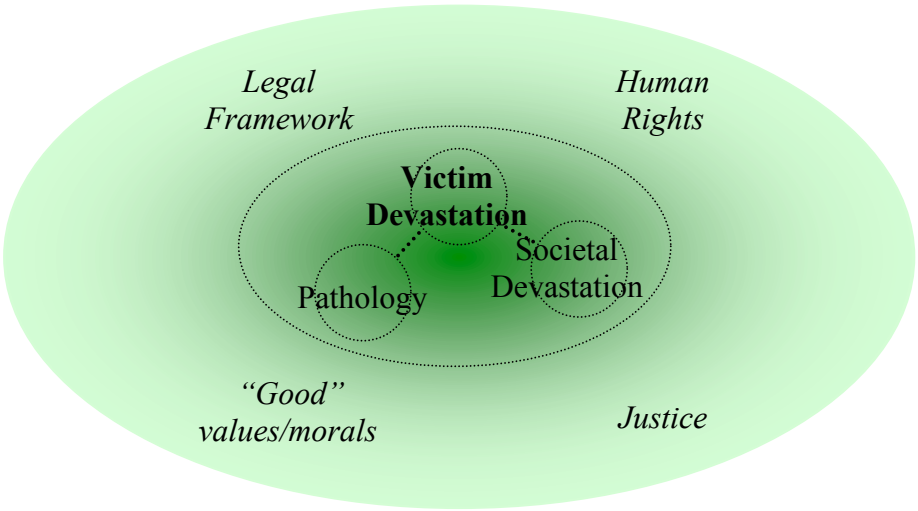

Figure 6: Structure of awareness - CSA as devastation
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

Figure 6 shows that the external horizon delimits CSA to devastation. Unlike in the previous category, an aspect of human development has entered the internal horizon.

A *Devastation* dimension of variation of two values, *victim* and *societal,* is related to *Pathology*. Victim devastation is dominant in the internal horizon.

Category of Description Three: Crime

Referential aspects

Many personnel felt very strongly that above all else, CSA was a crime. They stated that regardless of the type of abuse, it should be reported and punished. Interviewees who identified most obviously with this category were prone to focus very strongly on justice and the judicial process, and lamented that such crimes existed. Many referred to CSA as a violation of children's rights.

> *I think that, apart from my workmates, people think it's more serious when it's rape, when there is penetration, than when there is touching. Although physically there is certain truth in that, all cases must be denounced.* (11.12)

> *Why isn't there a strong punishment for these people? Maybe if there were strong punishment, no one would do it!* (13.8)

> *If it is against their will it's abuse whether or not there is penetration – oral, anal, whatever – and even if they were willing, with a minor that is rape. Also a violation of their rights.* (19.3)

A small number of interviewees further clarified that CSA was particularly rampant in rural areas for the simple fact that rural dwellers may not be aware of their rights, or how to defend them.

> *I think that sexual abuse occurs more at the rural level than urban. I believe that it is lack of education, or that people are not directly*

> *aware of this problem. Sometimes they don't know the corresponding channels to denounce and find help.* (15.3)

For interviewees in this category, the problem of CSA became even greater in scope than in the previous category. The conception of CSA as a crime placed the phenomenon in the public realm, thereby requiring public response and mounting the demand for charges against sexual abusers.

> *Now there is greater openness. That creates for us a bit of calm in the sense that he who abuses has to be punished. That it must be shown that really, abuse must be punished with the full weight of the law.* (17.8)

Finally, interviewees differentiated between two typologies of crime. Roughly half of the personnel in this category interpreted the crime of CSA within a legal framework, whereas the comments of the other half were very morally charged. Of the following quotes, the first denotes crime in a legal sense, while the second represents the speaker's interpretation of a moral crime.

> *It does not depend solely on the Ministry of Health, but also on the law, that the laws are fulfilled, that no abuser or rapist is pardoned. I think that it is also important that the laws are felt here like in other countries.* (16.17)

> *Sexual abusers, to me, deserve nothing. And if the death penalty existed in Nicaragua, in my opinion they would be the first there. He who abuses the integrity of another is not a person. /---/ They are unwelcome in this society*. (14.6)

This category introduced the aspect of justice. Many who spoke of CSA as a crime were quite knowledgeable about the country's legal framework. Yet there were others who spoke in a more affective way, revealing that CSA was a violation of not only law and rights, but also a moral code in society. Interviewees in this category underlined the importance of reporting and reprimanding abusers.

Structural aspects

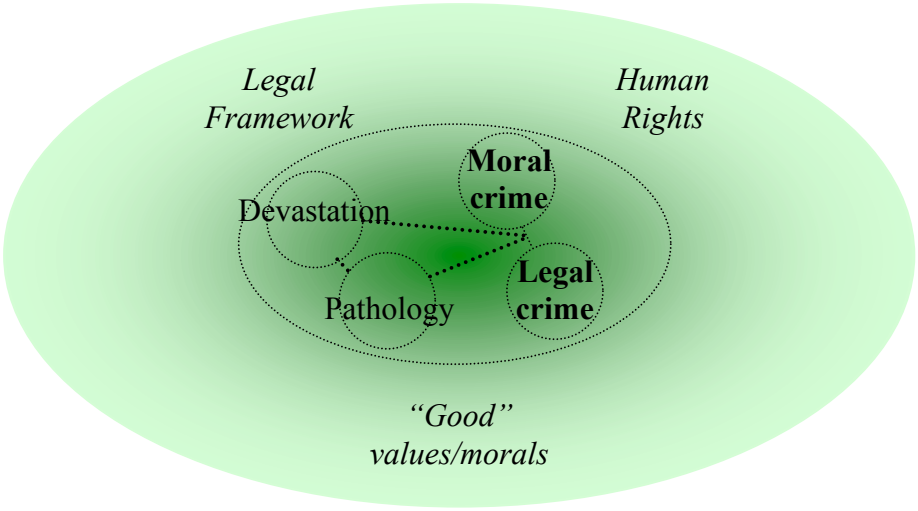

Figure 7: Structure of awareness - CSA as crime
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

As in Figure 7, this conception is characterized by delimitation of CSA to a serious, punishable crime. Justice becomes the focus of awareness, creating a *Crime* dimension of variation with two values, *legal* and *moral*. As mentioned earlier, the *Devastation* dimension of variation is normally present, but not in every case.

Summary

In answer to this study's first research question, there are three different conceptions of CSA that appear amongst health personnel. These conceptions, as represented by categories of description, are *Pathology, Devastation* and *Crime.* The hierarchical relationship between the categories indicates that there are increasingly complex ways of conceptualizing CSA. These conceptions are closely linked to the health services that personnel provide to CSA survivors. Health personnel's conceptions of these services are described in Chapter Four.

Chapter 4: Health personnel's conceptions of health services to child sexual abuse survivors

The second research question solicits the conceptions constituted amongst health personnel in regards to the health services they provide to survivors of CSA. In analysis for this question, only interviews with the 20 personnel that provided health services directly to child patients were considered. The conceptions that emerged from analysis are presented in this chapter. As mentioned above, these categories represent a collective understanding and are not attributable to any one interviewee. In fact, interviewees could express more than one conception within a single interview.

Interviews with 20 personnel uncovered the following categories:

Category One: Health services to child sexual abuse survivors are a specialty located outside the normal role of medical personnel.

Category Two: Health services to child sexual abuse survivors are specialty services for which personnel would like to be more adequately prepared.

Category Three: Health services to child sexual abuse survivors are a professional duty of health personnel.

Category Four: Health services to child sexual abuse survivors are a human duty.

The outcome space and conceptions of health services

The "complete" phenomenon of health services provided to CSA survivors can be graphically represented as in Figure 8. The first and second categories, *Extraneous specialty* and *Desired specialty*, are the simplest categories of the four. However,

interviewees in the first category saw CSA health services as irrelevant to their responsibilities, whereas those in the second category recognized a role for health personnel in cases of CSA – even if they did not believe the role was being adequately fulfilled. The next category, *Professional duty*, placed CSA services among the obligations of the health sector. In the final category, *Human duty*, interviewees stepped out of their health personnel roles to claim that care for CSA survivors was a duty of all adults. In this way, the four categories are arranged hierarchically according to increasing complexity and expressed personal commitment to CSA health services. As such, the outcome space could be likened to a spectrum of conceptions. At one end there is strict focus on physical care and perhaps even a denial of involvement. At the other end, a sense of duty spurs personnel to look beyond the physical pathology of the child.

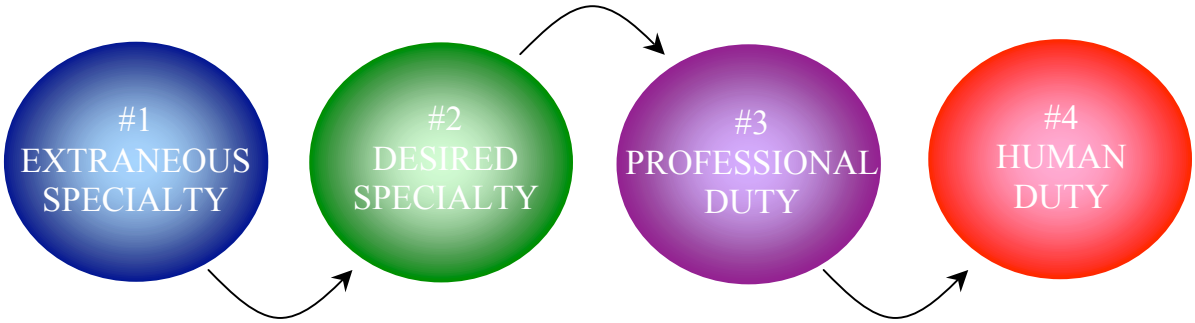

Figure 8: Outcome space of health personnel conceptions of health services for CSA survivors
Source: *Author's interpretation of interviews, Estelí, 2007-2008*

In the previous chapter, some interviewees were said to bear all three conceptions of CSA. This is not the case here. No interviewee could be placed in all of the four categories as represented above in Figure 8. Nor was it essential for an interviewee who expressed conceptions of one category to have the conception of the preceding category. For example, transcripts that manifested *Human duty* did not necessarily manifest any of the other conceptions. Even so, the intrinsic meaning of the phenomenon of health services to CSA survivors clearly combines specialization, professionalism and humanity. A table description of this outcome space is also found in Appendix D.

Category of Description One: Extraneous specialty

Referential aspects

A small number of interviewees expressed that CSA services were located outside their standard role as medical personnel. These interviewees generally did not identify with the provision of CSA services, and considered them to be the work of someone else. They acknowledged that they had attended to CSA survivors, but drew a distinction between their services and CSA services, based on an underlying assumption that CSA requires specialization they did not, and would not, possess. This conception reveals a very atomistic view of health care services; interviewees in this category were centered on the physical component of care and openly negated any suggestion that they could attend to the psychological. When presented with cases of CSA, their strategy was to deal with the physical pathology and then refer the patient to specialist care.

> *We can't do more than give some counseling, then refer to wherever is adequate to follow the case, be it the teen clinic or Psychology.* (19.4)

> *The specialist – gynecologist, pediatrician, surgeon… – is more interested, and logically should be, in resolving the technical biological problem, than to attend the psychological cause.* (4.3)

> *We provide the part of care that corresponds to us, which is the medical part. We channel the patient towards psychological and psychiatric attention and alert the relevant authorities so that they solve the case.* (6.5)

The matter of detecting CSA surfaced quite frequently in the interviews. Interviewees in this category acknowledged that although detection was important, it was not part of their profile. Besides, they claimed, CSA was an invisible problem they could not see anyway. As one interviewee explained, even if he did suspect sexual abuse, he preferred not to investigate further for fear of revictimizing the child.

The medical profile, of doctors and nurses alike, is more about treating harm – not the cause of harm. /---/ So medical care, what the patient seeks first, does not work in detection, but in care. (23.3)

I believe that every one of us here is aware that this must not exist, that there mustn't be child abuse. But we do not have a way of knowing which boy or which girl is affected. We can't know because many times the family itself hides what goes on at home. (22.9)

No 13-year-old rural girl already has a partner. Generally they're subjected to abuse. But we don't want to make her relive something that already happened. (6.2)

Although they had cared for CSA survivors, the interviewees represented in this category viewed services for sexually abused children and adolescents as extraneous to their own specialties. CSA detection was not considered part of their role.

Structural aspects

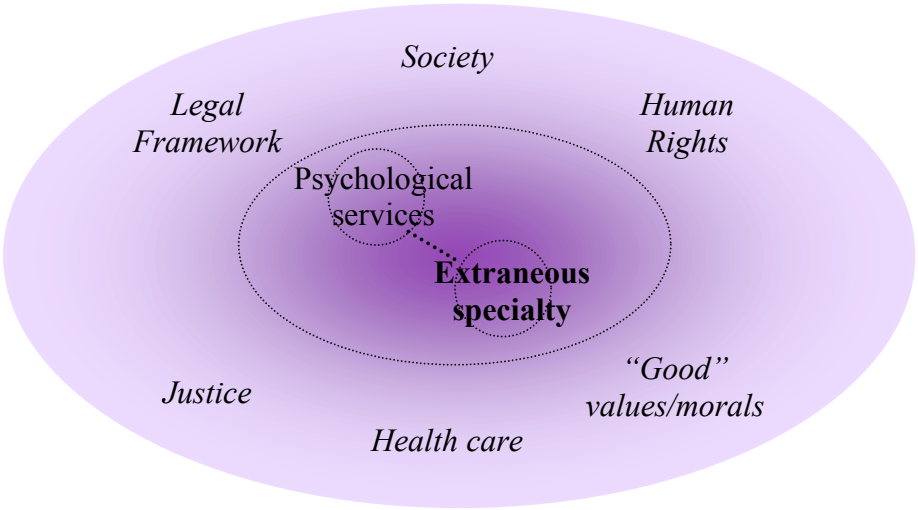

Figure 9: Structure of awareness - CSA services as an extraneous specialty
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

Figure 9 illustrates that in this category, the external horizon delimits CSA services to something outside of the personnel's role and specialty, largely because mental pathology is said not to be something they can treat. As a result, CSA services are seen as psychological services and an *Extraneous specialty.* Aspects such as justice, rights and values are in the external horizon.

Category of Description Two: Desired specialty

Referential aspects

Unlike in the previous category, interviewees who focused on their personal inadequacy in providing services to CSA survivors displayed awareness beyond what their services were, to what they should be. They spoke with normative language and great self-criticism. Their services were dubbed things like "half the care necessary" or "like a stoplight," to convey that even if abuse was detected, no action was taken. They felt constrained in their ability to provide good service, often citing time pressure as a factor.

> *When you don't have knowledge, you remain there with your arms crossed saying, "How horrible!" But you only scandalize without acting.* (2.8)

> *We don't investigate, find out the cause to be able to help. Maybe the child suffers violence, maltreatment, a variety of things but because he's so small he cannot come and say, "I pee the bed for this reason, because this is happening to me." I feel that we limit ourselves sometimes and don't evaluate the magnitude of the problem.* (18.4)

> *If you're in a health centre or a hospital and you know you have to see 30 patients in a certain time, then you don't even raise your head or have time to look the person in the face to see what is happening, even*

> *less a child to whom maybe the only thing I say is, "How much do you weigh?"* (12.5)
>
> *Because of work sometimes you don't have time to think of anything else. But when an abused person comes to you, not until that moment you think and say, "How atrocious!" In that moment you realize there's a void.* (9.19)

Another major factor in interviewees' feelings of being poorly prepared was lack of training. Only eight interviewees of all 23 said that they were trained to care for CSA survivors. Of these eight, one was a government official who normally did not provide care to patients, one was a forensic physician who specialized in attending to rape and abuse victims, and four worked in the non-governmental sector. The other two each had more than 20 years of work experience. And of these eight, about half let known they wanted a refresher course.

SILAIS explained that all governmental personnel had been trained four or five years earlier (SILAIS, 2008). This was in contrast to what interviewees claimed. No matter the case, personnel were quite quick to describe the incompetence of MINSA workers relative to those in the non-governmental sector.

> *We have received very conversational training, very… but not in the area of care but in detection, investigation. But not in how to provide care. So we remain at the first step: how to suspect when we have a patient like that. /.../ Yes, we've been capacitated in: "If you have this and that, suspect there might be abuse." But not: "You have an abuse, you have to do this, this and that."* (4.11)
>
> *At university they teach you this illness can be for this reason, comes from this problem, is treated in this way, with this treatment, this pill. But the affective or psychological parts remain a bit relegated. And until one works maybe in an organization like this one that is focused on these things, only then you start to realize*. (12.5)

Unfortunately, even when personnel felt they should and were qualified to deal with a case of CSA, they were constrained by the conditions around them. Some felt that the patients did not give enough opening to investigate abuse. Others explained that they feared becoming embroiled in legal matters and being fined for not addressing things correctly. A few feared retribution on the part of the abuser. And nearly every hospital employee pointed to the lack of a hospital psychology department as a major impediment in proper CSA care.

Structural aspects

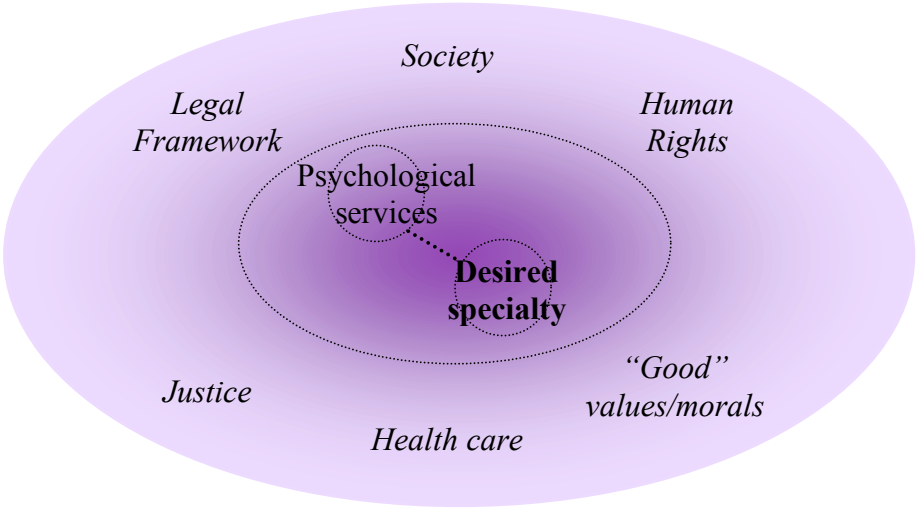

Figure 10: Structure of awareness - CSA services as a desired specialty
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

As illustrated in Figure 10, CSA services in this category are delimited to services for which personnel consider themselves poorly prepared, although they would like to gain specialty in the area. Focus remains on CSA services as psychological services, in which they have no specialization.

Category of Description Three: Professional duty

Referential aspects

Those who felt a strong duty as health personnel to protect the wellbeing of the population made up this category. In stark contrast to the voices heard in Category 1, interviewees who conceptualized a *Professional duty* said the health sector must not limit itself to physical care. Detection *should* be a major part of services, they claimed. In this category, justice became a major focus.

> *When you graduate from school you promise to serve, attend, not to reject the people, and this is what you try to do even if very often you are tired.* (11.2)

> *Especially when you work in health… you cannot allow that they keep maltreating someone, raping her, committing however many atrocities!* (9.4)

Interviewees spoke of their obligations, most notably among them to detect abuse and believe and protect the abused child.

> *The child says it because they don't lie. If the child says he or she was touched, or was fingered or something else, if that child says it, our obligation is to believe, and we have to confirm that it is true. Then we denounce it to the police because you have to find out who the abuser was.* (17.9)

> *I denounce the abuser. Because according to the Children's Code, the guardian of children and adolescents is the state. When that child enters the hospital, the guardian is the hospital and as I am the representative of the state, the guardian is me.* (2.4)

> *As the Ministry of Health many things correspond to us because we have to be there accompanying all of these people. It is our responsibility to give orientations to the population, to stage prevention activities, education activities focused on these problems.* (18.17)

Interviewees further explained that detection was not possible without being proactive and routinely asking patients about abuse. They said that they were obligated to interpret the signs the patient gave them and ask directly about abuse rather than wait to be told. Many commented on the pivotal role they played within a team of personnel that would attend to the victim. Thus it became clear that in this category, health services for CSA survivors were understood as a process, as a series of appointments with different types of health personnel. Some interviewees expanded the process to include authorities from outside the health sector as well. A number of interviewees felt they represented the patient's first entry point in that process.

> *The first one they meet in the health unit is the doctor – so me. It is the first entry, the first person: the first who is going to meet the patient. So I think that if I was the first person with whom the patient meets, with whom the patient is going to face the problem, I believe that it is primordial, but primordial, the role I will play in this case.* (14.11)

> *This is teamwork. The police work with us, us with the psychologist and all together we pass and return the ball, so to speak, the police, the judge, the lawyer. This is teamwork.* (5.16)

Thus, *Professional duty* implied a health personnel obligation to collaborate with other relevant actors in order to protect the population.

Structural aspects

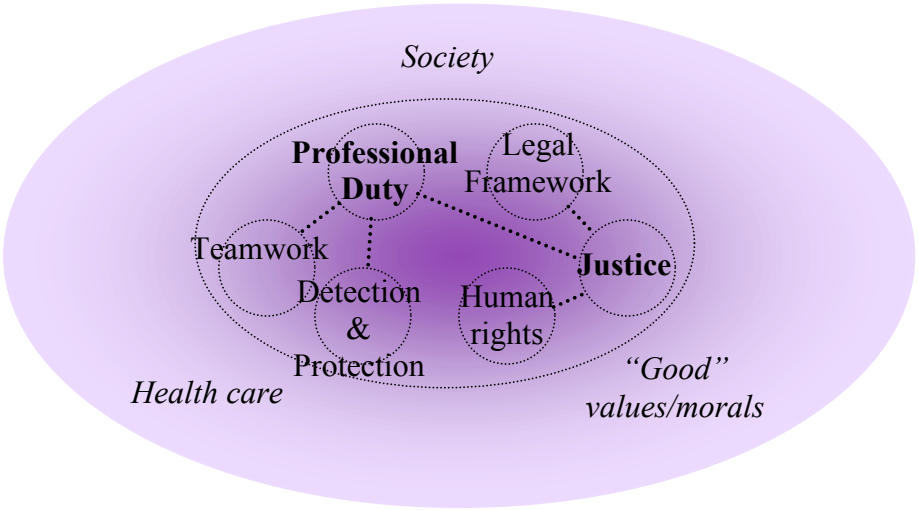

Figure 11: Structure of awareness - CSA services as a professional duty
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

In this category, as portrayed in Figure 11, the external horizon delimits CSA services to a professional duty of health personnel, based on teamwork, detection and protection. Justice, human rights and the legal framework are clearly in focus, as they move from the external to the internal horizon.

Category of Description Four: Human duty

Referential aspects

Interviewees who related to CSA services as *Human duty* saw such services as a matter of course and very plainly thought in a context outside of their health personnel role. They articulated a very strong desire to do anything and everything they could to help a sexually abused child or adolescent – not as health personnel but as fellow human beings.

Many complications could be avoided in this sector. I think that if only we all had the conscience not to see it as something that is somebody else's business…. /---/
Researcher: It's not somebody else's business?
No. That is my point of view. I wish that were how it was. (1.12)

The stage of a girl is to enjoy other activities, and we – as adults, not just health workers – are duty-bound, are obligated to provide protection to children whether they're our children, our family or our clients. (7.6)

As a father, not just a health worker, I believe it's one of the things we should influence upon. A large part of the fault belongs to adults. (4.5)

Whereas previously interviewees may have felt restrained by a lack of resources, personnel in this category claimed that initiative and desire to help were simply more important. One interviewee described how she purchased her own toys, colouring pencils or other materials for children, even though they were often stolen from her office. A few others explained that they took it upon themselves to be informed about the latest studies or laws related to CSA. They felt health services to CSA survivors constituted a special kind of care that required a varied approach.

To be able to dedicate a bit of time to this it is not necessary to have funds or protocols. It's no more than making the effort and having the will to want to do it and help the person in need. It's having goodwill. (18.21)

It's not just another patient! It's a patient completely different from others I have attended. Because of the emotional burden, the disorder, the emotional disturbance, a pregnant girl who wanted a child and a pregnant girl who did not want to be pregnant are not going to respond the same way. (14.12)

As in Category 3, services were seen as a process. However, focus shifted away from the team. Although interviewees still acknowledged the multitude of actors that must be involved, they saw themselves as individually involved throughout the process,

rather than at a single time. They emphasized the need to establish close, trusting relationships with the patient, over many appointments.

> *I try to calm the family so that they let me work. Because what they want to know is who it was, to throw him in jail. /.../ But I am not a judge. What interests me is that my patient is able to feel well and that she confides in me.* (16.2)

> *Sometimes they are scared and many times in a single visit you cannot ascertain all that is happening. So it's a way of investigating and treating her well, to strike up good communication for the next appointments.* (9.1)

These interviewees claimed to make considerable emotional investments in cases of CSA. But as a consequence, they admitted to effects on their personal lives; several described their misgivings about others, even in their own family, and the fear they felt for their own children. Still they did not waver in their idea of CSA services as a human responsibility and, if anything, felt they had learned to put themselves in the place of the victim when providing their services.

Structural aspects

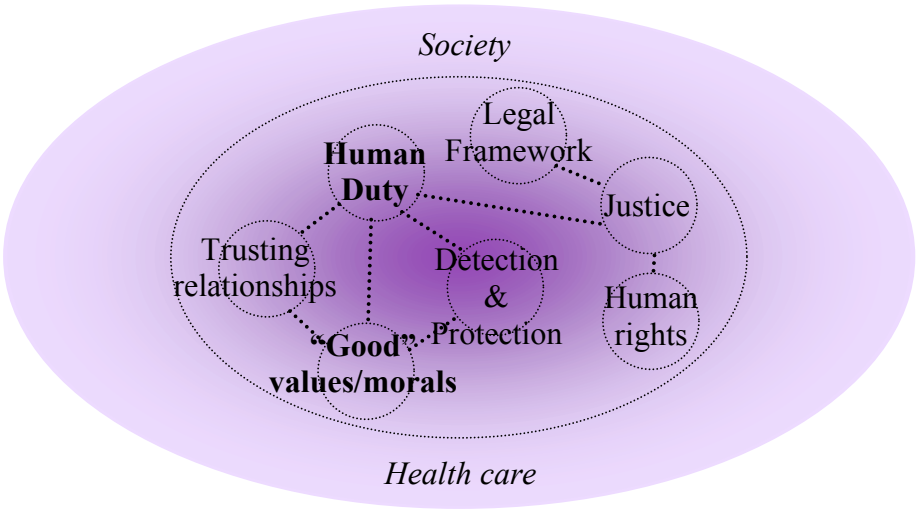

Figure 12: Structure of awareness - CSA services as a human duty
Source: *Adapted from Marton & Booth, 1997 and Cope, 2004 based on interpretation of interviews, Estelí, 2007-2008*

Figure 12 depicts how CSA services are delimited to a *Human duty* based on justice, detection and protection but also the establishment of close, trusting bonds with the patient. Good values and morals have entered the internal horizon, leaving the dimensions of health care and society in the external horizon. Values and morals are very much the focus of awareness.

Summary

In answer to this study's second research question, four different conceptions of CSA services were discovered amongst interviewed health personnel. The four conceptions are *Extraneous specialty, Desired specialty, Professional duty* and *Human duty.* The categories of description that represent these conceptions are related hierarchically according to increasing complexity and increasing commitment to the patient. What remains to be addressed is how these four conceptions link back to the conceptions of CSA presented in Chapter Three.

Chapter 5: Consolidating conceptions

A framework for understanding

Health personnel's notions about illness inevitably influence health services. Helman (2000: 85) refers to these notions as "Explanatory Models" that guide the practitioner in his or her treatment decisions, assumptions about etiology, and prognostic considerations. In phenomenographical terms, conceptions inform human activity (Svensson, 1997) and thus have bearing on health personnel's provision of services. It follows that the conceptions revealed in Chapter Three share content and meaning with the conceptions presented in Chapter Four. Upon examination of their structures of awareness, the two sets of conceptions can be conceptually linked, based on three foci of awareness: mental health (mental pathology), justice and human development.

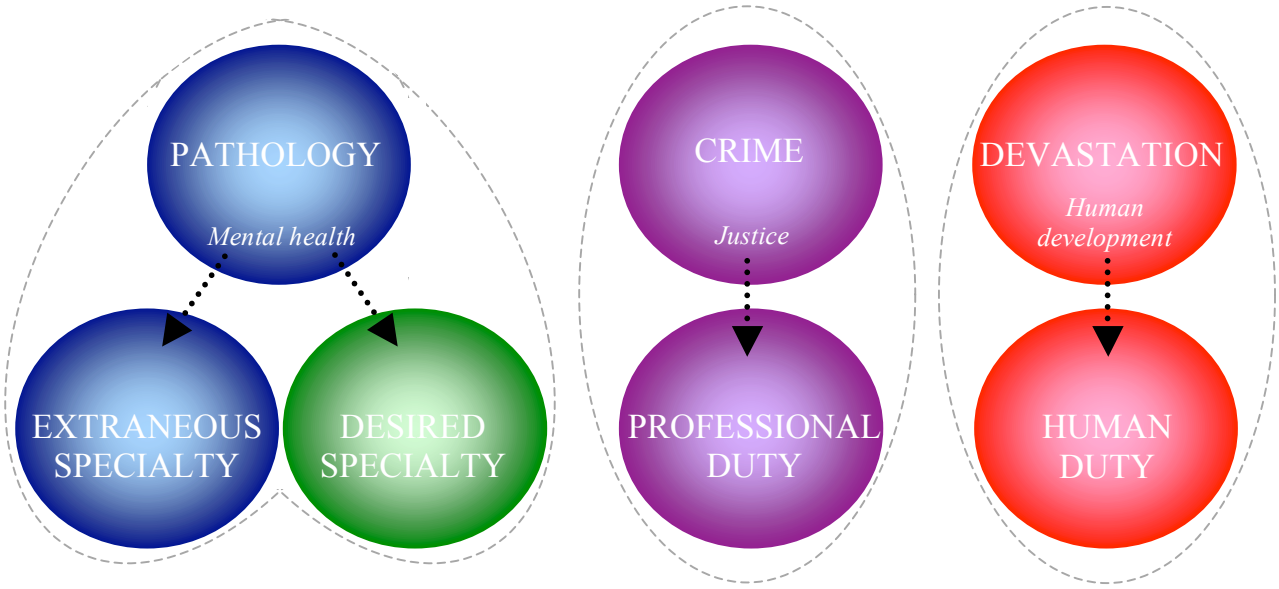

Figure 13: Conceptions of CSA linked to conceptions of CSA services
Source: *Author's interpretation of interviews, Esteli, 2007-2008*

The three conceptions of CSA and the four conceptions of CSA services clarify each other as illustrated in Figure 13. First, a focus on mental health links *Pathology* with *Extraneous specialty* and *Desired specialty*. In the eyes of personnel who conceptualize CSA as a mental pathology, their services to CSA survivors are inadequate or even irrelevant. Second, *Crime* and *Professional duty* are linked via their focus on justice. This propels CSA as a crime into the public realm, granting a mainly legal role to health workers. Third, a focus on human development connects *Devastation* and *Human duty*. This appeals to the affective side of health services and a more instinctive desire to protect other humans.

Avowedly, this consolidation of conceptions cannot be seen as a stringent rule in practice. An individual's conception of a phenomenon is unlikely to be as steadfast over time or context as Figure 13 might suggest (Bowden, 1997). Nonetheless, it presents an empirically derived conceptual framework for understanding and categorizing health personnel and their relations to the phenomena of CSA and CSA services. Future qualitative and quantitative study would be required to verify this theory.

Still, a look at the distribution of interviewees over the different conceptions provides preliminary support for this proposed framework. After classifying each transcript

according to the conception of CSA with which it identified most strongly, the transcripts were classified once more, according to conception of CSA services. Thus, Figure 14 portrays the distribution of interviewees *in terms of their conceptions of CSA,* over the conceptions of CSA services. Only the 20 interviewees who provided services directly to patients were included.

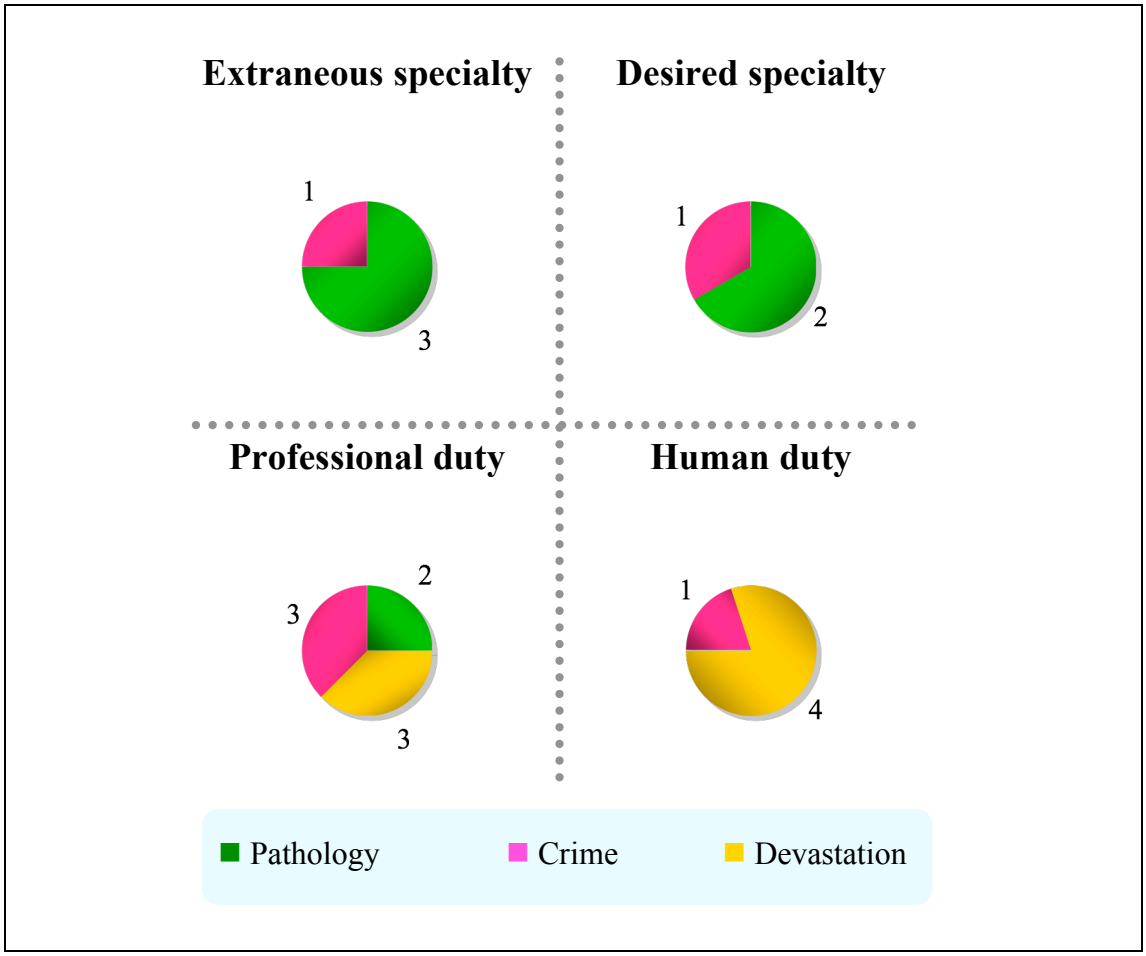

Figure 14: Distribution of CSA conceptions over conceptions of CSA services
Source: *Author's interpretation of interviews, Estelí, 2007-2008*

These distribution results are neither conclusive nor generalizable – but nor do they refute or dismantle the framework in Figure 13. In fact, it is visible that interviewees with the conception of CSA as a pathology tended towards conceptions of CSA services as *Extraneous specialty* and *Desired specialty*. Those who identified most strongly with CSA as a crime are predominantly located in the *Professional duty* quadrant. And every interviewee that saw CSA as devastation also saw CSA services as a duty – inclining slightly towards a human duty.

It is worth highlighting that most personnel in the *Desired specialty* quadrant also expressed conceptions of duty to CSA services, only that duty was not dominant in their structures of awareness. In the case of interviewees who thought CSA services were extraneous to their roles, no duty was communicated.

By contrast, all personnel from NGO women's centres related to CSA services as a duty. It is even more heartening that a majority of governmental personnel also felt obligation to provide services to CSA survivors. This finding points to a desire and will to care for CSA survivors – a desire and will that should be quenched with additional personnel training. Although they may have identified most strongly with conceptions of duty, many of these personnel also felt inadequate in the services they provide.

Reflections

To a certain extent, this thesis serves as an evaluation of the effectiveness of CSA health training conducted thus far in Estelí. Results here attest that personnel have at least basic knowledge of CSA. Most interviewees claimed to be untrained in CSA services and wished for more capacitation opportunities. Also, very rarely were interviewees aware of the scant number of attention protocols that exist, let alone familiar with their content.

Even those personnel who conceptualize CSA services as a duty require training to know how to care for CSA survivors adequately and appropriately. This study describes the conceptions of CSA and CSA services amongst health personnel. With this knowledge, training can be designed strategically: first, to encourage personnel to see CSA services as a duty, and second, to even the balance between competing interests of justice and health.

CSA services as a duty

A major discovery in this study is that a large majority of interviewed health personnel exemplify desire and will, not only to detect CSA but also to adequately

care for sexually abused children and adolescents. Furthermore, only slight difference is detectable between the conceptions constituted amongst MINSA personnel and those amongst non-governmental workers, a difference that likely originates from non-governmental personnel's relatively higher level of capacitation. Nonetheless, all interviewees displayed a basic understanding of CSA and its effects. Although aspiration and basic knowledge do not translate automatically into adequate service, it is apparent that at least the majority of personnel interviewed would be open to receiving more advanced capacitation on how to attend to CSA survivors. These are encouraging findings.

On the other hand, public perception of MINSA services remains low (Expert Interviews, 2008; Explotación Sexual Commercial, 2005). FGD participants in this study felt strongly that psychologists were the only ones who truly cared for their patients – all other health personnel were assumed to be more concerned with their wages. Even the youngest FGD participants clearly articulated the distinction between *role* and *responsibility,* pronouncing that despite their different roles, all health personnel have equal responsibility to investigate and satisfactorily treat abuse. Article 76 of the Nicaraguan Code of Children and Adolescents legitimizes this by stating all health personnel are legally bound to provide "special protection" to sexually abused children or adolescents (Consejo Nacional, 2006:16). In other words, health personnel have a professional and human duty to protect the population. Even a surgeon whose specialized skills are in physical care is expected to ensure violence and abuse victims receive necessary attention.

Obviously, when CSA victims do not openly offer details about their situations without being asked, it is necessary to detect the abuse before care can be given. The Code of Children and Adolescents makes it unlawful for health personnel to withhold suspicions about abuse, an act punishable by fine of a month's salary – though it is improbable this fine has ever been incurred (Consejo Nacional, 2006:38; Expert Interviews, 2008). Some interviewees admitted they do not ask patients about violence for fear of revictimizing them. This fear reflects lack of training; studies have shown that violence victims are willing to reveal the truth when asked in a sensitive manner (Ellsberg & Clavel, 2001; Heise, 1994; McFarlane, et al., 1995). In a FGD, one adolescent survivor of sexual abuse shared:

In hospital no one asks me anything….
Researcher: Do you want to talk to someone?
Of course! You want to vent, to get it out.

Upon overhearing this exchange, others in the group concurred. Indeed, FGD participants called for continued improvements of the health attention given to violence victims. Not yet aware of the categories of description that would be the outcome of this study, they unanimously agreed that services should be more professional, and more humane. They described professionalism as detection, thorough investigation, immediate attention and monitoring. The human side of care, they said, included validating the patient's feelings, believing the patient, and offering advice, comfort, encouragement and trust. Experts saw services in the same way; one explained that care should be based on quality (professionalism) and human warmth and sensitivity (Expert Interviews, 2008).

Certainly, the conceptions of CSA services as professional and human duties are something to strive for in the health sector. Yet such obligation was not recognized by a small number of personnel interviewed in this study. To borrow terminology from the FGD participants, a small number of interviewees seemed to allow their roles to supersede their responsibilities. This indicates that a change of attitudes and beliefs is necessary. A view of CSA as a mental pathology causes personnel to shirk involvement in care for CSA survivors, on the premise that they cannot deliver mental health services and are thus irrelevant. But as one expert explained, it is a myth that only psychologists can work with sexual abuse survivors (Expert Interviews, 2008). Any health worker can inquire about abuse and any health worker can listen, orient and provide information (Ellsberg & Clavel, 2001; Expert Interviews, 2008). Unfortunately, some personnel's values and attitudes inhibit their ability to fulfill their responsibilities. Lewis & Bor (1994, in Warne & McAndrew, 2005:681) attest that personnel's "durable attitudes" – or Explanatory Models, or conceptions – are the main influence on health practice. Therefore, training must emphasize awareness of CSA as a multifaceted whole, the sum of its *Pathology*, *Crime* and *Devastation* parts. As this study indicates, the fuller the conception of CSA, the more likely health personnel are to see CSA services as a duty.

A health-justice disequilibrium

In answer to this study's first research question, three conceptions of CSA were revealed. All interviewees related to CSA as pathology, but they differed in their focus on either human development (*Devastation*) or justice (*Crime*). Despite their health professions, more interviewees focused on justice than on the health and wellbeing of abuse victims. Given the weight that current Nicaraguan society gives to justice over health (Expert Interviews, 2008), this is not surprising. Whereas Nicaraguan CSA research from a health perspective is in short supply, the judicial aspects of CSA have been extensively researched and promoted within the country (Centro de Mujeres, 2007; Meza Gutiérrez, et al., 2005; Velázquez & Sequeira, 2000).

When asked about the importance of justice relative to the overall wellbeing of the CSA survivor, FGD participants and expert informants all put in plain words that although both were important, the child or adolescent's wellbeing was even more so. One CSA survivor explained that from the victim's perspective, justice could not even be fathomed until strength and wellbeing were recovered (Expert Interviews, 2008). Indeed, sound physical and mental health is crucial to arrive at justice (Butchart, et al., 2006:55). Health personnel who urge court cases before CSA patients are emotionally ready grasp neither their own advantageous position to help, nor the magnitude of health consequences of CSA. As per the framework described in the previous chapter, if more personnel are to relate to the services they provide to CSA survivors as a human duty, greater awareness must be raised in regards to the human devastation caused by CSA.

Then again, this is not to say that health services to CSA survivors should be seen as a human duty and not a professional one. Rather, training must be designed for a fuller understanding of CSA and CSA services, so that services are seen as a synthesis of specialization, professional duty and human duty. Each of these conceptions is part and parcel of full, integrated care. The goal is to steer health personnel towards seeing CSA services in this way.

Chapter 6: Looking forward

As a way to assess the Nicaraguan health sector's capacity to respond to child sexual abuse, this study sought to reveal the conceptions of CSA and CSA services amongst health personnel in the Nicaraguan city of Estelí. Although not the first time it has been used in health or violence research, phenomenography was applied for a first time to CSA. The results of this phenomenographic study are categories of description representing three conceptions of CSA – *Pathology, Devastation* and *Crime* – and four conceptions of CSA health services – *Extraneous specialty, Desired specialty, Professional duty* and *Human duty*.

The two sets of conceptions can be consolidated to create a framework for classifying health personnel and their conceptions of CSA and CSA services. This framework should be of use to governmental and non-governmental health sectors alike, in Nicaragua and beyond, in the promotion, design and evaluation of future CSA training for health personnel.

Directions for future research

In view of the major health burden that CSA represents, CSA research with a health sector focus is strangely absent in Nicaragua. A comprehensive, nation-wide prevalence study of sexual abuse would be invaluable. In the same vein, health centres across the country have a responsibility to collect data on their encounters with CSA, which would be equally important.

In light of this thesis, several avenues for future qualitative and quantitative research could be explored. First, considering the conceptual framework proposed here as generated theory, it is only natural that this theory be further elaborated and subject to tests of verification. It would be useful to examine its endurance and relevance to other regions, particularly those deemed less "sensitized" to CSA than Estelí.

Of course, the framework can also be employed as background for a more extensive quantitative survey of health personnel. Knowledge about the distribution of conceptions of CSA and CSA services amongst health personnel would be advantageous in the design of future CSA training. This knowledge could also be fed into the medical training of university students.

Moreover, collaboration between different actors involved in CSA health services could benefit from knowledge about one another's conceptions. This could increase the efficiency of any joint collaboration, be it intrasectoral, multisectoral, or between local organizations and international donors.

Finally, it would be groundbreaking to engage in a long-term study connecting the conceptions of CSA and CSA services to their outcomes. Such a study would gather a wealth of data on evidence-based best practice in public health.

Recommendations

The Estelí health system has made major advances in recent years in regards to its approach to CSA. Nonetheless, four main recommendations flow directly from this research. These recommendations are meant for the health sector as a whole – governmental and non-governmental, officials and personnel.

1. It is time to initiate a new wave of CSA service training for all health personnel, as well as implement regular and frequent workshops in CSA service skills. Training should include information on the judicial process and personnel's legal obligations. Emphasis should also be given to the human side of care: listening; seeing the patient as a whole person, not mere physical components; and monitoring of patients. Costs can be significantly minimized if MINSA and NGOs reach a mutually beneficial agreement to share their expertise with each other.

2. An attention protocol that deals specifically with CSA should be written. Admittedly, current intrafamily violence protocols briefly discuss CSA.

However, personnel who position CSA within the family tend to see it as a component part of a euphemized, invisible whole and thus underestimate the magnitude of CSA. These protocols also deal more with women as victims, not children and adolescents.

3. The health sector would be wise to convey to the public that it has the desire and will to approach such sensitive health problems as CSA. The governmental sector in particular needs to strengthen its community profile so that Nicaraguans recognize health personnel's desire to protect children, and learn to trust health services in the event of sexual abuse. To do this, the health sector can lead efforts to raise community awareness of the impact sexual abuse has on health, especially children's health.

4. New life must be given to past projects that have stagnated. The protocol for attention to child abuse that was elaborated and approved a few years ago was never implemented. A majority of personnel interviewed in this study were unfamiliar with or had never read the current intrafamily violence protocol. Psychological attention is said to be primordial in the treatment of CSA, yet the Estelí hospital does not have a psychology department. CSA and other types of "hidden" sexual violence must be given greater priority, if not for the devastation experienced by the victim, for the financial costs associated with repeated visits to health centres by CSA survivors who have not received integrated care.

Concluding remarks

The health sector is of enormous consequence to the detection and treatment of child sexual abuse, and as such stands sentinel for the health of the population, and even the human and socioeconomic development of a region. But the Nicaraguan health sector has barely been studied in relation to sexual abuse in the country, and although public perception of MINSA is dismal, there has been little formal evaluation of the health sector's governmental and non-governmental capacity to respond to CSA. As a way to assess this capacity, this study sought and revealed the conceptions of CSA and

CSA services constituted amongst a sample of health personnel, and identified areas for improvement of health services and personnel training. True to developmental phenomenography, this study's results can be used to inform future actions and research. Particularly in a lower income setting where access to other resources is limited, health personnel play a momentous role in the treatment of patients. Their conceptions, therefore, weigh heavily on the health sector's capacity to respond to such a multifarious problem as child sexual abuse.

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Appendices

Appendix A: Health personnel interviews

Interviewee Briefing: Explanation of Study and Interview
English translation

The following information was passed to each interviewee before the audio recorder was switched on and interviewing began.

Good morning/afternoon, my name is Crystal Milligan. I am a Master's student in International Development and Management at Lund University in Sweden. My studies have a public health focus. Until March 2008, I aim to collect data for my thesis study on Estelí health services provided to child and adolescent survivors of sexual abuse. I am conducting this study independently.

My investigation aims to discern the conceptions about child sexual abuse amongst health personnel, as well as how health personnel understand the services they provide to child and adolescent survivors of sexual abuse, with the objective to gauge the level of sensitivity towards and awareness of child sexual abuse in the governmental and non-governmental health system of Estelí. A qualitative approach has been chosen for its ability to allow for greater understanding of people's perceptions. Thus, I need to interview health personnel from different backgrounds and places of employment.

The goal of this interview is that you speak openly and freely about your experiences and perceptions. My questions will be open, to which there are no right or wrong answers. The quality of interview data depends on your honesty and openness. Please feel free to think aloud.

The interview should last no longer than an hour. To facilitate transcription, I will record the interview. Only my transcriber and I will have access to the recordings and transcriptions. My transcriber will never know your identity. The interviews are anonymous, in other words, your name will not appear in any document related to the study. Your answers are completely confidential and shall be kept secret.

The final thesis in English will be presented in Sweden in June 2008. Afterwards, it will be translated into Spanish to share with all those in Nicaragua who are interested. If you are interested, I will send you a copy of the Spanish report by email when it is ready.

Your participation in this study is entirely voluntary. You are not obligated to participate if you do not wish to. You may also suspend or end the interview in any moment you wish.

Do you have any questions or concerns?

[Pause to give interviewee time to consider and respond. When questions/concerns addressed, turn on audio recorder and proceed.]

In light of all that I have just told you, do you give your consent to proceed with the interview?

[Wait for answer, then proceed.]

Interview guide for health workers, English translation

Opening Vignettes
Please tell me how you would react in these situations – what you would do, what you would think, how you would feel. 1) A 13-year-old girl from a rural town comes to the hospital/health center/clinic. She is pregnant and avoids questions about the father of the baby. 2) A mother brings her five-year-old son to the hospital/health center/clinic. He visits repeatedly because of headaches. The mother says that in the last week he has wet the bed three times. You are under a lot of pressure this day and have to tend to many patients in little time. 3) A teenaged girl patient tells you she has been sexually abused. She says that the abuser is a wealthy relative who is very respected in Estelí.

Sample prompt questions
• Could you tell me, in as much detail as possible, about your experiences providing health services to victims of child sexual abuse? • How do you understand "child sexual abuse"? (What things can be considered child sexual abuse?) • Could you tell me about your knowledge about child sexual abuse and how it has helped you (or not) in your work? • As your knowledge about CSA has increased, have your attitude or way of providing service changed? • What does it mean to you to provide health care to child and teenage victims of sexual abuse? • How do you provide care to CSA victims? To non-victims? • Could you tell me about the response of health services in Estelí – in other words, their role – in the face of child sexual abuse?

Sample probe questions
Could you tell me a bit more about that? Could you please explain that a little more? Do you have further examples of this? Is there more that you would like to add about this? So what you mean to say is….

Table of Interviewees

No.	Profession	Workplace	Conception CSA	Conception CSA services	Trained?
1	Psychologist	MINSA	Devastation	Human duty	✖
2	Physician	MINSA	Crime	Professional duty	✔
3	Other	MINSA	Crime	-	✖
4	Other	MINSA	Pathology	Desired specialty	✖
5	Physician	MINSA	Crime	Professional duty	✔
6	Physician	MINSA	Pathology	Extraneous specialty	✔
7	Other	Other	Crime	Desired specialty	✖
8	Pediatrician	MINSA	Pathology	Professional duty	✖
9	Pediatrician	Other	Pathology	Professional duty	✔
10	Nurse	Other	Crime	Human duty	✖
11	Psychologist	Other	Devastation	Professional duty	✔
12	Physician	Other	Devastation	Human duty	✖
13	Nurse	MINSA	Devastation	Professional duty	✔
14	Physician	MINSA	Devastation	Human duty	✖
15	Other	MINSA	Crime	-	✖
16	Psychologist	MINSA	Devastation	Human duty	✖
17	Pediatrician	MINSA	Crime	Professional duty	✖
18	Nurse	MINSA	Devastation	Professional duty	✖
19	Nurse	MINSA	Pathology	Extraneous specialty	✖
20	Other	MINSA	Pathology	Desired specialty	✔
21	Other	MINSA	Crime	-	✔
22	Physician	MINSA	Pathology	Extraneous specialty	✖
23	Other	MINSA	Pathology	Extraneous specialty	✖

Appendix B: Focus group discussions

Focus group discussion descriptions and participants

No.	Group description	Participants	Others in attendance	Date
1	Established self-help group for young women who had been sexually abused	Four female participants aged 13 to 18	One psychologist One intern from host NGO	February 16, 2008
2	Youth representatives from the Estelí Children's Commission	Three female participants aged 11 to 16 Four male participants aged 15 to 16	One psychologist One coordinator of Children's Commission	February 23, 2008
3	Established self-help group for sexually abused women	Six participants aged 16 and older	One physician (group leader)	March 1, 2008

Focus group discussion guide

Although not every FGD was facilitated in exactly the same manner, the guide below is a good representation of the topics covered and activities undertaken. Lessons learned in each session allowed for improvement of the next – most often in terms of dynamism and enjoyment for the participants.

No role play was conducted in FGD 1, and in FGD 2 some time in the beginning was also devoted to discussing what participants new about CSA and its relation to health.

FGDs were not audio recorded.

Duration: 8:30am to 12:00pm, lunch served afterwards

FGD Objectives:

- Discuss preliminary results of health personnel interviews
- Discover participants' perceptions of the health system response to CSA/health services for CSA survivors
- Evaluate response/services in Estelí
- Brainstorm suggestions for improvement of health services to CSA survivors

Program:

1) Welcome
2) Game to create enthusiasm and learn all participants' names
3) Presentation of researcher and study – explanation of voluntary nature of participation, request for consent
4) Activity One: Interview statements
    a. Divide in two groups
    b. Each group receives approximately 10-14 cards with interview statements written on them
    c. Read the cards. What do the statements mean? What do we think of the statements? Do we agree with what is said?
    d. *If time available:* group statements into categories and present to other participants
5) Snack & Game
6) Activity Two: Role play simulation
    a. Divide in two groups
    b. Each group receives a scenario, either Vignette #1 or #3 from the health personnel Interview Guide.
    c. Prepare a short skit in which the participants assume the roles of characters that could be involved in the scenario.
        i. Skit should show:
            1. How health services should NOT be in this scenario
            2. How health services should be
    d. Skit presentation, including explanation from actors
7) Final discussion & recommendations for health system

Appendix C: Expert meetings and interviews

Expert Meetings 2007

Organization	Location	Date
Save the Children Norway http://www.reddbarna.no/	Managua	September 13, 2007 November 7, 2007
Movement Against Sexual Abuse	Managua	November 7, 2007
PATH-Alianza Intercambios http://www.alianzaintercambios.org/	Managua	November 13, 2007
Centre for Demographic and Health Research, UNAN-León	León	November 16, 2007
Centro Dos Generaciones http://dosgeneraciones.org/noticias/	Managua	November 16, 2007
Aguas Bravas	Managua	November 19, 2007
Children's Commission	Estelí	November 28, 2007

Expert Interviews 2008

Organization	Location	Date
Centre for Demographic and Health Research, UNAN-León	León	February 26, 2008
PATH-Alianza Intercambios http://www.alianzaintercambios.org/	Managua	February 27, 2008
Aguas Bravas	Managua	February 28, 2008
Movement Against Sexual Abuse	Managua	February 28, 2008
Save the Children Norway http://www.reddbarna.no/	Managua	March 2, 2008

Interview guide for Expert Interviews 2008, English translation

Interviews were not audio recorded.

1) How should health services for CSA survivors be?
2) Why has there been little focus on children, to date?
3) Is one more important than the other?:
    a. The judicial process
    b. Recovery from trauma/health

c. Other

4) In my research I have come to realize that it is more likely that a sexual abuse victim go to the police than to a health centre. What do you think of this?
5) I have been told that all health personnel in Estelí have been capacitated in care for sexual abuse victims, or at least, in violence. What do you think of this?
6) Share selected statements from interview and ask for comments/reactions

Appendix D: Outcome spaces

Research question 1: Conceptions of child sexual abuse

Category	Referential Aspect	Structural Aspect	
		Internal Horizon	External Horizon
3	Crime	A serious, punishable crime, in both legal and moral terms, because of the devastation and pathology of CSA. The relationship between legal and moral crimes is poorly discerned. Greater focus is on CSA as a crime than on devastation or pathology.	Delimits CSA to a serious, punishable crime. Justice has entered the internal horizon.
2	Devastation	Devastation of the victim's personal development and of society, due to significant physical and mental pathology in the victim. The devastation of society is dependent on devastation of the victim's personal development.	Delimits CSA to devastation. Human development has entered the internal horizon while justice remains in the external horizon.
1	Pathology	A pathology both physical and mental, although the mental pathology is dominant.	Delimits CSA to a significant pathology, particularly a mental pathology. Human development and justice are part of the external horizon. In other words, they are not in the focus of awareness but health is.

Research question 2: Conceptions of health services for child sexual abuse survivors

Category	Referential Aspect	Structural Aspect	
		Internal Horizon	**External Horizon**
4	A human duty	A human duty based on justice, detection and protection but also the establishment of trusting relationships with the patient. Great focus on good values and morals.	Delimits CSA services to a human duty. Good values and morals have entered the internal horizon, leaving the dimensions of health care and society in the external horizon.
3	A professional duty of health personnel	A professional duty of health personnel, based on teamwork, detection and protection. Much focus is placed on justice, human rights and the legal framework.	Delimits CSA services to a professional duty of health personnel. Justice, human rights and the legal framework have entered the internal horizon.
2	Specialty services for which personnel would like to be more adequately prepared	A service for which personnel consider themselves poorly prepared, although they would like to gain specialty in the area. Services still seen as psychological services.	Delimits CSA services to services for which personnel consider themselves poorly prepared. Many different dimensions are located in the external horizon.
1	Specialty services located outside the normal role of medical personnel	A service located outside the role of medical personnel because it is the specialty of someone else. Services are seen as psychological services and therefore extraneous to their roles.	Delimits CSA services to a service outside of the personnel's role and specialty. Many different dimensions are located in the external horizon.

Appendix E: Ethical Approval, National Autonomous University of Nicaragua, Bioethics Committee

UNIVERSIDAD NACIONAL AUTÓNOMA DE NICARAGUA
FACULTAD DE CIENCIAS MÉDICAS
UNAN LEÓN

Comité de Ética para Investigaciones Biomédicas (CEIB)
FWA00004523/IRB00003342

Miembros Honorarios:

- *Dr. Uriel Guevara Guerrero* (q.e.p.d.)
- *Dr. Jaime Granera Soto*

Consejo Ejecutivo:

- *Dra. Nubia Pacheco Solís* Presidenta
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- *Dra. Eliette Balladares Cardoza* Secretaria
- *Lic. Irella Romero Salazar* Miembro

Fundado en la Facultad de Ciencias Médicas UNAN – León Nicaragua 1995

Expiration data 30/03/10

León, 25 de enero del 2008

ACTA No. 4

Dra. Cristal Milligan
Investigadora
Sus Manos

Estimadas Doctoras:

Después de haber revisado el Protocolo de Investigación titulado"**EL ABUSO SEXUAL INFANTIL Y SERVICIOS DE SALUD EN ESTELÍ, NICARAGUA, UN ESTUDIO CUALITATIVO Y FENOMENOGRÁFICO**" revisión realizado por miembros del Comité de Ética y consultores independientes, se determina lo siguiente:
Se aprueba la conducción de dicha Investigación, basados en que cumple con los principios delineados en la Declaración de Helsinki y reúne los principios éticos básicos.

Como Comité de Ética, valoramos muy positivamente la importancia de este trabajo y esperamos que sus resultados sean eficaces. Copia de esta carta debe estar presente en el Protocolo e Informe Final.

Sin otro particular, nos es grato suscribirnos.

Atentamente,
COMITE DE ETICA PARA INVESTIGACIONES BIOMEDICAS UNAN-LEON-NICARAGUA

DRA. NUBIA PACHECO S.
Presidenta del CEIB
Facultad de CC. MM.

DRA. ELIETTE BALLADARES C
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