

SOCIOLOGY

Patriarchy, New Left Post-Neoliberalism, and the Valuing of Care Work: The Labor Conditions of Nicaraguan Nurses under Sandinismo's "Second Stage"

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This article examines how the labor conditions of nurses in Nicaragua have evolved through twenty-five years of health care policy and regime transition, focusing on the period since the return to power in 2007 of the Frente Sandinista de la Liberación Nacional (FSLN). I ask whether the deterioration in nurses' work-related well-being that were imposed by neoliberal health care restructuring have been redressed by the FSLN. I connect findings from interviews and focus groups with over fifty nurses to long-standing patterns in the gendering of care work, as well as the Sandinista track record in exploiting these patterns. Also relevant is the FSLN's mutual antagonism with feminist movements and its incremental but pronounced turn toward a regressive stance on gender equality. Finally, a steady drift toward authoritarianism by the FSLN government constrains the capacity for nurses to collectively assert their interests as workers and professionals.

Este artículo examina la evolución de las condiciones laborales de las enfermeras nicaragüenses durante 25 años de políticas de salud y de transiciones del gobierno, con un enfoque principal sobre el período después del retorno al poder del Frente Sandinista para la Liberación Nacional (FSLN) en 2007. De interés particular son los deterioros de las condiciones y el bienestar de las enfermeras a raíz de la reestructuración neoliberal en la salud. Se indaga hasta qué medida estos han sido abordados por el FSLN. Al presentar los hallazgos de entrevistas y grupos de enfoque con más de 50 enfermeras, se examina cómo la falta de mejoramiento en su situación está relacionada con patrones de larga trayectoria en la relación género y trabajo de cuidado, y con la tendencia de los sandinistas de explotar estos patrones. De relevancia también es el antagonismo mutuo entre el FSLN y los movimientos feministas, y el paulatino pero marcado rechazo de parte del FSLN hacia la equidad de género. Por fin, la gradual deriva del gobierno del FSLN hacia el autoritarismo restringe la capacidad de las enfermeras de reclamar colectivamente sus intereses como trabajadores y profesionales.

Introduction

This article examines how labor conditions for nurses¹ in Nicaragua have evolved through the major regime transitions and accompanying policy re-orientations of the past three decades. Temporally the main emphasis is on the ongoing "second stage of Sandinismo" (Kampwirth 2011) that began after the 2006 presidential election. Three central questions are addressed. Firstly, has the deterioration in nurses' work conditions and remuneration generated by the neoliberal restructuring of health care between 1990 and 2006 been redressed with the return to power of the Frente Sandinista de la Liberación Nacional (FSLN)? While Latin America's new left governments all share in common a disavowal of neoliberal policies, the situation of health care workers in these countries has received little scholarly attention. Secondly, how

¹ The study is focused on professional nurses, not the somewhat more numerous and lesser trained *auxiliares*.

is the extent of improvement (or stasis) in nurses' work conditions related to the government's approach toward gender inequality and care work in Nicaragua? Thirdly, what sort of political environment exists for nurses to defend their interests as professionals and workers?

Based on data obtained primarily from focus groups and interviews conducted from 2010 to 2013, I argue that nurses' situation has not improved under the FSLN of the twenty-first century. Despite the partial rollback of some of the previous decade's neoliberal reforms in health care, nurses' conditions have actually worsened in several ways. I argue that this reflects a long-standing pattern of reliance on women's unpaid work at the household and community level in Nicaragua. It is also an outcome of the low prioritization of gender equality issues by the FSLN and a steady drift toward authoritarianism that has been under way within the party since at least the 1990s.

Care Work Recognition, Gender Essentialism, and the Rise and Rollback of Neoliberalism

A feminist lens is indispensable for analyzing nurses' work-related well-being and how it varies over time and place. Feminist perspectives on care work are relevant to understanding how nurses' work is situated in a hierarchy of material and status rewards. In the "devaluation of care" thesis, gendered notions of who is suitable for care work play a decisive role in how we value care. The thesis holds that care-giving work is undercompensated because women are deemed to be enacting innate tendencies and abilities, not exercising a set of learned skills and scientific principles. Hence care workers overall face a wage penalty relative to other occupations requiring similar levels of education (England, Budig, and Folbre 2002).²

The extent to which care occupations are valued should be thought of as encompassing not only salary but also staffing levels, equipment, supplies, adequate education, and infrastructure for care workers to perform duties at humane levels of physical and mental exertion (Bigo 2010). The work conditions of nurses and other care workers, and the adequacy and fairness of their remuneration, vary considerably across time and place (Razavi and Staab 2008). Undoubtedly the gendered understandings that sustain the devaluation of care are themselves more deeply entrenched in some societies than in others, owing to a complex array of sociocultural factors. In some Latin American countries, households have historically had to assume a relatively greater responsibility for social welfare provisioning (in education, health, childcare, etc.), while the state's involvement and investment have been minimal (Martínez Franzoni et al. 2010, 1). Nicaragua is one such country within the region whose welfare regime is referred to as "exclusionary," in reference to the very limited availability of state-funded social services to the majority of the population. This coverage deficit, in which households must fend for themselves, predates neoliberal cutbacks to social services by several decades (Filgueira 1998; Martínez Franzoni and Voorend 2011). Under these kinds of welfare regimes, it is primarily women's unpaid caring labor that is enlisted (Martínez Franzoni 2005).

Beyond sociocultural patterns, human agency clearly also has a bearing on "the boundaries of the responsibility mix" in welfare and care provision, that is, the relative weight of the contributions of government, market, community, and households. In particular, "the claims of social networks and organized interest groups (for example, trade unions and women's groups) as well as . . . state action" (Razavi 2007, iv) will be relevant. States have a decisive role in either lessening or entrenching women's taken-for-granted role in care provision, through overall policy orientations and specific programs. In this regard, neoliberal policies were part of a broad package of reforms enacted across Latin America as the remedy for the financial crises experienced during the 1980s. While the precise mix of policies varied from country to country, they generally entailed reduced state expenditure on personnel, a greater role for private enterprise in various aspects of health care, and the tying of people's care entitlements to the capacity to pay. In poor communities in less-developed countries, this shifting of the onus for social service provision from the state to the market, households, and communities had the effect of feminizing the burden of responsibility for poverty (Chant 2008), reinforcing rather than disrupting traditional gendered expectations regarding care work.

For nurses in public sector facilities, personnel cutbacks intensify the workload among those who remain, arguably both reflecting and reinforcing a view of nurses' care work as relatively natural and easy to perform. The undervaluation of their work will be directly embodied in increased rates of injury, illness, and burnout. In addition, falling salaries and the increasing precarity of nurses' employment may compel them to hold more than one position, subjecting them to even longer periods without rest. Some combination of all

² These authors find that nurses are actually an exception in the care work wage penalty in the United States, which they speculate owes to a high market demand for nurses compared to other kinds of care work. This attests to the variability of nurses' situation across societies.

of these deteriorations have been documented in several Latin American countries (Mesa Melgarejo and Romero Ballén 2010; Romero Ballén, Mesa M., and Galindo H. 2008; Ugalde and Homedes 2005).

Since the late 1990s, forces disavowing neoliberalism rose to executive office in a number of Latin America countries, a phenomenon that some refer to as the “pink tide.” This allusion to what results from creating a lighter tone of the (socialist) color red is an apt metaphor for the moderate character of the new left governments’ reforms, which have largely been compromises with the neoliberal agenda rather than reversals of it (Isbester 2010; Sankey 2016). Common to all the governments that have made “left turns” since the late 1990s are “agendas that privilege collective rights and solidarities and aspire to achieve universal social citizenship” (Beasley-Murray, Cameron, and Hershberg 2010, 4). Many of these governments, including the FSLN in Nicaragua, declared an about-face in citizens’ entitlements to health care and other public services (Tejerina Silva et al. 2009). But there have been surprisingly few studies of governments’ fulfillment of these commitments (for exceptions see Heaton et al. 2014; Tejerina Silva et al. 2009; Tejerina Silva et al. 2011). It might be argued that changes in the gendered expectations and rewards for care work should not be expected because the neoliberal reforms are themselves difficult to reverse. Even though the crises that justified these policies have passed, some have observed a “crystallization of neoliberalism as the dominant economic and political paradigm” (Goodale and Postero 2013, 2). But new left governments in the region employ combinations of social policies that distinguish their rule from neoliberal predecessors, and also from each other (Reygadas and Filgueira 2010), making it worthwhile to examine outcomes in specific sectors such as health. To take Central America as an example of contrasts, El Salvador’s Frente Farabundo Martí para la Liberación Nacional (FMLN) government enacted expansive reform in health care soon after obtaining power in 2009, in striking contrast to Nicaragua.

In regard to the outcomes for nurses, two contrasting predictions for new left government health care reforms are plausible. One is the restoration of an adequate number of nursing personnel, healthier workloads for them, better pay, more job security, and so on. Alternatively, governments intent on expanding the reach of social services may expect nurses to absorb renewed demand on the system. In other words, they may fall back on essentialist views of care work, treating nurses’ physical and mental capacities as infinitely expandable. This scenario finds support in feminist research on unpaid care work; some Latin American governments that have reasserted the state’s role in social policy have nevertheless retained programs that “shift the costs of social reproduction onto women’s shoulders” (Neumann 2013, 802).

Whether governments act to reinforce or dismantle patriarchal expectations of women and care work is at least partly an outcome of their responsiveness to gender inequality concerns, and the quality of their current and past relations with feminist movements. Second-wave feminist movements can have an indirect effect on nurses’ autonomy, authority, and work conditions by making the state more responsive to nurses’ demands. Their impact lies in “creat[ing] a social context in which the state has become more willing to grant professional privileges to these professions” (Adams and Bourgeault 2003). In several Latin American countries, scholars have noted ambivalent and sometimes conflicted relations between political forces of the “old” left and feminist movements that emerged in the 1980s, notwithstanding the parent-offspring nature of their linkage (Kampwirth 2002; Shayne 2004). An emerging body of scholarship examines how new left governments in the region (Friedman 2009; Zarembeg 2016), including that of Nicaragua (Kampwirth 2011), have addressed gender inequality and women’s empowerment. Examining how nurses have fared under the FSLN and its changes to the health care system since 2006 can contribute to this discussion.

Finally, the space accorded to civil society actors such as labor unions to autonomously formulate and express their concerns also has a bearing on governments’ attention to the well-being of nurses. Common to all of the recently elected left-of-center governments in Latin America is that they “accept democracy, at least in principle” (Beasley-Murray, Cameron, and Hershberg 2010, 9). The extent to which this is realized in practice is the focus of several studies that evaluate the durability and transformative capacity of these regimes. Some scholars warn that illiberal tendencies could derail some of the new left projects (Beasley-Murray, Cameron, and Hershberg 2010). Administrations identified as sliding toward personalistic rule, clientelism, and corporatism are that of the late Hugo Chávez in Venezuela, Evo Morales in Bolivia, Rafael Correa in Ecuador, and Daniel Ortega’s FSLN government in Nicaragua (Beasley-Murray, Cameron, and Hershberg 2010; Colburn and Cruz 2012; Grisaffi 2013; Kampwirth 2014; Martí i Puig and Wright 2010; Martí i Puig 2013; Reygadas and Filgueira 2010).

Compared to other new left political forces, it is safe to say that the FSLN in Nicaragua, with its history of controlling politically kindred organizations, has been less tolerant of civil society autonomy from parties and the state (Kampwirth 1998). Furthermore, the country has a long history of personalistic rule which preceded the FSLN’s initial attainment of power, and which did not disappear in that period. “Danielismo”

made a resurgence during the FSLN's sixteen years in opposition and since 2006 has become a serious threat to democracy (Colburn and Cruz 2012; Martí i Puig and Wright 2010). These structures and practices would certainly constrict the political space for trade unions and professional associations, the types of organizations that are crucial to nurses' collective agency.

Nicaraguan Health Care Policy, 1979 to the Present

Nicaragua has undergone several major transformations in health care policy since 1979. The first of these was launched by the Sandinistas upon wresting power from a forty-three-year dictatorship. Their health care reform aimed at redressing long-standing sharp inequalities in access to care (Anderson 2014; Isbester 2001). One of the first actions of the FSLN government was the creation of the country's first Ministry of Health (MINSA) to govern the disparate pieces of a mostly impoverished public system. The one well-resourced part of the system was the Instituto Nicaragüense de Seguridad Social (INSS), established in the mid-1950s ostensibly for workers, pensioners, and the disabled. In 1979 it covered 8 percent of the population (employees of the state and some private industries) yet received 50 percent of the health budget (Anderson 2014). The FSLN brought the INSS into a Sistema Nacional Único (SNUS) under MINSA auspices, an arrangement in which services in the former were made broadly available to the population. To finance its reform, the FSLN augmented the percentage of the national budget for health care from 4 percent to 10 percent between 1978 and 1980, and possibly to as high as 18 percent in some subsequent years (Anderson 2014). But it also relied heavily on donated labor for some of its expansive goals; tens of thousands of volunteers were mobilized through the first half of the 1980s to deliver primary care services such as basic sanitation and nutrition, health education, and vaccinations (Chinchilla 1990). About 75 percent of the voluntary health promoters were women (Isbester 2001).

Following the FSLN's electoral defeat in 1990, the center-right Unión Nacional Opositora (UNO) coalition embraced the World Bank's Project for Health Care Modernization in Nicaragua. Accordingly, in 1993 the UNO government dismantled the SNUS and privatized most of the INSS's functions, reducing its role to channeling employer and employee premiums to new entities called *empresas médicas previsionales* (EMPs). Additional cost-recovery mechanisms were the introduction of user fees for various kinds of services, and "differentiated services" within ministry hospitals—private sector units catering to people who could afford to pay directly for care and those insured through the INSS (Mathauer et al. 2010). UNO and subsequent neoliberal administrations also cut state expenditure on health care through the 1990s. Public health spending reached its lowest point in 2001 at 2.8 percent of GDP.³ Thousands of public sector jobs, including those of nurses, were shed through a mix of "voluntary retirement, forced resignations, or firings" (Rossman and Valladares 2003) known as the *compactación del estado*. By 1999, over fifty thousand state jobs were "compactados" (eliminated). This led to an 18 percent drop in health care staffing by 2003 (PAHO 2007). By that time the number of professional nurses employed in the MINSA facilities had dropped to 64 percent of 1995 levels. It hit its lowest point in 2001 at 42 percent (Rodríguez-Herrera 2006, 14).

The FSLN's return to power in 2006 marks a third turn in health policy since 1979. Toward its pledge to halt neoliberal policies (Perla and Cruz 2013) and its declared commitment to universal health care (Mathauer et al. 2010), the FSLN government removed differentiated services and abolished user fees in all Health Ministry clinics and hospitals. To reinforce the awareness that all public sector health services were now free, publicity materials encouraged patients to assert these entitlements and report any instance of their denial. Along these same populist lines, "*el pueblo presidente*" (presidency of the people) was the government's slogan to refer to new opportunities it would create for citizen participation in social programs.

In terms of investment, the FSLN increased health care spending relative to the previous administration as a percentage of GDP, hitting a peak of 5.1 percent in 2014. This still places Nicaragua below the average (5.6 percent) for most low to medium income countries, and trailing neighboring Central American nations.⁴ While it is known that a considerable amount of increased funding for health and other social programs derives from loans and grants by the Venezuelan government, and not from the national budget (Kampwirth 2011), the precise amounts are not public knowledge. This lack of transparency on the part of the FSLN government has earned widespread criticism (Martí i Puig 2013; Rogers 2011). As to the effectiveness of the FSLN health care policies and programs, several sources signal that they have fallen short of the promised

³ World Bank data on Nicaragua's health-spending changes over time compiled by Factfish, <http://www.factfish.com/statisticcountry/nicaragua/health%20expenditure%2C%20public%20of%20gdp>.

⁴ "Gasto en salud y presupuesto MINSA como % del PIB," Federación Coordinadora Nicaragüense de ONG que Trabaja con la Niñez y Adolescencia (CODENI), 2017, <http://www.codeni.org.ni/salud/inversion-en-salud/gasto-en-salud-y-presup-minsa-como-del-pib/>.

improvement in quality and accessibility. Primary care, for example, is said to suffer from a deficiency in human and material resources (SIDA 2009; Kvernflaten 2013). Meanwhile, the major neoliberal alteration to the system—the privatization of employment-linked social insurance—was left untouched.

Research Methods

The data on nurses' work lives and labor conditions were collected primarily through interviews and focus groups. I conducted three focus groups in Managua in February 2011 with twenty-three nurses. All but one of these participants had obtained a *licenciatura* (bachelor of science degree) in nursing or its equivalent. Several had additionally attained postgraduate degrees, typically a master's in nursing or health care policy. In February and August 2011 I also conducted individual semistructured interviews with twenty nurses and seven key informants, most of whom were nurses. Several from this latter group were interviewed again in May 2013.

To recruit particular types of participants I utilized nonproportional quota sampling, whose goal is to include "a minimum number of cases belonging to the key categories" (Trochim 2008). The main categories that I strove to represent in the sample were number of years in the profession, type of clinical setting (hospital vs. rural clinic and health care post), and sector (the Health Ministry facilities, the "traditional" private sector, and INSS-EMP private sector). All of the nurses in the study, with the exception of one key informant, were female. The focus groups were conducted at the Universidad Nacional Autónoma de Nicaragua (UNAN) with the help of two Nicaraguan assistants, while most individual interviews were done in a relatively undisturbed and solitary space within the facilities where they worked. All the interviews and focus groups were audio-recorded. The focus groups were asked to discuss three main themes: the conditions and environment of their work; recognition for their contributions to health care; and what needs to change and how can nurses influence that. In interviews I sought more specific biographical details, but the same basic themes shaped those questions.

Although I am fluent in Spanish, I enlisted two native Nicaraguans, one of whom has a degree in anthropology, to co-facilitate and organize the focus groups. One of these assistants later transcribed most of the materials. As a check on my understanding of the nursing-specific content of the transcribed material, I drafted a lengthy summary report on my findings in Spanish for feedback from several high-level nurses in Nicaragua who were key informants in the study. Given that most of the participants were Managua-based, caution is required in extrapolating from their experiences to the national level, in particular to the rural areas and the autonomous Atlantic Coast regions, which have distinctive ethno-cultural and economic characteristics.

The participants in both the focus groups and interviews were recruited with the help of the anthropologist assistant. We directly approached the nurses in leadership positions such as directors of nursing schools and executive members of the Nicaraguan Nurses' Association (Asociación de Enfermeras/os Nicaragüenses, AEN). For the direct care nurses, we presented the project description to nurses with midlevel administrative authority in several hospitals. These nurses, briefed on the ethical imperative of assuring potential participants there would be no negative consequences for volunteering or not, in turn presented our request to colleagues who fit our criteria. This mechanism, necessitated by the centralization of authority in Nicaragua's public institutions and in the nursing profession itself, introduces the potential for a selection bias that would presumably manifest in restraint from airing discontentment with health care system authorities and their policies and practices. This concern is mitigated, however, by the sharp and critical frankness with which the majority spoke about their superiors within and beyond their profession. Furthermore, their grievances about work conditions mirrored the findings of two studies conducted by the AEN, one with a labor rights focus (AEN 2011) and the other with a focus on workplace aggression and violence (AEN 2012).

Findings from Focus Groups and Interviews

Remuneration

If remuneration is the most concrete measure of how care work is valued in a society, Nicaraguan nurses cannot be blamed for feeling increasingly underappreciated. Their salaries are in fact the lowest in Central America (Brenes 2010) and probably in Latin America. While nurses in the study noted that the real value of their earnings had fallen under the three neoliberal administrations from 1990 to 2006,⁵ they also felt

⁵ In 1998, Costa Rican and Salvadoran nurses' hourly earnings were 9.5 times and 4.3 times that of the Nicaraguans (Baumeister 2001).

that this had improved little under the FSLN. In 2012 the RN's monthly base salary of about \$140 covered about 37% of the urban basic market basket defined as food, clothing, and household essentials including fuel, electricity, water, and transportation (INIDE 2012).⁶ To put this in regional context, the base salary for RNs in El Salvador was roughly \$525. Though this was not the highest in Central America, it was 1.5 times the equivalent measure of living expenses in that country (UNDP 2010). In Honduras as well, the second poorest country in the region, the salary is sufficiently above that of Nicaragua (*El Nuevo Diario* 2006) to have enticed several of the study participants to migrate there for employment. Nurses' base salary in the MINSA sector is supplemented with bonuses for seniority and exposure to certain kinds of risks,⁷ as well as annual increases for inflation. But the general consensus among the participants was that, even factoring in these adjustments, their take-home pay was vastly inadequate in absolute terms.

There is an additional element of injustice in *relative* terms when doctors' salaries are considered. The inequity here is not just in the amounts, but in how policy-makers from both the centre-right dominated legislature in 2006, and subsequently the FSLN government, addressed the real wage decline that both nurses and doctors had experienced. By 2006, Nicaraguan physicians (like the nurses) were the lowest paid in Central America, with general practitioners and specialists in the public sector earning between \$400 and \$600 per month (*La Voz del Sandinismo* 2006). As a result of a lengthy strike over this issue, doctors won the "Ley de Equiparación Salarial" a few weeks before the inauguration of FSLN President-elect Daniel Ortega. The law mandated increases of 30% per year over a five year period, far above the annual inflation adjustments that nurses and other health care workers received under the minimum wage law introduced by the FSLN in 2007, which Central Bank figures show to have hovered between 4% and 9%. The increases would gradually put the doctors on par with their Central American counterparts, with monthly base salaries set to reach \$1,200 and \$1,600 respectively for generalists and specialists by 2011 (*Radio La Primerísima* 2006).⁸

Not only has the absolute stagnation of nurses' pay prompted many to seek employment abroad (Brenes 2008), but as one young nurse in a large MINSA hospital observed, it was also "the reason why people manage to work another job, to supplement basic expenses. Adding the two jobs it comes out to something like one basic salary." Although the government prohibits holding more than one nursing position in the MINSA sector, many take an additional job in the private sector. Some private hospitals have even adjusted scheduling to facilitate this. It was common to hear, for example, that nurses are assigned double shifts (twenty-four hours) so that they have more days available during the month for a second job. At one of the EMPs in Managua, nurses I interviewed held a "double contract" within the same hospital, which they explain is the employer's way of sparing them the inconvenience of working in two different facilities. This situation reflects Nicaragua's unusually flat pay scale for women across occupational groups; professional women in general resemble lower-skilled workers in their tendency to have an additional source of income-earning, often outside of their field (Martínez Franzoni et al. 2010, 38).

For nurses in the public sector, holding multiple jobs compounds the fatigue and other ill effects of short staffing (to be discussed below). It also takes a toll on their domestic lives—the quality of their family relationships, and even the health of their children—and limits their availability for additional training and to be active in their associations. One nurse told of discovering that her long absences from home were a factor in her teenager's attempted suicide. This brought a halt to her plans for further educational advancement. The impact of nurses' work-related time poverty needs to be seen in a context in which, participants concurred, a great many nurses in Nicaragua are single mothers, and in which most unpaid care or reproductive labor is left to women. That observation is borne out by official data; according to ECLAC, "40% of households are managed by women without a male partner" (2007, cited in Martínez Franzoni and Voorend 2011, 996). This nurse's poignant reflection gives a sense of how the gender roles and economic pressures interact:

For example, you're working from seven to seven in the day and then seven to seven at night with a salary of three or four thousand *córdobas* [about US\$ 105 to \$140]. If you're a mother and you're starting to earn, you look for another job. There are days that you work twelve hours, the next day

⁶ Some sources refer to this as the "expanded" market basket (*canasta básica ampliada*), restricting the "basic" basket to food expenses only.

⁷ Employee benefits, along with greater job security, were perceived as advantages of MINSA over the private sector, where salary and bonuses are more variable.

⁸ The strikes were conducted by the Movimiento Médicos Pro-Salario and the Health Workers' Central (FETSALUD), the large multioccupation union federation for the MINSA sector.

24, and the next day twelve. You only rest for one day. The husband leaves because you always get home tired. We have a fixed start time but we never leave at seven. We always leave two or three hours later.... I'm no longer married to my husband but to my mother-in-law because my husband left and I stayed living with her.... When I get home it's past 7:30 pm and she is always angry.

Short staffing and workload intensification

Interviews and focus groups signal a workload intensity in the public sector that strains nurses' own health and their ability to deliver care. Participants from several types of public sector facilities reported very low nurse-patient ratios as being the norm during most shifts, with a worse situation on weekends and at night. One or two *auxiliares* together with one nurse can be responsible for forty, fifty, or more patients. In critical care areas, nurse-patient ratios were reported to be much better, but still far below the ideal. Most of the nurses voiced a frustration with being unable to provide care "*con calidez*," or warmth and compassion, indeed being barely able to perform the minimal necessary tasks such as bathing patients and administering medications. Alejandra,⁹ employed in a public maternity hospital, gave an idea of what this looks like in her unit:

Although one wants to give everything good from one's knowledge, at times one can't give that much direct care to the patient. You can't, other than a quick pass. Because at times the patient load is higher than fifty or sixty and they are little patients that need care. You have to be there with them, taking vital signs every two hours, monitoring liquids, changing them ... and there are times when it's 8:00 or 10:00 in the morning and you haven't finished reviewing the file, or "I'm missing such and such." The patient tells me she wants this or that, but maybe I'm with an emergency, a pre-eclampsia that maybe came out of surgery and ends up going to the ICU.... So I can no longer give more attention to that patient.

There was widespread agreement among the participants that fatigue, injury, and illness were on the rise as a result of the staffing deficits, and that these produce a vicious circuit with absenteeism. Several participants in the study complained that MINSA officials overcount the nursing resources actually available for work in a unit or hospital by failing to take account of health conditions that produce prolonged absences or that make people less available for heavier physical tasks when they are on duty. Magdalena, a nurse with thirty years in the profession, reported that of the seventy-two nurses officially employed in her hospital, only half are working at full capacity or working at all. Luisa observed that typically if there are twenty nurses listed as staff for her hospital unit, only eight are actually able to work. Furthermore, according to many participants, Nicaragua's nurses are relatively old. Luisa pointed out: "And there is no policy for contracting new resources, for ordering those who are at retirement age, 'Man, retire!' while those with chronic illnesses, okay, let's give them a partial pension and bring in new people who want to work and can exercise their skills at maximum capacity."

Participants traced the staffing deficit to the 1990 to 2006 period of spending cuts. Recollections by those with long experience in the profession indicated that the situation was better several decades ago. But participants also voiced frustration that the FSLN had not begun restoring the positions that were closed. Even with the abolition of the differentiated services in MINSA hospitals, participants explained that the government did not transfer personnel back from those privatized areas. Rather, the vacated positions were simply not reopened. Among the participants there was frequent mention of a hiring "freeze" for nurses in the MINSA sector under the FSLN administration. Several were skeptical of this refrain, such as this key informant: "Look, I have never understood this term 'frozen' in this context. Because it's not true that the positions are frozen. It's something political that the government uses. The Ministry received the money for new positions but they use it for other things" (interview, May 2013). It was not lost on the participants that health care spending had increased in areas such as physical infrastructure¹⁰ and doctors' salaries.

⁹ Pseudonyms are employed for confidentiality.

¹⁰ In 2009 the FSLN government spent about \$26 million in 2009 on the rehabilitation or construction of Level II MINSA facilities (urban hospitals and clinics) and on equipment. This declined dramatically in 2010 but rose again in 2014. A similar pattern is reported for Level I facilities, encompassing mainly rural clinics, posts, and maternity houses. "Mejoramiento de la infraestructura en los niveles i y ii de atención," Federación Coordinadora Nicaragüense de ONG que Trabajan con la Niñez y la Adolescencia (CODENI), 2017, <http://www.codeni.org.ni/salud/inversion-en-salud/mejoramiento-de-la-infraestructura-en-los-niveles-i-y-ii-de-atencion/>.

Compounding the effect of short staffing, many participants perceive that the number of patients and family members within hospitals has been increasing in recent years. This coheres with official data indicating an increase in consultations with MINSA doctors (FCG 2013). This undoubtedly reflects the FSLN's removal of user fees and differentiated services, and its efforts to encourage greater utilization of the system. Its failure to augment the numbers of nurses' positions to keep up with increasing demand suggests a view of nurses' physical and mental capacities as highly elastic, and a view of care work as something that comes naturally to women.

Nonmonetary forms of care valuation and the pueblo presidente

The extent to which the care work provided by nurses is valued in a society also manifests in the treatment they receive at the hands of patients, employers, doctors, and their superiors within the profession. This treatment and the attitudes underlying it are amenable to governmental policy and discourse. One of the biggest stressors for the study participants in the MINSA sector since 2007 are threats by patients or their relatives to denounce nurses for inadequate service. The problem is that while the same basic number of nursing staff must contend with more patients than before, the latter have acquired a heightened consciousness of health care rights that were disregarded under the previous regime. This owes in no small part to government messaging that encourages people to vigorously assert their entitlements vis-à-vis the MINSA institutions. These factors together have created a perfect storm for a culture of complaint and denunciation. As frontline workers, nurses are the first and principle target of patient frustration. Several nurses, such as this focus group participant, concurred that MINSA clients have become more inclined to express impatience through verbal abuse.

Yes, it's very difficult dealing with people, with the family members who are always there demanding and even threatening us. Threatening! And at times you try to deal with them by explaining, "Look, look, *señora*, you see that we are very busy. We are working with this gravely ill patient who is going to die on us. Your person is recovering." And, "Well but why do you give her permanent permission [to visit] and not me? Is she better than me?" "You don't know what she has. I am not able to tell you," I tell them, "what she has." Maybe she has a metastatic cancer but she appears normal, but her family members need to be with her all the time.

Several participants, such as Angélica, a nurse for nine years, saw Sandinista policy and discourse as a contributing factor: "When we started with this government that healthcare is free—the famous free health! the "*pueblo presidente*"!—people took advantage of this and we would hear statements like "and that's what they pay you for?!" and "I'm going to go and complain so that they put the run on you." Rigoberto, a key informant who is a nurse, teacher, and leader agreed that patients' expectations of services in the MINSA facilities were heightened since 2007, and regards this phenomenon as gendered: "They [the patients] perceive the nurse as the employee, the domestic, the woman of the house, the mother who has to do everything for me. There is a dependence" (interview, May 2013). Supporting this assessment, a survey-based study by the Nicaraguan Nurses' Association (AEN) argues that nurses are experiencing gender-based violence in their work. Several of its key findings echoed the participants in my study. For example, the AEN found that 65 percent of the 847 respondents, employed in both the public and private sector, had experienced aggression by patients' relatives, most commonly in the form of verbal threats (AEN 2012).

Nurses' comments suggest that ministry officials in the FSLN government contribute explicitly, not just through neglect, to this culture of patient complaint bordering on abuse. Verónica, a nurse for almost thirty years, observed: "It bothers me when the national head of nursing arrives and goes from bed to bed. And look at the supervision that she does. [Nursing manager to the patients:] 'And how does the nurse treat you? Do you know the nurse? Do you know her name? Does she greet you?' But she doesn't have the dignity to come to me and say 'How have you managed to offer nursing care with one *auxiliar* and one shift nurse?'"

This situation amplifies the relevance of a warning by the Pan-American Health Organization: when policies encourage and empower patients to assert health care entitlements without altering the conditions in which employees provide that care, a hostile work environment can emerge (PAHO 2011). In addition, several nurses alluded to the interaction of social media use, on the rise in Nicaragua as elsewhere, with the increasing culture of complaint. This adds the risk of reputation loss to that of workplace discipline or legal sanctions.

The slogan “*el pueblo presidente*” does not apply in the private sector. But according to several participants in the study with current or past experience in EMPs or in the traditional private hospitals, employers tend to condone abusive behavior by the relatively affluent patients. Carolina, a young nurse in a private hospital, states: “The truth is that there are some patients who treat us in a rude way, even with mean nicknames based on some physical defect that one has. It can be a nurse, a gynecologist, a doctor, any staff member. The truth is that in some instances patients have even been physically aggressive which is, well, unacceptable, right? But as the *jefa* of nursing told us, ‘the patient is always right even though he’s not right.’ ... The institution ... is only interested in the patient.”

In her experience, nurses are more subject to patient abuse than other occupational groups. Participants also told of rigid discipline and surveillance of workers in some of the private sector facilities. Arcely recalled her experience in one of the largest EMPs: “Working under cameras is hard because everything that one does during a twenty-four-hour shift is being filmed and at the end of the day, if you maybe rested your feet in an armchair like that [gesturing to a recliner in the room] because maybe you feel tired, and they’re calling you from the head office to say why were you resting your feet, if we’re not paying you to be resting your feet but to work twenty-four hours without rest.”

Obstacles to agency

If one effect of Nicaraguan nurses’ low remuneration is the constraint it poses on their availability for collective action, a fourth aspect of their work conditions has a more direct impact on this. Several participants’ responses paint a portrait of a government exerting increasing control over the associational side of their work lives, and that more broadly has shown an increasing turn toward clientelism and authoritarianism in spaces that affect their professional and educational development. There is no nurse-specific union in Nicaragua. Nurses’ main organizational vehicle is the Health Workers’ Central (FETSALUD), a federation that comprises a number of occupational groups and dominates within the MINSAL system. A FETSALUD executive member interviewed in 2010 tersely dismissed the notion that nurses might benefit from having their own union or bargaining unit within the federation: “Everyone is equal. Here there is no preference for one or the other [occupational group], okay? Are we clear?”¹¹

It becomes clear from the interviews and focus groups that FETSALUD, which is tightly linked to the FSLN, acts as an obstacle to labor militancy. Participants observed that since the FSLN assumed office, the union no longer acts as a countervailing power on behalf of any of its twenty-five thousand members, “because we’re all Sandinistas now” (focus group participant). One interviewee observed: “I feel that the union staff are more with the administrative personnel than with us, and so ... they always rule that management is right. And it shouldn’t be that way because the union is there to defend us as workers.” Adela, a key informant, held a high position in a private hospital when I first interviewed her, and had been the head of nursing in a MINSAL facility for many years. The fact that the union is linked to a party that attained power, in her view, “is a disaster [because] it’s a union that is now going to be very compliant with everything that its party says to do. If it says kill, it kills, right?” In this regard, she said, the union has failed to defend members who are demoted or replaced for acting outside of FSLN dictates. Another nurse talked of constraints that the union places on freedom of expression at work: “When one expresses a disagreement with the status quo in the workplace, one feels a pressure and any small mistake you make can be used by the conformists against you. Being a party member in itself is not enough; you have to be conformist with all the central decision-making.”

Considering the power that FETSALUD wields at the highest level of government, such discouragement of dissent and debate would be very effective. Among the figures that make up Daniel Ortega’s circle of advisors with the power to override or simply substitute for ministerial decision-making, is FETSALUD president Gustavo Porras (Martí i Puig and Wright 2010). As another key informant wryly pointed out, Porras is popularly known as the *de facto* minister of health.

The interviews and focus groups also point to efforts to curtail independence of the nurses’ 1,500-member professional organization, the AEN. An anecdote narrated separately by Adela and another key informant, Gladys, illustrates this intrusion. Both recounted a highly unusual visit by President Daniel Ortega and his wife Rosario Murillo at the 2011 annual Nurses’ Day celebration, in which they imposed themselves on the agenda to deliver lengthy, platitudinous speeches. For Gladys, the fact that the AEN posted a photo of its president posing with Ortega on its Facebook page a few days later was a deeply troubling violation of the AEN’s long tradition of nonpartisanship.

¹¹ This interviewee evaded disclosing the percentage of nurses in its membership.

Nurses working outside of direct care roles have experienced additional manifestations of authoritarianism. Carlos, a nurse who teaches graduate-level courses, told of government efforts to preempt dissent and critical thought at the independent health policy institution where he works. In one instance a doctor attending his seminar on health care governance models phoned the institution's director in the middle of a class to complain that Carlos was "proselytizing against the government." Having worked under three different administrations, he did not experience the 1990–2006 governments as controlling and paranoid in this way.

Discussion

To understand why the situation of Nicaraguan nurses has not recovered from the deteriorations dealt by neoliberal reforms, we need to understand the broader historical, sociocultural, and political context of the FSLN's health care policy choices and its treatment of nurses. There are a number of features that, taken together, arguably distinguish present-day Nicaragua from other Latin American countries where the new left has been ascendant. For example, a similar shift away from neoliberalism occurred in neighboring El Salvador under a new left government that attained power at roughly the same time, the Farabundo Martí National Liberation Front (FMLN) headed by President Mauricio Funes (2009–2014). Elsewhere (Kowalchuk 2018) I have pointed out ways that the Funes administration improved nurses' work conditions and opportunities, in large part by embarking on a health care reform for which there is no parallel in post-2007 Nicaragua. The FMLN's reform, in expanding the long-neglected primary care sector, created close to nine hundred new nursing positions by 2014 (MINSAL 2014). It also gradually phased out precarious temporary contracts, which its predecessor had allowed to balloon throughout the public system over the previous decade and a half. Furthermore, by converting existing temporary positions to permanent ones, it has made hundreds of nurses eligible for the pay increases and benefits stipulated under the Salary Law. There was also a recognition that nurses with degrees should no longer labor in the pay grade of *auxiliares*. To be sure, the FMLN government could do more to redress the neoliberal legacy, which for nurses includes an ongoing problem of underemployment, and persistent understaffing in facilities least affected by the reform, namely the hospitals. But its expansive reform and more progressive approach to labor have required greater investment in nurses and other health care workers. Meanwhile, a culture of denunciation of nurses, fueled in Nicaragua by FSLN government messaging around patient entitlement, does not appear to exist in El Salvador.

The FSLN government's apparent expectation that nurses will simply absorb an expansion of demand on the public hospitals and clinics is in keeping with other ways that it falls back on an essentialist view of gender and care work. This is exemplified in its continuation of targeted poverty reduction programs begun under the neoliberal era that rely on women's voluntary labor (Haase 2012; Martínez Franzoni and Voorend 2011; Neumann 2013). This entrenches what Sylvia Chant calls the "gendered burden of poverty" (Chant 2008) and what Caroline Moser (1993) refers to as women's "triple role" (their responsibility for income generation, household care work, and community development). Poor women perform the necessary labor (with no or only token compensation) to implement NGO programs that the Sandinista government funds for household food security, early childhood development and education, community sanitation, and even data gathering and education in community primary health (Neumann 2013). In the latter, there is a special emphasis on maternal health through increasing in-hospital births. But a study of this programming points out, "The responsibility for institutionalizing births is removed from the health system and the health facilities, and instead placed on the individuals at community level. In the process, weaknesses in the formal health system are downplayed and allowed to persist" (Kvernflaten 2013, 36–37). Instead of hiring more community health nurses to do this educational work, as has occurred in El Salvador's health care reform launched in 2010, the FSLN government opts for voluntary (female) health promoters.

Several other new left regimes in the region have likewise carried on with the targeted poverty reduction projects that centrist and right-wing governments introduced. To a great extent this has been for reasons of political and economic convenience (Reygadas and Filgueira 2010, 179). But Nicaragua is also distinctive in having a social welfare regime in which a high number of care activities are performed by households rather than the state, the market, or community organizations. Within this sociocultural pattern, which long predates the neoliberal reforms and even the first phase of Sandinismo, households in Nicaragua typically "rely heavily on mothers, daughters and other female family members" for their broader "survival strategies" including subsistence provisioning (Martínez Franzoni and Voorend 2011, 996). Time-use surveys reveal a greater gender gap in participation in unpaid care work in Nicaragua than in several other countries in Latin America, notably Argentina (Budlender 2008), Mexico, and Uruguay (Martínez Franzoni 2005), correlating with Nicaragua's exclusionary welfare regime. Further augmenting women's care burdens, a

large percentage of households in Nicaragua are composed of extended families (Martínez Franzoni and Voorend 2011).

Reliance on this complex cultural system enabled the victorious FSLN revolutionaries to expand social services after 1979. As mentioned earlier, mass campaigns in health and education depended enormously on women's volunteerism. The FSLN's present-day utilization of women's unpaid care work for many of its social programs, then, represents continuity not just with the preceding neoliberal administrations but with its own history of exploiting women's unpaid care services. The Sandinistas did not oppose the neoliberal governments' formalization of volunteerism for the targeted delivery of social services when they were out of power because they regarded grassroots participation in community development as a way to "defend the revolutionary achievements" (Martínez Franzoni and Voorend 2011, 1016).

In the FSLN's continued adherence to this model of social service provision, women are implicitly expected to be selfless care providers in both voluntary and formally employed capacities. This certainly seems to be the case when it comes to nurses, whose work President Ortega himself described as fundamentally "social and humanitarian." In the speech he gave to the AEN's annual Nurses' Day event in 2010, Ortega also referred to the occupation's founder, Florence Nightingale, as an exemplar of "abnegation," and repeated the words "heart" and "love" as nurses' most important traits, on equal footing with scientific training (*La Voz del Sandinismo* 2010).

Arguably this essentialist understanding of the care work performed by nurses does not just correlate with but also reflects a low prioritization of gender equality concerns in the FSLN since it took power in 2007. A stark illustration of its stance on gender is its recent equivocation around domestic violence legislation (Law 779) passed in 2012; its backtracking points to "a commitment at the top to enforcing a social order of Christian family values—including reifying men's authority in the family and making women responsible for maintaining family unity" (Jubb 2014, 290). It must be acknowledged that there is an uneven commitment to gender justice issues on the part of similar regimes across the region, which have been generally reluctant "to undertake direct challenges to gender power relations" (Friedman 2009, 43; Zarembeg 2016). But no other "pink tide" president has been as aggressively antifeminist as Daniel Ortega, notwithstanding some advances for women under the FSLN in socioeconomic rights and in participation in politics (Kampwirth 2011). This antifeminism manifested in a campaign of legal harassment of several feminist organizations just after Ortega took power in 2007, and the FSLN legislators' National Assembly vote, on the eve of the 2006 presidential election, to outlaw therapeutic abortion. As Kampwirth points out (2011), no other new left president took the lead in making all abortion a criminal offense.

Furthermore, in the past couple of decades the feminist movement in Nicaragua has had a much worse relationship with the governing party than in other new left regimes. Though this movement and its leaders trace their political formation to the socialist revolutionary movement, particular circumstances generated a rift. The core "offense" of the feminist groups was their successful pursuit of independence from the party's vertical control. Of the civil society groups that were linked to the FSLN, the women's movement was the only sector to attain autonomy once the party's electoral loss presented the opportunity for this in 1990 (Kampwirth 1998). Underlying this push was growing impatience with the limits the Sandinista revolution placed on the aspirations for multifaceted gender equality. Feminist groups' support for Daniel Ortega's stepdaughter, Zoilamérica Narváez, in the sexual assault case she brought against him in the late 1990s, further soured the party's stance toward the movement (Mannen 2009). Recent scholarship clarifies that the Sandinistas' commitment to gender equality had always been lackluster (Jubb 2014; Lacombe 2014). The advances for women enacted during the 1980s centered primarily around income poverty, economic participation, and so on, leaving unaddressed core realms of subordination to men (Lacombe 2014; Haase 2012). These developments have implications for the work conditions of nurses. Whereas in some countries feminist movements have had an indirect effect on nurses' status by making the state more responsive to their demands (Adams and Bourgeault 2003), the FSLN's overt antagonism to gender equality since 2006 seriously limit any such influence.

The FSLN's steady drift toward authoritarianism further reduces government receptivity to nurses' needs. Since the mid-2000s some feminist organizations have been explicitly signaling "abundant evidence of running roughshod over the rule of law and democratic principles" as an additional deep grievance they have with the party (Lacombe 2014, 285). Hybrid or quasi-authoritarian regimes are ones that use "intimidation" and "co-optation" instead of naked violence to control dissent (Martí i Puig 2013). Several scholars concur on features of the present-day FSLN government that make this categorization an apt one. These include enormous power exerted by the first couple over the party and over government, seen for example in the direct control exercised by Rosario Murillo over the deceptively named Citizens' Power Councils (Consejos de

Participación Ciudadana), which distribute poverty-reduction resources to poor Nicaraguans. The clientelist councils, renamed Citizens' Participation Cabinets (Gabinetes de Participación Ciudadana) in 2013, moreover, interfere with autonomous feminist organizing by channelling projects primarily through women who are FSLN loyalists (Zarembeg 2016). Murillo herself was transformed from first lady to vice president in the 2016 election in which her husband also won his third consecutive term as president.

Such behaviors and structures are in keeping with a long tradition of clientelism (Kampwirth 2014), strong-man rule, and family dynasty in Nicaragua (Colburn and Cruz 2012). Certainly antidemocratic tendencies were apparent in the FSLN during the 1980s. But these have become more entrenched in the years following its electoral loss in 1990. Evidence of growing "Danielismo" precipitated a split within the party by the mid-1990s, with those favoring greater internal democracy forming the Movimiento Renovador Sandinista (MRS). Ortega then consolidated his hold internally and was also able to translate this into considerable power in governance structures more broadly, despite his party's status as an opposition force. Crucial to this was a pact that Ortega signed with Arnoldo Alemán of the Constitutionalist Liberal Party in 2000 that enabled both leaders to circumvent democratic institutions and decision-making channels, and to extend patron-client ties throughout the country (Colburn and Cruz 2012; Martí i Puig and Wright 2010; Martí i Puig 2013).

These scholarly diagnoses of Nicaragua's reversion to personalistic rule confirm and extend the observations of the nurses in my study regarding the constraints on their agency. They also go some way toward explaining their worsening work conditions. Shahrá Razavi (2007) observes, in regard to developing countries, that the extent of political democracy is decisive in the prospects for care work to become more highly valued. In particular, a major hurdle for women's organizations or other civil society groups to push for positive change in the valuing of care work is the turn toward antidemocratic practices and structures by political elites. This is especially the case where "parties are not well established around social programmes, but rather tend to be vehicles for personalistic power ... ambitions ... [and where] trade unions are relatively weak" (Razavi 2007, 23). This general observation certainly finds echo in what political scientists have documented about Nicaragua, and what the nurses themselves narrate.

Conclusions

Nicaraguan nurses endured a deterioration in their work conditions under the neoliberal restructuring of health care between 1990 and 2006. The findings of the focus groups and interviews indicate that this has not been redressed by the FSLN since its return to power. In fact, in some ways their situation has worsened. We see a persistence of the short staffing generated by the earlier spending cuts alongside measures by the FSLN to increase people's use of the MINSAs facilities. Thus it is not surprising that public sector nurses report experiencing no relief from the intensification of their workload. Another aspect of continuity between the neoliberal administrations and that of the FSLN are nurses' extremely low salaries. A ripple effect of this in their subsistence strategies is time poverty, which in turn negatively affects their self-care, capacity for civic participation, and domestic lives.

Both the staffing deficit and the record-setting low pay reflect an unwillingness of this government to invest in the well-being of female care workers. A thread linking the FSLN with its predecessor right-wing administrations is the patriarchal notion that care work (performed by women) is easily augmented, as it is linked to women's natural abilities. This may reflect cultural tendencies in Nicaraguan society that predate the FSLN's existence. But it also stems from policy priorities and overall leanings of the present government. Far from disrupting gender essentialism in both paid and unpaid care-giving, the FSLN exploits and entrenches it.

What seems to be a relatively new feature of the nurses' present-day work conditions is the culture of complaint and outright abuse, a finding echoed by the AEN's study. Again, this reflects policy choices by the FSLN government: at the same time that it fails to increase the number of RN positions to deal with increasing demand on MINSAs facilities, it encourages patient denunciation of services they deem inadequate. A further new stressor for nurses has been a clamp down on critical thought and speech in spaces that could potentially transmit their interlinked concerns about their well-being and that of their patients. This reflects a deepening authoritarianism in the FSLN that has been reverberating throughout Nicaraguan society.

There is much need for further research on the work conditions of Latin American nurses. A fruitful direction would be to comparatively examine the factors that permit nurses to mobilize for policies that benefit both themselves and their patients. It is striking, for example, that there has been strong mobilization by Honduran nurses in a political environment that, since 2009, has been much more repressive than that of

Nicaragua (Pine 2013). Broader comparative research on nurses' professional associations and unions could inform interventions by nurse leaders activists and their allies at home and abroad.

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