AMANI Trust

Knowledge, attitudes and experiences of nurses on human rights, their violations and medical ethics in Zimbabwe.

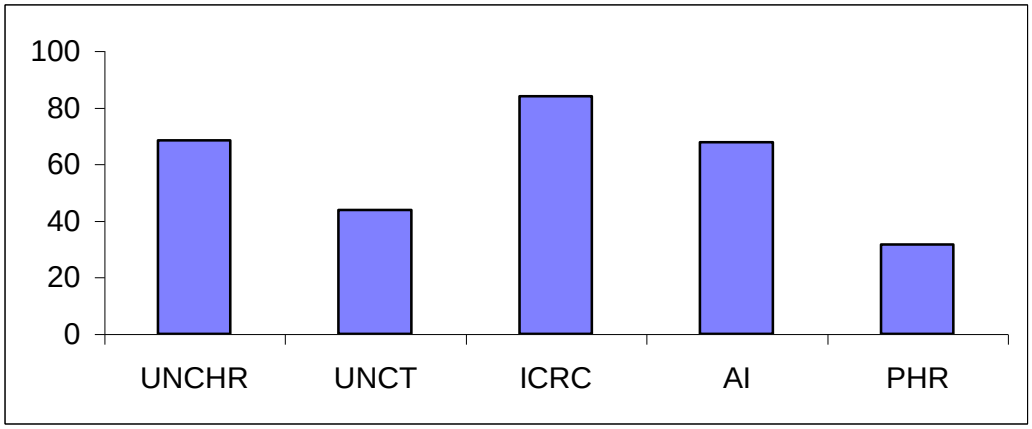
May 2001

Background:
This study was conducted as a preliminary to the launch of a Forensic Nurse training course, and the aim was to investigate the understanding by nurses of human rights issues in relation to nursing. The approach was similar to that used in a previous study of medical students carried out in 2000 by the Amani Trust, in conjunction with the Zimbabwe Medical Students' Association.

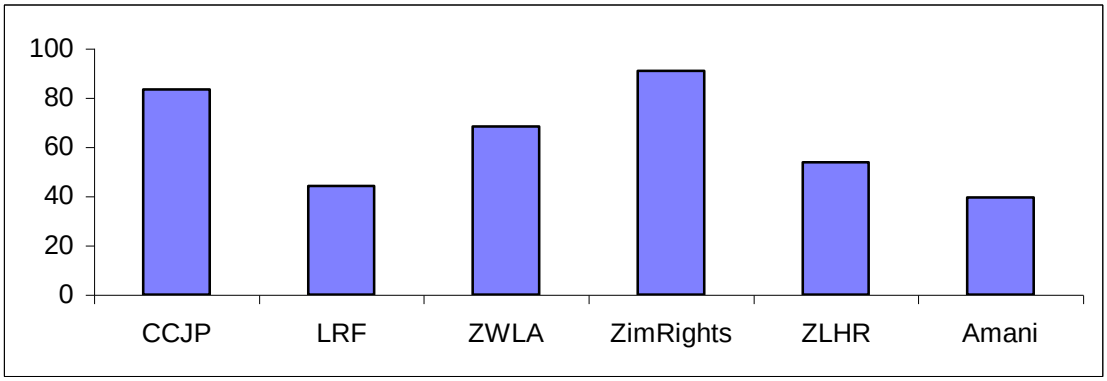
Methods:
A previously developed questionnaire was used, and modified for nurses as opposed to medical students.

A total of 198 nurses responded, of whom 90% were women. The majority were SRN, and 49% overall had post-basic qualifications. 33% had one post-basic qualification, 9% had two post-basic qualifications, and 7% had three or more post-basic qualifications.

Human Rights
90% felt that there were at least some universal human rights, but the numbers who knew either the international or local routes for dealing with human rights violations was highly variable. As can be seen from the table below, the sample knew about the ICRC, to some extent about the UN High Commission for Human Rights, and obviously Amnesty International. The sample was less knowledgeable about the UN Committee Against Torture or Physicians for Human Rights.



The sample were interestingly varied in their knowledge about local human rights groups, as can be seen from the table below. Both ZimRights and the Catholic Commission for Justice and Peace [CCJP] were relatively well-known, but not so the other groups. It was interesting that the Legal Resources Foundation [LRF], Zimbabwe Lawyers for Human Rights [ZLHR], and Amani Trust – that have all been very much in the press in recent years – were known by less than 50% of the sample.



The majority was aware of the codes of medical ethics in the country, and a majority had received formal training in such ethics. About that half felt that there was need to further define medical ethics, but, equally, half felt that the existing codes were satisfactory. We did not explore knowledge of the ICN instruments.

Table 1.

Medical Ethics	Formal Education	Define Medical Ethics
83.4	82.4	54.2

A majority felt that non-adherence to medical ethics negatively affected nurse-patient relationships.

Torture

The UN definition of Torture requires 4 elements to be present for torture to be accepted:

1. Severe **pain and suffering**, whether physical or mental;
2. **Intentionally** inflicted;
3. With a **purpose**;
4. By a state official or another acting with the **acquiesance** of the State.

The sample had no cases that could provide all 4 elements of the above definition – 58 could give no definition, 101 had one element, 16 had two, and 3 had three. However, 65% of the sample felt that they had seen a case of torture previously. 18% stated that they had been personally witness to a case of torture.

Of these, a minority had been brought by the police, as can be seen from Table 2 below.

Table 2.

Police	Relatives	Someone Else	Came on his/her own
44	69	45	64
22.1	34.6	22.6	32.1

Half of the sample felt that they would not examine a victim of torture in their clinic, but the reasons for not doing so were contradictory. 18% felt that they did not deal with medico-legal cases [which is generally the case in Zimbabwe], 16% felt that they did not have the expertise, and 8% would not manage such cases because they did not come through the police.

As regards involvement in torture, 5% stated that they had administered drugs to facilitate interrogation, another 5% had withheld treatment, and yet another 5% had given treatment

without the consent of the patient. Although these are very low levels of involvement, and need further investigation, they are of concern.

Rape

Nearly 70% of the sample had dealt with a case of rape. Most victims [74%] were brought either by the police or the relatives.

The sample had very good knowledge about what constituted rape. Over 96% gave definitions that included the key elements of rape, and over 85% knew the procedural steps to take in a case of rape: medical examination, informing the police, informing the family, providing psychological support. They were also very aware of some of the technical difficulties involved, such as the unavailability of rape kits, fear and resistance on the part of the patient [and especially with children], and the resistance on the part of parents or family to police involvement. Most knew about organizations dealing with rape victims. Here the following were mentioned most frequently:

- Musasa Project
- Family Support Trust
- Womens' Action Group

The sample were asked whether they thought that violence and explicit sex had an effect on people. 86% thought that such media was having an effect.

Skills to manage torture and rape

We also asked about nurses' skills in managing torture and rape. As can be seen from the table below, more than half felt that they were familiar with the effects of torture and rape, but, equally, very small percentages felt that they had the competency to treat torture or rape.

Table 3.

FAMILIARITY WITH EFFECTS OF TORTURE	FAMILIARITY WITH EFFECTS OF RAPE	COMPETENCY TO TREAT TORTURE	COMPETENCY TO TREAT RAPE
66%	70%	37%	35%

The sample was more convinced that rape can be detected by physical examination [40%] than could be torture [22%]. This may well reflect greater experience and training in the management of rape and sexual assault, but it complicated by the results of asking about knowledge and competency. The results, shown in Table 3 above, indicate that the sample felt equally competent and knowledgeable about torture and rape.

Table 4.

Psychological effects of torture	Psychological effects of rape
88%	**86%**

It was also clear that the sample understood that both torture and rape had detectable psychological effects. This is illustrated in Table 4 above. Similarly the majority of the sample knew where to report torture and rape, as can be seen from Table 5 below.

Table 5.

Where to report torture	Where to report rape
67%	72%

Involvement in gross human rights violations

A significant number [21%] of the sample knew of health professionals who had participated in torture, but this may reflect knowledge of some of the more notorious and public cases rather than direct personal experience. A majority [83%] felt that any such behaviour should be professionally censured, whilst a number [16%] felt that there some grounds for falsifying medical certificates or autopsy reports. Clearly, it will be important for the future to discover, in respect of the latter, what such grounds might be for nurses.

Preventing and reporting on torture and rape

A majority felt that nurses had an ethical duty to prevent torture and rape, but seemed clear that this should take place with the established channels. A very small number felt that recourse should be made to the press.

Table 6.

Ethical duty to prevent torture & rape	Informing the media about torture	Informing the media about rape
80%	22%	20%

A majority [74%] felt that victims should receive special treatment, but only half felt that victims should have a choice either of their own carer, or women a choice of women examiners. On the other hand, a large majority felt that examinations should take place in the presence of the police.

Table 7.

Level of care for victims	Choice of carer	Presence of Police during examination	Female examiners
26%	51%	13%	57%

Only half of the sample felt that dealing with torture victims should be part of the nurse's role, but, equally, the majority [89%] had had no training. A majority felt that formal training in clinical forensic nursing would be useful.

Table 8.

Role of nurses to include examining & treating torture	Have you had training in examining & treating torture	Formal training in forensic nursing
57%	11%	80%

Conclusions:

This little survey indicated overall that there is a need for more specific education in human rights and ethics for nurses. Although nurses generally have a good grasp of the international standards governing nursing practice - 90% felt that there were at least some universal human rights - but the numbers who knew either the international or local routes for dealing with human rights violations was highly variable.

A majority felt that non-adherence to medical ethics negatively affected nurse-patient relationships.

Half of the sample felt that they would not examine a victim of torture in their clinic, but the reasons for not doing so were contradictory. 18% felt that they did not deal with medico-legal

cases, 16% felt that they did not have the expertise, and 8% would not manage such cases because they did not come through the police.

As regards involvement in torture, 5% stated that they had administered drugs to facilitate interrogation, another 5% had withheld treatment, and yet another 5% had given treatment without the consent of the patient. Although these are very low levels of involvement, and need further investigation, they are of concern.

Nearly 70% of the sample had dealt with a case of rape, and the sample had very good knowledge about what constituted rape. Over 96% gave definitions that included the key elements of rape, and over 85% knew the procedural steps to take in a case of rape: medical examination, informing the police, informing the family, and providing psychological support. They were also very aware of some of the technical difficulties involved, such as the unavailability of rape kits, fear and resistance on the part of the patient [and especially with children], and the resistance on the part of parents or family to police involvement. Most knew about organizations dealing with rape victims.

More than half felt that they were familiar with the effects of torture and rape, but, equally, very small percentages felt that they had the competency to treat torture or rape. A majority felt that nurses had an ethical duty to prevent torture and rape, but seemed clear that this should take place with the established channels. A majority [74%] felt that victims should receive special treatment, but only half felt that victims should have a choice either of their own carer, or women a choice of women examiners.

Appendix 1.

International Nursing Standards on Human Rights

THE NURSE'S ROLE IN THE CARE OF DETAINEES AND PRISONERS
International Council of Nurses, 1975

At the meeting of the Council of National Representatives of the International Council of Nurses in Singapore in August 1975, the following statement was adopted:

ROLE OF THE NURSE IN THE CARE OF DETAINEES AND PRISONERS

Whereas the ICN Code for Nurses specifically states that:

1. "The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering.

2. "The nurse's primary responsibility is to those people who require nursing scare.

3. "The nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit upon the profession.

5. "The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person."

WHEREAS in 1973 ICN reaffirmed support for the Red Cross Rights and Duties of Nurses under the Geneva Conventions of 1949, which specifically state that, in case of armed conflict of international as well as national character (i.e. internal disorders, civil wars, armed rebellions):

1. Members of the armed forces, prisoners and persons taking no active part in the hostilities

   (a) shall be entitled to protection and care if wounded or sick,

   (b) shall be treated humanely, that is:

   - they may not be subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned and carried out in his interest,

   - they shall not be wilfully left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created,

   - they shall be treated humanely and cared for by the Party in conflict in whose power they may be, without adverse distinction founded on sex, race,nationality, religion political opinion, or any other similar criteria.

2. The following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

(a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;

(b) outrages upon personal dignity, in particular humiliating and degrading treatment

WHEREAS in 1971 ICN endorsed the United Nations Universal Declaration of Human Rights and, hence, accepted that:

1. "Everyone is entitled to all the rights and freedoms, set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Art.2),

2. "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Art.5)"; and

WHEREAS in relation to detainees and prisoners of conscience, interrogation procedures are increasingly being employed which result in ill effects, often permanent, on the person's mental and physical health;

THEREFORE BE IT RESOLVED that ICN condemns the use of all such procedures harmful to the mental and physical health of prisoners and detainees; and

FURTHER BE IT RESOLVED that nurses having knowledge of physical or mental ill-treatment of detainees and prisoners take appropriate action including reporting the matter to appropriate national and/or international bodies; and

FURTHER BE IT RESOLVED that nurses participate in clinical research carried out on prisoners, only if the freely given consent of the patient has been secured after a complete explanation and understanding by the patient of the nature and risk of the research; and

FINALLY BE IT RESOLVED that the nurse's first responsibility is towards her patients, notwithstanding consideration of national security and interest.

THE NURSE'S ROLE IN SAFEGUARDING HUMAN RIGHTS
International Council of Nurses, 1983

Responding to requests from national member associations for guidance on the protection of human rights of both nurses and those for whom they care, the Council of National Representatives of the International Council of Nurses adopted the statement given below at its meeting in Brasilia in June 1983.

STATEMENT ON THE NURSE'S ROLE IN SAFEGUARDING HUMAN RIGHTS

This document has been developed in response to the requests of national nurses associations for guidance in assisting nurses to safeguard their own human rights and those for whom they have professional responsibility. It is meant to be used in conjunction with the ICN Code for Nurses and resolutions relevant to human rights. Nurses should also be familiar with the Geneva Convention and the additional protocols as they relate to the responsibilities of nurses.

The current world situation is such that there are innumerable circumstances in which a nurse may become involved that require action on her/his part to safeguard human rights. Nurses are accountable for their own professional actions and must therefore be clear as to what is expected of them is such situations.

Also conflict situations have increased in number and often include internal political upheaval, and strife, or international war. The nature of war is changing. Increasingly nurses find themselves having to act or respond in complex situations to which there seems to be no clear cut solution.

Changes in the field of communications also have increased the awareness and sensitivity of all groups to those conflict situations.

The need for nursing actions to safeguard human rights is not restricted to times of political upheaval and war. It can also arise in prisons or in the normal work situation of any nurse where abuse of patients, nurses, or others is witnessed or suspected. Nurses have a responsibility in each of these situations to take action to safeguard the rights of those involved. Physical abuse and mental abuse are equally of concern to the nurse. Over- or under-treatment is another area to be watched. There may be pressures applied to use one's knowledge and skills in ways that are not beneficial to patients or others.

Scientific discoveries have brought about more sophisticated forms of torture and methods of resuscitation so that those being tortured can be kept alive for repeated sessions. It is in such circumstances that nurses must be clear about what actions they must take as in no way can they participate in such torture, or torture techniques.

Nurses have individual responsibility but often they can be more effective if they approach human rights issues as a group. The national nurses associations need to ensure that their structure provides a realistic mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with these difficult situations. Verification of the facts reported will be an important first step in any particular situation.

At times it will be appropriate for the NNA to become a spokesman for the nurses involved. They may also be required to negotiate for them. It is essential that confidentiality be maintained. In rare cases the personal judgement of the nurse may be such that other actions seem more appropriate than approaching the association.

The nurse initiating the actions requires knowledge of her own and others' human rights, moral courage, a well thought through plan of action and a commitment and determination to see that the necessary follow-up does occur. Personal risk is a factor that has to be considered and each person must use her/his best judgement in the situation.

Rights of those in need of care

(i) Health care is a right of all individuals. Everyone should have access to health care regardless of financial, political, geographic, racial or religious consideration. The nurse should seek to ensure such impartial treatment.

(ii) Nurses must ensure that adequate treatment is provided - within available reasources - and in accord with nursing ethics (ICN Code) to all those in need of care.

(iii) A patient/prisoner has the right to refuse to eat or to refuse treatment. The nurse may need to verify that the patient/prisoner understands the implications of such action but she should not participate in the administration of food or medications to such patients.

Rights and duties of nurses

(i) When considering the rights and duties of nursing personnel it needs to be remembered that both action and lack of action can have a detrimental effect and the nursing personnel must be considered accountable on both counts.

(ii) Nurses have a right to practise within the code of ethics and nursing legislation of the country in which they practise. Personal safety - freedom from abuse, threats or intimidation - are the rights of every nurse.

(iii) National nurses' associations have a responsibility to participate in development of health and social legislation relative to patients' rights and all related topics.

(iv) It is a duty to have informed consent of patients when research is done on them and when they receive treatments such as blood transfusions, anesthesia, grafts etc. Such informed consent is a patient's right and must be ensured.

NURSES AND TORTURE
International Council of Nurses, 1989

A statement on nurses and torture was adopted at the meeting of the Council of National Representatives of the International Council of Nurses in Seoul in May 1989. The text, last reviewed in 1991, is given below.

NURSES AND TORTURE

Violations of human rights have become more pervasive, and scientific discoveries have brought about more sophisticated forms of torture and methods of resuscitation.

Although nurses may not voluntarily participate in any form of physical or psychological torture, they must know what is expected of them and what action they must take to safeguard human rights.

Nurses need to know that, although the apparent motive for much of the treatment during and after torture is the protection of the victim, it is often carried out more as protection of the torturers.

The nurse may be called upon to act alone or to assist in the following situations :

To perform physical examinations on suspects before they are subjected to forms of interrogation, which might include torture

To attend a torture session in order to intervene when the victim's life is in danger

To treat the direct physical effects of torture, so that later the interrogation can be continued

The nurse's primary responsibility is to those people who require nursing care. If the victim of cruel, wanton, degrading or any other inhuman procedure or treatment (in the independent opinion of the nurse) requires nursing care, then no motive should prevail against the nurse giving such care to the highest standard possible.

The national nurses associations (NNAs) need to ensure that their structure provides a realistic mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with these difficult situations. Verification of the facts reported will be an important first step in any particular case.

The Responsibility of the Nurse :

The nurse shall not countenance, condone, or voluntarily participate in :

Any deliberate, systematic or wanton infliction of physical or mental suffering or any other form of cruel, inhuman or degrading procedure by one or more persons acting alone or on the orders of any authority to force another person to yield information, to make a confession or for any other reason.

Any treatment which denies to any person the respect which is his/her due as a human being.