Medical Relief After an Unnatural Disaster: How International Health Care Providers May Prove Counter-Productive to Recovery

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MEDICAL RELIEF AFTER AN UNNATURAL DISASTER: HOW INTERNATIONAL HEALTH CARE PROVIDERS MAY PROVE COUNTER-PRODUCTIVE TO RECOVERY

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ABSTRACT

Equally severe natural disasters that hit equally populous areas produce vastly different impacts and outcomes depending on preexisting political and economic conditions. International relief organizations and civil defense disaster response teams employ effective life saving protocols in the immediate aftermath of a disaster. However, there is little information that addresses the ongoing needs or assesses appropriate responses to the persistent hardships and ill health remaining months after a disastrous event hits an impoverished nation. This article relates the experience of 27 volunteer health care workers who provided relief care to Nicaraguan victims of Hurricane Mitch three months after the event. Issues addressed include how the disaster exacerbates the everyday suffering of already destitute populations, the inherently arbitrary and difficult nature of trying to determine who are the most affected and medically needy, and how well-meaning international health care providers may inadvertently be counter-productive to long term recovery. Analysis from a critical medical anthropologic perspective reveals how the skills, resources, and expertise of volunteer providers may be more appropriately used to contribute to long term sustainable changes in the health conditions of vulnerable, disaster-affected populations.

INTRODUCTION

When catastrophic geologic or climatic events like floods, hurricanes, or earthquakes occur relief efforts directed to restoring the infrastructure of the area and preserving the health of the affected population swing into action. However, when a natural disaster hits two equally populated territories with the same force the immediate outcomes and long term needs can be vastly different. The disparate impacts created by similar natural events reflect the prevailing political and economic situations within the affected areas (Bendaña 1998; Faber 1999). Where people are impoverished and poorly organized, the environment degraded, and the government has few resources or little interest to mount a response, the toll in lives and infrastructure lost will be far greater than where there is an effective organized emergency response network. The job of reconstruction and the adverse impact on the health of the more impoverished population will persist much longer.

An extensive literature suggests that the large relief agencies of the United Nations, the International Red Cross and numerous voluntary and religious affiliated health care NGOs have learned appropriate emergency and long term health care responses for populations displaced by disasters and wars residing within refugee camps (Toole and Waldman 1993; Clinton-Davis and Fassil 1992; Muecke 1992; Elias 1990). Similarly,
throughout the world civil defense agencies and national guards are trained to respond to local needs immediately after disasters. Their prompt responses keep death and disease to a minimum. However, the literature does not report on what happens to a people’s health over time when a catastrophic event occurs but no national disaster is declared, when a government does not have the capacity or interest to respond, when state supported structures of civil defense, police, fire, public health or municipal bodies do not exist, or are severely understaffed and undertrained with minimal communication links to the outside world. Attempting to provide relief care in the aftermath of a severe disaster in such a poor country raises a number of unique challenges for international volunteer health care providers. This uncharted territory was encountered recently by an unsuspecting brigade of health care workers arriving in Nicaragua three months after Hurricane Mitch.

By recounting the experience of the medical relief brigade working in Nicaragua from Feb 21 through March 5, 1999, this article explores the ways in which medical needs and responses are determined by pre-disaster conditions. Through the lens of their experience, the meanings, applications, and responses to emergency medical relief in a setting of severe chronic poverty will be examined. Specifically, how can the health care needs of the disaster-affected population be prioritized when civil society is barely functioning, when no effective infrastructure operates beyond the walls of the emergency shelters? How do chronic poverty, environmental degradation, disaster, relief efforts, and ill health intersect? How is quality medical care, or adequate medical care defined, much less done? When curing is impossible and caring is extremely difficult, is there even a role for medicine, and if so, what is it? The interaction of global economics, information exchange, and medical expectations, with issues of charity, dependence, and empowerment will be addressed. The theoretical framework for this inquiry is provided by Singer’s 1995 description of praxis in critical medical anthropology:

a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interactions between the macrolevel of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology, and environmental factors.

BACKGROUND

From October 27 through November 1, 1998, Central America, especially Honduras and the northern half of Nicaragua, was devastated by Hurricane Mitch, the worst disaster in regional history. Torrents of water created massive flooding and mudslides, killing at least 10,000 people, dislocating over 2 million more, and sweeping away animals, houses, hospitals, warehouses, factories, bridges, and roads. As hurricane force winds died out, torrential rains continued for a total of ten days dropping an astounding six feet of water on the region. Many survivors throughout Honduras and Northern Nicaragua were stranded for as long as 10-21 days without fresh food or water (Orlandi et al. 1998). In the immediate aftermath, multilateral assistance, governmental, non-gov-
ernmental, and military from around the world poured into the region. Yet the devasta-
tion to the land and infrastructure was so complete that experts believe it will be at least
another decade or two before either Honduras or Nicaragua can recover to their pre-

Many observers described the pre-Mitch situation “a disaster waiting to happen”
(Faber 1999; Bendaña 1998). Chronic poverty had already left the population with vast
unmet needs; the public health system had been severely weakened and there was insuf-
ficient infrastructure to mount an emergency response (Quixote Center 1999).

Nicaragua which is a small, impoverished Central American country no larger or more
populous than Iowa, has suffered from centuries of colonial exploitation, social and polit-
ical disruption, and a multiplicity of natural disasters. The low intensity conflict of the
1980s involving nationalist Sandinista forces and U.S. backed Contra forces was only the
latest chapter in a centuries-long war fought intermittently since the earliest rule of
Spanish imperialists. The structural violence of global economic policies constitutes the
most recent attack on Nicaraguans. Nicaragua’s infrastructure and public health system
was in shambles before the storm hit, due in part to the recent civil war, but much more
so, due to the deep cuts in public spending mandated by the World Bank and
International Monetary Fund (Nicaragua Network 1998; Russell 1999). Two-thirds of
the Nicaraguan budget goes to debt relief—more than two-and-one-half times the
amount spent on education and health together (Oxfam 1999). Thus it was said that the
country ruined by war was ruined again by structural adjustment policies before the
winds of Mitch ever blew over the land (Bendaña 1999).

Under the mandates of international debt restructuring programs, health care
infrastructure and overall population health have eroded (Jubilee 2000/USA 1998). Money
that had once provided a weak but functioning social support network, even dur-
ing the civil war, has been diverted to national debt repayment with resultant withdraw-
al of public investment from basic state functions. This loss of critical funds has lead to a
marked deterioration in civil defense, health care, schools, social, and agricultural servic-
es, with increasing malnutrition, child mortality, and environmental instability. Public
buildings, bridges, roads, schools, and hospitals no longer supported or maintained by
the state were in no shape to withstand the powerful forces unleashed by Hurricane
Mitch.

Small farmers and peasants had been forced off their traditional lands under these
same economic policies that favor large land holders engaged in export-oriented agricul-
ture. After foreclosure many poor, small farmers have settled precariously on steep defor-
ested hillsides, along flood plains, and on other marginal lands (NERRC Proposal 1998).
The best land, reserved for export crops like coffee, cattle, cotton, and other cheap
export commodities, was only moderately affected by the hurricane (Faber 1999). For
Nicaragua’s poor majority Mitch washed away the last of their meager tools for survival,
including the very land itself. Land that had been marginally productive for subsistence
food crops was completely washed away and replaced by sand and rock throughout the
area scoured by Mitch. Despite the loss of lives, lands and infrastructure, the president of
Nicaragua, Arnoldo Aleman, never declared a state of national emergency (Bendaña
1998; IFCO 1999; Russell 1999); it is conjectured that to do so would have deprived
him of control over national lending practices, taxes, relief supplies, and other revenues.

**BRIGADE CONFIGURATION**

Two small U.S. based NGOs, the Committee for Health Rights in the Americas (CHRIA) and the Nicaragua Network worked closely with the Nicaraguan based relief agency FUNDECI to provide emergency medical attention. Both CHRIA, based in the San Francisco area, and Nicaragua Network of Washington DC, have existed for over two decades; FUNDECI began in response to the earthquake that rocked Nicaragua in 1972. All three NGOs have long been active in educational and work exchanges for health and infrastructure support, advocacy, and material aid, but until Hurricane Mitch, with the exception of FUNDECI, they had not been involved in direct emergency relief.

Due to the unprecedented destruction caused by Mitch the three NGOs decided late in 1998 to combine resources and create special medical relief brigades. The first jointly supported medical brigade arrived in December 1998 during the immediate aftermath of the hurricane and had responded to the injuries and the predictable cases of skin, pulmonary, and systemic infectious diseases like cholera, leptospirosis, acute diarrhea, respiratory infections, dengue, and malaria. On Feb 20, 1999, twenty-seven health care providers from across the U.S. arrived in Managua, Nicaragua as members of the second voluntary two week emergency medical relief brigade to bring needed medical attention to the people of Northern Nicaragua who were still suffering the effects of Hurricane Mitch. The group was self-financed and each provider brought as many donated supplies and pharmaceuticals as airline restrictions allowed.

Members of the February brigade were veterans of work or study in Nicaragua and other countries of the Third World; collectively they had many years experience working in the chronically impoverished and war-stressed area. Professionals from across the spectrum of health care were included; almost all were fluent in Spanish. The physicians were specialists in internal medicine, family medicine, pediatrics, surgery, gynecology, psychiatry, and emergency medicine. Nurses came with backgrounds in midwifery, women's health, emergency care, hospice care, and family practice. Other professionals included a health administrator, nutritionist, pharmacist, respiratory and physical therapists as well as a psychologist and social worker both of whom had experience working with victims of torture and post traumatic stress disorder. Only one physician in this second group had been to the country since Hurricane Mitch. No one knew exactly what to expect but everyone was prepared to work hard and remain accommodating to whatever was encountered.

The brigade was assigned to work in the rural Northern half of Nicaragua along the area of Mitch's greatest impact. This mountainous area was also the location of the most intense fighting throughout the Contra war. It is an agricultural region ribboned with rivers all of which flooded, destroying or washing away seventy bridges, most roads and water mains, electric and phone lines (Alegria 1998). Economic destruction to area infrastructure was estimated at over $1.5 billion. Four thousand people of the region were killed outright, 2000 of whom were buried alive by a devastating mudslide in the towns of Posoltega and Proveni. The rice crop along with most of the corn and bean crops and topsoil were lost. Potable water was unavailable across the region.

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Cities en route were illusory islands of calm in a surrounding sea of rural chaos. Most secondary and tertiary roads and bridges remained impassable and hampered distribution of relief items. By the time the brigade arrived, main roads connecting the capital city of Managua with Northern commercial centers had been reopened or alternative routes had been established with the help of international engineering crews. Water was running within the larger cities. Red Cross units based in the cities, and emergency food distribution centers were functioning smoothly or had already ceased to function; road and building repairs were well on their way to completion. The appearance of Managua was that little had changed even though thousands of homes and people in and around the city had been displaced by flooding and were in desperate need of assistance. This disconnect between the appearance of normalcy and the reality of need contributed to the confusion and frustration felt increasingly by brigade members about their role in general.

**DOING THE MEDICINE—TIMES AND PLACES**

The brigade spent the first day in Managua being oriented to current conditions and strategizing. Local analysts and epidemiologists from other NGOs and the Ministry of Health reported there would be fewer cases than expected of acute infections like cholera, malaria, leptospirosis, and dengue. Instead, the group was told to expect post-traumatic stress disorder syndromes, depression, gastro-intestinal pain syndromes, pneumonia, urinary tract and skin infections, parasites, vaginal complaints and pelvic pain. As evidence of the degree of emotional trauma remaining, the areas where the brigade was slated to work were rumored to be experiencing at least one suicide per week with frequent reports of murder-suicides involving parents killing their children and then themselves. Access to adequate food and clean water sources were noted to continue to be problematic in many of the more remote areas. Brigade members briefly discussed addressing the food situation, but concluded it was a problem to be addressed by other aid groups. The brigade planned to stay focused on medicine and medical responses only.

Needed supplies and medications beyond those that had been carried into the country by brigade members were determined and purchased wholesale in generic form from local pharmaceutical producers. The formulary consisted of oral and topical antibiotics, anti-parasitics, anti-fungals, anti-asthmatics, analgesics, antacids and anti-spasmodics, antihistamines, ophthalmic preparations, cough and cold remedies, a few female hormone preparations, and vitamins in formulations appropriate for adults, infants, and children. Since brigade members were unable to provide continuing care, it was decided to purchase few antihypertensive, cardiac, anticonvulsant, or diabetes medications. Even with these exclusions, the brigade purchased well over $20,000 worth of low-priced pharmaceuticals to combine with the hundreds of pounds of medications brought along.

The group was divided into two teams to respond to the medical needs of a broader area. One team was assigned to serve Esteli and the region around it, the other was assigned to Matagalpa and its region. Both cities are commercial centers in the northwest of Nicaragua that had been hit hard, and both still had several refugee camps situated in their outlying areas. On the fifth day the teams were scheduled to move further north into poorer, more isolated areas where hurricane victims had received little beyond
plastic sheeting for shelter, and some emergency food supplies. The Esteli team was moved to San Juan de Limay, the other half of the brigade moved from Matagalpa to Waslala. The latter is in an impoverished region made notorious for its renegade bands of ex-combatants who have survived as highway robbers since the end of the Contra war. Brigade members were only dimly aware of this potentially dangerous situation when they set out. Once outside the main commercial centers, both groups set up clinics in crude, open air sites in similar circumstances. During the last few days both teams set up clinics in even smaller remote villages not directly accessible by car or truck. To do these clinics, brigade members walked in and supplies were brought in on horseback by local villagers.

DOING THE MEDICINE—CLINICS AND PATIENTS

For the first few days, general clinics were set up within existing clinics called Casa de la Mujer in both Esteli and Matagalpa. Patients were admitted to the building, registered by Casa staff sitting just inside the door, and given a number and a clinic note sheet. Each patient was then briefly interviewed in the same open waiting area by a brigade nurse or social worker and triaged to the most appropriate care provider available. The obviously depressed, severely anxious, potentially suicidal patients were steered to the psychiatrist and psychologist, others as needed, to the pediatrician, gynecologist, internist, or surgeon. At times the Esteli medical team included a young Nicaraguan doctor who otherwise staffed this clinic part time. Once the clinic started, patients quickly filled all available chairs and niches throughout the building creating intense noise, crowding, and chaos.

After visiting with a doctor or the nurse practitioner, patients would be sent with their clinic note sheet doubling as prescriptions to the make-shift pharmacy, the door to which was located opposite the building entrance and at the beginning of the hall leading to the exam room area. Patients crowding around this door effectively created a loud bottle neck between the waiting area and the exam room hallway. Despite all efforts at maintaining order within the clinic, the cacophony of voices was deafening.

Creativity, flexibility, and patience were required of each provider when interviewing and examining patients. The exam rooms were semi-private at best since few walls reached to the ceiling. Most doors did not have locks or latches so people and children constantly moved in and out whether or not invited to do so. Some rooms had electricity, but most were naturally lit by clear plastic roofing material. Most rooms did not have plumbing. Only two rooms had exam tables. These were padded but rusty and poorly functioning, long ago donated by someone from the U.S. Two doctors examined patients on counter tops, one used a desk top, and another used an unhinged door suspended between chairs. Adding to the congestion and confusion, the building had only one functioning toilet for use by staff and patients alike, which was located within an exam room. Each clinic day ended when it became too dark to continue; the few bare light bulbs in the clinic did not provide adequate light to sustain activities.

The team’s arrival opened a flood gate of patients wanting to be seen, each with innumerable complaints and unanticipated problems. Unknown to brigade members, thousands of entry tickets had been sold by the staff of the Casas de la Mujer prior to the
brigade's arrival. The pressure imposed by this tide of preselected patients was overwhelming. Most were women and children who came by the hundreds each day from designated barrios around the city— even though at any one time there were never more than 4-6 physicians or nurse practitioners available in the clinic. Patients, from tiny, malnourished and lice-infested babies and toddlers to the very old and frail, waited patiently but persistently to be seen. They were standing pressed to the building 4 and 5 deep at least an hour before each clinic was to start. There they remained pressing tighter and tighter as the sun and temperature rose higher and higher.

It was the rare patient who did not bring a complaint list that started at the top of their head and ended with a painful foot fungus. Virtually all patients had pain syndromes that involved multiple muscle groups from headaches to backaches and leg pain; almost all had gastro-intestinal problems and fatigue; the vast majority had significant skin infections. Seizure disorders and neurological, sleep, and psychiatric complaints were common. Many elders had cardiovascular complaints, and essentially all women from 15-50 years had hormonal and reproductive system concerns. Interestingly, few mentioned their obvious malnutrition or problem with intestinal parasites unless directly questioned. Given the number and variety of complaints expressed, most patients could have potentially been seen by the psychiatrist and virtually every other brigade practitioner. Similarly, each patient could have easily been given multiple medications, antibiotics, analgesics, and vitamins if most or even many of their presenting complaints were addressed.

In an effort to attend to those most adversely affected by Hurricane Mitch, small, spontaneously assembled sub-groups of providers, especially those with psychiatric and pediatric skills, escaped the noisy clinics and went out to the refugee camps to provide impromptu, open air clinics-without-walls for anyone who approached them. There they found the same problems already seen in the clinic only more so: the lice, scabies, skin infections, malnutrition, and evidence of post-traumatic stress disorder (PTSD refers to the debilitating psychiatric syndrome that can occur following the experience or witnessing of life-threatening events) were more pronounced. There was little that medicine could do in such a setting. The psychologist and social worker started play groups for children to draw or tell stories about their fears; groups of women were encouraged to discuss the sources of their nervios (which in translation closely resembled PTSD) and taught to provide simple massage for each other. These were important coping skills for the camp dwellers to learn, but still they wanted medicine. Whether working in the clinic or in these spontaneous camp groups providers were relieved when they were able to diagnose and treat the occasional pneumonia, asthma attack, or urinary tract infection. At least these were conditions about which they felt they could do something effective.

After the last patient of the day left the clinic, the exhausted brigade workers convened to review, discuss, and evaluate the day’s experience to better plan for the succeeding days. Evening debriefings became an important component of group cohesiveness. Some providers expressed distress over their realization that the clinic patients, as impoverished and desperate as they appeared, were not the most needy hurricane-affected people they had expected to see. Few of the people seen initially came from the refugee camps, almost all were able-bodied (that is, overlooking the missing limbs from old land mine or war related injuries), and few had acute illnesses. The volunteers had
arrived with poorly formed notions of who were the patients and what were their needs. However, they resolved to provide medical care to those they thought most needed their services. From the very beginning the brigade struggled with determining and appropriately responding to what they considered the most significant or serious health concerns. A small group with limited funds and supplies could not possibly serve the entire population of the region! Criteria for providing medical attention were decided collectively based on arguably arbitrary and unenforceable determinations of medical “need”. Such criteria directed providers to attend to acute versus chronic concerns and avoid medicalizing people’s tendency to somatize their distress.

The brigade left Esteli for Limay early on the fifth day. Workers, pharmaceuticals, supplies, and personal belongings were loaded on an open flat bed truck. All along the dusty, curvy, rutted two hour journey, the destruction and loss of land in the formerly fertile valley were obvious. Large numbers of hurricane victims were noted to occupy make-shift houses of black plastic sheeting. Limay itself was an old, sleepy, dusty town distinguishable from the surrounding desert only by the clustering of houses. There were few motorized vehicles; transportation throughout the town was by horseback or on foot. Slow moving pigs, chickens, cows, and other miscellaneous livestock lined the roadsides rooting and scratching for something to eat.

The Limay clinic site was arranged in a thatched roof bar/dance hall, which, ironically providing comic relief, was replete with ads for beer and cigarettes, and posters of buxom naked women. Private space for exams was created by hanging sheets of black plastic around roof support poles. Tables for patient exams were sturdy, hard, hand-hewn tables quickly constructed by local carpenters. Plumbing included latrines and a questionable water supply. Nevertheless working in the open air was a welcome relief from the dark, crowded, and noisy Esteli clinic.

A team of two volunteer Cuban doctors had been stationed in the area to help serve the 15,000 residents since the hurricane. There were also two Nicaraguan doctors available part time from the Public Health Service, but these two doctors had almost no functioning equipment, laboratory resources, or medicine at their disposal. Few area residents frequented their clinic because it was commonly felt that the doctors there had little to offer. The brigade was assisted one afternoon by the Cuban doctors, and by a pleasant and helpful volunteer fourth year medical student.

Just as in Esteli, the crowd lining the street formed early. Regardless of the seriousness of their physical concerns and complaints the prevailing mood was that of a friendly and familiar crowd waiting to get into a long anticipated show. In fact, for most this was the only show in town; not much else had happened in the area since the war’s end and the hurricane’s arrival. Leaders of the town thought that everyone needed attention because they had been left behind and unserved for such a long time. This was the first medical brigade to ever come through the area. It did not matter to the populace that an adequate history or exam could not be done, that the context of their many problems could not be addressed, or that continuing care or follow-up could not be arranged in most cases. All these mundane concerns had little to do with the apparently exciting and exotic nature of the event.

In contrast to Esteli, given that this was a more remote area, many people walked
for hours in the hot sun to seek medical attention, often with young children in tow. Turning away anyone would have been heart breaking, regardless of the “appropriateness” of their complaints or our inability to respond adequately. In this more remote and isolated area the effects of hunger were more apparent. Some patients who started with the too familiar litany of head to toe pains promptly stopped when questioned about food in the house. Simply stated, they were hungry. These patients realized along with the providers that medications would have little impact if hunger were ongoing. Even more women in Limay listed their craving to eat dirt (known as pica), the cessation of their menses, or extremely heavy bleeding with menses as their more urgent concerns. These symptoms could have resulted from decreased caloric intake, increasing anemia, pregnancy, or the emotional trauma of having their homes and possessions, including their animals and farm lands, washed away—probably a combination of all of these. Worries about undetected or unwanted pregnancy from unprotected intercourse were paramount in the minds of many young, hungry women who were already caring for young children and babies.

As brigade members became more aware of the necessity of coordinating services with local resources it became apparent that there were local programs with some food and medicine. Unfortunately, these programs were unwilling to share or distribute their supplies. Program managers foresaw the end of the post-Mitch largess and fearing even worse times, they wanted to hold onto food and medical supplies. In a poor country perennially on the edge of disaster and starvation, international attention and generosity are short lived. A worse disaster, famine, was envisioned to be in the offing when the current and next harvest time produced little food for the region. From the perspective of a very poor country, so-called natural disasters don’t have a natural beginning or end. They simply worsen the usual bad state of affairs.

Other supplies were held back for less comprehensible reasons. When questioned about family planning supplies, the local doctors, including the two from Cuba, admitted to having contraceptives at times that they did not readily distribute. They questioned the women’s motivation in requesting family planning assistance. What if the women wanted to sell the birth control pills, and worse yet, what if their husbands did not want them using contraception? Instead of helping to educate the local population about the negative impacts of unrestrained fertility, these male doctors defended the local machismo attitudes around childbearing. To me, a clinician addressing desperate women requesting family planning assistance, this attitude was morally offensive.

The last two days’ clinics were held in small primitive villages outside of Esteli and Matagalpa where we had to walk in. We arrived and people materialized seemingly out of thin air to help with hauling our supplies and making exam rooms out of open class rooms or public meeting spaces. By then we had great respect for the creative ingenuity of the local people who helped make the event happen. With their help and energy we had learned how to set up and take down the mobile clinics in less than an hour’s time. This was fortunate because after 10 days the brigade staff was sorely depleted. Many doctors and nurses were laid low by fevers, fatigue, and acute gastrointestinal illnesses. Efforts at disease prevention, hygiene, water safety, and food precautions proved largely inadequate and served to remind us of the challenges faced by these people every day.
DISCUSSION

Surprisingly, this group of seasoned, flexible medical professionals was shocked, frustrated, and often angry at being unprepared to respond to the situation encountered. The immediate aftereffects of the hurricane involving predictable injuries, risks, and infectious diseases had passed and a gaping undefined area of devastating need had emerged where the effects of chronic poverty were exacerbated. In such a setting, the interaction between the brigade’s mobile medical unit and the informed albeit impoverished and often illiterate population might more appropriately be described as medicine-as-magic, or as entertainment, or, in some cases, medications as currency.

Many troubling realizations surfaced after just one day of working with the first three hundred patients in the Esteli clinic and refugee camps. Too many patients needed ongoing, follow-up care or fundamental changes in their living conditions. How would they get it? Brigade members knew little about the specifics of local resources – medical or otherwise. They assumed such resources were inaccessible or inadequate for most of these very poor people. Patients and families with complications of severe lice and parasitic infestations had limited access to clean water so medication could do little beyond providing temporary relief; reinfection was certain. Most of the women were suffering from pain syndromes associated with the incredibly difficult lives they lived, frequently complicated by situations of domestic abuse. Those fortunate enough to be employed worked as market women carrying heavy baskets on their heads, or stood for 10 hours a day bent over work tables in stuffy and dimly-lit tobacco factories. Even those who referred to themselves simply as housewives spent many hours grinding corn, doing laundry by hand, cooking over wood stoves in dark, poorly-vented rooms, carrying water, and caring for “mountains” of children or grandchildren. Most patients complained that their eyes and throats burned and their muscles ached. Further complicating all these problems, most also had severe dental disease, and many reported visual difficulties. In such a setting, traditional relief medicine alone was a sorry response.

Several concerns based on the perceived need to ration energy and supplies haunted brigade members throughout the stay: first, determining who were the patients most in need of attention, then, deciding what were appropriate patient requests, and finally what constituted adequate medical responses. The line of traumatization between those who still had homes, personal resources and/or family, and those residing in the refugee camps was often agonizingly fine and indistinct. The entire community seemed to manifest a frightening realization of just how precariously close to the edge they all were. Over and over again biomedically oriented brigade members raised questions about how could needs and responses in this setting begin to be prioritized, how could the so-called “truly medical” pain syndromes, those with “objective” pathology, be differentiated from those that were merely “medicalized” syndromes synonymous with difficult lives? (May, Doyle and Chew-Graham 1999) A related question asked what did stress management training mean in a setting of unimaginable grinding daily stress? Given the limitless needs, attempts to set limits and boundaries regarding who to see for what problems were elusive and essentially impossible to implement at any point in the brigade’s activities.

Then there were the “difficult” demanding patients who, like their counterparts in
the U.S. or even in other parts of the Third World (Kamat and Nichter 1998; Nichter and Vuckovic 1994), came requesting, by brand name, the medication they felt their condition required. Despite their difficult lives and lack of the most basic resources, this population does not lack certain highly specialized information. A globalized pharmaceutical industry has created global demands for its products. For some, acquiring the “right,” usually high priced, medication carried virtually magical connotations. Few of the expensive, but widely advertised or promoted brands of antimicrobials or gastrointestinal agents requested were available from the brigade. Such pre-programmed patients required relatively more time to negotiate a mutually agreeable resolution to their concerns and in the process drained much provider energy. They were not satisfied with that which was offered to them from the formulary consisting of locally produced generic medications augmented by a few herbal products for symptomatic relief of common complaints. Direct-to-consumer advertising in this poor country has meant that, in this situation of complex needs, health as a state of well-being was equated with that which could be obtained by consuming the right pill. At times such patients became sullen or angry, claiming they were being cheated of quality care if not provided with the brand made familiar by local pharmacies, drug company signs, radio or TV ads. Such artificially distorted perceptions of need made the brigade’s task more difficult.

Also troubling was the concern that a desire for so many medications to relieve so many complaints might represent plans to sell or trade the medications. In a significant number of cases the medical history and exam seemed irrelevant to the patients’ task of acquiring medications. If the response to a given list of complaints was not adequate, the complaining would begin anew. Each of the providers often felt trapped by a desperate sounding patient requesting more and more from the limited supply. It had not occurred to brigade members at the outset that with so much unemployment and so few avenues to generate an income, medications might become a means to acquire cash or other necessities. At best, it was easy to imagine people hoarding the medicines the way people might be expected to hoard food and water in a disaster. Whether hoarding for cash or personal future use, the tropical climate could quickly render medications useless or toxic. The specter of stockpiled outdated or unstable medications for any reason was frightening.

Given these preoccupations and difficult encounters, the relief experience included many redeeming moments. The fact that the brigade traveled to remote locations was an acknowledgment and validation of people who felt forgotten by the outside world. The vast majority of patients expressed deep and genuine gratitude to the providers for the attention they received, however brief, despite the inconveniences imposed by the challenging physical spaces, technical constraints, and limited supplies. Hugs and tears of gratitude were the norm ending most interviews. People appreciated the opportunity to express their suffering and misfortune to U.S. health care providers; they appreciated the opportunity to transfer their pains and concerns unto a caring listener. Many mentioned that brigade doctors were the first to ever actually examine them, to touch them in their sensitive and painful areas. For the most part, patients accepted the fact that beyond the simplest of medications for a week or two of palliative care of their most urgent yet lifelong pains and cares, not much else could or would be done for them. Even if reluctant,
most understood the limited nature of brigade interventions, and the need to spare or share the limited supplies.

For many providers this heartfelt emotional demonstration of gratitude is a profound experience. The hugs and tears can be enough to make all the inconvenience, expense, fatigue and gastrointestinal upset worthwhile. In itself, appreciation provides the driving force, the secondary gain many caring physicians receive when doing medicine as a charitable good deed for those systematically excluded from the health care system. Gratitude is a heady narcotic especially since so many U.S. health care providers come from medical practices that are increasingly bureaucratized, emotionally sanitized, and not infrequently adversarial. However, while it verifies that something good happened, patient gratitude is not enough. While one could argue that a healing touch is not insignificant, it is important to recognize that good-will alone has limitations.

There are many troubling questions about the role of “relief” or charity medicine in the setting in which we found ourselves. Quality evaluation or intervention by any usual medical standard was impossible. Where and how do the symbolic value, placebo effect, and magical thinking of such a distorted practice of medicine begin and end? In the press of numbers, noise, confusion, and the lack of laboratory or other diagnostic equipment, the brigade health care providers functioned more like shamen. How often was medicine’s prime directive, primum non nocere (first do no harm), violated whenever providers guessed about the source of the patient’s distress, or did not have the time to explain the potential risks of allergies, side effects, or drug interactions of the medications they prescribed, or to make certain that patients understood them?

The level of patients’ gratitude dramatically underscores just how unresponsive the local health care system has been forced to become. These people received very little substantive medical attention even in the relief clinic we brought to them. To be so grateful for such small crumbs of care is the strongest expression possible of malign neglect or structural violence within the current regime. In retrospect, the brigade’s version of relief medicine was unlikely anything that might be considered effective or efficient, and certainly not sustainable or empowering.

Disasters like that of Hurricane Mitch are predictable in an increasingly impoverished and environmentally unstable world characterized by expanding inequality between peoples and nations. Population growth and economic disparities have led people around the globe to settle in flood-prone valleys and unstable hillsides, where deforestation and climate change have increased their vulnerability to so-called natural disasters (Abramovitz et al. 2001).

Each of the issues raised by the experience of this brigade overlaps and impacts the others and all stem in the final analysis from the absence of a functioning and concerned public health system. Since the public sector of the Nicaraguan medical system, like so many throughout the developing world, has been decimated and degraded by privatization, people have stopped using it except in the most desperate situations. The local medical doctors, members of the now essentially defunct Public Health Service, who have no status, also have no power to educate or intervene in medical disasters.

The good intentions of the brigade added to this health system devaluation by rarely seeking to coordinate efforts with local providers, in effect applying yet another
assault on local self-reliance and self-respect. Wherever the brigade worked, with the exception of the two most remote villages, there were Nicaraguan Health Service physicians stationed nearby. Despite the obstacles to their practice there was no reason to think they were not well informed, creative, or well-trained doctors. These physicians are as trapped as the general population in a system that puts little value on human life or on those who would provide some succor to the suffering. In the recently privatized health care system, they are looked upon with suspicion and derision since, bereft of equipment and supplies, they are impotent to provide much other than written prescriptions that patients cannot afford to fill. Their inability to do much in the face of so many needs on a chronic basis has soured the local residents. Such physicians sit virtually unemployed while efforts like our relief brigade become the main attraction. By overlooking or failing to more actively incorporate local resources or engage local energy in creative problem solving, relief workers inadvertently collude with the powers that made their presence necessary in the first place.

The volume of patients who present to the international brigades with their many illnesses and concerns raises the risk that even highly motivated, altruistic providers like those in our group could rapidly become overwhelmed and develop negative attitudes that discount the very real pain caused by the life experiences of the majority of Nicaraguans. Concern about “medicalizing” pain as noted by Scheper-Hughes and Lock (1986) in essence neglects “the particular, the existential, the subjective content of illness, suffering, and healing as lived events and experiences.” Nearly one hundred percent of patients seen complained bitterly of some combination of chronic back pain, headaches, fatigue, or pelvic pain. Rarely do any of these complaints stem from easily demonstrable organic pathology. Traditionally they are assumed to have a close relationship with bodily fatigue, depression, and anxiety. Overworked, undernourished, fatigued bodies ache. What is a person to do if they ache too much to do that, which is required for survival, much less to resist their oppression or fight for change? Health care providers have to take patients at their word; if they hurt, try to help them find relief of their pain. Most importantly, give them sustainable options for relief of their pain.

Health care providers working in traumatized Third World settings have to be careful not to add to patients’ sense of being devalued by devaluing their suffering. It is worrisome that members of the brigade wanted to avoid “medicalizing” these patients’ complaints, or what Quesada terms their embodied distress (1998), while having few alternative solutions to offer. The intellectual and emotional distance between complaints labeled appropriate and worthy of attention and patients considered appropriate or worthy of attention is very narrow in such pressured situations. The medical moral subtext of an apparent disparity between expressed symptoms, measurable signs of pathology, and perceived disability becomes especially dangerous and murky territory in a setting of charity-driven medical care. How can U.S. health care providers with plane tickets out of the country even begin to define what medicalization or somatisization means in this transformed setting? The moralistic and reductionist approach of Western medicine to pain syndromes does not incorporate the lived experience of many destitute patients. Using a biomedical model that identifies individuals as the focus of medical attention is a painful trap when the suffering community itself may more appropriately be understood

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as the patient. This struggle of the group to determine medical need and respond within the framework of biomedicine alone was a powerful demonstration of the contradictions inherent in medicalizing significant socio-political sickness.

Additionally, patients’ apparent inappropriate preoccupation with specific medications, whether for use as currency, future uncertainty, or simply resulting from the magic of advertising sets up dangerous precedents for misunderstandings, and abusive or adversarial relations between doctors and patients. Potentially serious problems result from direct advertising of pharmaceuticals and the absence of regulation of or restraint on the activities of the pharmaceutical industry. Product promotions potentially distort the nature of health concerns presenting in any clinic. In the setting of “relief” they are especially troublesome and drain limited personal and financial resources. Besides exaggerating potential problems of drug overuse and misuse, the unrestrained promotion of drugs obviously tends to increase self-medication and to distort or decrease the tolerance of any symptoms, further complicating efforts to prioritize “need”. Medical brigades need to consider this phenomenon and make their plans accordingly.

Lastly, the presence of a group of well-funded volunteers from abroad can encourage a certain kind of exploitation by less than scrupulous members of the local NGO community looking to enhance their own position. In this case, the reason for the sale of clinic tickets and the patients selected, or excluded, by ticket sales was never adequately addressed. The sale of inexpensive tickets to a free clinic can be understood as a source of needed revenues for ongoing activities. At the same time such fees inject a level of seriousness and value into the enterprise. But just as easily, mandatory fees can degenerate into exploitation of both patients and providers. Even when done for the best intentions such a practice can introduce an element of distrust about who and how medical need is determined. Who besides the designated patients benefits from the brigade’s work? How and to whom tickets are sold, who is denied a ticket, and whether or not those who cannot afford a ticket, presumably those most in need, are nevertheless offered a place in the clinic line are important issues to address before a clinic is started, not after, as occurred in the experience of this brigade.

CHALLENGES AND OPPORTUNITIES: LESSONS TO BE APPLIED IN FUTURE DISASTERS

Regardless of climatic or geologic events, where people are suffering primarily from chronic lack of food and limited access to potable water and all the diseases these two conditions initiate, food and water must be the drugs of choice in any relief efforts. When the only employment available in this situation is backbreaking, low paying, drudgery in virtual sweatshops, support for safe, meaningful employment must be understood as an intervention.

This does not mean, however, that medical brigades have no role. On the simplest level such work can serve to educate and sensitize concerned persons from the industrialized, developed North about conditions in the South. To have a lasting impact on the local situation however, medical aid interventions have to be thoughtfully designed to empower the local people rather than to legitimize the degraded status quo, instigate, or perpetuate dependency on charity from developed nations. Such a stance simultaneously...
allows the local government to abrogate its responsibility to serve the people. Rather than contribute to a mind-set of dependency that looks for solutions outside the local resource base, international health workers must consciously support local efforts at problem solving.

The legitimacy and status given to health workers from industrialized nations can be used to help re-legitimize local health care providers if the two openly work side by side and devise follow-up plans together. If the resident providers are as prominent as the U.S. doctors in a brigade, if they are noted to confer together, if their assessments and prescriptions are endorsed by each other, people will realize that local providers come equipped with a similar knowledge base and perspective. Brigades like ours can also be used to help facilitate self-help groups searching for simple locally derived solutions to their problems. Rather than lamenting their inability to purchase expensive hypnotics for insomnia, for example, people can be instructed in the empowering benefits of locally grown, soothing herbals and teas. Similarly, as evidenced by the well-organized and creative logistical support received by the brigade during their two weeks stay, representatives of civil society are able to mobilize and coordinate community resources. It’s vitally important that these leaders be granted the respect and support they deserve to sustain their work.

Those patients who shared and discussed fears and anxieties experienced ever since the hurricane, or their problems with depression, anger, or domestic violence, found group experiences supervised by the brigade helpful and uplifting. They also felt they would be able to use some of the stress management techniques of massage and relaxation in broader contexts. Providers may be able to use these unique opportunities and help educate people on additional public health messages like the importance of separating human and animal spaces and waste products, and of removing garbage from communal living spaces. Other appropriate educational interventions could highlight family planning, sexually transmitted disease prevention, prenatal and other primary care issues before or simultaneous with clinics or providing medications to individuals.

Lastly, the expertise of U.S. based health care providers, whether social scientists or physicians, might be applied more effectively to monitor, document, and disseminate information regarding the adverse health impacts of debt-related poverty and environmental degradation in settings like Nicaragua. Such documentation can contribute to the mounting evidence challenging globalized economic policies that ignore health and human consequences. Documentation of need and illness patterns, especially after so-called natural events like Hurricane Mitch makes real the potential for devastating and long term human impacts of harsh economic and political policies.

CONCLUSIONS

Nicaraguans, like people in all indebted developing countries clearly need help especially after a disastrous event like Hurricane Mitch. However, the need is much more complex than providing health care or food alone. Health will not be achieved until the economy, environment, and civil society are restored or initiated. Without significant changes in the macro-economic political structures that in turn influence the structure, functioning and funding of local public health activities, the lives of the populace will con-
continue to be extremely precarious. Economic and social improvements must begin with permanent debt relief and ongoing aid appropriations directed to rebuild and maintain social support infrastructure. Physicians, public health personnel, and other health care providers have a unique role to play in rebuilding self-reliance and self-respect among traumatized people of the Third World. We can use our status as trusted members of society to encourage sustainable gains in global health by providing intellectual and financial support of indigenous efforts at initiating, restoring and maintaining health. More importantly, we can clarify the relations between poverty and poor health and make this information public knowledge in the developed nations.

REFERENCES


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END NOTES

i Jubilee is an international movement in over 50 nations advocating a debt-free start to the Millennium for a billion people. Within individual countries Jubilee 2000 is a coalition of NGO’s, Aid Agencies, Religious, and other organizations calling for a one-off cancellation of the unpayable debts of the world’s poorest countries under a fair and transparent process. The movement is interested in changing the global debt structure that increasingly impoverishes populations of the majority world while enriching the already wealthy North. This movement grew out of and beyond the organizations of the previous “50 years is enough” campaign targeting the policies of powerful creditors like the world bank and IMF. Signors of the Jubilee 2000 petition note that debt repayments divert money away from basic life-saving health care and estimate that if funds were diverted back into health and education, the lives of seven million children could be saved within a year.

ii Ironically, when translated, Provenir means “the future.”

iii I was assigned to the Esteli group. Reports by members of the other team concur that the experience in both places was essentially the same.

iv *Casa de la mujer*, or literally, house of the woman, is a loosely affiliated network of women’s clinics in a number of Nicaraguan cities with links to AMLAE, the official organization for women within the Sandinista party. Women’s clinics in Nicaragua are quite different from clinics in the U.S. in that they provide many social and legal services for women besides direct health care. A good example of one such expanded service, of course, would be how they provided a site and organized patient flow for a brigade such as ours.

v The fact that women and children comprised the majority of patients may have reflected the fact that the community health workers for *Casa de la Mujer* are all themselves women, or it may have reflected the altered demographics of the area. Men have been leaving the area disproportionately over the last two decades in search of more lucrative employment. They either become part of the seasonal labor force on the large coffee plantations, go to work in other cities within Nicaragua, or seek employment in Costa Rica, Mexico, or the U.S. This aspect of the brigade’s work was never directly addressed.

vi This is the adjective the Nicaraguan women themselves use to describe their childcare burdens. I think it aptly conjures up the situation they face.