

BPREP: Beneficiary perspectives on the performance of humanitarian healthcare missions in Nicaragua

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A qualitative study supported by the Humanitarian Healthcare Ethics Research Consortium

2015

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Acknowledgements

The research team would like to thank the Nicaraguan community members and healthcare team staff who took the time out of their busy days to share their experience and knowledge with the interviewer for this study. The team also wishes to acknowledge the support of a number of organizations and individuals without whom this study would not have been possible and whose engagement with the study was highly appreciated. These include AVODEC, El Ayudante, Esperança, Global Brigades, and the Victoria Motta Hospital (Jinotega). Special thanks to Luis Enrique Lanzas and Victorino Centeno at AVODEC for your kindness and generous logistical support. Dr. Medina, Dr. Steve Cogorno, Wes Gristy, Donald Jordan, Christina Araiza, and Laurie Green: thank you for your engagement with the study and facilitation of trust-formation on the ground. Within the HHE research group, I would like to extend particular thanks to Lisa Schwartz, HHE founder and senior researcher created the space for this study and to Laurie Elit and Sonya deLaat for their careful reading and feedback on the report. Terry Martens provided her always excellent administrative assistance at the Canadian end. Funding for this research was provided by a Hamilton Health Sciences post-doctoral fellowship and a Canadian Institute for Health Research post-doctoral fellowship (award #: 129822).

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Suggested citation

Nouvet, E; with Chan, E; Schwartz, L (2015). *Perceptions of Medical Missions in Nicaragua*. Hamilton, ON: Humanitarian Healthcare Ethics Research Group (HHERG).

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TABLE OF CONTENTS

1. BACKGROUND	5
1.1 Nicaraguan context	6
1.2 Valuing local perspectives	7
2. STUDY METHODS	7
2.1 Selection of partner organizations	8
2.2 Participant recruitment and sample details	9
2.3 Interview questions and approach	11
2.4 Data Analysis	13
2.5 Ethics	14
2.6 Study limitations	14
Accessibility	14
Social desirability bias	14
3 FINDINGS: NICARAGUAN PERCEPTIONS OF TRANS-NATIONAL HEALTHCARE MISSIONS	16
3.1 Doing good in local terms: factors underlying positive perceptions of missions	16
Free and needed care	17
Resolution of health problems and symptom alleviation	18
Caring not just curing	20
Accessibility	24
Foreign medicine viewed as superior	24
Trans-national collaboration and learning	26
3.2 Factors limiting participation and satisfaction in missions	29
Pre-arrival communications	29
Community Selection	30
Feelings: Indifference, Anxiety & Fear	30
Site, set-up, and management of primary care missions	32
Privacy	32
Mission schedules conflicting with work schedules	33
Transport/accessibility	33
Availability of medical equipment	33
Cost	34

Long lineups	34
Physician-patient communications	35
Temporary relief	36
3.3 Nicaraguan hopes for the future of medical missions	37
Expanded powers of diagnosis and treatment	38
More teaching please!	39
4 ADDITIONAL FINDINGS	40
4.1 Problems in local care	40
4.2 Dependency	42
4.3 Perceived powerlessness: “Beggars can’t be choosers”	44
CONCLUSION	45
APPENDIX 1: Community member questionnaire (for patients, family members or neighbors of patients)	49
REFERENCES	50

1. Background

The BPREP (Beneficiary perspectives on the performance of humanitarian healthcare missions in Nicaragua) study was conducted in the Nicaraguan departments of Jinotega and Leon. From July 1 to August 24, 2013, the principal investigator conducted one-on-one interviews with Nicaraguan physicians, nurses, community leaders, patients, and family members of patients who have received medical attention from one or more foreign medical missions in the last two years, as well as community members who have avoided foreign medical missions. The goal of this study was to gather Nicaraguan perspectives on the work of foreign humanitarian healthcare missions working in their communities. More specifically, this research set out to provide organizations and volunteers supporting foreign medical missions in Nicaragua with feedback on the performance of their organizations from the perspective of local 'beneficiary' community members, as a means of contributing to reflection and quality improvement in Nicaraguan-directed but also other trans-national medical care.

This research, led by anthropologist and healthcare ethics researcher Elysée Nouvet, was supported by the Canadian Institute for Health Research (CIHR) and McMaster University Health Sciences post-doctoral fellowships. The BPREP study inserts itself within the broader research agenda of the Humanitarian Healthcare Ethics Research consortium, a tri-university group of researchers dedicated to studying and improving healthcare ethics in a range of humanitarian contexts. As a group, we are interested in leading evidence-based discussions and training of volunteers centered on strengthening humanitarian healthcare providers' ethical practice, often in clinically and culturally unfamiliar contexts, to determine whether or not the priorities and practices of their organization coincide with the expectations and priorities of beneficiaries. Ensuring there is a resonance between medical mission objectives and practices aimed at "doing good" and local perceptions of "doing good" is crucial to developing and maintaining trust in, safety for, and sustainability of trans-nationally funded and staffed medical care in contexts of humanitarian need.

1.1 Nicaraguan context

Nicaragua is the poorest nation in Central America. In 2013, its estimated GDP of \$4500 per person placed it 116th in the world, and most recent measures indicate that 42.5% of its population lives under the poverty line (CIA 2014). While Nicaragua has benefited from increases in government expenditures on healthcare over the last decade, from 71\$/per capita government healthcare spending in 2000 to \$139/per capita in 2009 (WHO 2012: 138), Nicaragua's healthcare system remains under serious duress. In principle, Nicaraguans have the right to free medicines and medical care. In 2008, the Sandinista party eliminated user fees in hospitals and public clinics that had limited the ability of many Nicaraguans to use the public system at all. In reality, for a majority of Nicaraguans, accessing the health care they need remains a true challenge.

Primary care clinics in rural areas may be difficult to reach, have limited hours of operation and often very limited diagnostic abilities, few prescription drugs on hand, and share nursing and medical staff with other neighboring rural communities. In public hospitals, surgeries are regularly delayed, the principal investigator was told, due to a lack of painkillers. Even when and where materials for surgeries are available, operating theatres may remain unused for much of the day. While short supplies of essential materials such as drugs used for anesthesia may exacerbate the situation, the fact is that surgeons in the Nicaraguan public system divide their time between their public positions, and private practices. Being the lowest paid physicians in Central America, Nicaraguan physicians supplement their salaries in the public sector with private practices run in the afternoons and evenings. In 2009, 92.6% of health expenditures (prescriptions, tests, ultrasounds, surgeries) were paid for out of pocket by Nicaraguans, without the support of prepaid private healthcare plans. Given that there is anywhere from 30-70% unemployment and under-employment in the country, wages are low, and social security payments to the minority who receive these represent a fraction of living expenses, paying for healthcare is not an option for most. This is the context within which Nicaragua's citizens depend on dozens of medical missions annually. The vast majority of the medical missions travelling to Nicaragua are American, Spanish, and Canadian "parachute" missions of 6-14 days.

1.2 Valuing local perspectives

“we should “take a deep breath” in the midst of our reporting and funding deadlines. We should, in short, listen to what people say. To do so is fascinating; it is also helpful. And it is the responsible and respectful thing to do” (Anderson et al. 2012: 147)

Over the past decade, the importance of attending to local perceptions of humanitarian aid efforts has been increasingly recognized within the humanitarian and aid sectors. Gathering local population experiences, expectations, and assessments of specific humanitarian projects and practices has been advocated in the name of accountability and transparency, respect for local populations, security, sustainability, and effectiveness (Abu-Sada 2012; Bailey 2008; Bonino 2014; Christian Aid 2009; Cohen 2008; Donini 2008; Doyle 2011; Jacobs & Wilford 2008 & 2010). The growing efforts of organizations to ask affected populations and beneficiaries what they think about the more qualitative dimensions of humanitarian aid reflects a realization that perceptions matter. Aid ‘effectiveness’ cannot be measured solely by counting just what gets where, how fast, to how many people. Effectiveness is not just about access but what happens between promise and delivery (Slim 2002), and how organizations, volunteers, and services are lived.

This research responds to the call of policy-makers, scholars, and practitioners for more discussion, debate, and ethical guidelines aimed at ensuring the world's poor have some say in the sort of care prioritized by foreign medical aid projects in their communities (Schwartz et al. 2010 & 2012; Slim 2002). This work was not commissioned by any organization, but benefited from partnership with Nicaraguan and transnational NGOs. The very possibility of this study speaks to the commitment of the participating communities, healthcare professionals, and organizations to listening to patient, family, and community perspectives on the work of medical missions in their communities.

2 Study methods

Interview-based data collection began in July 2013 and continued until the end of August. The study target was to gather the perspectives of

approximately 40 Nicaraguans encompassing a range of first-hand perspectives (physician, nurse, community leader, patient, family) on the humanitarian healthcare efforts of trans-national healthcare missions.

2.1 Selection of partner organizations

Two non-governmental organizations that coordinate medical missions in Nicaragua were invited to participate in the BPREP study. Both welcomed this opportunity. The Principal researcher approached these organizations purposively, based on a number of criteria. First, the two NGOs organize medical missions that are typical of medical missions operating in the country today. These are transnational short-term missions providing healthcare services to Nicaraguans free of charge. These missions are funded through voluntary donations and fundraising outside Nicaragua, and dependent on the voluntary participation of expatriate healthcare professionals accompanied by junior learners (nursing or medical students). Secondly, these NGOs operate in different parts of the country, ensuring the study involves the perceptions of Nicaraguans from at least two regions: the department of Leon and the department of Jinotega.

The Jinotega-based NGO facilitates the work of approximately 12 surgical missions in Nicaragua per year. The Leon-based NGO, active in Nicaragua on a range of social and economic development fronts since 2001, coordinates and hosts approximately 10 primary and oral healthcare missions to small urban and rural communities in the Leon region every year. These NGOs were purposively selected based on their track records of engaging with the communities they serve. Our goal with this study is to provide data that can help guide, inform, and strengthen future humanitarian healthcare in Nicaragua. In the interests of maximizing this potential, we wanted to work with NGOs that have a track record for seeking out and integrating community feedback into their programming.



Figure 1: Political map of Nicaragua, names of departments/regions in which BPREP study conducted underlined in red by author (*source Embassy maps.com*)

A third organization was opportunistically added to the study in July 2013. While conducting interviews in Jinotega, the primary investigator was approached by a third NGO, then in its first-year of community health development activities in the Jinotega area. The principal investigator accepted to complete a small number of interviews (10) with Nicaraguans who had, as patients, family members of patients, or healthcare professionals, experienced first-hand the primary care brigades organized by this newly active NGO in the Jinotega area.

2.2 Participant recruitment and sample details

Participant recruitment for interviews was purposive and opportunistic. The minimum eligibility criteria was for interview participants to have sought out, received or accompanied a family member receiving care from at least one trans-national medical mission in the last two years, or else had supported or been approached to support a trans-national medical mission as a result of their role in the community: as a nurse, physician, or community leader. All interviews

were conducted in Spanish by the principal investigator. For interviews with patients and family members of patients who had received surgical attention, a representative from the patient's circle of care contacted the potential participant by phone or in person to determine their willingness to be approached for an interview. For interviews with individuals who had first-hand experience either as patients or professionals supporting trans-national primary care missions, the principal investigator travelled to beneficiary communities where, working with a community leader, she sought permission to interview community members that met eligibility criteria. Interviews were conducted in the privacy of participants' homes or, in the case of healthcare professionals, in the privacy of their office. To reduce patients or family members feeling any pressure to participate in interviews, all requests for interviews were made after the departure of medical missions (not simultaneous with the mission's presence and activities in the region).

In total, **52 interviews were completed** with:

Participant type	# of interviews
Nurse	5
Physician	5
Community leader (non-patient)	3
Community leader + patient	3
Patient	30
Relative to patient	7
Actively avoiding missions	2
TOTAL	52

Interview respondents included 16 males and 36 females. Thirty-nine non-health care professionals were interviewed. The age distribution amongst these patients, relatives of patients, and other community members is summarized in the table below:

Participant age (yrs)	# interviewed
18-20	2
21-30	5
31-40	11
41-50	8

51-65	7
Over 65	6
TOTAL	39

To ensure that beneficiary community members interviewed represented the majority target of medical missions, which is to say Nicaraguans who cannot afford regular medical care, participants were asked to indicate their income level on a demographic collection sheet prior to the interview (see Appendix 1). Most interview participants indicated poverty-level incomes by Nicaraguan standards. Amongst the 42 individuals interviewed who were neither nurses nor physicians, 83% or 35 individuals reported a family income of \$100/U.S./month or less.

2.3 Interview questions and approach

To elicit participants' perceptions of trans-national medical missions in their community, interview questions were designed to focus the participant's attention on their most recent experience receiving, observing, or assisting (as a nurse, physician, or community leader) in such care transactions. The interviewer asked participants first to describe events and thinking leading up to their involvement/contact with this trans-national medical mission. Healthcare professionals and community leaders were asked about their roles and responsibilities vis à vis the work of missions in their area. Patients and relatives of patients were asked:

What made you decide to seek out (or not seek) treatment from the medical mission in your community this last (month, two months ago, etc.)?

What did you think the foreign medical team could do (or not do) for you?

Participants were then asked to highlight, and where necessary explain in detail, the healthcare they had received, observed, heard of, or supported. This included their interactions with members of the local and expatriate healthcare teams, challenges experienced and whether or not/how these were resolved, level of satisfaction, willingness to recommend this medical mission to a fellow

Nicaraguan, and opportunities for improvement. For patients, key questions here were:

Did you walk away from your visit to the (clinic, health fair, hospital) satisfied with the care and treatment you received? Why or why not?

Was this experience of care and treatment similar to other experiences you have had with healthcare, either through public and private clinics, or with other medical missions? How so?

Did this mission strike you as different in any way than others you have seen operating in the area, or that you have accessed? How so?

If you could change 1 thing about the way this or another medical mission operates what would it be and why?

For healthcare professionals and community leaders interviewed, detailed accounts of how they perceived the work of particular missions were elicited by asking them to share specific examples:

Can you begin by telling me about one patient case or event during which the practices of the foreign medical team with the community struck you as particularly good?

Can you tell me about one event during which the practices of the foreign medical team in this community struck you as less than perfect?

What would have been better practice, or a more satisfying outcome in your view?

Probes included solicitation of details about what specifically qualified the care they received or observed as “good” or “not so good”. Interviews lasted between 15 and 47 minutes and were for the most part digitally recorded and

transcribed. Five participants were uncomfortable having their interviews digitally recorded; note taking was used in these circumstances.

2.4 Data Analysis

Interviews and interview notes (where applicable) were transcribed and transcriptions were reviewed for accuracy by the principal investigator, before being translated. Thematic content analysis (Green & Thorogood 2013) was used to extract and organize responses related to the two main objectives of the interview: understanding from the participants' perspectives, (1) positive perceptions with medical missions, and (2) concerns/suggestions for improvement for medical missions. The principal study investigator (EN) and a learner (EC) independently reviewed the transcripts to develop a set of themes, with a focus on possible gaps, repetition, or lack of clarity. The PI and learner met to discuss and refine the analysis, reaching consensus on the key themes and subthemes presented in this report.

Participant responses to questions aimed at understanding local values and experiences informing positive evaluations of missions were quite consistent across the different groups of respondents (physicians, nurses, community leaders, patients, family). In terms of bases of dissatisfaction and suggestions for improvement, responses were less homogenous across the different groups of participants. The longer set of themes for concerns and suggestions reflects this diversity in participant responses.

An interpretive approach was used to code and analyze sentences and passages in interview responses that could not be categorized as describing either bases of satisfaction, concerns, or suggestions for improvement. Two research team members used an inductive process to gradually identify and organize additional themes within the interviews that they felt, in a preliminary assessment, could be of interest to stakeholders in Nicaraguan healthcare missions. A preliminary set of these additional themes were presented to and discussed with the senior author on this study (LS) and other members of the Humanitarian Healthcare Ethics team at McMaster, with the objective of further clarifying the value (or lack of value added) in attending to this data. Grouped under "Additional findings" in this report is an outcome of these discussions and interpretive analysis of this data.

2.5 Ethics

All dimensions of this study and its analysis occurred in accordance with the Canadian Institute for Health Research's guidelines for the Conduct of Ethical Research and received approval by the Hamilton Integrated Research Ethics Board (HIREB). The research protocol was reviewed and approved by partner NGOs before the study began. Consent forms were explained and signed or verbally assented to (in the case of illiteracy) by all participants.

2.6 Study limitations

Limitations to this study can be grouped under three main factors: accessibility, social desirability bias, and power imbalances.

Accessibility

Participants were selected based on a combination of representation (age/gender/role in community) and accessibility. While aiming for a balance between male and female respondents, participant selection was constrained by accessibility: patients were selected amongst those living less than 1 day travel from Jinotega. The greater number of females interviews in the study reflects the difficulty of finding men to interview during the work day, and the difficulty of scheduling interviews with members of rural households at night due to lodging and safety logistics.

Social desirability bias

Antonio Donini, one of the leading scholars in Humanitarian Performance evaluations has suggested the impact of perceptions studies is always limited because "... we hear what we want to hear and people often tell us what they think we want to hear" (Donini et al. 2008). The cynicism expressed by Donini is not reflected uniformly throughout the aid industry, and many of us are

optimistic in our support for user-centered healthcare evaluations. In the Humanitarian Healthcare Ethics research group, we are committed to healthcare quality improvement based on feedback from multiple perspectives: including those involved in the delivery of care and those involved in receiving or supporting (as family members for example) those receiving care. Support for user feedback, however, does not mean we can ignore limitations of perceptions studies such as this one. There certainly is a risk that participants interviewed in such a study will over-emphasize their satisfaction, and/or downplay, or even omit mention of, problems or concerns. As has been noted for other 'perceptions' based studies, participants may fear that any negative feedback they provide could jeopardize needed aid.

In any interview, there is also the issue of the interviewer's identity to consider. While an outsider, such as the study's head interviewer, can elicit more candid interview responses than a local, their identity may alternatively limit the candidness of responses. Elysée Nouvet, while adept in local idioms, accents, and social norms, and well-practiced in rapport building as a trained anthropologist, is a white North American woman. While she ensured interview participants knew before the interview began that her presence in that community was as an independent researcher, a few did reveal their belief that she was there with a medical mission during the interview. Dr. Nouvet promptly corrected such (rare: 3) misunderstandings, but these events do indicate the difficulty some locals might experience relating to a foreigner as a researcher, rather than as an individual who is connected to a donor organization. Associations between outsiders and foreign aid in rural and remote mountain communities where most of the interviews for this study were conducted may have, consciously or subconsciously, led some participants to provide answers aimed at pleasing the interviewer. It should be noted, however, that social desirability bias is a possibility within all interview sets. While important to note, it does not render interview responses invalid, but rather suggests caution in taking these as the full story.

Participants' perception of their own powerlessness

A number of Nicaraguan community members did not see themselves as entitled to providing feedback on the care they received through transnational missions. The spirit of these comments was: "Beggars can't be choosers". Unpacked in more detail in section 4.3 (under "Additional findings") of this report,

what is important to flag here is that at least some Nicaraguans may have encountered the perceptions gathering exercise as being at odds with their routine exclusion from processes of decision-making. This may have limited feedback shared with the researcher, or rendered difficult for them the process of thinking about the care they observed or received in terms of strengths and weaknesses.

3 Findings: Nicaraguan perceptions of trans-national healthcare missions

A number of themes were identified in our analysis of interview responses. These have been grouped as follows: 1) Doing good in local terms: factors underlying positive perceptions of trans-national healthcare missions; 2) Factors limiting participation in and satisfaction with healthcare missions; and, 3) Unmet needs – Nicaraguan hopes for the future of healthcare missions in the country. Each of these key themes is described in detail and discussed in the following pages.

3.1 Doing good in local terms: factors underlying positive perceptions of missions

The vast majority of Nicaraguans interviewed in the context of this study expressed high levels of satisfaction and gratitude towards the trans-national medical missions and the care these provide. Both primary care and surgical teams from abroad were trusted, welcomed, and according to some study participants, truly “loved” by the community. This section unpacks the bases of these positive experiences and perceptions. Amongst a range of interview responses, we identified six key factors underlying Nicaraguans’ positive experiences with medical missions: Free and needed care; Resolution of health concerns; Caring not just curing; Accessibility; Foreign medicine viewed as superior; Appreciation of trans-national collaboration and learning. All but one of these factors were highlighted by all categories of study participants: local healthcare professionals, community leaders, patients, family relations of patients. The one factor that was not found across all participants was: “appreciation of trans-national collaboration and learning.” This source of

satisfaction with trans-national healthcare missions was emphasized exclusively by Nicaraguan healthcare professionals and community leaders.

Free and needed care

An overwhelming majority of study participants cited the free and needed care offered by foreign medical brigades as central to their positive experience. A majority of patients and relatives of patients explicitly connected appreciation for the foreign medical brigades to the fact that these provide prescription medications and other health services free of charge. As one agricultural worker summarized: “We don’t have to find money from our own pockets. That is the most important thing.” For Nicaraguans with household incomes under USD\$100/month, buying medications, even for diagnosed bacterial infections, asthma, blood pressure, or diabetes, is impossible, given their daily struggle to feed themselves and/or dependents.

“Some of us don’t have any way to medicate ourselves. We are poor. At least that is my case. I don’t have anyone giving me anything. Not even my children, so that is a huge help for us.”

“There are many people here who don’t have the means to even go for an exam or a consultation. This situation is critical. Because if you have even 200 or 300 or 500 cordobas for an exam, you still won’t have any money to buy medication.”

“Those of us who live very economically squeezed, it’s difficult if we get a prescription for even 90 cordobas in pills [USD\$3.50]. For example, if you have a prescription for 10 pills, which I got for my blood pressure, and they are 9 cordobas each, I’ll buy 3 let’s say and then maybe 3 more another day but I’m no longer following the medical instructions for the sequence of dosage...Many times I’ve bought a fraction of the prescription, that little bit, and I distribute it in a bunch of demons and a little holy water.”

Nicaraguans who may fear certain medical attention have been convinced to seek it out on the basis of this service being free. This represents a rare opportunity for those who have no opportunity to save up for or travel to the capital for care. One woman living in a remote mountain region talked about feeling great fear at the thought of her child receiving a cleft lip and palate operation through a foreign brigade. She and her husband had accepted their

child's way of being, on the premise that "if God gave her to us like this, that's how she must be." She was finally convinced to overcome her fear and bring her child in for an ultimately successful operation, by her account, as a result of members of her community telling her again and again she *had* to go because "It's free!" Nicaraguan healthcare professionals were equally appreciative of the free and needed care provided by trans-national missions:

"It is good for us as Nicaraguans and as doctors. To improve the quality of care to the patients. Because there are not many, how can I say it, conditions here. There is not a lot of staff and there are long waiting lists, so the trans-national medical teams come to help relieve the pressure. They help us shorten waiting lists."

The provision of free and needed care is not only appreciated because it allows Nicaraguans to access consultations, medications, and operations that are otherwise unaffordable, but the free care also appears to hold a symbolic value for many. While always emphasizing that free-of-charge care matters because it ensures access to healthcare for the poor, some study participants also explained this trans-national healthcare as originating in foreign volunteers' feelings of trans-national solidarity with the poor. Many interpreted the free care provided as a "blessing" and "the fulfillment of God's will," from which often followed explicitly stated perceptions of volunteers with missions as "angels" "moved by God". A few participants expressed strong sentiments of joy in association with their description of the care received: "Free operations! Imagine! How beautiful!" It was particularly common for parents to express satisfaction and contentment at being able to have their children seen by a pediatrician, as in Nicaragua, these are specialists that one will usually pay to consult, considering that free appointments in hospital can take months to arrange.

Resolution of health problems and symptom alleviation

"The most essential is that one sees that one is going to get through this major discomfort soon and quickly. One is finally going to be without what is painning you."

When mission-provided healthcare services managed to alleviate uncomfortable symptoms and/or resolve health issues, this was a powerful basis of satisfaction with the missions. A number of Nicaraguan patients and family

members of patients recounted dramatic changes in their day-to-day lives as a result of having received a prescription or operation from a medical mission.

- A woman who had suffered and watched her daughters suffer for years with constant vaginal itching, redness, and pain. After having asked the local healthcare center about her problem to no avail, this woman credits the anti-fungal soaps left by a trans-national medical team, combined with the team physician's tips for ensuring the most hygienic washing conditions possible, with the alleviation of her painful symptoms.
- A teenager's acne had cleared, making them feel 100% better, thanks to a cream given to them by a trans-national primary healthcare team.
- One study participant who had lived with pain in their colon for months received effective relief via a colon infection medication from the medical mission that travelled to their community.
- A woman whose tumors were removed by a surgical mission was, according to her neighbor, "buying things to sell in Managua in a perfect state" only 15 days later.
- Rural Nicaraguans were delighted with free dental care that allowed them to receive fillings, admitting they most likely would have resolved their pain by pulling their tooth out rather than subjecting themselves to what all characterized as an extremely painful public dentist's chair.

Most dramatically, for some, the care they received from missions was experienced as the difference between their life and death:

"In my case, without the operation, I wouldn't be here today. My kids would be in an orphanage."

The interview data provides dozens of stories of lives improved through the care provided by trans-national primary care and surgical missions, care that for the most part, in the view of the community members interviews, would not have been accessible outside the context of these missions.

The resolution of health problems was not only appreciated at the individual level. Health care professionals were particularly keen in their interviews to outline the importance of the services provided by trans-national medical missions to the Nicaraguan Ministry of Health (MINSAs), strengthening the

state's and their abilities as healthcare centers and providers to meet the currently unmet health needs of their population. The healthcare professionals interviewed described the efforts of surgical missions as particularly crucial in this respect. Many surgeries, such as laparoscopic surgeries, varicose vein surgeries, plastic surgeries, clubfoot surgeries, urological surgeries, are not available within the Nicaraguan public health system and/or are only available in Managua due to limited equipment and capacities outside the capital. Provision of these surgeries by trans-national missions is highly appreciated:

“A brigade that comes to do minor surgeries that we could resolve in the hospital here, that doesn't have much impact. What has a lot of impact is to complete surgeries or procedures that we do not have the opportunity to offer the population normally.”

While the above statement suggests at least some healthcare professionals do not regard all surgeries performed by trans-national missions as equal, most Nicaraguan healthcare professionals did not distinguish between more or less important surgeries. Nurses and physicians alike described Nicaraguan public hospitals as unable to meet the demands of the population, due to a lack of personnel, equipment, and medications such as painkillers. Within the context of an overwhelmed public healthcare system, trans-national surgical missions that come in for one week and perform up to 60 surgeries are perceived by Nicaraguan healthcare professionals as providing essential help. Even when completing surgeries that can be and are routinely carried out in local hospitals, trans-national surgical missions are providing valued assistance because they are reducing the case-load of hospitals and the wait time of patients.

Caring not just curing

Not all Nicaraguans interviewed were satisfied with the medical attention they received from an trans-national mission, for reasons discussed in the following section, but all Nicaraguans who sought medical attention from a trans-national healthcare mission nevertheless qualified the treatment they received as “very good” and would not hesitate to recommend the missions to their relatives and neighbors. Core to such satisfaction is the experience of trans-national medical teams as caring: thoughtful, gentle, warm, respectful. Certainly, for some, the very presence of the trans-national medical teams was understood as a testament of their concern for Nicaraguans:

"I think the North Americans care for Nicaragua. They are worried about the sick. All those operations, they are not going to do them here."

For many, however, it was the direct experience of observing or receiving care from the missions that formed the basis of their assessment. The gentle touch and tone of voice of certain volunteers with primary healthcare missions were cited by dozens of study participants as a positive dimension of the missions in general and their care experience in particular. A friendly bedside manner was interpreted by many as a sign of respect for the patients and/or an indication of genuine concern for the community members' well-being.

"They attend to us with kindness, which for us is the most important. They are kind with their way of being, with their smile, it is visible...I feel different, happier, more communicative, because they are very friendly people."

The caring quality of mission care was surprising to many who cited being used to harsh words and treatment in the Nicaraguan public healthcare system that in their experience, discriminates against the poor.

"Here, there is discrimination. There are people who come [to receive care in public health clinic] and they are told, come back this other day. And those from other countries: so generous with us. Even the Father speaks very highly about you. He said that he saw something he hadn't seen any Nicaraguan do, even he wouldn't do: A *gringa* lifted an old woman from her bed and looked over her foot...It's very beautiful these brigades that come. I'm enchanted."

"Sometimes one comes to the hospital and one is not attended to because of some discrimination. And them, the gringos, no. They have a lot of love for us Nicaraguans and more when we are poor. They are dedicated to us."

"In every way they are friendly: in giving us the medication, in examining us well, in speaking to us nicely – in every way. It's not like here where they bark at you: 'You! Sit down!'"

Where missions did manage to see all in a community who showed up seeking medical attention, this was interpreted by locals as caring:

"No patient who shows up for a foreign mission that I know of gets refused. The foreign doctors never turn them away or reject them. In fact, it's the contrary: they seem to make an effort to make sure you get seen,

examined. They are interested in knowing what they can do for you. They actually ask you, 'what can I do for you?' That friendliness or kindness is notable above all else."

Special attention to the children in the community by volunteers with primary care missions, sometimes through the provision of a snack, balloon, or used articles of clothing or toys, impressed many adults, especially as distractions were sometimes used to ensure parents could focus on their discussion with the medical team.

Beneficiaries of the surgical missions were particularly satisfied with the care they received, and in their praise, detailed local and foreign healthcare team members' attention to their psychological and physical comfort as central to their positive experience. Many of the surgical brigade patients were deeply touched, for example, by the time taken by local support staff and foreign physicians and nurses to listen to their concerns and fear, hear more about their pain, or check in with them after the surgery.

"They told us not to be afraid, that everything would be successful...They asked us if we still had any fears. They asked us if we were afraid and reassured us...Everything was explained to me. They told me not to worry"

"The foreign doctors would come to see us. They personally came to us, to see how we were healing. They would come and ask us, 'Is everything ok? The nurses have orders that if anything hurts, tell them so that they give you something. At any time, if you have pain, call the nurse and they'll give you something...It was magnificent!"

"The staff were very polite. The foreign doctors came out, one of them spoke Spanish, and explained to me when they done with her that all had gone well. The foreign doctors came to check on her a couple of times. They told her that if she had any needs or problems, to speak to the nurses. The nurses were very nice also. They were gentle and came quickly when patients called."

Speaking about a member of the local support team, one patient exclaimed:

"He has the most wonderful way about him. He doesn't have any pride. He is calm in the face of all. He watches out for people. If you have a pain, he says, 'tell me.'...He is a great person. He says, 'If an old woman is operated on and can't bathe herself, I'll bathe her.' He didn't have any of those idiot ideas like other doctors who don't even touch you."

Attention to the physical comfort of patients was also noted and appreciated by many:

“They treated me well. It was very beautiful care. It is difficult what one might get in the hospital. I’ve seen that in the hospital, you can’t do some things, they reproach you, and there, no. The attention was lovely. If you need to do something [go to the toilet], you don’t have to worry, they’ll help you. They tell you, ‘We’ll help you.’”

“We are happy, because when we went, they gave us clothes, shoes, soap, comb, toothbrush and toothpaste...everything they gave to us. We didn’t have to bring anything...It was a great help for us.”

“Happy, because in the morning they called us in to eat. At noon as well. In the afternoon they called us again to give us fruit: plantains, bananas, mandarins, everything! And they gave this all to us. Mandarins, bananas: the girls loved that. For that reason they were happy. They gave them...cream, cheese, beans, egg. Egg! That they like!”

The provision of monies to travel to and from operations, hospital-stay basics such as clean sheets, soap, comb, and toothbrush, as well as food were all highly appreciated by surgical patients and their family members, and interpreted as a sign of foreign volunteers’ concern for them as patients and/or as a sign of their awareness of the economic realities of the Nicaraguan poor:

“...with them everything is free. The service but even the soap in the hospital. There are clean sheets. So that really is in our favor because we are poor people, we have difficulties.”

Local healthcare professionals supporting the work of the trans-national brigades shared their patients’ enthusiasm for the quality of care they provided.

“Their treatment of the human is exceptional. The human warmth they bring to the patient, to each of their patients, is special. They treat all the patients equally. All with this kindness, with this love, with this charisma. I think those they see feel healthy as soon as they arrive, just through the way they are received. They bring this warmth and human touch to everything they do.”

Accessibility

Physical access to medical attention is a challenge for many Nicaraguans who live outside major city centers. For some of the Nicaraguans interviewed, their homes are lengthy walks from the closest public transportation route. Transport in and out of the area is available, in some cases, only once a week. Moreover, public transit is subsidized in Nicaragua, but it is not free. Study participants with incomes under USD\$100/month cited travelling on a bus into the city and missing a day or more of work as a barrier to their seeking medical attention in town, especially when spending time and money might yield only frustration if the clinic is closed, or even leave them stranded in the city overnight if a bus is cancelled. It is in this context that the geographical accessibility of trans-national medical missions was praised across all categories of respondents. Community members appreciated primary care missions setting up their day clinics within walking distance of their homes. The women in rural communities stressed their appreciation of being able to consult, often for the first time in their life, a gynecologist or pediatrician for their children's health.

Many patients who received surgeries from a trans-national mission travelled significant distances to do so: hours and in some cases days. What made their participation possible, many insisted, was provision of their bus fare and in some cases private transport by mission organizers.

Foreign medicine viewed as superior

"Within our culture, there is this thinking that because they are people from abroad, they are better."

"That has happened to me. I've said: 'What? Where have these people been hiding?' When a brigade comes, they decide, 'Listen, I'm going to go, because they feel sure that the medical attention being given by a foreign brigade is safe.'"

Popular understanding of foreign medicine as being superior to Nicaraguan medicine is a significant factor feeding satisfaction with and participation in trans-national medical missions. Many study participants explained that foreign physicians are trusted more than their Nicaraguan counterparts because they are assumed to have "access to more up-to-date

evidence” for their diagnoses, they are regarded as “more specialized,” as having “experience local doctors and nurses maybe do not have”, and preferred on the basis of an assumption that they “bring with them the latest science and better technique.” Surgeries led by foreign healthcare teams, as encapsulated in the second quote above, appear to be widely regarded by patients and family members of patients as safer and having better outcomes than surgeries led by local healthcare teams in public hospitals. The conditions in which surgeries are performed, particularly with respect to levels of cleanliness, were reported by many patients as very comfortable and superior to what would normally be their experience in a public hospital, based on what they have heard (as many had never been in a public hospital outside the mission context). Moreover, many patients appreciated the small scars left by surgeries in the abdominal surgery, waking up from a surgery with healthcare professionals at hand, and generally faster recovery for laparoscopic surgeries than would be possible after local non-laparoscopic interventions for the same problem. All patients interviewed who had received a prescription through a trans-national medical mission drew attention to the superiority of the product they received, as compared to local products they had tried. The prescribed medications and creams received were also regarded as reflecting a wider variety of products than normally available in Nicaraguan pharmacies and clinics, thus allowing for more tailored prescriptions. The success stories shared in communities in the aftermath of missions, whether praise for a topical cream, eardrops, or the small scars left after a major surgery, reinforce this strong sense of “foreign medicine as superior” to public Nicaraguan healthcare. Word of mouth on the success of operations carried out by foreign missions deepens this perception of foreign medicine as superior. As one participant stated: “she was waiting for the Americans or ‘the Whiteys’ as we call them out of preference, because we have seen their successes.”

It should be emphasized that the belief that “foreign medicine is superior” to local options has not been confirmed by empirical evidence. This perception impacts actions, however. This perception was cited by some participants as key to their decisions or discussions with relatives aimed at getting them to accept surgical interventions they had previously feared and refused:

“When I heard the brigade was operating, I told my son, ‘with them, it’s going to be different. The stitches hurt less. They cut less.”

Citing safety, a few participants explained that they had delayed even urgently needed surgery until they could have it completed at the hands of a foreign healthcare mission team:

“I went to get a test at the specialist’s. That was in January. The doctor told me, ‘Look, you need to be operated immediately, because the stones in your gallbladder are very big now....the brigade was coming to perform operations but in June. I decided, God protect me, I’m going to wait.’”

Aware of the widespread view amongst Nicaraguan patients and communities that “foreign medicine is superior”, many nurses and physicians interviewed stressed the positive side of this perception, which is that Nicaraguans who might otherwise fail to seek out medical attention are doing so in the context of highly popular and trusted trans-national brigades. Thus, a woman who lived with her uterus outside her body for over 20 years finally left her home to seek treatment. Pregnant women who have not shown up for their check-ups, women in need of pap tests, and parents who have missed vaccinations show up when a trans-national brigade comes, allowing the Ministry of Health to increase its care to these populations. As one nurse put it:

“When the brigade comes, we take advantage to do what we need to do. While it benefits the community, it benefits us because we increase our coverage and our productivity.”

One concern of the research team is that high trust and appreciation of foreign medical brigades might undermine the public healthcare system if a growing number of Nicaraguans choose to wait to receive medical attention from foreign medical brigades. At present, however, this does not seem to be a concern amongst any of the Nicaraguans interviewed for this study.

Trans-national collaboration and learning

“They share with us. They don’t speak to me about democracy or politics, they come to attend patients. They come to provide a humanitarian service to people who need medication, regardless of age. It is their responsibility to share with us and us with them. To share with friends. And so we feel proud. They don’t come here to impose. Instead, they come

here to give us the little bit of sand that their brothers in their countries give, so that they can give medication in this country.”

“We do not regard one another as foreigners and nationals. No, we see ourselves as one group. It's not like charity. There is a participation like work colleagues.”

Exemplified in the above, a majority of healthcare professionals and community leaders interviewed framed the work of trans-national brigades as a collaborative effort between Nicaraguans and foreigners. This collaboration is understood by Nicaraguans as driven by a trans-national commitment to providing healthcare to Nicaraguans in need, and experienced in positive terms by Nicaraguans supporting the brigades because they feel valued and equal in this relationship. Interviewees highlighted a number of practices that in their eyes, reinforced their relationship with foreign volunteers as one between equals. This included: foreign physicians enquiring about, rather than passing judgment on medical decisions that surprised them, accepting and adapting to hospital recycling practices (re-using gloves and other materials normally discarded in the United States), foreign and Nicaraguan doctors discussing cases together as colleagues, foreign physicians never refusing to see a patient a local physician recommended they examine, and eating together (and eating the same foods). The adaptability of foreign volunteers to limited facilities, equipment, and human resources made a good impression on a number of nurses and physicians. This adaptability was understood by some as the foreigners “learning from us”, and was also appreciated in contrast to the reticence of other healthcare missions with whom these Nicaraguans had worked who “held back” or “completed less surgeries” in the face of limited materials.

While recognizing that trans-national missions come with capacities to diagnoses and treatments they do not possess, Nicaraguan healthcare professionals recognize that they have a unique and necessary role to play in supporting these missions.

Nurses interviewed highlighted the cultural knowledge and sense of the familiar they contribute to trans-national brigades. For example, when a foreign healthcare team recommends a patient consume or avoid certain foods to speed their recovery, the nurse helps by making these recommendations relevant and feasible in relation to the normally limited foods available to poor and rural Nicaraguans. If a patient or their relative is afraid, nurses noted that it is the local member of the healthcare team that will best understand the “many

taboos for different types of surgeries.” Patients sometimes feel more comfortable, according to one nurse, with a Nicaraguan healthcare professional because of the language:

“It’s not that the Nicaraguan will do the work of the foreigner or can replace the work being done by the foreigner, but I feel that patients feel a bit more comfortable, first of all through language, because they can feel a better relationship [with the Nicaraguan healthcare professional] through the language.”

Physicians noted that they bring to trans-national missions important region-specific epidemiological knowledge, for example familiarity with dengue and leprosy, facilitating trans-national teams recognition and appropriate treatment for these:

“I think it’s very important that a national doctor be present in every brigade, because the epidemiology of every region is very relevant to a clinical diagnosis...we are thinking based on what we know, based in what we see on a daily basis.”

Physicians and nurses interviewed appreciated the opportunity to learn from the foreign medical groups: about teamwork, equal treatment of all, respect and “love for the patient”, and new surgical techniques. This learning was experienced by those who mentioned it as an exchange between equals: “We learn from them and they learn from us.”

Community leaders, and other Nicaraguan partners, such as health ‘brigadistas’ embraced the opportunity to support trans-national missions. Community leaders appreciated being consulted on the location and set-up of primary care missions. Community leaders were seen by physicians and nurses interviewed as playing a crucial role in convincing members of their communities to attend trans-national primary care missions or seek out a surgery at the hands of a foreign mission.

The majority of Nicaraguan healthcare professionals and community leaders valued their support to foreign medical missions. This was valued as an opportunity to contribute to the care of Nicaraguans in need and specific communities, as well as an opportunity for collaboration and learning between professionals. This finding highlights the importance of global-local partnerships to the acceptance, locally defined value added, and overall positive experience of short-term missions.

3.2 Factors limiting participation and satisfaction in missions

Five main factors were found to limit participation and satisfaction: (1) pre-arrival communications, (2) fear, (3) the site, set-up, and management of primary care missions, (4) physician-patient communications, and (5) temporary relief.

Pre-arrival communications

A number of study participants noted a lack of clarity in pre-arrival communications. These applied to both surgical and primary care missions, though certain issues are particular to primary care missions only. According to one nurse interviewed,

“Things would have been easier for us if they... told us what day the mission was coming, so that we have our papers ready. It's good to have advance notice.”

The primary concern raised under this sub-theme was lack of notification in advance of the arrival of the missions. This requires communication between different groups, such as physicians, patients, aid organizations, and local health volunteers. Communication involves discussing aspects pertaining to the function of the mission, including method of selection of beneficiary communities, and cultural and contextual barriers. Many interviewees mentioned that they were not aware of a mission being in their area; “I didn't see them. Maybe they left early?” When questioned whether anyone from the clinic or on the streets notified them about this, their answer was, “I didn't hear anything, otherwise I would have gone”. This is a troubling finding as it indicates that there appear to be at least some Nicaraguans who miss an opportunity they value to seek care, despite the mission being in their direct vicinity. There were a significant number of people who were in similar situations where they had no idea a mission was present, but would have gone had they known. This lack of notification in advance affects the number of people the mission is able to serve, also preventing community members from notifying those they know or those around them. For example, a woman stated, “I have a nephew from

another neighborhood quite far away who never realizes. He would like to come but since we don't find out in advance we cannot notify them in time."

Community Selection

Feedback from local medical personnel, volunteers, and community leaders involved with the medical brigades suggested that there are individuals within these groups that do not have a clear understanding of how communities are selected for primary medical missions. For example, a nurse (who declined to be recorded) spoke of the lack of communication and interaction between the health center she worked in and the medical mission. The health center was contracted by the local health ministry to serve ten communities in the area; however, the mission who worked out of the health center only had the capacity to serve 6 communities. Consequently, some who had travelled far to seek care from the mission were turned away on the day the mission was present. The nurse was upset by this situation, and felt it was not ethically responsible to turn anyone away. It was not clear to her how the local NGO coordinating the mission had determined which six communities out of the ten to serve. From this finding we can extrapolate that many patients and families may not know why or how communities are selected. This may create dissention and misunderstanding between the mission and communities, or between the communities themselves. Greater transparency through clarification of this process to all levels of society, perhaps included in a briefing session, could be implemented to mitigate this issue. Additionally, missions may benefit from consulting local nurses in the community selection process, given that nurses are a key stakeholder in managing community health, often supervising health centers on their own.

Feelings: Indifference, Anxiety & Fear

Community members (patients and non-) as well as healthcare professionals noted the difficulty some Nicaraguans had being convinced to attend a foreign mission. Some study participants explained that some individuals they knew, always men, would not miss work to receive a medical consultation from any party unless they were suffering acutely: "it is not the

custom." More commonly reported by study participants as limiting their own or others' willingness to access mission healthcare were feelings of anxiety.

Many study participants interviewed about their perceptions and experiences of surgical mission care highlighted fear and distrust as factors that delayed their seeking medical attention from foreign missions. Many spoke of being fearful of open surgery, of dying, and of the unknown. Such fears were general, and not directed at foreign missions in particular. However, study participants also noted that many Nicaraguans harbor concerns related to being operated on by a non-Nicaraguan. This concern stems from the potential occurrence of any complications after surgery, and relates, according to our participants, to a fear amongst some community members that individuals/patients will be "left alone: nobody would do the follow-up" once medical missions have left. As one study participant summarized:

"Because many people say, if those gringos operate me and I am left not well, who will take care of me?"

The presumption of some Nicaraguans has been that if one receives care from a foreign doctor, follow-up may be difficult to obtain in the public system afterwards. Indeed, as reported by local healthcare professionals who now partner with the foreign surgical missions, some medical colleagues refused to provide follow-up to patients when these missions first started working in the area, citing that "If the gringos operate, they should do everything." Today's reality is different, according to these study participants. Many specialists and general practitioners are ready at any moment to lend support to patients from missions, understanding this as their duty. Healthcare professionals interviewed stated that they have been successful in working to overcome this kind of fear through better informing of local health workers about Nicaraguan-transnational partnership. The local NGO supporting the surgical missions in Jinotega coordinates follow-up care efficiently as needed (which does not appear frequent), visiting patients with more complicated surgeries in their community after the surgery. The primary researcher observed this follow-up care first-hand. Despite this, there appears to remain amongst a minority of rural community members some anxiety about follow-up care. Educating communities through information sessions could be a potential solution to the presence of these feelings and perceptions, again indicating that communication is a key factor in ensuring the quality of care provided in medical missions.

The presence of primary care missions does not, based on this study's findings, evoke such mistrust and anxiety about follow-up care. For some participants however, the long-lineups that often occur with these primary care missions provoke anxiety related to shame. This is due to the possibility, in these Nicaraguans' experience, that they will not get seen or not obtain a prescription they seek if it runs out before their turn. Culturally, it is problematic for at least one of the communities involved in this study to need and ask for help:

“For us it makes up feel ashamed, asking for help... And then it is worse if we go ask and we get nothing.”

As explained in detail by members of one particular rural community, the very basis of transnational missions “helping” them and their families is stressful.

Site, set-up, and management of primary care missions

Within this sub-theme are grouped concerns related to the following: privacy of consultations in primary care mission consults, mission schedules, transport/accessibility, availability of medical equipment, long lineups, and occasional costs associated with receiving care.

Privacy

Lack of privacy related to space limitations can prevent patients, especially women, from fully disclosing health concerns. Concerns involving maternal and reproductive health, and sexual activity may be missed as a result. Privacy for the discussion of medical issues was cited by many in our study as important to their idea of quality care:

“To find a good space, because for example if they set up in the public center, and there are ten specialists, that's a problem. People are almost on top of one another. There is no privacy.”

“I don't like it when everyone is listening. You know women's problems, we are more comfortable with other women, not with anyone.”

Mission schedules conflicting with work schedules

In many communities, fewer men than women will attend missions. While this may be connected to a number of cultural norms, including women being the prime caregivers in a family and a dominant culture of 'machismo' that values masculine toughness (Lancaster 1992) which may make it less easy for men to seek any form of assistance, study participants also emphasized the difficulty of attending primary care missions that provide care when many must work. This is a problem for both men and women working outside the home, but was reported as a greater barrier for men:

“Us men, we work. Housewives, they have their chores in the house but they can leave the house for a little bit to go [to the mission]. Whereas the man, he has to go far to work. If he misses the day, the company is not going to pay him. He could even lose his work.”

Clinics run during the night may be effective in serving the working population, the majority of whom are men.

Transport/accessibility

Some form of transportation could be organized and prepared to provide access for those who have limited mobility or cannot leave the home: “Visiting them in their home would be very good. I'd like all brigades to do that. And that all have a vehicle present.” There is evidence of this already being implemented: “There are some brigades that work with the community leaders so that when they come, they go with those leaders to visit people who are in their homes and cannot come to the mission.”

Availability of medical equipment

“They assumed that I had everything they needed here. That was poor communication. They did not bring sufficient anesthetic which here, in truth, it is very difficult for us to obtain on the spot.”

“Better if they bring all their equipment, because here there is sometimes not very good maintenance given to the equipment”

Evidently, communication between medical missions and the communities they serve allows for both parties to have improved preparation plans and organization, such as being aware of medical equipment that needs to be brought along. It should also be emphasized that local communities who interact regularly with medical missions have of their own initiative been working to address issues such as these miscommunications, thereby learning from past mistakes: “For the next time we will know to ask what medications they are bringing, and if they don’t say it, to ask about it.”

Cost

Cost itself was a barrier limiting participation and satisfaction, as according to feedback, there seems to be a substantial number of people who do not realize that everything the medical mission provides is free: “People are always asking me, And do I have to pay? An operation is so expensive!” There are however, some mentions of missions recommending patients to obtain tests and medications that are not free, and must be obtained from the hospital or health center, which then may require additional travel: “Last time they brought some specialists. The only thing is, we had to pay for the exams. I didn’t do it because I didn’t have the money. It was for a blood test.” Most missions do cover the cost for transport, medications, and tests, and this is evidently important to prevent cost from being another deterrent to those seeking care.

Long lineups

Many people commented on how lineups for the clinics could be better managed. Concerns stemming from long lineups include patients being exposed to the elements during long waits in spaces with no shelter, and that many people see the long lines and either do not bother trying to line up themselves, or simply do not have the time to line up. Thus, long lineups can act as a deterrent for those seeking care: “They see that it’s a really long wait. The cues are very long. Maybe for that reason some don’t go.” There were also some mentions of unfairness and lack of order, where those who were friends with the volunteers of the mission were able to bypass the line, indicating that there are instances of preferential treatment:

“They’re friends with the man guarding the door and they get in quickly”

“There are a lot of people who don’t manage to get seen. That is not my case... when I go, I speak with some of the local volunteers whom I know, and they let me in.”

Most suggested giving out numbers to keep track of who had come to the clinic that day, and to give patients a better idea of what time they would receive care: “If they gave out numbers, we wouldn’t have to wait all day. We would know early on if we can get in or not.” Although it seems that even with the use of numbers, some preferential treatment may occur.

Physician-patient communications

There was overall satisfaction and great appreciation of the care received from foreign health workers. One issue mentioned that could serve to strengthen patient experiences further relates to the communication between expatriate healthcare teams and patients. Many Nicaraguans interviewed as patients or relatives of patients in this study reported that they do not seek out medical attention on a regular basis for physical ailments. A number also reported living with multiple healthcare problems, either diagnosed at some point or suspected. At the same time, it appears many patients in Nicaragua are not used to taking an active part in their care plan or even asking physicians and healthcare team professionals questions: in a doctor’s consult, the doctor or nurse asks the questions and the patient or relative of the patient answers. While making for easy to manage patients, this puts all the responsibility for information gathering in a consult on the physician and their team.

In the context of mission-provided healthcare, this can lead to disappointment for Nicaraguans if consults are structured with an expectation that patients will pro-actively volunteer their health problems and questions. For example, one patient was disappointed with his consult in a primary care mission, stating “It would be good if the doctors explained in more detail what they are finding out.” This patient had lined up for a consult to become better informed about his urine test results and reasons for being prescribed something for his kidneys. Asked whether or not he had shown his test results to the expatriate healthcare team, the patient admitted that he had not shown it to the physician attending him, but simply held it in his hand. He did not directly ask the physician or part of the physician’s team to go over these test results with him. Another study participant raised a similar complaint, having brought test

results to the mission consult. This participant says that she did initially emphasize to the expatriate healthcare team, through a translator, her interest in understanding her test results, but these were not looked at or discussed. Asked by the study interviewer why she did not raise the issue again before the consult ended, the participant shrugged and said she didn't know. In these circumstances, pre-arrival community-based meetings may be beneficial, where healthcare providers, volunteers, or community leaders can explain that Nicaraguans should not feel shy asking the foreign doctors to look at another health problem or answer a question that remains unaddressed when that doctor believes the consult is over. Likewise, leaders of international healthcare teams and their local partners might consider reminding volunteer nurses and physicians to check with their Nicaraguan patients, "Is there anything else?" when they believe they are done.

Temporary relief

Another concern that was brought up related to primary care missions only, and was how medications prescribed by these missions run out fast. As a result, these only provide temporary relief for usually quite minor ailments through pain medications, eye drops, and topical creams: "As they did not give me much cream, it has run out so I have not been able to treat the other parts."

Primary care missions do not have the ability to resolve chronic health issues, and this was a source of disappointment and anxiety for some patients. For example, one patient who had been unable to sleep for several years and tried several prescription medicines finally was "granted her dream" of sound sleep via a prescription drug from the recent medical mission in her community. For this individual, the approaching end to a two-week prescription she could not get refilled locally even if she could find the funds was extremely stressful.

"I cannot be without this treatment once again. I have been looking for this treatment for 11 years...So, it's quite worrisome to be in this situation. When the pills run out, I will not be able to sleep again."

Many community members and healthcare professionals did not qualify the inability of primary care missions to resolve chronic issues as a problem, but did note this as a significant limit to care provided. As one healthcare professional stated:

“They come here not for prevention but for diagnosis, to give out treatments. And even for diagnosis, it is difficult in such a short time for more complicated cases. There is not much they can do, for individuals with chronic health issues.”

Another community leader, who shares responsibility for informing the community about upcoming missions, reflects an awareness of primary care mission's limited abilities to address more serious health issues while explaining their self-editing when discussing health issues with foreigners:

“Personally I don't even tell them about anything more serious I might be feeling. I know they don't operate so why would I? I recommend to people who are coming to see the missions to stick to the most primordial. The essential. For example, medication for the throat, pills for the stomach, or something for stomach pain or for arthritis. Things like that. Though we know that for arthritis, there is no cure. All there is are painkillers, anti-inflammatory drugs. That's what that person might get. So people come to see these missions for their primordial needs.”

3.3 Nicaraguan hopes for the future of medical missions

Most of the feedback and suggestions for improvement related to the hope for “more”. As noted in the outset of the present report, there are many aspects of care such as basic and specialist healthcare needs that are minimally or not at all addressed by the local public health system. It is clear in this study that many Nicaraguans, especially those in rural areas, access foreign medical missions in the context of being unable to afford travelling into the city to see specialists, or receive operations. In all areas, the majority of Nicaraguans struggle to get prescriptions for even chronic diseases filled. This is the backdrop against which many study participants expressed hope that foreign medical missions would not only continue to travel to Nicaraguan to provide healthcare services, but that, particularly with respect to primary care, these missions might expand their powers of diagnosis and treatment.

Expanded powers of diagnosis and treatment

There were many requests for primary care missions to rural areas to be more frequent and of longer duration:

"My wish is that they come all the time."

"The best would be if they could come sooner, more often, but we are not the only community they are attending. So they are quite good."

Local healthcare professionals working closely with the missions also emphasized their wish that their foreign colleagues could stay longer:

"If there is something to suggest could be improved it would be that the time could be longer. Four days, 1 week of work and after we are left here missing them. The reality is that when they come here they solve many problems for us. They see many patients in a short time. They also teach us many things. So from my point of view, what is not so good is that they are here for such a short time."

A number of participants expressed their hopes that future primary care missions will bring more specialists. Specialist care is particularly difficult for rural Nicaraguans to access, as this would require spending time and money travelling into town to try and book an appointment with one of the few specialists in the public healthcare system, or else travelling to a bigger urban center to pay for a specialist consult in a private clinic.

Two areas that are currently routinely included in primary care missions, and highly appreciated as evident in patient feedback, are gynecology and pediatrics. There is high satisfaction regarding the provision of pap tests in particular. In contrast, ultrasounds, nephrology, dentistry, optometry, and surgery were the most stated areas of currently unmet need regarding specialist care. Other specialist needs mentioned include: oncology, cardiology, and dermatology. A majority of those interviewed in this study stressed a great need for kidney specialists (nephrologists) in their community. It was expressed that, "If we could find out about why so many have kidney disease, this would be a huge gift to the community." Many voiced that even many of the younger population were affected and there were many deaths in the community attributed to kidney disease. Prevalent accounts of kidney problems in all communities visited indicate that addressing kidney-related concerns would be a particularly welcome contribution of future trans-national medical missions.

More teaching please!

With the exception of one participant, all local health workers emphasized the presence of foreign medical missions in their community as an actual or potential opportunity to strengthen their professional practice. Local health workers who work side by side with surgical missions placed a high value on the educational dimension of this experience, and expressed their interest in more education and exchange on patient cases, techniques and treatments.

“We could get together to discuss the patients..., to share cases and experiences, but before the mission starts or are at the end.”

“I have had this experience with the Managua brigades. We go to a place to discuss every case.... They could give us a talk, based on the area that is the focus of the mission.”

With respect to primary care missions, the requests for more teaching come in a context of currently having little or no contact with mission volunteers. With primary care missions coming in and out of a community in a matter of hours, many local health workers working in the host community may only exchange a few words with mission volunteers at present. While local health workers did not presume it would be easy to create time for learning and exchange, they did underline the current format of primary care missions as a missed opportunity: “They don't really have the time for any teaching for us, orientation around their techniques or even teaching in the community about prevention which would be helpful.”

It is important to highlight that no study participant framed their hope for more frequent visits from missions, more powers of diagnosis and specialists within these, more medications, or more teaching, in terms of entitlement. Indeed, as the title of this section is intended to emphasize, Nicaraguans do not expect, but only hope that foreign medical missions continue to provide desperately needed healthcare in their communities, and likewise hope that foreign health workers might increase this support. Again and again, participants who highlighted that many health needs remain unmet in their own lives or that of their community despite a recent healthcare mission visit, simultaneously stressed: “We cannot complain.” Trans-national care was cast in

such comments as “a favor” to Nicaraguans and a “gift”: “The foreigners do not have to do this, so we are grateful.”

4 ADDITIONAL FINDINGS

4.1 Problems in local care

Almost all patients and family members of patients interviewed in this study qualified their appreciation for the work of trans-national medical missions as linked to their negative experiences within the public healthcare system. Nicaraguans with limited resources were aware and often frustrated by the lack of available free medicines in community health centres for a range of conditions, but especially coughs, eye and ear infections, and uncomfortable skin and vaginal infections. Their appreciation of free medicines from trans-national healthcare missions was inextricably linked to this local shortage. Many patients and community members had suffered poor and hurtful treatment in the Nicaraguan public healthcare system: being ignored for hours on end by nurses, callously dismissed, made to wait while richer Nicaraguans stepped ahead in line, and most often verbally attacked by healthcare professionals. Such events were understood by many as based in common class discrimination, so that their poor treatment in the public healthcare system was linked to their poverty.

“[After my Caesarean], I couldn’t get up on my own, so they left me hanging, trying to get up, falling out of bed [laughs]. It was mistreatment. That’s why I can say that the attention received from the medical mission was beautiful. Because they helped me to get up, they took care of me with love. That really struck me.”

“with the mission it’s the best medical attention you can get. They won’t mistreat you.”

In addition, many participants recognized the lack of resources available in the public healthcare system, and connected their satisfaction with the efficiency of care provided by trans-national groups to the inefficiency of the Nicaraguan system that is the result of this lack of resources. Rural patients in particular were extremely happy to undergo an assessment of their condition, referrals and completion of exams, an operation, and recovery in a window of

time sometimes as short as one month within the context of an trans-national surgical mission. This was dramatically different, in their account, from what was possible in the Nicaraguan public healthcare sector, where due to limited specialists, clinic hours, and (as physicians clarified in our study) operating hours, steps leading up to a surgery might require an individual to travel from the countryside into town on several occasions to complete one discrete step in preparation for the surgery. This process is a struggle and can feel impossible to many who earn their living on a daily basis, cannot afford losing time or money should they show up for an appointment that ends up being rescheduled: an occurrence which study participants, often based on rumour rather than experience, report as common.

Problems in local care are not the focus of this study, but we consider this data significant to thinking through the overall findings of this study in two ways. First, Nicaraguans' overall high satisfaction with the quality of trans-national healthcare missions is contextual: it is in the context of a strained national healthcare system that has limited personnel, equipment, and medical resources. Positive perceptions of mission care cannot be disconnected for many participants from their negative experiences in the public healthcare system. The second reason this finding of 'problems in local care' is included is that the research team feels these accounts of what is lived as class-based discrimination in the public healthcare system could be considered in future trans-national capacity building efforts. If, for example, more teaching/learning opportunities are created for Nicaraguan healthcare workers within the framework of future missions, Nicaraguan healthcare professionals might be invited, implicitly or directly, to reflect on differences in their approach to patient care. It is this research team's assessment that the situation is likely far more complex than accounts of mistreatment and "class discrimination" allow. The conditions under which public healthcare workers in Nicaragua work, including poorly equipped facilities, limited personnel, complex populations with complex issues, limited pay, may contribute to strained patient-health care professional relations in this context. The prevalent experience of "poor" care in the Nicaraguan system, however, with many Nicaraguans locating their hopes for future good care entirely in the hands of foreigners, does imply an opportunity to make non-technical, patient care training a part of any teaching/capacity building foreign missions introduce.

4.2 Dependency

Nicaragua and Nicaraguans depend on the foreign medical missions that come to their country every year. Hospitals, as confirmed by the healthcare professionals interviewed, rely on trans-national missions to regularly shorten waiting lists for surgeries. Transnational teams are not only providing valued labour and expertise; they bring anaesthesia, equipment, and other supplies essential to operations. Foreign-funded local NGOs through which they work also assume coverage of any expenses related to diagnostics, patient transportation and their hospital stay, as well as follow-up visits. Certain surgeries that are linked to significantly increased quality of life, such as cleft lip and palate, hip replacement, and heart surgery, are available in certain parts of the country to the poor majority only if and when a trans-national mission comes in to make these a reality. In short, there is little reason to believe that the majority of Nicaraguans who get operations through trans-national missions would be able to do so in their absence. This is a relationship of dependency.

Not one healthcare professional interviewed underlined their hope for a more robust and well-resourced public healthcare system. Many did, however, express hope that trans-national medical missions continue to provide the crucial support they do. Community leaders, patients, and others, from their different vantage point, shared this hope:

“I hope that always they keep supporting us with medicine and surgeries. In our health centres there are no medications. That is a problem. We are always going begging from hand to hand looking for medications. We are begging. The medical brigades are very important for maintaining us in health because without them many of us would have no medications.”

“They have helped us in an important way. I want them to keep doing this forever.”

Wrapped up with hope for the ongoing support of trans-national groups are fears missions will stop coming. The term “abandonment” was used by a number of community members. Implicit in such concerns seems to be a conviction that local, national, public solutions to current healthcare shortages are unlikely if not impossible. The following statements provide further insight into the nature of these fears:

“We here are poor people. What would we do without that help? Our lot would be to die from diseases”

Such comments underscore the current lack of healthcare options available to Nicaragua's poor, as well as a dominant sense that Nicaraguans are intensely dependent on foreign medical professionals and missions for healthcare. Comments such as that above also reaffirm the symbolic importance of medical mission help that is lived as trans-national caring, not just curing.

Women in at least one community wait for trans-national missions to get their pap tests, sometimes waiting up to three years, because the conditions for pap exams in their community clinic leave them exposed to the prying eyes of curious boys, and travelling into the city for such an exam is complicated and difficult to coordinate in the public sector. In both the interview samples of primary care and surgical missions, some interviewees reported they will from now on delay seeking medical care in the local system, should the need arise, until they can access care from foreigners.

“...always one has to trust. Not that I have heard of any one dying for such an operation, when these are carried out by the local doctors. But for me, it's more certain. I've put my trust in the foreigners and I do not feel the same way with them.”

“I know a woman younger than myself and she had her gallbladder operated on in the hospital here. The doctors were Nicaraguan, and she died 8 days later. And how many gallbladders the missions remove and no one dies?”

“She spoke to me after the day of the mission. She was enchanted with the experience. Really really happy. How well they did the pap exam! She said. Like no other pap exam she'd ever had.”

While healthcare professionals we interviewed defined themselves as partners and equals in foreign mission's provision of healthcare to Nicaraguans, patients and their relatives did not perceive themselves in this light. Instead, many clearly felt they were “beneficiaries” as they expressed gratitude for the “gift” of the care provided to them by foreign volunteers and partner NGOs:

“What is important for us is that they come all the time. All those who have been operated have not complained, of any mistreatment, they are very satisfied, they have come out well. If anything **they are grateful for the**

favor that is being done for them. The foreigners do not have to do this.
(emphasis added by author)

Nicaragua and Nicaraguans value, but also need the support of trans-national medical missions in the face of their own public healthcare system's limited reach and resources. This is a classic situation of dependency, in that withdrawal or even reduction in the care provided by medical missions might result in increased suffering amongst the country's poor. The way forward in such a relationship requires further and careful analysis.

4.3 Perceived powerlessness: "Beggars can't be choosers"

This statement emerged within the context of this participant's description of not having been selected to obtain an orthopaedic device he needed from one of the medical missions, and wishing there were more orthopaedic devices available through these foreign missions. Along similar lines, while commenting on a desire for more private consultation spaces, one participant explained:

"If a doctor tells you to stand under a tree for a consult, you do it. No one is going to say, 'I'm not standing there! I'm not going to be in the sun, in front of everyone.' Nothing of the sort. If I'm told to stand there I'll stand there. I am a person in need and one has to accommodate oneself to the situation, to the circumstances. These doctors do not come every day so if they are giving consults under that tree, that's where I've got to go. What there is, is what we have. There's no option to refuse."

Such comments highlight the feeling amongst many of the Nicaraguans interviewed that, while they might hope for continued and even expanded trans-national healthcare, they do not expect or feel entitled to these hopes:

"If anything they are grateful for the favor that is being done for them. The foreigners do not have to do this, so we are grateful."

Many Nicaraguans are acutely aware of being in a position of limited power: the receiving end of needed healthcare, and with no 'buying power' to go elsewhere. Such awareness of the inequality in power between receivers and givers of 'aid' certainly can be expected to limit locals' willingness to highlight gaps or make suggestions to trans-national medical missions, but this awareness

is also why perceptions research is needed. Perceptions research supported by aid organizations and local communities creates a unique space for 'beneficiaries' to provide feedback on their experiences of trans-national care, particularly for poor Nicaraguans who may not feel empowered to make suggestions or requests otherwise, due to the strong class system in the country.

Is there a limitation to perceptions studies in general? How useful is feedback from local community members on trans-national medical missions? The research team welcomes your comments and feedback on this study and the usefulness of these findings.

Conclusion

There is nothing in need of urgent correction in the practices of trans-nationally provided primary and surgical care examined. The majority of those interviewed in this study are highly satisfied with and grateful for the medical care provided to their communities via trans-national missions and volunteers. There exists a strong perception of trans-national groups "doing good" in the realm of healthcare, providing quality free medicines, safe and fast surgeries, and caring, respectful medical attention, all of which are difficult for Nicaragua's poor majority to access free of charge in the public healthcare system. Community members are generally welcoming missions with open arms. A growing number of local healthcare professionals and community leaders, according to our interviews, are eager to support trans-national health brigades. Some groups of volunteers have long-standing relations with specific health centres, communities, community leaders and healthcare professionals. Trust, friendship, care, respect, and gratitude dominate the relations between trans-national groups and volunteers and the Nicaraguan communities they serve. That said, this study provides an evidence-base for increasing the positive impact of volunteer-led trans-national medical missions in Nicaragua.

It seems that suggestions for improvement differ from mission to mission, and from community to community, which indicates that there is quite a bit of variation in pre-arrival communications, set-up of missions, and community expectations of what missions can and cannot do for them, which then impact satisfaction of care received. Thus, missions and their Nicaraguan partners (community leaders and organizations) might give greater consideration as to

how best to ensure that standards of care are consistent across different missions. For example, some missions have been able to inform neighborhoods in advance of their arrival, while others have not, affecting how many people missions are able to serve.

Establishing with local partners a standard protocol to ensure adequate pre-arrival communications might be an effective means for addressing many of the factors limiting participation and satisfaction found in this study. Community members could be informed earlier on of an upcoming mission, particularly important information for many who must make arrangements to miss work to attend a mission. While earlier communication bears the risk that relatives and friends from surrounding communities will show up to receive care, pre-arrival communications could include clarification of how communities have been included/excluded for this mission, and discussion of these criteria with the local healthcare professionals. In at least one primary care mission whose services were discussed in this study, the communities served by the mission did not include all the communities served by the public health center out of which the mission clinic operated. This did not make sense to the locals, and might have been addressed in a pre-arrival discussion. Where this is not already the case, pre-arrival communications might include outlining in the community meetings, goals and limitations of each mission: how many personnel they are bringing, what specialists will be coming, and if available, estimates of how many people they will be able to serve. While important to expectation management, this also can increase the effectiveness of consults if community members come prepared to discuss or seek attention for problems the mission is equipped to address.

Medical missions might consider finding ways to improve collaboration with the healthcare professionals (nurses in particular) responsible for the communities the mission is serving. At least one nurse resented having no idea, beyond what her patients told her, what if anything the foreign healthcare team might have detected, recommended, or prescribed. Having a Spanish-speaker work with foreign primary care missions to record any diagnoses and recommendations on a piece of paper that could be added to a patient's file is something to consider where it is not already in practice.

Earlier preparation could also hopefully address other organizational issues, such as identifying spaces for a mission that will provide sufficient privacy and confidentiality to patients. Additionally, efforts to inform locals about the objectives of missions could be increased through implementing information

sessions and orientations aiming to reach individuals who are reluctant to seek care from foreign missions, or who could benefit from being told they are welcome by the foreign teams to bring to the mission consults any questions or concerns, while understanding that the missions are limited by the composition and equipment of their teams. By working towards addressing these barriers, missions will be able to maximize the number of people and communities they are able to serve and serve them even better than they already do.

Local healthcare professionals and community leaders place a high value on their partnership with foreign medical missions, primarily because this is a means for them to help Nicaraguans in need, but also because for many this is an opportunity to acquire and strengthen their clinical skills. Creating more opportunities for Nicaraguan healthcare professionals to discuss patient cases with foreign medical teams, as the equals they are, and share techniques and skills is a clear request of local healthcare professionals. This would increase the sustainable impact of the current work of trans-national medical missions in important ways.

Whether or not, and in what respect, it is feasible or desirable for foreign volunteers and organizations to provide more frequent healthcare to communities and individuals in need, and involve more specialists in these trans-national efforts, is a complex question. There is real need in Nicaragua. There is no question that more foreign missions with more diagnostic powers would “do good” by providing free and timely healthcare that is currently unavailable to many Nicaraguans living on or below the poverty line, especially to those living in rural areas with only minimal health services. Many of this study’s participants emphasized that foreign medical missions are providing Nicaraguans with respectful, valorizing care, where the Nicaraguan public healthcare system regularly fails Nicaraguans, especially the poor. This perceived failure is attributed by some study participants to the poverty of the country and the under-funded health system, by others to a lack of healthcare professional training and a culture of class discrimination, and by many to some combination of these things. What we find troubling as researchers in the field of healthcare ethics is that while so many Nicaraguans we interviewed appear to trust and hope foreign medical missions and volunteers will continue their good work, study interviews yield no parallel hope that the quality and quantity of Nicaraguan public healthcare will improve. This raises the question: could positive experiences of foreign, short-term medical missions in Nicaragua be facilitating acceptance by all parties involved (government, donors, healthcare

providers, patients) of these missions as a solution to the Nicaraguan public healthcare's problems?

Considered in this way, the mainly positive perceptions of foreign short-term missions identified through this research cannot be taken as an indication that all is well with these transnational efforts. The perceived high(er) performance of foreigners in the delivery of healthcare to Nicaraguans may undermine rather than strengthen the Nicaraguan public healthcare system. NGOs and individuals currently involved in coordinating trans-nationally staffed and funded healthcare to Nicaraguans might, if they are not already doing so, consider how the high esteem and trust which they appear to have, for the most part, successfully cultivated with locals and local healthcare professionals, might serve to support longer-term, sustainable healthcare solutions for this country. It is up to foreign organizations, groups and Nicaraguan government, NGOs, and healthcare providers and administrators, to determine whether or not developing health system strengthening strategies lies within the scope of these parties' vision of what trans-national health partnerships can or should be.

Appendix 1: Community member questionnaire (for patients, family members or neighbors of patients)

1. What is your sex?

Male _____

Female _____

2. What is your age? _____

3. What is your occupation? _____

4. How much money is earned by members of your household, including yourself, on a daily basis? _____

5. How many people live in your household, counting yourself?

1

6

2

7

3

8

4

9

5

10

More than 10 _____

6. Which of the following applies to you (choose all that apply)?

I have visited one or more medical missions in 2013

I have received medical attention from one or more medical missions in 2013

I have accompanied a family member to one or more medical missions in 2013

I have avoided accessing care from one or more medical missions in 2013

7. How many times in your life have you sought attention from a group of foreign medical mission for yourself or someone in your family? _____

8. Which of the following donations have you accepted as a member of this community?

school knapsack or uniform

cafeteria meals for children (comedor)

cafeteria meals for family

food baskets

Christmas toys

used clothing or shoes

house

water well

latrine

sporting equipment

other _____

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