The Triple Menace in Volunteer International Aid Work: Three Harmful Pitfalls

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Introduction

International instability, wars, and complex political transitions of power have created a substantial increase in forced migration and flows of refugees from one country to another.[1] A concurrent increase in non-governmental organization presence and activity in crisis settings has had a dual effect. More people are served—essentially more lives saved—but there is also an increased risk of causing harm.[2] Harm can be caused not only to patients; culturally inappropriate care can also damage working relationships at an organizational level.

Emergency nurses are some of the best-trained professionals to provide care in humanitarian response. We have broad diagnostic and technical skillsets that meet the needs of the injured and acutely ill. Nurses and nursing students have many options; they can travel to remote areas—nationally and internationally—to provide essential life-saving services. But what is the risk that we may cause more harm than good? What is the potential that we may be contribute to the negative effects of what some call the humanitarian industrial complex,[3] and how can we mitigate the potential for causing unintentional harm? Merton's theory of unanticipated consequences of purposive social action posits that, despite good intentions, actions with which we intervene—in our case, health care—can result in unintended negative consequences.[4] It is imperative that if there is a way to anticipate and mitigate these unintended consequences, we must take on the ethical obligation to do so.[5]

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This article proposes the concept of a "triple menace": three concepts prevalent in short-term humanitarian response work that can cause harm. The purpose of this article is not to discourage nurses from providing aid in medical missions; rather, it aims to make the reality of the triple menace known in order to raise awareness of common pitfalls that reflect lack of cultural humility. The triple menace addresses three general aspects of many of the complications nurses face when providing short-term humanitarian assistance. We believe that these three elements can compromise cultural humility as well as strain working relationships between national and international aid workers. Cultural humility, for the scope of this paper, has been defined by the work of Hook et al[6] and Tervalon and Murray-Garcia.[7] They create a model of cultural humility that emphasizes the importance of community and partnerships over the work of the individual, while also recognizing that cultural humility is process rather than product oriented. Thus, cultural humility is learned over time through experience and collaboration; it is not something that can be taught in a classroom or lecture hall. There is emphasis on "developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships."[8] Foronda et al emphasize that cultural humility is a lifelong process when it comes to nursing care.[9] Because of the sensitive and longitudinal nature in developing cultural humility, short-term medical missions, by nature, pose a challenge to developing humility because aid workers do not always have sufficient time to assimilate into the culture or community they are serving. The three elements proposed in this commentary may help as guides to enhance some aspects of cultural humility. More importantly, recognizing these three aspects of the triple menace could decrease the potential for causing harm. The elements of the triple menace are emergency mind trap, volunteer entitlement, and misinterpretation of leadership.

Emergency Mind Trap

Protracted humanitarian settings—for example, long-term refugee camps such as the Kakuma Camp in Kenya, in

FIGURE 1

Nurse Tim Cunningham holds an incoming patient at the Maforki Ebola Treatment Center in Sierra Leone, January 14, 2015. (Photo by Rebecca E. Rollins/Partners In Health).

FIGURE 2

Nurse Tim Cunningham (right) and Dr Luanne Freer (left) carry supplies necessary for patient care at the beginning of their shift at the Maforki Ebola Treatment Center in Sierra Leone, January 14, 2015. (Photo by Rebecca E. Rollins/Partners In Health).

operation since 1990—have seen thousands of aid workers pass through who have come to support refugee families and then have left.[10] Aid workers may not realize that such camps—where children have been born and have lived for their whole lives—are more like cities and communities than temporary settlements. Although conditions at Kakuma and Dadaab, in Kenya—two cities that host massive refugee communities, or the island of Lampedusa off the coast of Italy—remain in dire straits and in constant need of supplies, these camps have been around for a long time. Volunteers see those conditions and may forget that the conditions have been "that bad for that long." We have witnessed aid workers come to a setting and try to apply "quick fixes" to improve the conditions of a protracted aid setting. Without proper supervision, these quick fixes can not only disrupt the normal work flows of a clinic, for example, but they can often be unsustainable and end when the aid worker completes his or her assigned time in that setting. Innovative ideas are welcomed and important. Nurses with experience "on the ground" often understand and can aptly address and implement strong ideas to improve situations; however, new ideas from volunteer aid workers must be tempered with an appreciation of protracted time. Unfortunately, it is difficult to implement rapid change in long-term refugee as well as short-term emergency response situations.

Aid workers who arrive wanting to change practice and work flows immediately should develop their ideas and thoughts (for they may be helpful), but they should be slow to try to implement them. Depending on the length of deployment, it may be unsafe and inappropriate to try to designate new practice protocols if an aid worker will not be in the field for long. Médecins Sans Frontières (Doctors Without Borders), for example, has a strong and valuable tradition in requiring new aid workers to work with them for long periods of time (6 to 9 months) and learning from their protocols before attempting to implement new policies and procedures. This system is effective in that it allows an aid worker time and space to first understand what practices have been in place and why. Although entering a humanitarian situation can bring on a sense of urgency and anxiety, aid workers desiring to help should remain mindful of the protracted nature of displacement, disease, and emergency response. One's sense of time can be misleading.

Volunteer Entitlement

Although it seems this may be more common among volunteers, paid staff on short-term time scales may also experience problems with volunteer entitlement. As aid workers, we understand that we are intentionally placing ourselves in stressful situations. These stressors, however, can sometimes overwhelm the provider, leading to compassion fatigue.[11] Compassion fatigue can then lead to a series of sequelae including apathy, burnout, disassociation, and a negative sense of ambivalence.[12] These aspects of compassion fatigue can cause a breakdown in teamwork. Providers who are experiencing compassion fatigue—and who are on short-term missions—may stop doing the jobs they are required to do. Letting protocols slide or simply saying, "this is not what I came to do" can