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Cruise ships and bush medicine: Globalization on the Atlantic Coast of Nicaragua and effects on the health of Creole women

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Abstract

Objectives—Global health research into the relationship between health, economic inequalities, and globalization is necessary to address increasing health disparities in low income countries. Nicaragua has high levels of poverty and extreme poverty when compared with other Central and South American Countries.

Design—Photovoice and ethnographic research methods were used to explore health experiences of Creole women in Bluefields, Nicaragua and the intersections between culture, socioeconomic status, and gender.

Sample—Twelve Creole women participants, ages 18–45.

Measurements—After initial focus groups, participants used disposable cameras to document health experiences. Follow up interviews were conducted about the meaning of each photo. Participants then selected photos to be included in a city-wide photoshow.

Results—In initial focus groups, participants described great distress over changes they perceived in Creole culture and how these changes affect the health of the next generation. Participants related most of these changes to the economy and globalization. Photos taken were primarily of aspects of Creole culture, including household practices and traditional remedies from Creole culture.

Conclusions—Findings on the relationships between culture, disease and community-identified health risks in this minority population can help healthcare providers and public health policy makers develop and sustain culturally appropriate health interventions.

Keywords

Women's Health; Vulnerable Populations; Transcultural Nursing; Qualitative Research; Global Health

Background

Poverty has an inextricable impact on health and healthcare in populations the world over. Research into the links between economic inequalities and health disparities has for the most part been conducted in more developed higher income countries, sometimes due to a lack of longitudinal surveillance data on health indicators in low income countries (Chopra, 2005). Researchers exploring globalization and health have increasingly suggested using country-specific cases to explore these links and better understand the unique factors influencing globalization and health in the developing world (Cushon, Muhajarine & Labonte, 2010). Globalization is defined by the World Health Organization (WHO) as, “the increased interconnectedness and interdependence of peoples and countries” (WHO, 2014).

Classified by the United Nations Development Programme (2013) as 129th in the world on the Human Development Index, Nicaragua was ranked in the ‘medium development’ and ‘low income’ categories. Nicaragua’s 2010 gross domestic product (GDP) at \$6.55 billion ranked the nation, “as the second-poorest country in the Western Hemisphere” (U.S. State Department, 2011). Based on a 1998 National Quality of Life Survey, “47.9% of the population was living in poverty and 17.3% was living in conditions of extreme poverty” (Pan American Health Organization [PAHO], 2008). More current data and data disaggregated by geographic region and ethnic group are not available to explore differences between groups and geographic regions.

The Atlantic Coast and surrounding inland territory is divided into two politically autonomous regions: Region Autonoma Atlantico Norte (RAAN) and Region Autonoma Atlantico Sur (RAAS). The political seat and largest city in the RAAN is Puerto Cabezas (Bilwi), and Bluefields is the political seat and largest city in the RAAS.

The Atlantic Coast of Nicaragua is characterized by ethnic diversity. However, little is known about the unique health and healthcare experiences of each of the ethnic groups living there. It is only within the last few decades that the Mestizos (the largest ethnic group nationally) have outnumbered the Creole population on the Atlantic Coast. After Mestizos, the Creole population is the second largest ethnic group in Bluefields (Barrett, 1995a). Barrett (1995b) defined the Creole population as, “derive[d] from both African and English heritage, and speak[ing] a Caribbean Creole dialect of English in the home” (p. 405). Today, most of the Creole population in Bluefields is bilingual in Spanish and Creole.

Language skills have afforded the Creole population of Bluefields some economic opportunities. Because the Creole spoken there is linguistically close to English, Creole people have increasingly secured jobs in the tourism industry throughout the Caribbean. Many Creole men and women work on cruise ships at some point in their lives, sending money back to family members in Bluefields. Contract lengths vary, but are most often eight to ten months of the year, meaning family members are gone for the majority of the year. Remittances of salaries earned on cruise ships or earned in other places (often the U.S.) are in fact the second largest form of income in Bluefields (Personal communication, March 2013).

Limited economic opportunities exist on the Atlantic Coast, and the jobs that are available are predominantly available to men, with the majority of formal employment going to the Mestizo population (Personal communication, August 2010). The marine industry is the primary source of income for most people in the Atlantic Coast region (Barrett, 1995a), with artisanal, small-scale fishing being the largest form of informal employment. This leaves subsistence level jobs for the remaining groups in Bluefields, and families are often dependent on remittances from relatives (most often in the U.S. or Costa Rica).

Researchers who have explored health and healthcare on the Atlantic Coast of Nicaragua include Barrett (1993; 1995a; 1995b; 1998), Coe and Anderson (1996a; 1996b; 1997; 1999; 2004) and Coe (2008; 2008b; 2008c). Coe (2008a) notes that of the healthcare used by women in the Atlantic region today, 30% is biomedical, and 70% is traditional. In eastern Nicaragua, 70% of all births take place at home. A variety of other kinds of traditional healers exist in addition to midwives, including snake bite healers (Coe & Anderson, 2004). Barrett (1995b) found that, “[w]ithin Bluefields, traditional medical knowledge was held disproportionately by the Creole [in comparison with other ethnic groups]” (p. 410).

Specific Aim

Because each of the six ethnic groups living on the Atlantic Coast are distinctly different, more research is needed to explore the experiences of the women in specific groups who use these remedies. In this historical and cultural context, the specific aim of this study was to explore the health beliefs of childbearing/childrearing Creole women living in Bluefields.

Methods

Design

Community based participatory research (CBPR) models have particular relevance when working with populations that have been historically disenfranchised, as power over the research process, decisions, and findings should be shared between participants and researchers (Castleden, Garvin & Huu-ay-aht First Nation, 2008). Photovoice research methods (Wang, 1999) which allow participants to choose the objectives of the study, were used to explore the health experiences of Creole women in-depth and from their perspective. Ethnographic research methods were used to research the cultural context in which Creole women living in Bluefields experience health and disease. Through participant observation and interviewing key informants (community members selected based on professional experience), the researcher was able to not only explore Creole culture, but also to better understand the culture of Bluefields as a whole (Bernard, 2006; Fetterman, 1998; Agar, 1992; and Cohen, Kahn & Steeves, 2000).

Sample recruitment strategy and characteristics

Using cultural brokers (Fadiman, 1999) as “gatekeepers” or cultural bridges to the Creole community in Bluefields (Leffers & Mitchell, 2011), twelve Creole women participants were recruited to participate in the Photovoice portion of this study. Cultural brokers were identified based on experience living in and traveling to Bluefields, and were asked to find other women who identified as Creole who might be interested in participating in the study.

In total, twelve Creole women ages 18 to 45 (mean=26.4) were included in this study. Participants ranged in level of education from the last year of secondary school to completing a degree at one of the two local Universities. Four participants were married, and all married participants had one or more child. No unmarried participants had children. All participants lived in one of the three predominantly Creole *barrios* in Bluefields, out of the total of seventeen *barrios* (at the time of data collection).

Procedure

Once cultural brokers identified participants, two initial focus groups were held with four and seven participants respectively and were guided by the first author using a semi-structured focus group guide. A twelfth participant was included and interviewed individually, because she was not able to attend either focus group. Each participant was informed of the study purpose and procedure, and provided informed consent. Participants discussed health and healthcare issues Creole women and their families experience in Bluefields, and then were given disposable cameras with 27 exposures to photograph the issues discussed. After one to two weeks, participants returned the cameras to the researcher for the film to be developed. The researcher met with participants for follow up interviews once the photos had been returned, and each participant gave a description of what each picture represented or meant. At the time of the interview, all participants selected photos and descriptions to be included in a city-wide photo exhibit, to which community stakeholders were invited in January 2011. The purpose of this photo exhibit was to raise awareness of community identified health issues. All participants received copies of their photos as compensation for being in the study.

Research Ethics and Protection of Human Subjects

This study received approval through the University of Virginia's Institutional Review Board for Social and Behavioral Sciences. Participants selected a pseudonym to be referred to throughout the study. Data was never linked to participants by their true name.

Analytic Strategy

All focus groups and follow-up interviews were audio-recorded and transcribed verbatim. Debate remains over whether Creole is its own language, and no standardized written Nicaraguan Creole yet exists. Therefore audio-recordings were transcribed into Standard English spelling with word choice and order as it was spoken. One interview was conducted partly in Spanish (at the request of the participant) and this recording was transcribed into Spanish, translated into English, and then back-translated to ensure accuracy.

Transcriptions and field notes were reread at each stage of the research process to aid in developing categories and themes in data coding (Cohen, Kahn & Steeves, 2000). Data strips (or meaningful recurring words or concepts) were identified and overarching categories and themes emerged (Agar, 1992). Rigor was addressed through extended contact and respondent validation via multiple meetings with participants (Maxwell, 2005). Field notes and journaling were used for researcher reflexivity. Additionally, an auditable trail of research decisions was used to promote transparency of the research process (Sandelowski, 1993).

Results

The greatest concern all participants identified in both focus groups was for the health of the younger generation of Creole women growing up in Bluefields now. All expressed great anxiety over perceived cultural changes, with the most often cited culprit for these changes being the economic situation in Bluefields. Results were classified into three categories: factors influencing cultural change; reactions to this cultural change; and the importance of preservation of Creole culture. The first and second areas were primarily explored in initial focus groups, while the preservation of Creole culture was discussed at length in the follow up interviews about photos. Verbatim portions of quotations are presented here in Standard English spelling with word order as it was spoken.

Factors Influencing Cultural Change

Participants often referred to years past (“first time” or “old times”) as a “healthier time”, and described how the younger generation of Creole women in Bluefields was at risk for health issues because they are losing cultural buffers, strengths, and supports against illness. While a confluence of internal and external factors was blamed by participants for causing this change in traditional culture, the majority were related to the economic situation in Bluefields and throughout the Atlantic Coast. Several participants said that in the Creole culture, women were most often the heads of household and were responsible for supporting the family, including financially. Unemployment and underemployment are high in Bluefields, a phenomenon compounded by what participants described as ethnic tensions. The Atlantic Coast is a region known for celebrating diversity; however participants cited racism in industry:

A problem for health and social is plenty sickness around, no job around, no nothing, people all around, and plenty little young girls just growing up...And problem with we Creole women is: we living in a country that full of racists. You might study, take out your degree and have a title and them don't give a Creole woman a constant job, like an office job they'd rather go for a Spaniard [Mestizo]. If a Spaniard taking over, they go for their own race...you have some discriminate we Creole women because we are Black.

Women often must leave the community to financially support their families. One participant said of women's options, “How can we make life? We have to go out of our Country. The majority of we Coast women, Bluefields woman out. We not in the country working.” The most common form of employment out of the country participants described (for men or women) was on cruise ships, often in kitchens or as wait staff. Having a family member (man or woman) working out of the country had several effects on women's health and the health of families in Bluefields, including increased stress and increased risk for STIs: “Women have needs ...and some of we, the women then looking on next man and sometimes that cause the problem in your health because it no have to be HIV that the man has, it could be another disease...and through wanting that little bit, it could be from that one thing you could get your death, infection...” Participants here described the potential for increased risk of sexually transmitted infections while family members were gone related to increased extramarital affairs. All participants agreed that in the current economy,

remittances from family members abroad were crucial to the survival of families in Bluefields: “what the only benefit we Coast women have about the ‘ship out’ husband or whatever family, is the economic help. That is what help us.”

Such remittances were also important in accessing healthcare. Several participants expressed frustration in trying to access Ministry of Health clinics or the hospital in Bluefields (the only hospital in the RAAS.): “For get healthcare? Well the majority of we Creole women what have maybe a job or have people without health, then well we go private and spend money.” Participants described the importance of remittances in accessing healthcare in Bluefields, “well all of we, we Coast people, Coast women them we can’t say we have money because we really is a poor country, really. Well we naturally, if they no send [money] for we –people we have out working – they no help us out with something, we no see we headway. An example: someone have to make an x-ray, they have to wait till a month for do it.”

If women did stay in Bluefields, they frequently needed to be out working, and therefore were absent from the home so long that younger Creole girls didn’t have role models from which to learn the cultural expectations of Creole women. One participant said, “it’s very hard because these generation what coming up now them always look the wrong road, into drugs, we have plenty prostitute. It’s hard sometimes you know we woman alone can’t bring up the whole family in the right way because we have to work and can’t have time for look after the children.”

Many participants agreed that this was common but also new in Creole culture, “That’s why I tell you the old time people example they used to give you was something well different. You never see old people doing that.” One possible explanation for this change in parental behavior was, “also...now-a-days the parents them is young mother so it’s like ‘I want my freedom too, so I don’t have time for them’ ...one girl have 15 years she have a baby and when she have like 20 she want to enjoy herself, she never had time to enjoy herself.” In further explanation for these changes in parenting culture, one participant explicitly cited globalization for the adoption of these new practices:

In class they gave us a question to analyze about if you think that a society that have the cultural and tradition will survive in a globalized world. Sincerely I think it is really difficult. I think that is exactly what is taking place here in our society... because one of the things our old people used to say - even in my Mom time she would say - that the theme of Black culture was that a child couldn’t be raised just by the family, the child was raised by the community and that is something what is lost in our society in Bluefields. Now no one permit no one to tell kids anything – even in the school it have been prohibit for teachers to chastise the kids. And as parents we keep busy – mother is working out now and otherwise, which time we have to really raise our children which what they need...so that have to do with the globalization you know? First time women had the privilege of being home and of helping raising your kids and creating a better society and now women don’t have the time – they are too tired – to really assume that responsibility...

This participant went on to further describe the consequences of adopting new (and foreign) practices on health and the culture of family: That's where globalization come back in again.

That's where different practices we assume from developed country. Because first time when a girl for example...my age if we think of getting pregnant when we was in secondary [school] or something like that it was like 'if I get pregnant, my life done right here'...Now...[girls] have so much rights but they no teach you the obligations and the information that they're giving the young people is like 'ok when you reach a certain age you get a need in your body and you want to experience, you can just experience just use a condom' – that's not the solution, they don't give the other information that when you do that you going to get your family poorer because when you're bringing another mouth into the house...The information is not complete. So now what is really happening is that you have a lot of kids having kids not only that it is the whole system is what causing the whole thing...Even as parents, if we talk to our kids and we try to tell them...

This participant believed that increase in education about condom use in adolescents and the increase in resources available to pregnant teens was a major cultural change and not necessarily for the better.

Reactions to Cultural Change

Participants described reactions to this perceived cultural change, including the need to document and preserve traditional Creole culture and health, as well as the need to increase awareness of health issues with younger Creole women. To the "system" referred to above, the impact of globalization, and influences from other outside cultures, the participant went on to say, "what we are not doing is taking those examples and those experiences and sharing with the younger people." The majority of participants echoed this sentiment, emphasizing the need for education in women:

Now we have two University and Creole not embracing it as it should. The University them was put up especially for the minority - we are minority but still we are not embracing it. The girls them, the family part of the community is trying somehow to prepare themselves. The man them are staying behind but that still put us back because we're still marrying someone who isn't prepared...so we have to convince the males that they need to advance also in that sense, that they are capable but...they don't want to work for anything anymore, if they are going to work it will have to be for a lot so their mentality is that they only way to do that is ship out [and work on a cruise ship]. That ship out is their answer. So when they have to go and clean toilet and clean up people mess what kind of development they can have with self-esteem? They come back feeling great because they have dollars in their pocket...but then they have to fall into reality sometime because some come and spend it out, drink it out a few weeks after and they won't have their pass [money for a ticket] to go back, some of them and they fall right back into the same situation and there is no progress.

Ramifications for Creole people working on cruise ships include: though the pay may be good, the work is demeaning; people return and spend money without saving it; along with

the increased income comes alcohol and drugs. This participant emphasized the responsibility of Creole women to become better educated, and to support education in the community at large.

In addition to University education, participants described the importance of health promotion and preventive care, and women understanding the importance of taking responsibility for their own health:

The next part is that we Creole women no like to make paps, the Creole woman no like to go up there and make them open up and look inside, the Mestizo woman prefer to try to do things to help themselves - the Creole women no custom and no like to do it. And that's a next thing that people have to get in it and believe it is something for your own body...there's so much cancer and when they find it, it done pass the time to do anything about it. And sometime the Creole man here have 1 sweetheart, 2 sweetheart, and the wife can't say nothing and when she does say something, man say it is lie.

The Importance of Preserving Culture

While the majority of the discussion of cultural change on health took place in the focus group discussions, participants also took photographs to document, preserve, and raise awareness of several cultural aspects of Creole health. The majority of pictures taken were of environmental concerns or of traditional or bush medicine commonly used by Creole women and families. Use of bush medicine was another tradition participants feared was being lost by younger Creole women. Some explained that this knowledge was traditionally passed along generationally, and said they had asked older family members or neighbors for explanations of the herbs they photographed. Of bush medicine one participant said:

...A lot of people use bush medicine...I love my bush medicine because the treatment, medical treatment that the doctor give you gives you different effect, it affect into your health maybe create other sickness so at least bush medicine cure, cure a lot of things. It more successful so the majority of people base it on that.

While participants agreed that the younger generation of Creole women were more likely to use Ministry of Health clinics or the hospital for healthcare needs, several agreed that it was common for older Creole men and women to either exclusively use bush medicine, or use it before accessing Western biomedical treatment. This population used bush medicine to both cure ailments and for wellness or health promotion purposes, such as semi-annual "purges to clean the blood" through herbal teas. Several participants described the healthcare services available at the Ministry of Health clinics or hospital as being harsh on the body, unnatural, or, "sometimes the medication it doesn't help us the right kind of way." Bush medicine used by the different ethnic groups on the Atlantic Coast were unanimously deemed important and necessary to preserve by participants:

...between the ethnic groups I think we have different practices, for example...you have several beliefs that Creoles have that the Mestizos really doesn't take into account...for example having kid...young girls Creole you have a grown mother keeping to them, telling them to keep inside, put cotton in your ears, bind yourself

or whatnot. The tradition is being passed on but sometime what happen is that the young girls don't take the advice...so in due time you see they will be paying the consequences of that.

Consequences most commonly cited by participants for not following such advice included repeat pregnancies, risking upper respiratory infections (or fresh colds) from not protecting the mother's ears, and delayed recovery from pregnancy and delivery when mothers don't use supportive bindings on their abdomens.

City-wide Photoshow

Photos and the narratives describing what each photo represented were selected by each participant to be presented in a community-wide photo exhibit, which took place in January 2011 at the Bluefields Indian and Caribbean University. The presentation highlighted the importance to Creole women of preserving traditional cultural practices (especially bush medicine) and raising awareness of community-identified health issues. Policy makers, NGO representatives, educators, University students, healthcare practitioners, and other stakeholders were invited. The majority of attendants were University students and professors. Findings were also presented to policy makers and the Ministry of Health (*Ministerio de Salud*) by the first author.

Discussion

Socio-cultural Changes

All participants expressed anxiety in focus groups over what they perceived as recent changes in Creole culture. The limited economic resources available in Bluefields have gone primarily to men or the predominant Mestizo group. The subsequently disproportionate economic migration of Creole men and women was seen by participants as a significant factor in the loss of Creole culture in Bluefields. Losing traditional Creole culture was consequently associated with health risks for the generation of young women growing up now in Bluefields. While several aspects of the economic situation in Bluefields were cited as contributing to the change in Creole culture in Bluefields, all participants emphasized the need for cultural preservation, and most used photos to document aspects of bush medicine and traditional Creole healing they obviously wanted to preserve.

Changes in Women's Lived Experiences

The economic situation in Bluefields was perceived as the biggest threat to the health of Creole women in this study. Women whose partners worked on cruise ships were thought to be at increased risk for STIs. Of the few studies available exploring the health of women who themselves leave to work on cruise ships, Thomas (2003) interviewed women from several countries who worked out of major ports in Florida. Data suggested they had limited access to contraception on ships, as well as decreased access to confidential medical services.

Several participants described the financial necessity of having family members leave Bluefields to work in other countries, most often in the tourism industry. While all acknowledged the necessity of the resources and money these family members sent home,

several participants identified specific health concerns they had as a result of family members being gone, including feeling increased stress, and potentially increasing the risk of contracting sexually transmitted infections, particularly for young people who lacked role models. For those who remained in Bluefields, women who were able to secure employment were gone from the home for long hours. Combined with the decrease in community parenting, this lack of parental supervision of girls was associated with the increase in teen pregnancy rates by participants. While participants in focus groups described resources newly available to teen mothers, these were associated with enabling teen pregnancy instead of helping mothers continue with their education. It's important to consider this culturally-associated perception in the context of Nicaragua's national adolescent fertility rate of 119 births per 1000 aged 15 – 19, one of the highest in all of Latin America (Meuwissen, et al., 2006).

Existing Resources and Potential Responses

Outside economic resources were often necessary to access healthcare in a timely way, but the available health services were not perceived as sufficient. Currently, health resources in Bluefields include NGOs working for women's health and the Ministry of Health's network of primary care clinics in and around Bluefields. Health services were perceived by participants as "belonging" to the Mestizos. Healthcare services available in Bluefields are primarily delivered in Spanish and while most Creole people speak both Spanish and Creole, some Creole women participants described experiencing culturally inappropriate interactions when seeking help.

Implications for Public Health Nursing and Nursing Research

Almost no research exists exploring the lived experiences and health of women of ethnic minority groups on the Atlantic Coast of Nicaragua. There is limited statistical evidence on health outcomes and on development trends for this region. As Barrett (1995a; 1995b) noted, the region is distinctly different from the rest of the nation. More research is needed to explore the health and health care experiences of groups living in the Atlantic Coast region.

Economics and poverty have an inextricable impact on health and health care in populations the world over. Understanding women's conceptualizations of health and illness, as well as traditional health care practices in a population or culture (Barrett, 1995a; Barrett, 1995b) can greatly enhance the effectiveness of any public health nursing intervention. Careful and specific recruitment strategies will be necessary for future studies. Research is needed to further understand women's and maternal health issues related to poverty in Nicaragua.

This study sought to increase understanding of health disparities and vulnerabilities related to culture, gender and economic status from an international perspective. Findings have the potential to inform health care practitioners and public health program planners in the Region to some of the barriers Creole women perceive in accessing health care in Bluefields.

Culturally informed gender and power issues have a significant impact on health and healthcare of women worldwide, including influences on access to care, domestic violence,

and maternal/child health outcomes. Nurses (who have always been sensitive to gender issues) are in a unique position to study women's health outcomes internationally. Such research must be conducted in collaboration with community partners in the international research site, in order to promote sustainability in international initiatives. Such a research model will help prevent the potential extraction of information and resources, and will include community research partners in professional collaborations.

Conclusions

Despite the small sample size of 12 participants, this study represents an attempt to engage women in discussion of health issues they identified in the Creole community and in the larger Bluefields community. Findings show that health issues they identified transcended national boundaries, and provide a unique example of the intersection of globalization and health disparities. Policy makers as well as local and national healthcare resources can use community identified and culturally tailored health concerns for more sustainable health promotion and disease prevention efforts.

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