THE ANATOMY OF EPHEMERAL HEALTH CARE: "HEALTH CAMPS" AND SHORT-TERM MEDICAL VOLUNTOURISM IN REMOTE NEPAL

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> My grandson will be born with sleeping pills in his eyes,
> his potency already dead, needing no vasectomy.
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> ~ Banira Giri, '*Samay timī sadhaiṁko vijetā*'
> (Time you are always the winner)

Introduction

This paper examines the emergence of "health camps" as an increasingly popular model of short-term medical care and voluntourism in Nepal. Broadly defined, health camps (*swāsthya śivir*) are stationary or mobile short-term medical interventions for target communities, generally lasting anywhere from a day to a week (Adams 1998: 189). There are many different kinds and combinations of camps, such as general health camps, dental and eye camps, reproductive health and family planning camps, uterine prolapse and fistula, specialized surgical, speech therapy, and even acupuncture and massage therapy camps. Equally vast are the assemblages of global institutions and groups that organize and sponsor them. These include non-governmental organizations (NGOs)—which have exploded in number throughout Nepal—other development and aid institutions, volunteer programs, private hospitals, and branches of Nepal's Ministry of Health and Population (MoHP). During and in the wake of the Communist Party of Nepal–Maoist's (CPN-M) *Jana Yuddha* (People's War, 1996–2006) against the state, both Maoist and government armies also conducted health camps—drawing Nepal's already fractured health care efforts into the battlefield and politicizing the movement and meanings of medicine in rural areas.

Statistics present a complicated, if incomplete, picture of Nepal's health and health care landscapes. According to the World Health Organization (WHO 2009: 100), there are only 5,300 physicians in Nepal[1]—most are clustered in Kathmandu—and their number per 10,000

[1] This number refers to biomedical physicians only, and does not include Ayurvedic and other traditional and popular healers, such as *āmci*, shamans, Lamas, practitioners of *jaḍibuṭī* (herbal medicines, plants, flowers and roots), homeopathy, acupuncture, or Unani. Though distinct, these ethnomedical

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is two. This compared to India (6:10,000) and Sri Lanka (6:10,000), Bolivia (12:10,000), Costa Rica (13:10,000), the U.S. (26:10,000), and Cuba (59:10,000). Nepal's 2006 Demographic and Health Survey (DHS) (MoHP *et al*. 2007) points to some improvements in health, such as a reduction in maternal mortality ratio (MMR) from 539 per 100,000 live births in 1996 to 281 per 100,000 in 2006.[2] Data also show that infant mortality has declined by 41 percent over the five-year period preceding the survey, from 82 deaths per 1,000 live births to 48. Under-five mortality dropped to 61 per 1,000 live births for the same period, putting Nepal on track to meet the Millennium Development Goals (MDGs) for maternal and child mortality. Yet, this still means that one in every 21 children dies in the first year of life, and one in every 16 before age five (MoHP *et al*. 2007: 125).

Aggregate national health indices mask considerable disparities across geographical regions, gender, class, and caste in Nepal (Tsai 2009: 516; World Bank 2004: 1). In addition, state-run health care delivery still suffers from a lack of coordination, complex bureaucratic structures, and internecine national political configurations that have forged enduring difficulties in bridging the formidable imaginative and geographical distance between city and village (Justice 1986; Sharma 2010; Stone

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traditions continue to actively blend in Nepal's pluralistic medical landscape. And though I don't focus specifically on them here, this breadth of healing practices remains crucial in conceiving of "primary" health care in Nepal, as they encompass many people's first choice in healing patterns of resort. I am thankful to Mary Cameron for this point.

2 Tsai (2009: 516) notes that there are wide confidence intervals around the MMR (obtained by dividing the age-standardized maternal mortality rate by the age-standardized general fertility rate) reported in Nepal's 2006 DHS, but a real drop is likely to have occurred. This is interesting given that the reduction occurred partially during the years of the People's War, when access to health care services was greatly limited. The MoHP attributes this decrease in part to increased knowledge and use of contraceptive practices (MoHP *et al*. 2007: 4). However, I wonder if there were also fewer marriages and subsequently fewer births during the fighting, as young men and women of reproductive age fled villages, joined or were conscripted into the conflict. In short, we must be careful in drawing conclusions about health trends from statistical interpretation alone because the collection of vital statistics—especially in remote parts of Nepal—is an admittedly inaccurate process that results in varying quality of data, time references, and sample coverage. "In particular," we are told for Nepal's 2006 DHS, "sampling errors associated with mortality estimates are large and should be taken into account when examining trends between surveys" (MoHP *et al*. 2007: 125).

1986).[3] Life expectancy in urban Nepal is 68, while in the remote Karnali district of Mugu it remains 44. In the neighboring district of Humla—ranked 75 of 75 districts in Human Poverty Index (HPI), literacy rate, and per capita food production, yet seventh in per capita development expenditure—90% of children under five suffer from chronic malnourishment and 72% from stunting (UNDP 2004, cited in Adhikari 2008: 11–12). Under-five mortality in the mountainous zones (128 per 1,000) is more than double that in the hills (61 per 1,000) (MoHP *et al*. 2007: 126). Rural epidemics, such as a 2009 cholera outbreak, continue to claim hundreds, and stand as glaring reminders of the basic public health work left to be done (Nepali Times 2009; Sejuwal 2009; Tuladhar 2009). More people-oriented health policies—returning to a focus on health as a human right and tackling disadvantaged regions and groups—have come to the fore of health policy discussions since the 1990 *Jana Āndolan* (People's Movement), and especially following the April 2006 *Loktantra Āndolan* (Democracy Movement, or second People's Movement) that preceded the formulation of a Maoist-led coalition government. However, so far these conscious efforts have been actualized only at the level of thinking and paper.

Here, I offer a critical analysis of short-term health camps in Nepal. I argue that the popularity of the short-term camp model operates in, and perpetuates, a global and national climate where ideas of "health" and "health care" are conflated, and where pills, surgeries, and syringes are championed at the expense of addressing the basic needs that promote and sustain health. The structure of the paper is as follows: In the first section, I revisit briefly the medical camp model's troubled history in India, and then contextualize the emergence of health camps in Nepal's changing health care system. I then turn to an ethnographic discussion of health camps in remote Nepal, focusing on the social and political lives of the camps and the medicines distributed (Appadurai 1988; Whyte, van der Geest, and Hardon 2003), which come to have meanings and uses beyond those immediately associated with treatment. In the last section, I focus on the growing and controversial field of "medical voluntourism"[4] before

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[3] Pigg (1992: 493–496) discusses the social and physical geographies that constitute "village" and "city" in such a rural nation. "The village," she writes, "being rural, is simply that which is not urban…But given the overwhelmingly rural character of Nepal, the first question is what is not a village in Nepal?"

[4] The term "medical tourism" commonly refers to the crossing of international borders to have access to cheaper, often specialized, medical services. A

concluding with a rethinking of short-term interventions and service initiatives that supplant plans aimed at addressing basic needs and primary health care efforts.

It is important to state clearly upfront that I am not arguing against the judicious use of medical care. To do so would deny its unquestionable role in improving health and well-being; more importantly, it would deny people's cries for reliable and affordable access to this care. However, participating in and researching health camps have led me to question the ethics, limits, and benefits that surround this short-term model. What might be some of the potential impacts—socio-cultural, biopolitical, medical—and unintended consequences of episodic service delivery, especially during times of conflict? Whose needs do health camps serve or overlook? Do they improve health? Are short-term volunteer stints and medical camps in resource poor settings indeed "better than nothing," as I heard time and time again? More importantly, what are the conditions that allow us to even ask this? In short, what do health camps do, and what do they not do? This ethnographic discussion is an initial attempt to answer some of these questions, as well as pose new ones for future research. Emergent within a particular political and economic moment in the tenuous formulation of a *Nayā̃* (New) *Nepāl*, health camps offer an important departure point for discussions about medical voluntourism, the social and political lives of medicines, short-term medical care, the structural determinants of health, and the medicalization of basic needs unmet in a new era of global health efforts.

Research Methods

This paper draws from my experiences in Nepal over the past six years, both volunteering with and conducting research on NGOs and health camps.[5] The bulk of my ethnographic research was conducted while living in Humla district in the northwest Karnali zone. A peripheral area in a peripheral country, Karnali is at once a region of insurgency,

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number of guidebooks have recently been published (Bookman and Bookman 2007; Hancock 2006; Kumar 2009; Woodman 2008). I use the term voluntourism here in the sense that Holtz (2009: 111–113; see also Mackinnon 2009: 23) describes medical tourism: anything short of long-term commitment to changing the actual conditions that cause health, and where volunteers often "treat themselves" – making oneself feel good without offering sustained and mutual benefit to the intended communities.

5 From October–December 2004, July–September 2006, June–December 2007, June–September 2009, and January–December 2010.

communist and democratic ideologies, and one that has become synonymous with hunger, poverty, and backwardness (Adhikari 2008; Blaikie, Seddon, and Cameron 2001 [1980]: 73; Dorjee 2009).[6] It is also a location of frequent government,[7] Maoist, and NGO health camps, and host to many *videśī* (foreign) medical volunteers.

I adopted a multi-sited approach to fieldwork (Marcus 1995), using snowball and purposive sampling to conduct semi-structured individual and group interviews. In order to contextualize the emergence of health camps in Nepal, I examined a range of documents to triangulate with in-depth interviews and observations. These include: policy papers, health camp reports, journal and newspaper articles, NGO websites and newsletters, and radio programs. "Movement as method" (Harper 2003: 49) allowed me to speak with people who are normally too busy to be found in clinics or hospitals, and in settings convenient for those who

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[6] The Karnali region has complex socio-cultural, political and economic histories. Famous as the birthplace of the Nepali language, and a once-wealthy hub of herding and trading salt and grain between India and Tibet, the region has come to occupy a prominent place in the imaginations of most Nepalis and onlookers of Nepal as a road-less "*kālāpānī* (literally, 'black water'), where it is difficult to maintain one's livelihood" (Adhikari 2008: 151). Tsewang Lama (2002: 36) notes that contemporary media coverage of the region depicts it as "some sort of a hellhole of Nepal because of the rampant hunger and poverty in the region." These representations are hyperbolic; at times they are politico-media embroidery, or are produced through I/NGO reports. To be sure, there is privation in Karnali. However, it varies throughout districts, and throughout VDCs within districts, within households, etc. Moreover, the reasons for this stem from a confluence of border tensions with China, grazing restrictions, internal state exploitation and economic liberalization, the politics of food aid, and institutionalized underdevelopment, which engendered drastic changes in agro-pastoral, transhumant, and trade practices in the region (Adhikari 2008; Bishop 1990; Lama 2002; Levine 1988; Masse and Citrin 2009; Roy *et al*. 2009; Shahi 2005). As the late Dr. Harka Gurung notes, to most people, "Humla is a mere jingle word appended with Jumla" (Gurung 1980: 93). I suspect he is referring to the refrain of a popular Nepali folk song, which—with the exception of a short stretch of road in southern Jumla, and an impressive bit cut from Purang (Taklakot) in Tibet over Lalung La down to Tungling in Humla's Limi VDC—continues to ring true so many years later: "*Humlā Jumlā gāḍīmā, kahile jāne ho*? (When will we be able to go to Humla Jumla in a car? – my translation).

[7] The National Planning Commission's (NPC) Three Year Interim Plan (2007/2008–2009/2010) proposed a number of special health service programs, especially "free of cost health service camps" run "particularly for the benefit of the poor people of the Far western region, and the Karnali areas of the Mid-western region" (NPC 2007: 286).

came to camps from far away. Walking countless mountain miles—at times chasing, and missing, health camps—I found conversations on the trail, in teashops and tiny hotels, and around many hearths. An exhaustive list of individuals with whom I spoke is not possible, but includes: village health workers (VHWs), government health workers (GHWs), physicians working in cities and remote district headquarters, local politicians, *videśī* and Nepali NGO staff, international medical volunteers, development and international aid officials, Maoist officials and cadre, medical college staff and students, passing traders, and Nepali villagers who attend and do not attend health camps. I wrote profusely in my journal, never knowing what would be important. With permission, and when appropriate, I recorded interviews (recorded=94, non-recorded=21), taking precaution to ensure anonymity.[8] In analyzing transcripts, I used open coding procedures to engage anew with my data, and to allow themes and a general descriptive framework to emerge through patterns and stories.

Ultimately, the text below is presented as I choose. Therefore, following Mosse's (2005: ix) methodological incorporation of Latour's (2000: 115) notion of objectivity—that is, maximizing opportunities for people to *object to* what is written and said about them—I have shared and discussed this manuscript with many of those whose lives and work are represented here. My observations will undoubtedly please some at the cost of angering others.[9] Some have suggested that I have omitted the most serious transgressions committed by certain NGOs or at particular health camps; however, indictment is not a goal of this paper. Here, I foreground the perceptions and voices of Nepali people with whom I worked and conducted interviews, who plan and attend health camps, and who volunteer their time and skills. Undoubtedly, their words and actions serve as powerful critique and recommendation. Beyond this, it is my hope that their experiences and knowledges will be brought to bear on the

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[8] The names of all individuals and organizations mentioned in this paper have been changed or omitted to maintain anonymity. Double quotation marks in the text surround only verbatim citations taken from printed text, recorded and transcribed interviews, or from field notes written during or shortly after an interview.

[9] I have written elsewhere about the conflicting accountabilities and relationship "fallout" that can result from simultaneous participation in and critical examination of NGO work and short-term medical interventions (Citrin 2008). See Mosse (2005, 2006) for excellent discussions on the challenges of straddling relationships and politics while conducting ethnographic work among international development institutions and other professional communities.

process of creating social justice-oriented policies that address longstanding, unmet basic and health care needs in the region. I see the continued task of a new generation of engaged social scientists to incorporate into ethnographic work the vested—and especially the contested—voices of our "informants" and coworkers. I do so here to more collaboratively unsettle comfortable assumptions surrounding medical care in remote settings.

Revisiting a Sinister History of Medical Camps in South Asia

> There were several worthy sons the country produced in the past…
> Many more worthy sons were yet to be born
> But, alas! Family Planning was introduced
> And, Effectively!
>
> ~ Vinod Ashrumali, *The Wonder of Family Planning*, 1989

Historically, models of medical care have emerged as symbolic institutions at particular political economic moments, as "certain social classes and interest groups at all levels…stand to benefit, both ideologically and politically [and, of course, economically], by promoting particular models of health service provision" (Morgan 1993: 3). Pharmaceutical companies, privatized doctors, politicians and elites at all levels rank among those who most evidently stand to gain. However, there are other forms of "power and domination to be had from defining a population as 'sick'…and in need of the 'doctoring' hands of a political administration that swathes itself in medical symbols" (Scheper-Hughes 1992: 202). One needs only to recall Indian Prime Minister Indira Gandhi's declaration of a State of Emergency in the mid 1970s, during which she implemented her draconian policy of forced sterilization through family planning camps.

A 1972 article in *Studies in Family Planning*, entitled "Kerala's Pioneering Experiment in Massive Vasectomy Camps," describes a one-month long "Family Planning Festival" that registered 78,423 "acceptors"—the passive name given to people who undergo sterilization. "The Ernakulum camp," boasts the article, "demonstrates that large masses of people can be motivated to accept sterilization in a short span of time by an organized and concerted effort" (Krishnakumar 1972: 177). Along with the terror imposed through sterilization came plans for the resettlement of those who had accepted. Widespread speculation arose throughout India as to whether the synchronized plans to forcibly sterilize and resettle—in the name of ushering in a new "politics of discipline and

development"—were in fact part of the government's methodical plan to wipe out entire segments of the population, mostly the poor (Gupta 1977: 85, as cited in Tarlo 2003: 37):

> People were rounded up at random, from streets, the tea shops, and the bazaars, and taken to the family planning camps to be sterilized. No distinction whatsoever was made between old men and young boys, between married and unmarried—the forced sterilization just went on and on.[10]

The ease with which familiar public servants (such as teachers, doctors and nurses) so straightforwardly enforced these policies through already existing state structures and delivery institutions (at health posts, clinics, and hospitals) is disquieting. As Tarlo (2003: 82) aptly writes, "The grotesque absurdity of a government policy which explicitly encourages illicit deals in human infertility" confounds the imagination. The early collusion of so-called philanthropic foundations—the precursor to NGOs—must also be pointed out here; such as in the end of 1976 when the Population Council—created in 1952 by John D. Rockefeller III to advance global population control and, subsequently, sponsor of the journal *Studies in Family Planning*—lent support to Gandhi's use of police raids during the massive sterilization round-ups (Hartmann 1995: 254, as cited in Smith 2007: 13).

A 2003 article entitled "The Sinister Targets of Indian Health Camps" documents the recruitment of women for fortnightly sterilization camps in northern Uttar Pradesh by local Auxiliary Nurse Midwives (ANMs). ANMs reported that, "to turn up empty-handed was to invite the wrath of officials" of the State Innovations in Family Planning Services Project Agency (SIFPSA), a USAID-funded project (Menon 2003: 1). To be sure, this is an extreme case. Nevertheless, that this form of duress remains—embodied still in the fear of being rounded-up for medical camps run in the name of reproductive rights—serves as a necessary reminder that the

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[10] Rohinton Mistry's (1995: 520–521) *A Fine Balance* also offers a wrenching portrayal of life during the *Āpat kāl* (Emergency), and of the fates of those who were taken to the sterilization "festivals": "The sterilization camp was a short ride from town. A dozen tents had been pitched in a field on the outskirts, where the stubble of the recent harvest still lingered. Banners, balloons, and songs identical to those at the marketplace booth welcomed the garbage trucks. The passengers' terrified wailing grew louder as the vehicles were parked in an open area behind the tents, alongside an ambulance and a diesel generator…."

camp model, and the constellation of political-economic relations surrounding it, still requires serious analytic scrutiny.[11]

Locating Health Camps in Nepal's Changing Health Care System

With the technical assistance of the U.S., family planning services were established in 1965 during Nepal's Third Five-Year Development Plan in an effort to curb population growth, which was seen as a major health problem and an impediment to modernization and economic growth (Justice 1986: 50). From the beginning, importance was given to permanent methods of family planning (Dixit 1995: 61), and by the mid 1970s sterilization for men and women was made widely available through outreach camps.

According to Shrestha (1988: 211), the government ran yearly sterilization camps in Deurali, "mobiliz[ing] all of its resources, sending volunteers to every eligible couple's house in the *pañcāyat*[12] to coax them to come forward for vasectomy or sterilization." Just as these "motivators" were paid "per client served," financial incentives in rupees were part of accepting sterilization (Thapa and Friedman 1998: 79).[13] The money was meant as compensation for lost time from work and out-of-pocket expenses, but it is not hard to imagine that conditions of poverty might render hazy the line between want and need, and between coercion and consent. Opting to take control over family size, a desire to engage with allopathic medical services, and being in need of money are different motivating forces in the political economy of reproduction.

Family planning camps were touted as successes in the fight to reduce population in Nepal (Thapa and Basnet 1998). A study conducted in 1998 revealed that 77% (n=445) of Nepali women who received sterilization in hospitals complained of "regrets," but the rate of regret for those who were sterilized at camps was considered an improvement at 50% (n=372) (Thapa and Friedman 1998). Thapa and Basnet (1998: 183) argue that a failure to provide these kinds of family planning services would demonstrate a lack of commitment to empowering women and improving

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[11] Harper (2002) has also documented police officials rounding up Nepali villagers who refused to attend Vitamin A campaigns.

[12] The *pañcāyat* is a South Asian political system in which administrative councils are elected indirectly at the village level. See Burghart (1994) for a contextualizing discussion of the Nepali Panchayat system.

[13] From 1979 to 1998, this incentive remained steady at 100 rupees (Thapa and Friedman 1998: 79), which, at the time of writing, is approximately USD $1.40.

child survival. There is no doubt this is true; though, I would suggest that the experiential accounts of Nepali women who were sterilized through the outreach camp model would productively complicate the reductive binaries offered in the passive epidemiological language of "success" and "failure," of "acceptor" and "regret." More nuanced understandings of the interplay between cultural and structural forces impacting reproductive decision making and outcomes are required (Chapman 2006), including those that explore economic strains, access to services, inter-household gender relations, stigma and social threats, women's education and empowerment movements.

In 1972, the Association for Ophthalmic Cooperation in Asia (AOCA), a Japanese NGO, performed 745 cataract surgeries in Nepal's first eye camp.[14] The next year's camp registered 978 surgeries.[15] Shortly after, ear, dental, uterine prolapse and other specialized camps appeared in Nepal. This process is part of what Stephen Bezruchka (2003: 30) calls the "organification" of medical care, and it represents a significant step away from the primary health care (PHC) efforts espoused in the 1978 Declaration of Alma Ata at the International Conference on Primary Health Care.[16] This important document acknowledges health as a human right; the relationship between poverty, political instability, and poor health; global disarmament as a policy measure geared towards freeing up resources; and the unacceptability of "gross inequality" in poor health

[14] Perhaps using a contemporary phrase in historical retrospect, Dixit (1995: 16) has suggested that the first eye camp was actually held in 1947 shortly after Mohan Shumsher became Prime Minister and invited some doctors from India's Sitamarhi Eye Hospital to examine his own eye problems. In fact, as Liechty (1997: 20) has noted, "By the late nineteenth to early twentieth century, doctors, dental surgeons, and even x-ray doctors made up by far the largest category of Europeans invited by the Rana government." We also might trace some of the earliest short-term medical camps in Nepal back to before the country officially "opened" its borders to the outside world. Perry (1993: 40) notes that medical missionaries were lined up along the 500-mile stretch of the Indian-Nepal Terai border, establishing key strategic points where they could operate "preaching tours" combined with mobile clinics that combed the area while they waited. See also Harper (2003, 2009) and Shah (1993: 35–40) for critical discussions of the medical missionary past in Nepal. For (auto)biographical accounts, see Fletcher (1964), Hale (1986, 1989), Hankins (1993), and Hawker (1984).

[15] Available at: http://www.aoca.jp/e-aoca-sub11.html. Accessed on 02 March 2010.

[16] The declaration can be accessed at: http://www.who.int/hpr/NPH/docs/declaration almaata.pdf.

status. Further, it ranked specialized medical services and the use of drugs behind a list of preventive components aimed at achieving "Health for All by the Year 2000"—behind education, food and nutrition, sanitation, and clean water. In short, the concept of health was situated firmly within larger struggles for social justice.

The same year as Alma Ata, Nepal's Institute of Medicine (IoM) enrolled its first medical students from all over the country. The hope was that they would return to their rural homes upon completion to work in the health, sub-health posts, and district hospitals that slowly spread throughout the country. This met with modest, but fleeting, success.[17] In 1987, King Birendra instituted a formal "basic needs" program (Khadka 1991: 698) which, building on the Decentralization Act of 1982, was intended to integrate and devolve certain powers to rural health care centers. "The major bulk of our people live in the villages," he said. "It is only fitting, therefore, that priority in our long-term health plan should be accorded to the rural development scheme" (cited in Stone 1986: 294). PHC efforts in Nepal resulted most visibly in a vast network of village health workers (VHWs), community health leaders (CHLs), and Nepal's renowned female community health volunteers (FCHVs), who made regular home visits in the areas they lived. Family planning remained a cornerstone of PHC in Nepal, and the task of organizing villagers for immunization and sterilization camps was given to VHWs (Stone 1986: 294).

Few could argue, publically, against a need for comprehensive, community-based approaches to addressing people's health and health care needs. But, the realities of reducing the power and privilege of the elite, and of more equitably redistributing resources in hierarchical countries in order to do so, proved difficult (Heggenhougen 2009: 182).[18]

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[17] The degree that was granted after graduating from the IoM was a medical science diploma of the doctor of general and community medicine (MSDDGCM). However, there was concern from the beginning that the community-oriented nature of the medical training and the odd title would produce "a second class of medical manpower" (Dixit 1995: 179) and not allow "upward" (read: urban or international) mobility. This degree was done away with when faculty at the schools began to push for internationally recognized credentials that would allow them—as well as their sons and daughters coming up through the ranks—to go abroad (personal communication with two sources who requested to remain anonymous).

[18] See Justice (1986) and Stone (1986) for excellent discussions on the difficulties that arose between planners, intermediaries, and the intended beneficiaries of rural health programs during the transition from Nepal's

In the 1980s, financed by World Bank (WB) Adjustment Credits and International Monetary Fund (IMF) Structural Adjustment Programs (SAPs), "tied aid" proceeded in Nepal—much like it did elsewhere—largely according to the conditions of the donors. However, Panchayat rulers and subsequent governments that emerged after the 1990 *Jana Ā ndolan* viewed the aid as free money, and therefore must also be held accountable for ushering in these policies. And, since they did not have to pay the money back personally, they had little interest in "killing the goose that lays the golden eggs for them" (Shrestha 1993: 19). SAPs capped public expenditures and steered social services towards the private sector, in turn, weakening national health systems (Wakhweya 1995). More "narrow strategies of care" based on the cost-effectiveness of vertical, disease-focused interventions were deemed more feasible and—perhaps, more importantly—less political (Janes 2004: 458; Magnussen, Ehiri, and Jolly 2004: 169; Werner 2001: 22). This shift to "selective" primary health care (SPHC) was proposed just one year after Alma Ata as an interim step (Walsh and Warren 1979), but it was a step in the opposite direction. The "era of optimism" dissolved into what David Nabarro (1983: 88) describes as a "sea of platitudes."

In line with the neo-liberal drive towards free-market policies and privatization, a range of institutions and foundations moved in to finance the switch to selective care. NGOs were promoted to fill the gaps in public services that resulted from reduced public spending (Pfeiffer 2003: 726), with international NGO-disbursed 'development aid' increasing tenfold between 1970 and 1985 (World Bank 1995: 40, cited in Ahmad 2006: 187). Their international growth has been widely noted (Edwards and Hulme 1996a, 1996b; Fisher 1997; Green and Mathias 1997; Kamat 2004; Klees 2002; Nichter 2008), but perhaps nowhere has this phenomenon been more visible than in Nepal.

Nepal has seen an exponential growth in I/NGOs of all kinds—from 193 in 1990 to figures some put near 30,000 (Khanal 2006; Shah 2008: viii; Social Welfare Council 2009). To be sure, a focus on projects reveals that a much smaller proportion of them are consistently active, and even less mobilize foreign funding to implement projects. Still, NGOs become inextricably entangled in local politics and, in many parts of rural Nepal, begin to take over the most basic functions and powers of a putatively

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Integrated Community Health Programme (ICHP) to a focus on PHC principles.

absent state (Shah 2002: 143).[19] NGOs—especially those working in the health sector in remote regions—have become part of the network of humanitarian assemblages that wield tenuous administration over survival within circumstances that do not favor it (Redfield 2005: 344; see also Cohen et el. 2008 and Fassin 2009: 133). In 1995, Dixit wrote that, while "some health services are provided by NGOs, health care delivery is by and large a government affair" (1995: 146). This is no longer the case. Rather, I would argue that the assemblages of I/NGOs that engage in medical care have both expanded and disaggregated the channels through which people have come to expect its delivery. Acting on particular bodies and minds, this kind of "minimalist biopolitics" complicates the "government of health" (Foucault 1994[1973]; Redfield 2005: 330; Rose and Miller 1992). Humla district provides an example, where, at the time of writing, there are 177 NGOs registered with the local District Development Committee (DDC) office—roughly one for every 270 people in the district.[20] The most recently published NGO Profile of Humla District booklet (2063 v.s.[2007]: 12–14) listed 106 DDC-registered NGOs, with 49 (46%) of them reporting work in the health sector. According to a GHW in the district, "There is absolutely no coordination between these organizations. That is the biggest problem."

The mission statement of one NGO in Humla states that they were recently founded "to run the district health system for a period of 15 years." This organization continuously rotates volunteer teams of *videśī* doctors and nurses—a topic to which I return below—for three-month stints to work in the district hospital. At the same time, according to the NGO's website, the Ministry of Health and Population recently gave them permission to install one of their Nepali employees as the manager of the hospital under the supervision of the acting District Health Officer (DHO), which changes yearly.[21] Yet, "Providing health care where no one

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[19] When this happens, "it becomes all too clear that 'NGOs' are not as 'NG' as they might wish us to believe" (Ferguson and Gupta 2002: 101). See also Edelman and Haugerud (2005: 27) and Fisher (1997: 451).

[20] Only a handful of these organizations are consistently active, and sometimes NGOs will register multiple times for a range of different inter-organizational projects.

[21] Here, the semi-official 'contracting-out' of the district hospital and its management is part of the MoHP's attempt to foster public-private partnerships (PPP) in order to improve health care service delivery in underserved communities, and when cost effective (NHSP 2010: v–vi, 44). The government's "intention is to achieve increased efficiency and effectiveness through more competition and performance-based contracts,"

else can or will!" is the slogan of another INGO working in the same district—from which the abovementioned NGO had originally split after disagreements over staff, projects, and finances. Still, a third INGO operates another medical volunteer program and health camps within its private, three-building hospital compound with working equipment the district hospital lacks, such as an x-ray machine. For various reasons, which I don't elaborate here, these NGOs have decided not to work together. In Humla, the expansion of what the late Nepali anthropologist Saubhagya Shah (2002: 156) termed "NGOdom" raises serious questions about the fragmentation of primary health care delivery (cf. Pfeiffer 2003: 726), and about these organizations' abilities to respond to the needs of the national health system and communities they propose to serve.[22]

During the People's War, fighting caused great difficulties in health care provision and access to services greatly contracted. Maoists shut down health projects, evicted NGOs, and ransacked health posts. The

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but it is unclear if this is occurring. The contractual approach to health care in resource-limited settings is a topic that requires further empirical research. See, for example, Soeters and Griffiths (2003).

[22] The play on "kingdom" resonates here because of the sweeping power the 240-year-old institution of monarchy retained and, in particular, because of its recent abolition by a then-Maoist-led government in 2008—turning the only Hindu kingdom into the world's newest federal republic. Though outside the immediate scope of this paper, the impacts and politicization of the rise of NGOdom in Nepal following the 1990 *Jana Āndolan* is another vital element in the anatomy of ephemeral health care in Nepal. More broadly, I am also interested in examining the ways that I/NGOs mitigate—but do not necessarily address—unmet basic needs through short-term aid and relief. In addition to health camps, food aid commodity chains and their impacts on agro-pastoralism and livelihood strategies in Karnali require further research. Contemporary studies should look to and build on key works like Bishop (1990), Adhikari (2008), and Adhikari and Bohle (1999), which lay out the universe of challenges related to food security that face mountain farmers, and how vulnerability is gendered, regional, variable within VDC and household, and based on an intricate nexus of socio-cultural and structural factors that include gender, caste, class, and war. What is required, I believe, is thoughtful, interdisciplinary research that "studies up," looking at powerful institutions such as the United Nations World Food Programme (UN WFP) and its assemblages of affiliate organizations, as well as the Nepal Food Corporation (NFC). I am left to ponder how and why half quintals of NFC bleached, medium grain, white rice grown in California and harvested in 2006 arrive at the Simikot *godām* four years later. As such, I/NGOs and their historical role in reconfiguring global, national, and regional political economies remain a continued focus of my larger PhD/MPH theses projects.

known use of road mines disrupted the flow of medicines throughout the country, and many doctors and health workers fled rural posts. International aid dried up in light of the increasing political instability. Delivering medical services to people outside cities became increasingly difficult. As a result, the Maoists, the Nepali government, and the growing number of I/NGOs utilized short-term approaches, like health camps.

Health *Camp*lications, and the Social and Political Lives of Medicine

The health camp is an example of what Malkki (1997: 87) refers to as a "transitory phenomenon"—an extraordinary, but unstable, site where brief but intense periods of intentional interaction create accidental communities of experience. Despite their fleeting conditions and uniqueness of circumstance, health camps leave social and material traces and afterlives. These seep back into administrative offices, into reports and representations used to attract funding and project participants, and into the perceptions and practices of all those involved in these episodic interventions. As I illustrate below, health camps occupy socio-political and health-related spaces in rural Nepal, where a complex array of global, national, and local worldviews interact. These include those of health institutions and medical practitioners, national and local governments, I/NGOs, and "target populations." The latter must be seen as knowledgeable agents bringing a range of medical and local meanings to the camp experience, many of which arise out of the exigencies of life in settings of structural violence. The health camp, then, is an event that "presumably begins at some point and ends at another. Yet, more often than not, those points prove remarkably elusive" (Hoffman and Lubkemann 2005: 317). This discussion attempts to locate and trace some of those points.

In 2004, with no medical training of any kind, I went to Humla on my first medical voluntourism trip to help a group of NGOs conduct what was being called "the mother of all health camps." The nine-day camp brought together volunteer physicians, nurses, surgeons, lab technicians, and students from Nepal, India, Austria, Germany, US, Canada, and the UK to provide free medical services. It registered roughly 6000 people, many having walked for days across the expanse of a vast and road-less mountainous district. As is often the case, a list of the free health camp's (*niśulka swāsthya śivir*) services were advertised in English and Nepali on radio and television, in newspapers, with sheet-sized banners, and posted on flyers throughout the district:

- Health screening, investigation and general test – diabetes, TB, etc.
- Pre- and post-operative care and patient counseling
- General surgery
- Internal medicine
- Gynecology, maternity and family planning services
- Pediatrics
- Dental component
- Eye camp component
- Orthopedics
- Ear, nose and throat (ENT) and skin
- STDs and communicable diseases
- Diagnostic services: x-ray, ultrasound, ECG, etc.
- Lab services – all basic investigative facilities (LFT test, TB, blood, sugar, culture/lipid test, gastrointestinal)
- Vaccinations: possibly – MMR (Measles, Mumps, Rubella) and/or Tetanus, Hepatitis, Polio
- Controlled and proper distributions of medicines
- Post-camp follow-up – patient care, monitoring, and final reporting

At the time, the People's War swelled fiercely throughout the country, and most NGOs had stopped work in the region—either voluntarily or at the armed appeal of the Maoists. At night, perched in the forested hilltop overlooking the district headquarters, the then-"Royal" Nepal Army (RNA) would rattle machine gun fire into the night sky, largely to flex their muscle and to remind Maoist cadre who hid in the jungles that they remained vigilant. Short chains of pink fiery dots fading into the sky accompanied the echoing bursts. "Nobody should have the habit of that noise in their life," my friend Yutol said one evening, gesturing to two young children who, in their play, imitated the firing of guns. Yutol was a village health worker, trained and at the time employed by one of the NGOs helping to organize the health camp. Her father had been a well-respected member of their village, but he was also a high-ranking Maoist who was taken from their house one day and disappeared by the Nepali Army.[23]

[23] And in an amazing display of providence, Yutol, herself, managed to survive not one, but two pressure-cooker bombings while sleeping inside the NGO's guesthouse where she lived and worked. The first one, the Maoists admitted, was an accident. A soldier carrying the bomb, which was meant for a government office close by, needed to hide briefly behind the guesthouse when it accidentally went off.

On the day before the camp began, I was helping to clean the hospital when a couple came running towards the building. A mother carried their infant wrapped in a blanket, which she thrust into the hands of one of the GHWs who brought the child inside without a word, as if he was familiar with this scene. The father sat on the ground sobbing, and began smoking a pipe full of *kakaḍ*, a local tobacco. He told the story of trying to come to the camp for seven days after hearing on the radio that *videśī* doctors would be there. He and his family lived two days by foot, but Maoist soldiers at a check post just outside the district headquarters had stopped them, doubtful of how sick the infant truly was. In Maoist-controlled areas during the conflict, permission to move about freely was restricted, so the man pleaded with the soldiers. Only that morning were they allowed to pass, in exchange—the soldiers said after writing down his name and ward number—for some of the medicine that he would receive at the camp. Tragically, this mixture of politics and triage cost the infant its life.

Against this backdrop, the provision of free medicine by any group represents more than just humanitarian gestures of goodwill or attempts to improve health. During the conflict, the army and the Maoists ran health camps in order to elicit support from the Nepali people. This was especially true in remote areas, where violence and excess caused widespread distrust and resentment towards all those who "fought" or "defended" in the name of the people (Sharma 2004: 45).[24] In Humla, the Maoists had systematically implemented their "Whole Time" program (WT) through which they forcibly registered one person from each household ('*Ek ghar, ek comrade*,' One house, one comrade) as soldiers, porters, cooks, donation or information collectors, ideological outreach workers, and cultural program participants.[25] In this manner, entire communities were initiated into the party, making it difficult to refuse shelter, food, or clothing to other Maoists who came knocking on the

[24] The provision of medical care as a legitimizing tool of (often repressive) regimes or militaries is not new, nor is it a typically Nepali phenomenon. For example, the Pakistan Army conducts free medical camps to bolster its public image. The U.S., too, has become increasingly involved in humanitarian aid to countries with large Muslim populations as part of its 'winning hearts and minds' strategy in the wake of the incidents of 9/11 in New York. See, for example, Feinstein International Center (2010).

[25] I heard from many interviewees their personal opinion that Humla was the district with the most number of "Whole Timers" in the entire country during the *Jana Yuddha*.

doors of villages under the cover of night. "First the Maoists come, then the army comes," one elderly woman told me, moving both hands together to imitate the action of firing an automatic weapon. "Then the tears come." She streamed her outstretched fingers down over her eyes to represent crying and shook her head.

Running health camps was one way of being ostensibly "for the people."[26] Manjushree Thapa's *Forget Kathmandu*: *An Elegy for Democracy* (2005: 232) captures the politicization of health camps and medicine during the People's War:

> [The army] conducted a medical camp in Pakha VDC, and they mixed poison with the medicine!'…Two children got sick…We told people not to go to the camps. Anyway, they don't want to go. They say—The army first comes and kills us, and now they want to treat us? We're not going to go to their camps. But the army's been forcing them to take poisonous medicine…People come to our camps because they know that we're working for them. They don't go to the army camps. At one army camp, the villagers even chanted against the army saying—We don't need medicine when we can't get justice!

A *Nepali Times* article entitled "Guns and Medicine" (Newar 2003: 4) further illustrates how camps were drawn into the physical and political terrain over which Nepali Army and Maoist soldiers continued to battle:

> The Maoists accuse the army of trying to probe their defenses…under the pretext of establishing a health camp. The army says the local people are in great need of medical attention…[and] the Maoists opened fire on the patrol while negotiations were going on about establishing the medical camp…Both sides agree on one thing: a civilian was killed in the crossfire.[27]

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[26] Adams (1998: 194) captures an excellent example of the interplay of populist politics, NGOs and health camps following the 1990 *Jana Āndolan*. She writes: "Villagers at the health camp expressed the opinion that if they towed this NGO's political line they would gain access to its privileges in the same way they used to obtain privileges from their local politicians. They had always known that loyalty brought rewards, and in the post-revolutionary context the system had simply been recast in terms of party politics and the work of NGOs." See also Harper (2003: 33, 54).

[27] Politics and health camps continue to interact. In a 2009 article in The Himalayan Times (2009), it was reported that cadres of Maoists had beaten a United Marxist Leninist (UML) official because "he had been running a medical camp without their permission."

Like the idea of 'medicine as poison,' this scenario further adds to the ambiguities surrounding the provisional use of medicine through episodic health care programs in rural areas. That one of the words often used for medicine pills in remote areas is *golī*, which also means bullet, seems a cruel irony here.

Walking to Simikot from Bajura district in 2007, I met a number of groups returning from a health camp. One middle-aged woman expressed the belief that NGOs ran health camps so that they can take pictures and write reports "to increase dollar collection" (*dollar collection baḍhāunu*). The man I took to be her husband expressed the opinion that they conducted them "for show" in such troubled areas (*yasto duḥkha bhaeko kṣetramā dekhāuna*/*dekhāwaṭīko lāgi calāune*). Others made reference to them being like a "play" (*nāṭak*).[28] Similarly, a Nepali NGO worker suggested that

> NGOs work in remote areas like these to show how it is done…where nobody could do the work because of Maoist dangers. In places where treatment could not be done, we did it. In the places that the government could not deliver, too, we did it. So, health camps are for show.

These comments also draw out the highly performative nature of camps. The presence of Nepali and international film crews like the BBC also contribute to this politics of visibility (cf. Harper 2002: 137) and the enactment of development.[29] Crews often film the opening and closing speeches made at health camps, which are typically delivered by local politicians or other *ṭhūlo mānche* (big people). These visits are choreographed presentations that contribute publically and politically to the social production of successful NGO initiatives. As Mosse (2005: 166) notes, "The more influential the visitors, the more formal, structured and shorter the visit, the more impenetrable the displayed public face of project rationality." However, in a candid interview, one NGO director spoke directly to the "messy" nature of running health camps during the People's War:

> When we looked back at the results of the camp, we'd felt it had been very difficult to run, an awful lot of unmanageable politics between NGOs, participating parties, the UML, Maoists, the CDO [Chief District

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[28] And as Mottin (2007: 325) has pointed out, "Nobody wants to be labeled a group doing 'NGO theatre,' alternatively known as *vikāse nāṭak*/*vikāse kām* (development theatre/work)."

[29] Madhusudan Subedi has likened health camps to a well pulled-off catering job (personal communication, February 2010).

> Officer]…Flying in doctors who had totally different aspirations and intentions as to what was the basic needs of the community…it's a mess. All of that left us totally disillusioned…[with] such an expensive event, very hard to deliver any real health benefit through them.

Many of the volunteer doctors with whom I spoke were also deeply troubled by the local politics and organization of the camps. A UK physician referred to a health camp he was running as an "outright medical circus" that "propped up an already smelly and corrupt system," while simultaneously perpetuated a 'boomerang effect'—"We just throw them away and they keep coming back." An Austrian pediatrician watched as enrollment books and registration stamps were stolen at the same camp, blood samples went missing, and local officials harassed three German medical students volunteering to run the stores about the future destination of leftover medicines. She became so enraged that she demanded the camp be shut down, and that the "free medical supermarket" stop immediately.

While volunteering with an NGO in 2006, I watched as the tail end of the monsoon continued to soak large groups gathered outside the barred windows of a district hospital room, which was transformed into a makeshift dispensary for a nine-day general health camp. Attendees shoved in order to position themselves closer to the outstretched hands collecting prescription forms through the dispensary window. On more than one occasion, crowds that were crammed up close to examination room doors came barreling through: "I waited here all day yesterday and you ran out of my medicine," shouted one man. "I'm not satisfied with this camp," another man told me. "The doctor said there was nothing wrong with me and he didn't give me any medicine." Attendees sometimes sent their own children, or borrowed others, to demonstrate an urgent familial need to have a prescription filled quickly. Some faked signatures and sat around in circles copying one another's prescriptions and dosages. Others simply reached for loose tablets through the dispensary window, tried to reuse already-filled prescription tickets, or tickets from previous health camps. Many attendees came right to the dispensary without even going for an examination, as they saw others receiving chewable tablets, antibiotics and painkillers, vitamin suspensions, eye and ear drops. One elderly woman held up a crumpled piece of newspaper, in which she had received 60 antacid tablets the day before: "Excuse me. I've eaten all my medicines and I don't feel better."

For many attendees, free medicine was an important reason for coming to the camp.[30]

As events where medicines are sought out, distributed, and traded, health camps become symbolic of other possibilities. What is often "encapsulated" in obtaining medicine is the chance to connect to those who demonstrate concern, to confirm and legitimize sickness and bodily discomfort, and to take control of the tenuous conditions of everyday existence.[31] Medicines, write Whyte *et al*. (2003: 5)

> can be exchanged between social actors, they objectify meaning, they move from one meaningful setting to another. They are commodities with economic significance, and resources with political value. Above all they are potent symbols and tokens of hope for people in distress.

Medicines can also be markers of inequalities (Singer 2008). While closing up a weeklong camp's dispensary each day in 2004, people would continue to bring prescription forms. I remember one local Nepali volunteer mulled out loud, "*Kati ṭensan bhayo* (What tension!). All these people keep coming, it makes my head hurt. What should I take?" She sifted through the medicines left out on the counter. Attendees waiting for prescriptions routinely saw GHWs and other volunteers sending family or friends to the front of long lines, or in this instance taking medications, which they considered free to them as participants in the camp. Sometimes they packed them up to take home for personal use, family members, or gifts to friends (see Subedi 2001). This confirmed for many what they already suspected to be true—that those with the connections to more easily access medicines do, in fact, take them behind closed doors.[32] In interviews, most camp attendees referred to this practice of *āphno mānche* ("one's own people")—or, having and accessing friends, family,

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30 A renowned Nepali physician who had conducted countless medical camps told me that people generally expressed this opinion to him: "We did camps in Nuwakot and for the ones who really can't afford it, we gave the medicine free also. But, others had to pay. And then people got annoyed. They said, 'You know, if you're not giving away free medicines, why are we coming to the camp?'"

31 In attempting to determine some of the impacts of health camps, it is also important to bear in mind what could be called the "placebo effect of presence"—simply being there.

32 Whyte *et al*. (2004: 22) has also observed that 'those big people' in Uganda have much easier access to the kinds of medicines that prolong lives, such as antiretroviral drugs (ARVs).

and other contacts in positions and circles of influence or power.[33] People's images of the kind of society in which they live are continuously reconfigured through these enduring, widely accepted social configurations of currying favor, adding to a growing awareness of a hierarchy of life possibilities. The health camp acts as a "social pharmacy" (Whyte *et al*. 2004: 14, 25) as much as it does a medical one.

Scheper-Hughes (1992: 200) has written poignantly on the "magnetism" and "charisma" of drugs to "relatively isolated populations." But, medicines are not necessarily being "pushed" on Nepali people at health camps. To say so would misconstrue how the "charisma of medicines" interacts, and is forced to change, with everyday ideas and practices surrounding their use. In fact, camp attendees engage the availability and efficaciousness of medicines based on a variety of fluid and sophisticated explanatory models and illness etiologies. I heard references to "cheap pills," "useless creams, like toothpaste," "the inauspiciously colored pills," "pills my grandmother refuses to take because they make her cold," "original" and "fake" medicines, those from India, China, and *videśī* medicines. "*Videśī* medicines are mostly chemical, so they are dangerous," was the response of one elderly woman who had just received some. To which a young man standing beside her replied, "No. They just work faster because they are made with knowledge and money, so one needs to be careful in eating them."[34] Every health camp attendee I spoke with expressed a preference for being examined by *videśī* doctors, as well as having more *viśwās* (belief) in medicines given by them. As Harper notes, "the capacity for biomedical services to cure certain conditions has come to be seen as an intrinsic property of the foreign doctor and their capacity to heal" (2009: 304). This is a view consequent on the geopolitical relations and vast structural

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[33] Along with *āphno mānche*, one might include *nātāvad* (favoring family members), *kripāvād*—"a Sanskrit neologism corresponding to the Western concept of favoritism" (Adams 1998: 48), and *cākarī*. Dor Bahadur Bista, Nepal's first anthropologist, notes that *cākari* is a social institution adapted into secular life from ritual Hindu practice of obeisance (1991: 5). *Cākarī*, he writes, "is an essential concept which means to wait upon, to serve, to appease, or to seek favour from a god" (1991: 89). See also Justice (1986: 43–44, 83, 90), and Weiner (1989) for a discussion of 'source-force' and the Nepal medical profession.

[34] A range of studies has documented how the socio-physical properties of drugs relate to expectations and practices surrounding their use and efficacy. See, for example, Bledsoe and Goubaud (1985), Nichter (2008: 87–88), Nichter and Nichter (1996), Senah (1997), and Whyte *et al*. (2003).

inequalities that exist between Nepal and its developed (*vikasit*) Euro-American elsewhere (Harper 2009: 304, 318; see also Pigg 1992, 1996).[35]

In a few instances, I observed government health workers stealing medicines during health camps to sell in privately owned stores. As told to me by one NGO-employed VHW,

> Medicines that you have to buy and those that we don't have in store, the GHWs take. The people don't recognize which medicine is which, but the GHWs know. If this medicine is expensive, if it's not available in the hospital, if it's your expensive *videśī* medicine, they take it. Perhaps some is also for personal use.

In many cases, health camp medicines were indeed used for personal needs. Two women I spoke with after a uterine prolapse camp in Dolakha district told me they took their medicines back to a nearby pharmacy for money, which they then took to buy food for their families. This should be seen as a deliberate—and instructive—act of 'de-medicalization'—of finding a way to ensure that medicines are used to address unmet basic needs. Again recalling the family who required medicines to return safely to their village, the utility and meaning of medicines clearly also extends to the meeting of much more urgent needs in situations where life is uncertain and dangerous (Whyte *et al*. 2003: 89).

Aided by the growing number and kinds of medical camps, medicines are more mobile throughout rural Nepal, further shaping the range of beliefs and practices that surround their use. These beliefs and practices often fall outside the concept of "rational drug use" as conceived in public health literature and evidence-based medicine (Nichter 2008: 95), and therefore force a rethinking of the different kinds of knowledges and needs brought to bare during these health care encounters. In remote areas, an influx of medical supplies (often thousands of dollars worth) means a great deal. I also suspect that the direct input of camp medicines

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[35] Being around health clinics, hospitals, and asking questions about health and suffering during interviews in remote Nepal, I am quite regularly assumed a doctor. I have been asked countless times for medicines or—it often seems, purely on the basis of my color—to examine someone or treat their child. A result of this has been a growing awareness of my position as a white male researcher from a rich country, situated prominently within broader systems of privilege and oppression (Heldke 2003: xxvii). As Farmer (2003: 224) writes: "That we can study, rather than endure, these abuses is a reminder that we too are implicated in and benefit from the increasingly global structures that determine, to an important extent, the nature and distribution of assaults on dignity."

was a primary reason that the Maoists allowed certain NGOs to continue conducting them during the conflict.[36] Though I have just begun to scratch the surface here, exploring the social and political lives of medicines within the range of active responses to sickness and suffering adds to an expanded understanding of how medicines are meaningful. Much like the stealing of medicines by government health workers—who were also frequently the target of Maoist extortion and threats—camp attendees' strategies used to stock up on health camps medicines must be seen in the context of basic needs, redefined and unmet, in settings of privation and structural violence.

Medical Voluntourism in Shangri-La

> You might think this mission to Mugu was glamorous, because after all it is a sort of backpacking trip with surgery thrown in. Possibly the ultimate way to trek, right? After this first trip, you would never think that way again. Two weeks is a long time to go without hot water or plumbing if you are not used to it, and the fun disappears quickly when your patient is suffering. 'Hard core' is a better term. Not just anybody can be on the team…
>
> ~ an excerpt from *The Hospital at the End of the World* (Niemczura 2009)

Conducting health camps is closely related to a burgeoning form of travel that involves short-term medical stints or service initiatives in poor countries by students or clinical professionals from rich countries—what can be called "medical voluntourism." Discussions surrounding these trips are often impassioned and volatile. Many argue for sustainable models that bring medical care or training to places in great need, rightly citing collaboration, awareness, and common goals with local communities as guiding principles (Federico *et al*. 2006; Hall 1990; Suchdev *et al*. 2007). Still, others—myself included—suggest that these trips raise serious questions and require further discussion (Banatvala and Doyal 1998; Bezruchka 2003; Gray 1992; Green *et al*. 2009; Illich 1968; Montgomery 1993; Rieff 2002; Wall *et al*. 2006).

International student and NGO-affiliated volunteer programs have found room to grow within this field of interest, and health camps in Nepal have become highlighted trips. I found this advertisement on Idealist.org seeking volunteers for ongoing camps. It is worth quoting at length:

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[36] In addition to those exacting 'tablet tax' from Nepali attendees returning from the camp, many Maoist soldiers came in plain clothes to seek treatment there.

> Many rural Nepali people are often reluctant to go to the hospital and other modern health services because of orthodox thinking, superstition and other cultural influences. Some Nepali people may visit a witchdoctor when they are suffering from an illness, so they sometimes die as a result of avoiding modern medications. By living and working with rural communities, Health Program volunteers also increase the exposure of rural Nepali people to modern medicine.
>
> Health camps are located in the mountainous and/or rural regions of Nepal. Volunteers live for one to two weeks in the same manner as the Nepali people. The participants camp in tents near the clinic and eat traditional food cooked by Nepali cooks. As this program will be organized in rural areas of Nepal, this program would give volunteers the opportunity to experience the rich culture, natural splendor, panoramic views, short treks and daily life of one of *the most beautiful yet poorest nations in the world*, and at the same time experience life in Nepal first-hand, working alongside Nepali people to help support local communities in Nepal. Before conducting health camps, volunteers will be involved in organizing and conducting health awareness to the youth clubs, women's groups, school children and other local organizations. If anyone is interested in joining this programme they may work in the permanent clinics in Kathmandu or in rural settings. Volunteers may choose a term of service ranging from one week to 2 months. *Whilst we would prefer volunteers with medical experience, anyone interested in healthcare is invited to apply for this programme* (my italics).

There are a few things to unpack here. Firstly, this sweeping and reductive social representation strategically deploys the monolithic trope of orthodox and superstitious culture as a social fact to justify medical intervention (Nichter 2008: 5). In the description above, missing are the various ethnomedical systems in Nepal, where a pluralistic syncretism of traditional, folk, and professional forms of healing has long been common. Also absent is any mention of the socio-cultural, political, and economic factors that influence health and health seeking beliefs and practices, such as gender, class, caste, stigma, war, and poverty.

Secondly, the invitation for “anyone interested in healthcare” is cause for concern. As Roberts (2006: 1492) notes, the use of untrained volunteers to deliver care and medications is not allowed in rich countries, and so it should not be allowed elsewhere. She argues that despite the good intentions that inspire many to do this work, such “duffle bag medicine” can put people’s lives in danger while simultaneously avoiding basic public health and preventive measures. This point resonates deeply with me, as I think of the countless pills I passed along to attendees while

volunteering in camp dispensaries. The most frequently heard question as I did so was, "*Kasarī khāne ho*?" (How do I eat [take] this?).

Thirdly, the representation of Nepal here capitalizes on and perpetuates a discursive tension common in the Himalayas: that between beauty and poverty, between Shangri-la and Least Developed Country (LDC).[37] Nepal voluntourism writing has often conjured up the mythical Shangri-la (e.g., Holmuest 2002: 128; Jackson 2008; McKersie 2005: ix). And for enlightenment seekers, trekkers,[38] and medical experts alike, the country plays host to the imaginations of fans of James Hilton's 1933 novel, *Lost Horizon*, which tells of a utopian lamasery tucked in the furthest reaches of the Himalayas. The website of an NGO running health camps and medical volunteer programs in Humla offers this description of "Shangri-la and the Hidden Himalayas":

> The upper Karnali River zone in NW Nepal is one of the poorest in the world…. Little wonder that most NGOs gave up when faced with the challenge of even accessing this area, let alone providing support to the people that need it most.
>
> Tourism is one of the biggest industries in Nepal…But the vast majority will never travel beyond the honeypots of the Kathmandu Valley, Annapurna, Pokhara and the Everest Region. Few will take the challenge of traveling in this remote area, but if they would, they could be lucky enough to experience the mythical Shangri-la…believed to be hidden deep in the mountains around Humla, a place of peace, tranquility and

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[37] In development discourse, a LDC is a 'comically generic' representation of a country with all the right developmental deficiencies and mostly poor inhabitants (Ferguson 1994: 70). Indeed, Ferguson has noted how reports written on the developmental challenges of Lesotho "look as though they would work nearly as well with the word 'Nepal' systematically substituted for 'Lesotho.'" I am thankful to Jane Dyson for first bringing this Shangri-la/LDC discursive tension to light (personal communication, 2006).

[38] Currently underway are plans to create a Great Himalayan Trail—a trekking route that will ideally span the length of Nepal's Himalayas, from Ilam to Humla. At the time of writing, pilot training programs for teashop owners, porters, and guides, as well as discussion workshops at the DDC level, are underway in Humla. Posters to advertise the Karnali side of the trail have been printed with the following quote from Michael Wood of the BBC: "If there was a real Shangri-la, this place is its living descent." The 'undeniable conditioning influence' of travel writing indulging in the Shangri-la image (Des Chene 2007: 213) seems to be at work here.

> happiness, where all the inhabitants are enlightened, and the people live without war or famine.[39]

Yet, the actual circumstances of living in remote areas of Nepal can jar cruelly with those in Hilton's novel. But, then, voluntourism is only for a short time. I interviewed one medical volunteer shortly after her plan to stay in a village in Humla for three weeks with her eleven-year-old son ended early. "I only lasted four days…we were mobbed by filthy children, always touching us…everybody wanted medicine. There was diarrhea everywhere you walked." When I asked her if she planned to return, she said that she definitely did. "But only after I prepare," and then added after a moment of further reflection, "But how do you prepare for something like that?"

For some, these instances of drive-by medicine not only offer a wholesale vacation spot (Roberts 2006: 1491) and the opportunity to 'bulk up your CV'—as suggested to me on two separate occasions by volunteer doctors working with NGOs—they also provide opportunities for current and aspiring medical professionals to study and document afflictions that have largely been eradicated in richer countries. Niemczura describes how he could "barely contain [his] curiosity and eagerness" when he heard a young boy had arrived with whooping cough to the historical mission hospital where he was volunteering in Nepal:

> *Whooping Cough. Cool. I want to hear the 'whoop…'* In the US, you can go for an entire career and never hear the whoop. When you finally do, it

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[39] Beyond the embellishment used here to recruit would-be voluntourists, there is also a modicum of truth; but it needs qualification. Rather than Shangri-la being hidden deep in the mountains of Humla, it would be more accurate to suggest that some who live in the mountains of Humla, at times, had a deep belief in a Shangri-la, as Nancy Levine documents (1988: 259–262). In her study of polyandry among the Nyinba of Humla, she notes that, in 1967, the second most common reason given for emigrating out of a community that placed tremendous importance on heredity and social obligation was a search for a "hidden valley paradise." In 1980, this still ranked second, behind 'external marriage' and above 'search for a better life.' The underlying reasons for this utopian search are complex and tied to the dynamics of polyandry amid changing political and economic conditions. She notes the Nyinba belief that, during times of great hardship "such Shangrilas would open their doors to people with the foresight to find them" (sic). For the Nyinba and other Tibetan-speaking groups in the region at the time, a decline in trading profits in the district created economic difficulties that had not been present for generations.

> is like being in the wild and hearing the call of a rare species of endangered bird (2009: 14, emphasis in the original).

During a general health camp I attended in Humla in 2006, a woman presented with worms so large that they had perforated her stomach. Plans were made to fly her down to the nearest capable hospital the next morning after the money required for her care was quickly offered up by some of the foreign volunteer doctors.[40] Her family sobbed as her stretcher folded up into the rear of the plane, but not before one of the medical volunteers could snap a photo with the woman in front of its Yeti airlines logo. The anesthesiologist who attended to this woman returned home and published an article describing the experience (Roberts 2007: 5):

> Finer issues of clinical governance recede quickly in the rarefied air and a consideration of risk/benefit ratio overrides all others…Anaesthetizing a critically ill patient with septic shock provided several firsts for the region: the first use of inotropes; dopamine via a drip in drops per minute. Post-operatively the relatives thought this was the elixir of life and proceeded to open it up fully at every opportunity, providing an interesting set of blood pressure readings on the charts. On enquiring if any blood could be made available, 40 minutes later I was both surprised and delighted to receive a bag of type-specific blood, a first for Humla. This was not really the time or the place to question its origin so after checking its compatibility with the patient, she became the first recipient in the region of a blood transfusion. The laparotomy revealed a perforation of her small bowel from ascaris worm infestation which the surgeon had to pull from the perforation: not my most pleasant viewing experience in an operating theatre! …We left fatigued, dirty, yet euphoric in the knowledge we had at the least contributed to the philosophy of improving healthcare to the population of Humla region, Nepal. And memories to last a lifetime! Namaste!

This description fits the typical "aid cowboy" that James Pfeiffer (2003: 729) describes: "non-ideological specialists and professionals not

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[40] Many at the camp celebrated this altruistic gesture. However, for at least one camp attendee I spoke with, this was a visible sign of inequality, of the 'source-force' that the majority of Nepal villagers lacked: "We heard one woman was flown to Nepalganj by [an NGO]…that is, they covered the expenses too. This is good, but it is not equal. For us poor people who have no money for treatment, we expect the health camps to be free. We hope they will be free, but it should not be free for some and not for others. She will get care and after my wife's operation, where will we go?"

particularly interested in…political history, culture, the context of international aid, or philosophical concerns with 'development.'" In conceiving of contemporary "global health care chains" (Nichter 2008: 173), and as we speak of the "brain drain" that draws the educated strata of poorer societies away from public service into the private sectors, and often to other countries, we should also think on the ethics of economically advantaged clinical practitioners who participate in short-term interventions in resource-limited settings with differing levels of accountability. Not checking the origin of the blood—even for a moment to see if any information was available from her family waiting outside—is negligent at best in a part of the world where conflict, trade, business, and labor migration cause increased travel over the Indian and Tibetan borders, and where the trafficking of women remains a shamefully gendered evil on the rise alongside HIV/AIDS. As a result of the surgery—though clearly not the ultimate cause—this woman was flown down to a hospital to die far from her family, a terrible tragedy in Nepal.

It is worth considering whether this kind of medical intervention for someone who, as another volunteer doctor at the camp noted, "would have died under the best conditions in the UK," is indeed better than nothing? What kind of contribution is this to the "philosophy of improving health care"? Perhaps a closer look at this phrase is needed, as Carolyn Nordstrom (2009: 73) suggests: "Who is it that cares? What exactly do they care about?" I agree, here, with Wall *et al*. (2006: 560) who argue that, in these instances, "the tendency to put one's surgical ego first and the best interests of the patient second must be resisted at all costs."

When I returned the following year, I had a chance to ask one of the GHWs how the communities responded to the loss of this woman, along with two others in the district who died in the weeks following the camp. This is what she said:

> Looking at the two health camps, people have not benefited as much as they are supposed to. The view of the people is that at least a foreign doctor should stay…How can they leave? This kind of situation should not come. For example, I have done the dressing [for] a foreign doctor with my own hands for three or four months after she did a uterus operation at the camp. If [an NGO] conducts health camps it should manage at least one person to stay who knows about gynecology…or those who know about other parts of the body…The people come from such a far distance for foreign doctors to completely cure the disease and feel secure, not put their life on death. If people have to go to the nearest

> city for the treatment of infection, buy medicines themselves, or lose their life, what is the meaning of a health camp?

Bezruchka (2000: 77) has written on medical tourism as medical harm to the third world, cautioning us to consider what we know or don't know about health and its determinants at home before heading overseas. Are these seemingly humanitarian, often volunteer, medical interventions beneficial? "Can it be justified?" he argues.[41] To limit medical harm—which is, itself, a difficult concept to pin down—"the best motto is 'don't just do something, stand there' — unless it is obvious that doing something will help."[42] More than four decades ago, Ivan Illich suggested that, typically, "The damage which volunteers do willy-nilly is too high a price for the belated insight that they shouldn't have been volunteers in the first place (1968: 8). Instead, he urged them directly to "freely, consciously and humbly give up the legal right you have to impose your benevolence."

Lastly, I would be remiss in not mentioning the many medical volunteers I met who were sensitive and concerned about the issues discussed above; about how their presence helped to merge the imagery of Western biomedicine with well-being, while potentially effacing the complex nexus that links health care with health outcomes. Through passionate discussions, many challenged me, as well, and together we wrestled over 'the best ways to help.' I also met dedicated individuals whose outlook on the determinants of health, health care, global inequalities, and privilege were realigned by their volunteer experiences. This will likely contribute to making them, as one volunteer put it, "more critical and compassionate practitioners at home and abroad." And, still a few other comments stand out. "I can't help but wonder if I'm treating hunger pains here," one volunteer said to me. "I don't know how much they've eaten today, or yesterday. What will these pills do?" Another returned from a long day working in a rural clinic and reported, "How do I tell people that their chronic pain comes from a life of chronic work, which they can't stop because their livelihood depends on it? I just feel like I'm doing band-aid medicine." One *videśī* doctor working in

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41 See also Bennett (2008) and Mackinnon (2009).

42 This point runs counter to what is often proposed as the core tenant of international volunteer work. For example, the organization Meaningful Volunteer has espoused three steps in thinking about what constitutes "meaningful" work, the first of which says, "Do something! Anything!" Available at: http://www.meaningfulvolunteer.org/page.aspx?ID=8. Accessed on 05 March 2010.

Kathmandu told me that it had been suggested that he had "lost his way" when, after returning from a volunteer stint in Humla, he turned down the request to volunteer at a health camp just outside of the valley with another INGO.

> And there will be more offers from people doing other camps. I've seen and heard of at least five camps going on in October, of course, they don't do it any other time. You know, very experienced doctors coming over, trekking and doing health camps, which are becoming more and more popular. It's quite frightening actually, what people are doing. If you go back home and say, I did a health camp in Nepal, it looks great…But there's a general lack of understanding in the population of what it involves and what effect it has. It's better than nothing; that is what they're saying, and probably what I used to think, as well. That's why I ended up going in the first place, but you soon realize that it's not that way at all.

I also find these reflections instructive. They highlight the intricate relationship between food, labor, and health, which is often overlooked in purely curative frames. They also force us to disrupt the inappropriate binary of humanitarian help/harm—notions that are often incommensurable, unfixed, and embedded in different cultural or medical systems. And, they force us to broaden our conceptualization of the lived of experience of health, while also critically examining, and weighing, the limits and possibilities of our desire to 'do good.'

Dispensing (with) Health?
Rethinking Short-term Medical Intervention in *Nayã Nepāl*

Redfield (2005: 329) points out that humanitarian responses to human suffering cannot escape the historical conditions to which they respond. It is, then, crucial to examine the growth and use of health camps as prominent interventions during a particular historical context. In light of the decade-long conflict and the path of poverty and hunger it trampled, it is worth considering if running health camps in *Nayã Nepāl* is a continuation of plans organized in place of those aimed at meeting the long-overlooked basic material and nonmaterial needs of the Nepali people—ample, self-determined food sources, clean water, education, employment, dignity, and hope—which, when met, might create the conditions for people to take control of their own health. In the words of a Nepali teacher in Humla,

> If you ask me, education is the basis of health…How we are living way out here is very complex, very sad. The people who organize health camps do not understand…To make one healthy, it is necessary to take concern on eating and drinking, but where and how can we get nutritional food? And, if people are thirsty, and they think water is good for health, shouldn't this water also be clean? To me, the health camp is a distraction from these issues.

Health camps may simultaneously feed and increase unnecessary dependence on the magical attraction of medicines.[43] Unnecessary surgeries and overeager dispensing in the context of basic needs unmet represents what Paul Farmer (2003: 203) calls "medical futility"—the instances where medical care is painful or dangerous, expensive, and prolonged well beyond the point of efficacy. In the long run, camps might also cause more health-related problems when surgeries are conducted in unsterile rooms or without proper follow-up, diagnoses are made through translations, or painkillers, antidepressants, and antibiotics are given out haphazardly. The possible forms of antibiotic drug resistance should be a concern here. Vitamins, worm tablets, and ibuprofen—among the most readily given medications at health camps—can also cause gastrointestinal problems such as constipation or ulcers when taken with too little water and food (DeCamp 2007: 22; Roberts 2006: 149). Even Oral Rehydration Solution (ORS), meant to stave off death due to diarrhea, can be counterproductive when made with contaminated water, and ORS mixed with too little water can increase dehydration (Werner 2001: 22).

Still, in places where common ailments can kill, health camps do fill a need.[44] Small-scale, specialized camps—such as dental camps, cataract camps, uterine prolapse, even orthopedic camps—can undoubtedly transform lives. No one can oppose the judicious use of medicine to treat and save someone who is ill or suffering, as Fassin suggests (2009: 133). However, I take issue here with an over-emphasis on treatment; for example, conducting orthopedic surgical camps that offer no opportunity for post-operative physical therapy, dental camps that forgo educational components on oral hygiene and changing foodways, or prolapse camps that remove uteruses without offering locally appropriate psychosocial

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[43] Ian Harper, personal communication, January 2008. See also Harper (2003).

[44] And, of course, temporary medical camps in humanitarian or emergency crises are another issue, though not without their own sets of ethical and practical complications. See, for example, Fox (1995), Lee (2005, 2008), McKenzie (2005), Redfield (2005), and Rieff (2002).

services (cf. Wall *et al*. 2006: 562). Considering these related issues will also force us to think of health in an expanded sense, beyond purely medical domains. Calling these interventions *health* camps—where surgery and dispensing pills are the most prominent features—risks obscuring and depoliticizing the reasons people become ill in the first place, and what really causes health. In the language of critical medical anthropology, this is known as the medicalization of health—when medicine is used "in an attempt to solve the problems that should be addressed in other ways" (Whyte *et al*. 2003: 87–88), and when the conditions that foster poverty, scarcity, sickness, and suffering are stripped of their human origins. As Scheper Hughes (1992: 214) reminds us: "We cannot forget that whatever else illness is…it is also an act of refusal, an oblique form of protest, and therefore, it too, can contain the elements necessary for critique and liberation." However, "once safely medicated, the scream of protest is silenced, and the desperate message in the bottle is lost." So, what is the message?

One controversial but crucial lesson emerges from recent studies in industrialized nations, which indicate that population health is about more than just medical care and that, historically, mortality responses reflect varying traditions of social justice, community organization, and resource distribution (Bengtsson *et al*. 2004; Bezruchka 2006; Krieger 2007; Navarro 2002; Wilkinson 1996, 2005; Starfield 2000; Wilkinson and Pickett 2009). This point is particularly relevant in the context of new global health efforts. As the growing number of global health programs at universities and health centers incorporate international training and health care service opportunities (Crump and Sugarman 2008: 1456; Kanter 2008), there is a need for thoughtful, inter-disciplinary discussions about the ethics, shortcomings, and benefits of such programs, and how they land—often, quite literally—in complex terrains of situated knowledge, experience, and conflict.[45] I argue that the debate must center

[45] Several websites committed to having honest discussion about the ethics and impact of these overseas service projects have already been created. Typically, these are websites belonging to institutions located outside the US. See, for example, Good Intentions are Not Enough: (http://informationincontext.typepad.com/good_intentions_are_not_e/2009/07/guideline-1-for-volunteering-overseas.html); University of British Columbia's Ethics of International Engagement and Service-Learning Project (http://blogs.ubc.ca/ethicsofisl/about/); and University College London's "Hitchhiker's Guide to Global Health" (http://www.ucl.ac.uk/cihd/undergraduate/ssc).

on the program's potential contribution to local struggles for social justice, particularly those surrounding clean water, food, and education—some of the most important determinants of health. From the perspective of medical service delivery, DeCamp (2007: 23) and Green *et al*. (2009: 11–12) offer further questions worth thinking through: Has the community been involved in the planning of the program? Are care seekers and their families happy with the care provided, and why? Is it culturally appropriate? What does that mean, and to whom? Has the means for evaluating the long-term impacts of short-term medical intervention—on the communities, the coordinating organizations, and the national health system—been planned? Bezruchka (2000: 78), too, offers sound advice:

> If you must go, focus on one country or region; learn the local language; and learn about the local health problems, as well as the systems of traditional and introduced care. Respect local cultural norms. Do not further propagation of the US-centered, global monoculture. Consider your strengths and what you have to offer. Teach appropriate skills using the limited locally available resources, and sign up for the long haul, at least in spurts.

The formulation of ethical standards and best practices for short-term medical interventions and volunteer stints is also a necessary and promising area for future collaboration (Crump and Sugarman 2007: 1458; DeCamp 2007: 23; Suchdev *et al*. 2007). NGOs which facilitate health camps and volunteer programs can play an important role here, just as they have in creating NGO codes of conduct aimed at strengthening national health systems (e.g., Health Alliance International 2009). A publically accessible list of signatories to an 'International Medical Volunteer Code of Conduct' could contribute to building transparent partnerships between health ministries, funding institutions, and NGOs. It would also provide a reference for volunteers and those who plan service initiatives to work collaboratively with organizations that focus on long-term professional relationship building and training programs conducted in accordance with MoHP priorities (Pfeiffer 2003: 736). In the end, this may help build collaborative, mutually beneficial projects that support already existing infrastructure and public sector health workers.

On a national scale, Nepal's Social Welfare Council—which oversees the work of many NGOs—and the Nepal Medical Council—which registers international medical workers—should also coordinate with the MoHP to take the lead in these efforts. Those who run health camps and

medical volunteer programs, especially in the same regions, must coordinate more with one another. Otherwise, they risk duplicating or further fragmenting service delivery. These organizations must also be held more accountable to local health care institutions, particularly district level health offices. Global institutions such as the WHO—which recently reconfirmed its commitment to the idea of PHC at their Southeast Asia regional meeting in Nepal (see also WHO 2008) and established a Global Priorities for Patient Safety Research initiative to, in part, look at the "epidemiology of harm" (Bates 2009: 1242)—will also have key roles to play.

In September 2008, a Maoist-led government announced a keystone public sector program in *Nayā̃ Nepāl's* first federal budget that aimed to provide free health care services, including village-level scale up and free maternity services, to all Nepali people (Peterson 2008). The "New Nepal: Healthy Nepal" initiative was, at least at the level of thinking, a conscious effort to begin to repair damage done to the health care system during the conflict. Nepal's current implementation plan for the 2010-2015 Health Sector Programme continues to assert adherence to the principles enshrined in Alma Ata, which is hopeful.[46] However, the people of Nepal have yet to see the actualization of a government's rhetoric for affordable, accessible and improved essential health care services.

The implementation plan also lists 'increasing mobile health camps' as a working strategy for improving service access in remote areas, and notes the importance of context specific analysis of interventions for the poor and marginalized (NHSP 2010: 108). While the use of more interpretative and "inter-subjective" qualitative data is often rejected as non-generalizable—and therefore insufficient to inform policy (Harper 2006: 65; see also Justice 1986: 135)—evaluations of the impacts and appropriateness of short-term health care models would benefit from more nuanced understandings of the specific political economic

[46] The MoHP 2065/2066 (2008–2009: 6) Annual Report for the Mid-Western Regional Health Directorate notes that, in accordance with the "spirit and feelings" of the *Loktantra Āndolan*, the largest political agitation in Nepali history: "We express our strong commitment to the world wide recognition of 'health being the basic right of people.' Our special focus will be on people of economically and socially deprived groups, sex, tribes, communities and regions to guarantee the health of the overall Nepali people…Toward primary health care, the services will be provided according to the proclamation of the Alma Ata Declaration."

conditions in which they are conducted. The voices and experiences of those intended to benefit from these programs must also be brought to the planning table. We have much to learn from them.

The potential long-term impacts of short-term medical intervention merit further consideration and collaboration—by ethnographers and epidemiologists, by clinical and public health practitioners, by students, governments, NGOs, and medical voluntourists alike. We must rethink the appropriate guidelines and boundaries for the provision of short-term medical care to people living in conditions that do not promote health. They are the real "stakeholders"—those who have the most *at stake*—in global health and humanitarian projects. But, let the necessary plans to provide prudent medical care to populations in need not supplant concerted efforts to also make it less necessary.

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suffering and sickness, as well as the means for new life possibilities in what many are calling, as if to conjure, a New Nepal.

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