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East German medical aid to Nicaragua: the politics of solidarity between biomedicine and primary health care

Assistência médica da Alemanha Oriental à Nicarágua: a política de solidariedade entre a biomedicina e a atenção primária à saúde

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Abstract

Between 1979 and 1989 the government of the German Democratic Republic provided health assistance to Sandinista Nicaragua. After initial relief aid, the Sandinista embrace of a primary health care-based health system made East German health support difficult. The non-convertible currency, the repressive quality of the East German leadership, and the lack of experience with primary health care processes all limited its potential to provide support. After 1985, when implementation of this system stalled, East German health assistance was revitalized with the donation of the Hospital Carlos Marx. Providing medical services to three hundred thousand people, it combined elements of a strictly East German institution, using German personnel and equipment, with some integration into local systems.

Keywords: Hospital Carlos Marx; German Democratic Republic; Nicaragua; primary health care; Sandinistas.

Resumo

Entre 1979 e 1989, o governo da República Democrática Alemã (RDA) prestou assistência médica à Nicarágua sandinista. Após a ajuda emergencial inicial, os sandinistas adotaram um sistema de saúde baseado na atenção primária à saúde (APS), o que dificultou o apoio da RDA. A moeda não conversível, o caráter repressivo da liderança da RDA e a falta de experiência com os processos de APS limitaram o auxílio da RDA ao estabelecimento do novo sistema de saúde. Após 1985, com a paralisação do sistema, a assistência da RDA foi revitalizada com a doação do Hospital Carlos Marx. Prestando serviços a 300 mil pessoas, combinou pessoal e equipamento de uma instituição estritamente alemã-oriental com alguma integração com os sistemas locais.

Palavras-chave: Hospital Carlos Marx; República Democrática Alemã; Nicarágua; atenção primária à saúde; sandinistas.

In 2008, at an event celebrating the 29th anniversary of the Nicaraguan revolution, the president of Nicaragua, Daniel Ortega, awarded the “Orden Cultural Rubén Darío” to Margot Honecker, the widow of the head of the last East German government, Erich Honecker, in recognition of the support the German Democratic Republic (GDR) had given to Nicaragua during the 1980s. When reporting this event in 2008, the German weekly *Stern* listed military aid, secret service counselors, and a hospital as examples of this support, and derided the anniversary event as a “revolutionary retro-party” (Käufer, 20 July 2008). This account suggests an image of the hospital as part communist folklore and part instrument of repressive governance. This view stands in stark contrast to a narrative that connects the hospital to Sandinista efforts to improve the health situation of the Nicaraguan population for which they received widespread international recognition, including from the World Health Organization (WHO) (MacLeod, 1990, p.20). In view of these contrasting images, this “gigantic project of socialist solidarity” (Centeno-García, 2010, p.48) can serve as a tangible example of the multifaceted, often controversial nature of medical aid.

Between 1977 and 1989, the GDR government supplied assistance in the medical sector to Nicaragua, of which the Hospital Carlos Marx (HCM) was the most visible example. This cooperation had repercussions on several levels. Politically, it was subject to Cold War logic; in developmental terms, it formed part of North-South relations; and, in health terms, it tied into public health considerations of post-Alma-Ata debates. This combination of factors produced some paradoxical results: GDR authorities, who had built a wall through a city in order to keep its population from leaving the country, sent a sizable number of medical experts to a far-way country, whose population had rid itself of a repressive dictatorship through an armed uprising. GDR experts were ostensibly assisting in the establishment of a Socialist society as a counterweight to Western capitalism, while they met (and occasionally cooperated) with Western experts whose work resembled their own. Meanwhile, Sandinista authorities, who had vowed to bring decentralized health care to the countryside, supported the establishment of a large hospital in its capital city. There is something contradictory about East German medical aid to Nicaragua that calls for a closer look.

This paper is a first and necessarily incomplete attempt at a comprehensive study of the institutions and its historical contextualization. While it makes use of material neglected until now from the East German ministry of health, it could not use either Nicaraguan sources or those from the ministry of external affairs, which will not be available to the public for years. Until then, this paper is meant to contribute towards a better understanding of this widely forgotten episode at the crossroads of the Cold War and public health controversies, and their respective developmental conceptualizations. Specifically, it asks how various, partly contradictory influences played out to determine the evolution of different forms of aid. What were the factors that shaped this seemingly likely, yet frequently unlikely, joint health cooperation?

The political dimension

Politically, the Hospital Carlos Marx was the result of the Sandinista rise to power in 1979 through armed insurrection against the Somoza dictatorship. Opposition against the

Somoza clan responded to perceived social injustice, whose victims were impoverished rural workers, peasants, and an urban (semi-)proletariat, as well as an evolving middle class who found no possibility for political participation (Biederman, 1983). Literacy rate was a mere 50% (Donahue, 1986). Meanwhile, the Somoza family treated the country much like a personal fief, owning substantial holdings in agriculture, industry, and banking (Waddington, 1989, p.5).

The opposition guerrilla movement Frente Sandinista de Liberación Nacional (FSLN), formed in the 1960s by middle class students inspired by the Cuban revolution (Dore, Weeks, 1992, p.9-10), gained little support until an earthquake struck Managua in 1972, destroying 70% of all buildings, killing approximately ten thousand people and damaging numerous hospitals and medical centers (WHO, 23 Jan. 1973). Growing outrage when millions of relief dollars disappeared while Managua remained unreconstructed strengthened the Sandinista opposition (Espinosa Ferrando, 2003, p.24-45). The revolutionary war turned out brutal, leaving fifty thousand people dead and one hundred thousand injured out of a population of approximately three million, as well as massive destruction (Kruijt, 2011, p.56). On leaving, Somoza left a country with US\$3.5 million in the treasury and a foreign debt of US\$1.6 billion while the National Guard damaged or destroyed sewage plants, water pumps and water treatment installations, hospitals and clinics. In addition, the country lost approximately US\$700 million in capital flight and US\$200 million in lost cotton exports (Donahue, 1986, p.150).

Though not solidly Socialist, the new coalition government pursued a redistributive agenda in the sense that it promised redress to various groups who had been disadvantaged by the kleptocratic Somoza dictatorship (Dore, Weeks, 1992, p.23). Given the staunch support of a series of US governments for the Somoza regime, relations with the United States were inevitably tense, but for a short while the Sandinista government and the Carter administration engaged in cautious cooperation, against the vehement opposition of conservative Republicans in the United States Congress (Leogrande, 1996, p.330). On the other hand, given the urgent need for support and the uncertainties of the future relationship with the United States, it seemed prudent to forge a broad alliance of new economic, political and military partners, including the GDR.

Traditionally, the GDR had few connections to Latin America, where the US influence was strong. After 1959, Cuba offered a chance to forge closer relations with a country in the area, and GDR authorities sought to cultivate this connection by providing substantial aid. The results were partly disappointing: these contacts failed to induce further connections with Latin American countries, and they also took a rocky development when the Cuban government shifted allegiance between the USSR and China (Wentker, 2007, p.299-300; Krämer, 1995, p.1986-1987). Thus, the prospect of having a connection to another Central American country was welcome in East Berlin, but in a limited sort of way, and GDR support for the Sandinista government remained more modest than it had been for post-revolutionary Cuba (Wentker, 2007, p.473). Nevertheless, some form of assistance to the new Nicaraguan government was inevitable. After decades of rhetoric about the ills of Western imperialism and the need to assist those who stood up against it, withholding aid from Nicaragua, the textbook case of revolution against such imperialism, would have been difficult to justify.

Initial assistance was military: in September 1979, Nicaraguan Defense Minister Larios Mantiel traveled to several Eastern European countries to ask for military assistance in view of what he saw as a real risk of imminent US invasion. In response, the East German government began providing military equipment including medical supplies (Storkmann, 2014, p.58-59). Although this early health assistance had a military quality, it engaged the institutions responsible for health assistance in general. The GDR knew two forms of cooperation with other countries in the health field. One was cooperation for mutual benefit, usually an exchange of personnel, expertise, and material with other Socialist countries. Another was cooperation on the basis of “solidarity” with low-income countries that were unable to pay for services, drugs or equipment. Respective policy decisions were taken by the Political Bureau of the Central Committee of the Socialist Unity Party (Sozialistische Einheitspartei Deutschlands, SED), headed by the General Secretary of the SED Central Committee, a position held by Erich Honecker in the 1980s. The responsibility for individual projects rested with the Ministry for External Affairs and other ministries (Claus, Taake, 1991, p.146-147). In addition to ministerial finances, important funding came from the Solidarity Committee, first created as a temporary measure during the Korean War and established on a permanent basis in 1960. It was headed by leading personalities of the SED and other mass organizations, and drew funding mainly from “solidarity stamps” which working citizens were expected to buy. Between 1986 and 1989, it provided 45% of grant aid (Howell, 1994, p.313).

Nicaragua, struggling against the legacy of a US-supported dictatorship and, increasingly, against US-supported military attacks, clearly provided an unequivocal case for solidarity aid.

From a health policy perspective, however, circumstances were complicated: a comparatively rigid East German aid program had to work with a new administration that was experimenting with radically new health arrangements while simultaneously needing to address large-scale destruction.

The health dimension

In 1978, the conference of Alma-Ata gave high-profile international backing to a horizontal approach to public health, which promoted health as a means of socio-economic development and emphasized prevention, primary health care (PHC), and community participation in contrast to centralized and specialized medical treatment. Subsequently, doubts about the feasibility and desirability of such a policy, especially in the United States, weakened its social components and shifted programs towards a more technocratic approach of “selective primary health care” (Cueto, 2004). However, key ideas of the Alma-Ata process kept resonating in many countries, including in Nicaragua, where the wildly unequal health situation under the Somoza regime had formed one of the driving forces of the revolution.

Before 1979, the responsibility for public health services was divided between 23 separate organizations, effectively preventing a coordinated policy. The most important governmental health institution, the National Institute for Social Security, offered curative services specifically to urban “salaried employees.” Generally, 90% of medical services were directed at 10% of the population, and only 28% of Nicaraguans had access to organized health services at all. The health status of the population was unknown since governmental

health data were clearly meaningless. The WHO estimated infant mortality rates to be as high as 120 per thousand live births (Garfield, Williams, 1992, p.13; Espinosa Ferrando, 2003, p.33; Waddington, 1989, p.7-8). The civil war of 1978-1979 further damaged population health. Many health care facilities were targets of attacks by the National Guard or ran out of supplies, and the health system virtually collapsed (Garfield, Williams, 1992, p.17-18).

The revolution was sustained in large part by the promise for better lives for the underprivileged majority of Nicaraguan people, including and especially healthier lives. Clearly, health would form a major field of work when the FSLN assumed power, but different factions of the health community held different views on the situation. The community-based health workers largely supported the Sandinista movement and expected support for their work (Sanders, 1997). Medical doctors were ambivalent. Though many doctors disliked the Somoza dictatorship and supported the uprising, most expected the subsequent government to remove his regime but otherwise change little in the social system (Lemos, 2008, p.244). Within the Sandinista movement positions ranged from abolishing all private medicine, to a Chinese system of prioritizing rural health, or to a pluralistic system of diverse forms of health care services (Garfield, Williams, 1992, p.24). In practice, all concepts could inform policies only up to a point in the face of real-life exigencies.

As one of its first decisions, the new Sandinista government created a unified health system, the Sistema Nacional Unico de Salud, which established health as a focus of the upcoming governmental agenda and placed all policies under the control of the Ministry of Health (MINSA). Faced with an acute demand for emergency responses to the medical needs resulting from the civil war, initial efforts focused on the extensive (re-)construction of hospitals. This obvious need attracted international assistance, and the early construction of emergency hospitals received financial support especially from Sweden and West Germany (Waddington, 1989, p.9). Thus, early GDR health assistance effectively formed part of a larger international effort. Between October 1979 and May 1981, the Solidarity Committee provided 72 tons of relief aid, including 25 tons of medical drugs, vaccines, and dressing material. In addition, 110 patients, injured during the war, were treated in the GDR between 1979 and 1980 (Stobinski, 2008, p.64-65).

By 1980, MINSA had to realize that this program of hospital construction was unsustainable. It was absorbing the entire health budget, leaving nothing for rural and disadvantaged parts of the population for whom the revolution had ostensibly been fought. In a change of strategy and with the support of Unicef and WHO, MINSA shifted the focus of its work from medical care to primary health care (Waddington, 1989, p.11). Clearly inspired by the Alma-Ata process, the new plan listed as principles the right of every individual to health, a public responsibility for health care provisions, universal access to health services, integration of the physical, mental and social dimensions of health, and community participation in all activities of the health system (Donahue, 1986, p.151; Espinosa Ferrando, 2003, p.39-45). In this vein the Sandinista government organized several campaigns (*Jornadas populares de salud*, addressing polio, hygiene, dengue, and malaria), all involving the training of thousands of so-called “multipliers,” volunteer health workers who, in turn, trained tens of thousands of “health *brigadistas*” (Ulate, De Keizer, 1985). *Brigadistas* were people, often with little education, chosen by their community, who received one month of initial training

and continued support from organizers through regular follow-up meetings. Making use of visual material, songs, role-playing, and dancing, they distributed information about hygiene, vaccination, and healthy ways of living (Lemos, 2008).

The shift of strategy was not complete and not without controversy. For years, practices and institutional policies vacillated between a medical approach, which emphasized quality care and clinical settings and regarded *brigadistas* as temporary assistants, and a popular health model, very close to the PHC approach of Alma-Ata, which emphasized the dissemination of health knowledge, health in non-clinical settings, and perceived *brigadistas* as a permanent and growing sector of the health system (Donahue, 1986, p.152-155; Ulate, De Keizer, 1985, p.158, 170). The Sandinista government privileged the popular model, although it never fully backed community participation, reserving the right to decide on local needs (such as vaccination or sanitation) rather than leaving these issues to the communities themselves (Ugalde, 1998, p.48).

Within a few years, these various efforts created impressive results both in terms of medical care and health data. By 1985, the country counted a total of 32 hospitals and 456 further health facilities, including 107 health centers and 349 health posts with doctors and/or nurses (Espinosa Ferrando, 2003, p.48-49). Between 1979 and 1983, infant mortality declined by half, vaccination coverage increased to near 100%, polio was eradicated, the prevalence of other diseases was substantially reduced, and maternal literacy increased from thirty to over 90% (MacLeod, 1990, p.20).

German Democratic Republic health assistance to Nicaragua (1): 1981-1985

These improvements would not have been possible without international assistance, notably from Cuba. After 1979, more than 1,500 Cuban doctors worked in all parts of Nicaragua as practitioners, teachers, and researchers, and their contribution to medical development was substantial (Prevost, 1990, p.127). By contrast, though these health campaigns were easily in line with a revolutionary rhetoric that could have been picked up in all Socialist states, very little assistance came from the GDR. Although in line with Socialist rhetoric, in reality a health policy which emphasized the popular model was not easily compatible with GDR programs of health assistance.

To begin with, the East German currency was non-convertible, making the purchase of locally available products very difficult, if not actually impossible. Therefore, in opposition to PHC principles, which emphasized local goods and services, equipment for East German health assistance had to come from East German production. In addition, the PHC focus on decentralized services and the active engagement of local communities was at odds with the GDR system of policlinics, which were decentralized but organized in a clear top-down hierarchy, controlled by pertinent authorities (Harsch, 2012). The idea of independent community initiatives was well in line with Sandinista policies, whose revolutionary success depended on grassroots support, but hardly with those of the East German Social Unity Party in the GDR, which saw uncontrolled grassroots activism as a threat both to the government and to the political system. Besides, working in and with local communities was incompatible with the East German principle of restricting contact of aid personnel with local populations

in order to minimize the risk of defection. Finally, there simply had been no discussion of PHC in the GDR, so East German staff had little to offer either conceptually or practically for the development of this health care model. Relatively untouched by international discussions on public health strategies, especially in low-income countries, the GDR had continued its forms of health-related support for Southern countries with little change since the 1950s, offering the assignment of medical doctors for treatment and training, the donation of equipment and of entire clinics, and the treatment of patients in East German hospitals.

As a result, East German health assistance did not end, but it was diminished to uncoordinated bits and pieces. The GDR government delivered medical equipment worth 2.5 million marks in 1982, although not in solidarity but as part of a commercial deal. On October 12, 1983, the governments of Nicaragua and the GDR signed a standard treaty of cooperation in the health field, entailing the training of Nicaraguan doctors in the GDR as well as the free treatment of patients from Nicaragua for hundred weeks per year (*Stand der Beziehungen...*, Mar. 1989). Admittedly, hundred weeks was a lot compared to other countries, but it remained in the line of relief aid instead of contributing to the new PHC approach to health care. The *Freie Deutsche Jugend* (FDJ) came closer to an adapted form of assistance by financing medical studies at the University of Greifswald for a Nicaraguan student and by donating, in 1984, twenty small microscopes and two mobile health stations to the Sandinista health movement (FDJ, 14 July 1989, FDJ, Undated-a, FDJ, Undated-d, FDJ, Undated-c). Probably the most interesting episode involved an improvised shipment of glasses. The literacy campaign revealed that an unexpectedly large number of people were unable to read posters and papers because they suffered from impaired vision. In one of the few private initiatives of support allowed in the GDR, a journalist asked people to donate their used glasses (provided by the East German health system every two years). Within six weeks he collected more than 62 thousand pairs, which apparently impressed authorities so much as to allow him to take them to Nicaragua in 1981 where they were integrated into the ongoing literacy campaign (Links, 2008, p.107).

A change of policy some years later resulted from several developments which, collectively, weakened the popular approach. One problem was the opposition of many medical doctors in Nicaragua, many of whom resented their loss of status and income under the new system. Before 1979, it had been common for specialist doctors to be paid for full-time work at hospitals while spending a lot of their time in far more lucrative private practices. A lot of doctors found an end to this practice and work in low-prestige health centers to be demeaning (MacLeod, 1990, p.21). Thus, many emigrated, worked exclusively in the private sector, or adopted an attitude of passive resistance (Ulate, De Keizer, 1985, p.168; Ugalde, 1998). By the end of 1986, about half of all qualified doctors active in 1979 had left the country, and although the intense efforts to increase medical education resulted in a rise in the number of doctors from 1,349 (1980) to 2,095 (1990) (Espinosa Ferrando, 2003, p.63), this departure left a painful scarcity of experienced practitioners. Young doctors were often enthusiastic but had been hastily educated with outdated textbooks. Misdiagnosis was common and masked by copious prescription of drugs, which patients expected as the essence of treatment. Eventually, lacking solid training and often working in seriously underfinanced health centers without even rudimentary equipment, many disenchanted or poorly qualified doctors ignored PHC

concepts and used health centers as “recycling centres, referring people to hospitals whatever their complaint” (MacLeod, 1990, p.22). Similarly, patients often avoided health centers and turned to hospitals instead (Slater, 1989, p.648). As a result, hospitals gradually assumed the function meant for primary health centers, regaining status in the process (Garfield, Williams, 1992, p.91-96, 159).

Another development was the deteriorating political and economic situation in the country. In 1981, the Reagan administration began a determined policy of destabilizing Nicaragua through economic sanctions and an undeclared war. By May 1984, this violence had created over twenty thousand internal refugees and had absorbed US\$66 million in relief and relocation costs, adding to the socio-economic difficulties of the country (Donahue, 1986, p.155). The FSLN leadership had little economic expertise and faced a double burden of inherited economic weakness and new hostile pressures. Thus, a combination of ill-planned large development projects, large-scale capital flight, and growing costs of fighting the insurgency of US-backed group *Contras* soon led to a growing debt problem (Kruijt, 2011, p.60-65). Meanwhile, all economic activity was burdened by a crippling combination of US economic measures, including strong pressure on international banks to withhold credit from Nicaragua, a trade embargo, and highly destructive acts of sabotage against economic assets such as ports and oil storage facilities (Leogrande, 1996, p.331-342).

For the health field, *contra* warfare was particularly destructive since health facilities were once again prime targets as symbols of Sandinista policies. By 1990, six hundred health facilities had been closed, damaged, or destroyed, and the construction of 22 facilities had been given up. By December 1987, 48 health workers had been killed by *contras*, including 25 doctors and nine nurses, and many *brigadistas* were killed, wounded or kidnapped, and tortured. The import of drugs and medical equipment, though officially exempt from the US embargo, declined because they came from US companies that no longer traded with Nicaragua, or because Nicaraguan authorities did not have the money to pay for them. At the same time, fighting increased demands on the medical system. Between 1982 and 1988, officially 6,760 Nicaraguans were killed and more than ten thousand injured, of whom roughly 60% were civilians. Nearly 10% of hospital admissions between 1983 and 1986 were for war-related injuries (Garfield, Williams, 1992, p.68-79; Waddington, 1989, p.23-24). Thus, in Nicaragua, a combination of ill-functioning health centers, lack of access to drugs, and the destruction of existing health-care facilities increased the need for funded and equipped hospitals.

Meanwhile, in the GDR, assistance to countries of the South was on the rise, making the country the second most important donor of the Socialist Block after the USSR (Howell, 1994, p.307-308). This development reflected a situation in which the Soviet Union under Gorbachev pursued a subdued foreign policy, seeking an entente with the United States, while the East German policy line vacillated between loyalty to the Socialist Block, an interest in retaining good relations with West Germany, and a cautious degree of independence from the Soviet ideological line (Scholtzseck, 2003, p.36-42). In this context, Nicaragua gained importance for the GDR as a way of testing a certain degree of departure from the unloved new Soviet leadership. One avenue was, again, military aid, which increased until assistance to Nicaragua amounted to roughly 20% of all foreign military assistance. Once more, this

development entailed an increase in health support, since military aid included a modest but tangible amount of medical equipment worth 46,500 marks in 1987 and 82,300 in 1988 (Storkmann, 2014, p.66, 73). In addition, GDR authorities increased the number of patients treated for free in East German hospitals. In total, 360 Nicaraguan patients would receive medical treatment in the GDR until 1989 (Stobinski, 2008, p.64-65). These conditions formed the context for the East German donation of a large hospital to Nicaragua in 1985.

German Democratic Republic health assistance to Nicaragua (2): 1985-1989

While donating a hospital responded to the big political picture, choosing Managua as a location made local sense. For safety reasons, placing foreign projects in rural areas had been almost out of the question ever since a French and a West German physician had been killed by *contras* in 1983. Besides, it was becoming less necessary to go to the countryside to assist rural people. During the 1980s, three hundred thousand people fled from *contra* attacks, most to Managua and other urban areas, ending up in crowded, unhealthy housing, and placing an additional strain on already inadequate infrastructures (Garfield, Williams, 1992, p.75-82).

The original concept of the hospital seems ambiguous. A document of the East German Ministry of Health refers to a “makeshift hospital” (*Behelfskrankenhaus*) for three hundred thousand people (MfG, May 1985), suggesting a limited and temporary commitment but also, possibly, care at a low level of sophistication. But the preparations suggest longer-term planning. After local visits, an East German-Nicaraguan group decided on Xolotlán, a low-income quarter of Managua without sanitation where roughly three hundred thousand people did not have access to quality medical care (Meynard, 2008). Soon after, a “solidarity campaign” was started in the GDR, aimed at providing funding for the project through donations (Schaller, 2008, p.36-37; Hoppe, 2008, p.58-60). The transportation and construction evolved smoothly, and on the 23rd of July, 1985, a mere four months after the initial decision, the health post named Hospital Carlos Marx (HCM) was presented to President Daniel Ortega. At the time, it was modest enough, consisting of green army tents for the storage of material and containers for seeing patients, for surgery, and for sterilization, but operated by a friendship brigade of 49 people, including 16 medical doctors (MfG, 20 June 1989). Services were limited to outpatient care, gradually expanding to in-house care.

HCM services were an instant success. By early September, HCM was treating up to 350 outpatients per day (Abteilung Brigaden..., 3 Sept. 1986). If the idea had ever been to end this project after a brief period, this lively demand made such an option virtually impossible. After three months of the rainy season, both the tents and the stored material were damaged and it was obvious that a more long-term arrangement would be needed, including real buildings, provisions for laundry, water, electricity, and food (Schaller, 2008, p.36-42). In January 1986, the Politbureau of the Central Committee of the SED agreed to a second phase of the project. Between July and November 1986, the tents were replaced by 21 prefabricated buildings, increasing inpatient capacity from 66 to 210 beds. The buildings were complemented by a multi-functional hall that included a heating system, a pressure station, a laundry, and a kitchen including cooling containers. The complex received further equipment and installations such as electric infrastructure, a well, sanitary installations,

and further medical material (MfG, 20 June 1989; *Stand der Beziehungen...*, March 1989; *Abteilung Brigaden...*, 3 Sept. 1986).

The construction as well as the continued operation of the hospital involved continued shipments of massive amounts of medical drugs, syringes, towels, etc. It was a time-consuming and old-fashioned process. In addition, the staff suffered from stuffy air in prefabricated GDR buildings with double windows, while Nicaraguan workers as well as patients struggled with exotic East German door handles. In addition, East German devices – as with all European items – required fifty hertz electricity instead of the sixty hertz produced by Nicaraguan power plants, modeled after the US system. So the use of all electric equipment required employing cumbersome frequency changers or diesel generators (Zimmermann, May 1998; Killing, 1987, p.39). These generators, though expensive and grotesquely inefficient, made HCM independent from public utilities, so that it was unaffected by the interruptions of electricity and water that increasingly plagued Managua. Being the only hospital with its own electricity and water, it occasionally helped out other hospitals with washing (Schaller, 2008, p.43). Less easily solved was the constant need for imported medicine. Thus, 95% of medical drugs and all medical equipment were supplied by the GDR (Klemm, 6 Feb. 2010).

The character of an East German bubble was reinforced by the constant concern of East German authorities that their staff might not return from a stay in a foreign country. Consequently, East German experts were separated from their surroundings as much as possible. FDJ regulations explicitly prohibited personal contacts with people from capitalist countries, as well as Nicaraguans, beyond the absolutely inevitable minimum. GDR staff all lived in the same hotel, and they were collectively transported to and from the HCM in a bus. Traveling in the country and shopping in markets was discouraged. In the bi-national hospital, and with international volunteers among the patients, these restrictions were impossible to enforce completely. But officially, GDR staff had to ask permission for private meetings, even for banal activities such as a visit to the beach with a Nicaraguan colleague. Being more than a formality, such requests could actually be turned down (Barckhausen, 2008, p.159). When contact with Westerners did happen, especially with West Germans, it had to be reported, and private relations were effectively curbed when they became too close and too open (Zimmermann, 1998; Volks, 2008, p.79). Friendship, therefore, had to remain on a sterile political basis while the FDJ organized a steady stream of official events, such as “dialogues with comrades” from Central American countries, concerts, sports events, or festivities on Lenin’s birthday, obviously designed to keep brigade members politically in line (*Statistischer Bericht...*, 1988).

Nevertheless, HCM policies aimed at integration in the Nicaraguan health system. The HCM cooperated with local health centers and engaged in the education and training of doctors, especially of urgently needed specialist doctors for general medicine (Schaller, 2008, p.42). There were regular classes for auxiliary nurses, x-ray and laboratory assistants, and medical school graduates, as well as medical students in their sixth year of study. Depending on the target group, topics addressed a wide range of issues, including malaria, hygiene, drug therapy, pre-surgery preparation of patients, nutrition of infants and the psychological treatment of accident victims (HCM, 1987). In some improvisation, ophthalmological care was added to the range of services. The idea was born during a visit of the Nicaraguan minister

of health in the GDR where she saw a mobile ophthalmological unit and asked for one to serve rural areas. By the time it arrived, armed conflict with the *contras* had intensified to the point that it was no longer safe to travel around the countryside. Consequently, it remained on the premises of HCM as an additional hospital unit and provided free examinations and glasses to patients, many of whom seemed to have no other possibility of gaining help to improve their eyesight (Volks, 2008).

While this expertise was clearly helpful, relying exclusively on East German products came with serious disadvantages, as became clear in June 1989, when one month's worth of oxygen supply was used up for one patient in three days (Lobodasch, 8 Sept. 1989; Schaller, 18 June 1989). While Nicaragua received material to build local pharmaceutical capacities from the Netherlands, Argentina, Italy, or Spain (Garfield, Williams, 1989, p.157), lack of finances, political will or consideration stood in the way of such assistance in the GDR. Instead, the HCM staff opted for a more low-tech strategy to mitigate the constant scarcity of drugs. A beginning was made with planting a strip of aloe vera plants, which proved useful for treating wounds. Beyond that, none of the East German or the Nicaraguan medical staff was knowledgeable about suitable native plants, and in 1988, Medical Director Schaller, the East German pharmacist and head nurse of the wards and the polyclinic, discussed how to make more use of native herbs and plants in order to decrease their dependence on GDR drug supplies. Luckily, with the aid of some informed, anonymous international volunteer the pharmacy cultivated a growing quantity of medicinal plants (Schaller, 2008, p.40-41). Irrespective of whether this was clear to Schaller at the time, this initiative was perfectly in line with a Nicaraguan initiative. Encouraged by the Health Minister, a botanical pharmacy in Estelí had begun drawing up an inventory of herbal resources and medicinal plants, and planned their integration into regular health services (Garfield, Williams, 1989, p.160). Inadvertently, HCM was growing a little less strictly dependent on the GDR and gained a more local character than originally planned. Meanwhile, Nicaraguan staff increased from 65 in late 1985 to almost two hundred in late 1987, and Nicaraguan institutions like the FSLN and the trade union formed part of the HCM leadership.

In December 1987, the GDR Ministerial Council decided to finance the construction of three surgery halls and a delivery room (MfG, 20 June 1989; Stand der Beziehungen..., Mar. 1989). This third and last phase of the construction and operation proved extremely difficult, burdened not only by hurricane Gilbert, which caused substantial destruction in September 1988, but also by increasing tensions resulting from the ever deteriorating economic situation both in Nicaragua and in the GDR. For the first time, Schaller complained about the attitude of new Nicaraguan staff, who, he explained, found it difficult to adapt to the HCM style of leadership and patient-oriented work. Besides, the Nicaraguan side did not make even minimal material or financial contributions while entertaining what, Schaller felt, were increasingly exaggerated expectations of East German provisions. On the positive side, the adoption of counseling for mothers and pregnant women as well as obstetric care completed the HCM profile as a hospital of basic health care. It also increasingly integrated into the local primary care system. The district had approximately twenty thousand births per year. In order to effectively reduce maternal and infant mortality, Schaller felt it was important to filter out those five to six thousand births that were medically or socially complicated and which

HCM could handle by providing them with at least two days of care. Therefore, HCM began instituting a system whereby HCM residents acted as a local *médico integral* or *barrio doctor* of first call in local health care centers (Schaller, 3 July 1989).

The *médico integral* was a new initiative of the Sandinista health planners, which responded to the perceived preponderance of specialist and hospital-based doctors. A three-year program aimed at producing doctors with broad skills who could manage municipal and regional hospitals as well as in larger health centers and isolated rural facilities. It borrowed heavily from Western family practice concepts (Slater, 1989, p.650). Ironically, by embracing this new Nicaraguan program, the HCM contributed to the establishment of a system which health planners in the GDR had tried hard to eradicate. In addition to providing counseling for expectant and nursing mothers while filtering the cases in need of hospital care, this system should prepare HCM residents for their future work in the *barrios*: health education, the organization of health programs, and cooperation with local state and party bodies. Schaller (3 July 1989) also hoped to gain reliable demographic and morbidity data in the process.

These medical programs came with clear political repercussions. Schaller proudly pointed out the systemic significance of HCM as a demonstration institution for effective coordination of state and community care, while official Nicaraguan plans for a system geared towards reducing infant and child mortality rates and community health education risked fading into dead letter (Schaller, 3 July 1989). Thus, Schaller effectively reconstructed the function of HCM from an institution of medical relief for an underserved population to one of systemic development. He had a point. As normal economic and financial structures broke down, the well-being of the population depended increasingly on the free public services they received, including and particularly health services. By 1988, the effects of the war are estimated to have amounted to US\$17.8 billion. Until 1989, a total of approximately sixty thousand people died, almost evenly distributed between Sandinistas and *contras*. By 1990, Nicaragua was a seriously poor country suffering large-scale destruction and hyper-inflation (Kruijt, 2011, p.73-76). Thus, HCM gained a political and social importance that went well beyond that of regular hospital institutions. It formed part of the few remaining pillars maintaining a minimal standard of living for people in Managua and it helped bolster the legitimacy of the existing Sandinista government.

But HCM was expected to bolster East German legitimacy, too. In his report to his superiors in Berlin, Schaller effortlessly mixed medical and humanitarian motivations with political ambitions. The purpose of this hospital, he stated, was to document GDR solidarity with Nicaragua through tangible medical aid; to assist Nicaraguan development by integrating HCM into the Nicaraguan public health system, one of the perceived cornerstones of the Sandinista revolution; and to strengthen the connections between Nicaragua and the GDR and the idea of international solidarity within the GDR. In addition, HCM supposedly displayed GDR medical equipment with an export potential. This commercial interest may explain the remarkable political flexibility when HCM staff foresaw (realistically, as it turned out) the possibility that the Sandinistas might lose the 1990 election. Putting *realpolitik* above ideological loyalty, after consultation with the GDR embassy the HCM leadership decided to offer medical care to members of parliament, including those of the opposition parties (Schaller, 3 July 1989). By portraying HCM both as a beacon of Sandinista-GDR

solidarity and as a potential entry to relations with a post-Sandinista government, Schaller's report must stand as an extraordinary document of political flexibility and loyalty, above all, to HCM as a health institution. Apparently, his arguments fell on fertile ground. In March 1989, representatives of the East German Ministry of Health visited the hospital and planned increasing long-term support by assigning an additional gynecologist and translator as well as further material (Funke, undated).

But the GDR was crumbling, making such sustained support increasingly unlikely. Crisis erupted when a growing crowd of people participated in weekly demonstrations, calling for free elections, freedom of speech and movement, and – eventually – for a reunification of Germany (Weber, 1999, p.345-261). In Nicaragua change was also in the air. In September 1989, though Schaller's successor Kurt Lobodasch expressed disgust for people who, back home, demonstrated "egotism, lack of trust in our Socialist Fatherland, and political blindness," he regarded local challenges as even more acute: in view of the ongoing election campaign and the rising Western influence, including the West German involvement in the construction of hospitals in San Carlos and Granada, the Nicaraguan Ministry of Health proposed expanding the HCM capacity using Nicaraguan funds and personnel in order to highlight the Sandinista achievements in public health (Zentralrat der FDJ, 17 Oct. 1989). Soon, however, this scheme was overtaken by events. On November 9, 1989, the passage through the Berlin wall was opened and within weeks the GDR collapsed. Some months later, in February 1990 the FSLN unexpectedly lost the election, the result of widespread fatigue among voters in the face of continuing warfare and a desperate economic situation (Krujtit, 2011, p.77).

Epilogue

The dissolution of both the GDR and a Sandinista Nicaragua withdrew the political justification from HCM, and for a while it looked as though the institution itself would fade away. In the end the HCM survived by becoming Nicaraguan. Nicaraguan staff was trained quickly and a new administrative framework was found. In 1990, Medico International, a West German NGO committed to long-term development projects in the health field, wrote a devastating evaluation of HCM. Noting high operation costs and insufficient integration into the domestic Nicaraguan health system, it counseled against West German agencies assuming those expenses and responsibilities. The verdict infuriated former HCM staff in Berlin, who formed a pressure group and tried to generate some influence to keep the hospital in operation (Funke, 2008).

The different evaluations clearly stemmed from different approaches and different expectations of what a health facility should achieve. Based on simple treatment data, the outcome looked good. The HCM had provided services to a community of low-income inhabitants of Managua who had not had access to qualified medical care before, and its services were eagerly sought. Between August 1985 and October 1989, HCM treated 394,449 patients in out-patient services, an average of approximately 255 patients per day. It also provided 7,321 pairs of glasses, administered 43,410 x-rays, 116,889 laboratory results, and 951,202 portions of drugs. It treated 13,014 in-patients, conducted 10,036 surgical operations

and (from July 1989 onwards) attended 239 births (Zentralrat..., 17 Oct. 1989). All treatment was free of charge. At the same time, it trained 92 medical graduates and 189 medical auxiliary staff (Meynard, 2008, p.190). However, the disadvantages of HCM also became clear, and within the larger picture of public health in Nicaragua the verdict was less clear. Though Nicaraguan authorities tried to restrict their contributions as far as possible, for years HCM was a heavy financial burden, apparently absorbing a substantial part of investment funds of the Nicaraguan health system (Schaller, 3 July 1989, p.14).

Eventually, HCM was integrated into the Nicaraguan health system, supported, for a while, by the West German governmental Society for Technical Cooperation (Meynard, 2008, p.189-191). In 1993, it was renamed Hospital Alemán Nicaragüense, and in 1998, it was completely taken over by the Nicaraguan Ministry of Health (Klemm, 6 Feb. 2010).

Final considerations

In conclusion, it is possible to see that the award Margot Honnecker received from Daniel Ortega in 2008 hides a complicated story of affinity, reservations, and improvisation. Politically, in the context of the Cold War, the perceived Socialist character of the Sandinista government and its tense relation to the United States exacted solidarity from other Socialist countries, including the GDR. The easiest form of direct assistance involved military aid, including its medical component, which answered an immediate need for defense support and emergency care, while assistance could be supplied with East German material and personnel. This strategy, however, was not easily applicable within a North-South context of long-term developmental assistance or in a context of PHC-based health policies, both of which emphasized the use of local material and people. For several reasons, the GDR was not well prepared for this type of cooperation, including the lack of a convertible currency, a general policy of minimizing the contact of GDR personnel with the local population, and a lack of familiarity with PHC in East German health circles. As a result, for some years health cooperation between the GDR and Nicaragua remained limited, belying an official image of close partnership. It was only when *Contra* warfare and domestic opposition weakened the Sandinista focus on long-term planning and on a popular health model that East German health assistance was revitalized. By 1985, a large-scale hospital was in line both with Nicaraguan needs and East German possibilities.

Though it was only begun halfway through the period of the Sandinista government, the HCM came to epitomize East German health assistance to Nicaragua. Depending on perspective, it can be regarded as a symbol of a weakening Nicaraguan revolution in that it represented a biomedical approach, which contradicted Sandinista developmental strategies. At the same time, in as much as the HCM answered to requests by Sandinista authorities, it also supported Sandinista governmentality and, implicitly, its focus on population health. This was particularly true towards the end of the Sandinista government, when HCM provided an important source of health services which the government was increasingly unable to supply. Similarly ambivalent, HCM can be regarded as an example of a repressive German dictatorship, which did not trust its own citizens, or as an example of East German

solidarity which supplied free assistance to people who had no other access to health care. Finally, while the shift of the Nicaraguan health system from a popular to a more medical approach, which emphasized treatment over prevention and collective work, formed the precondition for the establishment of the HCM, local circumstances and scarce funds both in Nicaragua and in the GDR led HCM personnel to embrace elements of PHC and to integrate to some extent into a horizontal health system.

The result was ambivalent for all of the actors involved, and was not without some ironies. Thus, US efforts to roll back all the Socialist influence, especially in its Central American “back yard”, inadvertently increased it in this particular field. It was to a large extent the impact of US-backed *Contra* warfare which increased the need for hospital care in Managua, thereby creating the conditions for a large and very visible East German health aid project to Nicaragua. For the GDR, the assignment of East German experts was an investment in the international alignment of the country and in its profile as a supporter of victims of imperialist aggression. Thus, the project was designed to – and probably did – strengthen the reputation of the GDR and its leadership, albeit at a high price. The extreme control over East German experts, restricting their every move and keeping them separated from the people they were supposedly helping in solidarity demonstrated how much this profile was in danger of being exposed as a façade. The high costs of the project also contributed to the economic difficulties which, finally, caused the disintegration of the GDR. For Nicaragua, the project helped bolster the claim of the Sandinista government to provide health care for its citizens, including and especially the lower classes, but at the price of disproportionately relying on individual hospitals like the HCM, which could only serve the minority of the urban population, who already had privileged access to health care before the revolution. Thus, ironically, defending the Sandinista government came at the price of giving up part of what this government had come to power for, while this shift away from Sandinista principles enabled the GDR to provide medical support, ostensibly defending the Sandinista revolution.

In the end, there were few winners in this project. Neither the HCM nor East German health aid to Nicaragua in general prevented the downfall of both the Sandinista government and the GDR. The Reagan administration succeeded in ending Sandinista rule and its project of a popular system of healthcare, but 25 years later, the policy of *Contra* warfare is widely condemned, Nicaragua has, once again, a Sandinista head of government, and the principle of publicly organized universal health coverage has become the global gold standard, acknowledged even by the 1990s proponents of a health care based on a strong private sector and a user fees (Jamison, Summers, 2013).

In a sense, the political and ideological underpinnings which determined events surrounding the HCM faded, but the hospital remained. Regardless of surrounding contingencies, the hospital treated patients and continues to do so, surviving the ups and downs of all humanitarian, political, economic and military hopes and fears. Though it is largely forgotten today – or remembered for misleading reasons – the HCM established a sustained service of medical therapy, testifying to the degree to which, irrespective of the eminently political character of health policies, medical therapy is universally coveted.

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