International Practicum

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Learning Goals

The IP was an excellent learning experience in which all of my goals were met and even enhanced beyond my expectations. At the many clinical sites in Honduras I was able to directly apply nursing theory and my previous education to the patients. I was able to effectively obtain history, perform a physical assessment, diagnosis appropriately and create a plan of care for the patient and his or her family. In regards to this goal, I learned the most about applying these skills to a different culture. I gained experience in using the culture as a background for history taking, diagnosis and management, which helped in communicating and treating patients in the context of their lives rather than in the context of what I have seen in previous clinical settings. This leads to culturally sensitive and appropriate care that enhances their willingness to be partners in their health and respect of the interaction between the health care worker and the patient and family.

My trip to Honduras with the College of Nursing also increased my clinical and community assessment skills in a global health setting and underserved area. This goal was important to me as I would like to work in these settings in the future. I was able to talk in depth with the group leaders and staff members about the development of the program over the years, including changes that have occurred as a direct result of community assessment. For example, this year we implemented a well-baby clinic in two villages for the first time in the trip's history. This was after a pediatric nurse practitioner on the trip noticed that care for babies was rare and inconsistent. She also noticed that because these infants were often healthy they would not be seen at the health clinics. Instead, the tickets were used for the parents or other children rather than for the care of the infant. Furthermore, the illnesses within these villages were well managed, and the people were healthier as a consequence of having their critical needs met. At

this point, as seen in Maslow's hierarchy of needs, primary care and health education to improve lives could be addressed. Therefore, a well-baby primary care clinic was instituted to promote this issue and meet the next step of needs for these patients. Also, as I walked through the villages and talked to various patients, I was able to gather information about living conditions, lifestyle and access to resources that created a framework for my assessment of the community and helped to effectively attend to the patients' needs and treat them. Without incorporating these skills, I do not believe I would have been a successful health care provider.

My goal of enhancing my cultural competence and communication skills in order to provide appropriate, quality health care was also met. As stated in the previous two paragraphs, approaching the patient in a holistic manner and partaking in community assessment activities, helped me to better understand the context of the patient's lives. They taught me about traditions and cultural practices that affect their lives and health conditions, such as keeping the "evil eye" away from an infant by distracting it with a bracelet. I learned about daily activities, their meaning of quality life and the family unit. I also grew in knowledge of their language. All of these characteristics combined to deepen my understanding of cultural competence and health care in the context of another culture. As the week continued and my learning expanded, my questions and education became increasingly directed towards my patient's culture rather than my own. I believe this is an important dynamic of culturally appropriate care, and I am very appreciative for the experience as a foundation for future work with people of different backgrounds.

I believe collaboration between health care professionals is extremely important; however, in my clinical settings thus far in the United States, I have not had many opportunities to partake in such an activity. In Honduras, I was able to work alongside family and women's

health nurse practitioner students, certified family and pediatric nurse practitioners, doctors and pharmacists. We taught and learned from one another, shared encounters, helped each other communicate, and worked well together to provide health care to those in need. I really appreciated being able to talk through diagnoses and treatment plans with my peers and ask questions of those with so much experience, which I believe helped to provide the best care to my patients. Furthermore, rarely is one able to work so closely with a pharmacist. This trip gave me the unique opportunity to ask questions and learn about medications that I otherwise would not know as in depth. This solidified the usefulness of collaboration between health care professionals and gave me a foundation for future interactions.

Finally, through this trip to Honduras, I was able grow in knowledge and comfort of working in a global health setting. Although I have taken numerous classes in the Global Health specialization, I had yet to travel outside of the United States in a health care capacity. This experience, however, gave me that opportunity. At first, I was unsure of what to expect. My comfort level was minimal, yet over the course of the week and after many interactions with the people of Honduras, my comfort in communication and ability to care for this population grew. Although new experiences will bring their own challenges, this trip gave me a foundation for future work in global health.

Infant Care in a Developing Country

While in Honduras, one of the areas of concern I observed was infant care. While at the clinics, often primary infant care was by-passed for the care of the adults or other children. Furthermore, the infants had often never been seen by a health care provider. A pediatric nurse practitioner who had previously attended the trip recognized this practice and developed plans to implement a well-baby clinic during this visit. While executing and managing the clinic, I saw

this pattern, as well. Mothers had been rarely assured of their infant's health or normal growth and also had numerous questions. Consequently, I will be addressing the issue of primary infant care in a developing country. Pertinent aspects of such a topic include growth maintenance and nutrition, health care access, immunizations, and newborn screening.

Breastfeeding is the main source of nutrition for infants in developing countries. With few resources, especially financial, in developing countries formula is not easily available or affordable for families to provide for their newborns and infants. Rarely are growth parameters measured for these infants. Doing these measurements is foundation to assessing the health of the developing infant. Whitehead and Paul (1984) found that while mothers greatly appreciated knowledge about their baby's growth, they became concerned at the three to fourth month deceleration of growth of their breastfed infant. Although this is a natural occurrence, the western growth charts applied to these infants caused the alarm. Whitehead and Paul (1984) then suggest that new growth charts should be developed and initiated that better reflect the normal growth of the breastfed infant in these areas.

Along the barriers to nutrition, financial limitations lead to poor health care for infants in these countries. Dutta (2008), however, believes a home-based newborn care approach is one possible solution to this problem. This concept would be aimed at improving knowledge of basic health care within homes for newborns, such as safety precautions, warning signs of a deteriorating infant, hygiene, and nutrition (Dutta, 2008). Dutta (2008) explains that the aim of this intervention is to also encourage and empower communities in the health of their population. Furthermore, the author found that the program has a positive influence on the care of neonates and mothers in the villages, with reduction of morbidity and mortality in these two groups (Dutta, 2008). Finally, while this program is meant to include mothers and birth processes, this

could potentially be expanded to include further education of infant growth and behaviors over the first year of life, hopefully improving the health of this age group and the skills and confidence of community members.

Vaccination in infants is another difficult accomplishment in developing countries but is significant regarding the health and safety of this population. Again, limited access to care and financial resources reduces vaccination rates in these areas. According to Sinno, Shoaib, Musharrafieh and Hamadeh (2009), overall compliance to vaccinations in children at the American University of Bierut Medical Center was 49.9%, leaving half the children under-vaccinated. This is less than the World Health Organizations goal of vaccinating children to maintain health standards. The authors found higher education levels in parents and the presence of a consistent provider were positively correlated with compliant vaccination records (Sinno, Shoaib, Musharrafieh & Hamadeh, 2009). Consequently, the authors suggest an emphasis on immunization education and program implementation in the area (Sinno, Shoaib, Musharrafieh & Hamadeh, 2009). In their work, Loevinsohn and Loevinsohn (1987) found that mass vaccination campaigns using volunteers had a higher vaccination success rate in children, showing a rate of 77.1% in those under age six. The authors also showed an increase in well-child clinic participation with the incentive of a small portion of food, increasing the rate of participation to 94.1%, which suggests a potential positive intervention in vaccination rates (Loevinsohn & Loevinsohn, 1987). Loevinsohn and Loevinsohn (1987) suggest that providing the incentive of food could increase infant and child immunization rates through increased attendance in well-child clinics. This, therefore, could increase care as well as protection from harmful diseases through vaccinations.

Another aspect of infant care is screening. Screening practices in a developing country, along with general health care, are rare. In their pilot study, Tanon-Anoh, Sanogo-Gone and Kouassi (2010) found that hearing screening in newborns in Cote d'Ivoire is a useful and necessary practice. Within this developing country they found hearing impairments in 6 per 1000 (Tanon-Anoh, Sanogo-Gone & Kouassi, 2010). Furthermore, they believed the implementation of such a practice to be beneficial and efficient in primary health care centers and neonatal centers (Tanon-Anoh, Sanogo-Gone & Kouassi, 2010). However, this does not allow for the access to these interventions for patients with limited resources, such as those in remote villages, and consequently, though the study was an important one showing the significance of infant screenings in developing countries, the more vital aspect is how to reach those with less opportunities to health care so that they can take advantage of these resources.

Dutta, A. (2008). Home-based newborn care: How effective and feasible? *Indian Pediatrics, 46,* 835-840.

Loevinsohn, B. & Loevinsohn, M. (1987). Well child clinics and mass vaccination campaigns: An evaluation of strategies for improving the coverage of primary health care in a developing country. *American Journal of Public Health, 77*, 1407-1411.

Sinno, D., Shoaib, H., Musharrafieh, U. & Hamadeh, G. (2009). Prevalence and predictors of immunization in a health insurance plan in a developing country. *Pediatrics International*, *51*, 520-525.

Tanon-Anoh, M. Sanogo-Gone, D. & Kouassi, K. (2010). Newborn hearing screening in a developing country: Results of a pilot study in Abidjan, Cote d'Ivoire. *International Journal of Pediatric Otorhinolaryngology, 74*(2), 188-191.

Whitehead, R. & Paul, A. (1984). Growth charts and the assessment of infant feeding practices in the western world and in developing countries. *Early Human Development, 9*(3), 187-207.

International Practicum Experience

While in Honduras, I was able to fulfill a variety of responsibilities, including manual labor, direct patient care, well-baby clinic implementation, and relationship building. Daily, I helped carry and set-up equipment and supplies in the various clinical sites, ranging from trash dumps to remote village health centers around Choluteca to a well-maintained school in Tegucigalpa. At these clinical sites, I was responsible for direct patient care. This included obtaining patient history and physical assessments, diagnosing, developing treatment plans, and providing appropriate education to patients and their families. Because my specialty is pediatrics, my focus was on those of eighteen years of age and younger. Therefore, along with my colleague, I was largely responsible for the care of children. While at times only one patient was presented for care, at other times there were up to five children to address. Furthermore, I had to maintain a persistent flow of patient care in order to allow as many patients as possible to be seen on any particular day. At the end of each clinic day, I helped clean the site and transport materials back to a secure location.

At two sites, I was responsible for implementing and managing a well-baby clinic. With the help of another pediatric nurse practitioner (PNP) student and two certified PNP's, I set-up an area for mothers to bring their healthy infants. At this clinic, I asked appropriate history and development questions, provided education and anticipatory guidance to the mothers regarding their infants growth and safety issues, such as keeping the child away from a fire and choking hazards, and performed a full physical assessment, looking for normal and abnormal parameters

such as infant reflexes, testicular descension in males and hip placement. While at the clinic, I also worked alongside family nurse practitioners students. I was, then, able to guide them in effective infant assessment skill strategies.

Beyond direct patient care, developing a relationship with my patients, the local workers and citizens was an important part of my time in Honduras. Establishing a line of communication, though difficult, was necessary when working in Honduras. Because my knowledge of Spanish was limited, I made an effort throughout the week to expand my understanding of the language, and by the end of the week, I was able to take a basic history independently. Also, I was intentional about maintaining an open and welcoming approach in order to develop a positive rapport with those in which I came in contact.

My experience in Honduras was a very positive one. I provided health care at six different clinical sites, and the diversity of the sites helped to provide a realistic view of the condition of those living in Honduras and their various needs. I greatly appreciated traveling to the different areas in order to treat and educate as many people as possible in the allotted time. I believe I was prepared for the trip by the orientation sessions and educational materials, and my expectations were very appropriate. The trip was very well organized, and I felt safe at all times. I also felt well-supported by the faculty and staff members that accompanied the trip, as well as the missionaries, translators, and staff within Honduras that helped make the trip a successful one. The travelling and sleeping accommodations were also very convenient and suitable for the circumstances. Though hot or clean water was not available through the facilities, I was prepared to meet such conditions upon arrival. Drinking water was available in a faculty member's room and traveled with us to the clinical sites so that we remained hydrated. Three meals a day were provided, also, which were authentic and fulfilling. Finally, there was time allotted for site

seeing, which though not excessive was appreciated by those who had not been to the country previously.

Negative aspects of the trip were very few. The language barrier was the largest obstacle to care and interaction with patients. The difference in language as well as culture made communication very difficult. Although translators were present, there were few available at any one time. Also, I was limited in my understanding of activities of daily livings, nutrition and eating habits, and religious and cultural beliefs and values that affect health care. Therefore, having a better understanding of these things would be beneficial to quality patient care.

The most exciting and unique aspects of the trip came during direct interactions with the patient. The kindness that exuded from the patients and their families was unlike that I have seen in the United States. They are extremely genuine in their gratitude in the services I provided and the assurance of health when appropriate. The most interesting case I saw was an 8 month old infant with neurofibromatosis. This rare disease manifested as café-au-lait spots on the abdomen, upper left extremity and bilateral lower extremities and a neurofibroma that consumed the upper right extremity. We talked to the mother and instructed her about signs of deterioration, seizures, and perfusion, especially to the right upper limb. One of the most fulfilling interactions was with a young boy with scabies and a super infection on top of the bites bilaterally on this feet. He did not want to wear shoes because they increased pain in his feet. I wrapped his feet with gauze and antibiotic ointment and provided the mother with additional materials to care for her son. We instructed her that when the infection was healed, she should begin treatment for the scabies. After I was done with his treatment, the young boy could walk on his feet again without pain. Taking care of this patient was one of the most fulfilling experiences I have had as a health care

provider. Throughout the trip, I also greatly enjoyed working alongside my colleagues and learning about a new culture.

Overall, my experience in Honduras was an extremely important one in my career as a future provider. I learned to implement cultural competence, collaborate with colleagues and other health care professionals, and had the opportunity to enhance my assessment, diagnosis and management skills. Advice to future participants in the trip includes attending the orientation sessions, obtaining a basic understanding of the Spanish language, and staying in groups when walking around the area. The trip leaders did an excellent job of preparing us for the trip and for emphasizing the importance of staying in a group. While in Honduras, one of the reasons I believe that I always felt safe was my obedience to this rule. Paying attention to the guidance of the group leaders and the missionaries made the trip, and I advice anyone attending such a trip to do the same.

Visual Story

Preparing the luggage when arriving in Tegucigalpa

At the World Gospel Mission House in Honduras

AFE (above) – the school outside the garbage dump (Right) in Tegucigalpa; First clinic site

Waiting for patients in AFE

Patients waiting to be seen at AFE

The PNPs (students and staff) after clinic (above)
Well-baby clinic at Choluteca dump (below)

Kids waiting at the Choluteca Dump –
Second Clinic

Weighing the baby at the clinic

Patients waiting to be seen at the Choluteca Dump

Skills school in Choluteca run by the Overholtz's (above); Health Fair (below)

Teaching CPR at the Health Fair

Treating an infant in 7 de Mayo – Third Clinic

Creating a spacer for the child's asthma

Teaching the lay health workers at 7 de Mayo

The pharmacy at 7 de Mayo

Cows at 7 de Mayo (below)

Around 7 de Mayo (below)

At Sans Colorado – Fifth Clinic

Patients waiting to be seen in Sans Colorado

Sans Colorado

Shower at the hotel in Choluteca (below)

Table for meals two times a day

Hotel room in Choluteca (below)

A local hammock shop in Honduras

Rotating luggage/equipment

Tegucigalpa
Girls' dorm in mountain reserve above Tegucigalpa (below)

Fruit stand in Tegucigalpa

Maria and Angie Overholtz and Mario our driver

All the staff together

School in Tegucigalpa – last clinic