Honduras

Julia Borghi
University of Pennsylvania
Honduras
Experiences Abroad

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I spent the summer at a hospital in a village in Honduras, learning firsthand how trust building and relationships between nurses and community members are necessary for effective health promotion and positive patient outcomes. I worked with an American women’s health nurse practitioner and two registered nurses to provide prenatal care at village clinics in the mountains and surrounding areas, routine gynecological care in the hospital and rural clinics, and home visits to families who have a child with a disability. Honduras is one of the poorest countries in the Western Hemisphere, and while there are public hospitals in the cities and small health clinics in rural areas, from what I observed these clinic facilities are understaffed and provide little more than immunizations, malaria drugs, and worm pills to the population. The hospital, doctors, and nurses I was affiliated with are part of a non-profit Christian organization, but because of the current Honduran political situation I unfortunately cannot acknowledge them by name. All of the health providers speak Spanish, although many are from the U.S. Primary care visits are emphasized, and surgery and inpatient care are available for adults and children who are acutely ill or injured. Although it receives no public funds, the hospital I was at provides essential services at little or no cost to people who otherwise have extremely limited access to health care. The nearest public hospital is over an hour away, by vehicle on an unpaved road, and few people have cars so transportation is by foot, bus, motorcycle, or piling into the back of a pickup truck.

The Central American culture of birth is rooted in superstitious beliefs and cultural practices. Some of the pregnant women I encountered would not let anyone know their due date for fear that another woman might put a spell on the labor to wrap the cord around the baby’s neck, killing him. Labor and delivery occur in the home without modern technology or anesthesia, and a traditional birth attendant is present to deliver the baby. These women learn how to attend births by working with another birth attendant, and there is no science-based medical component to their training or practice. Pregnancy complications that are easily being managed in the U.S. can be lethal for a baby or mother in Honduras, because of the lack of access to obstetric care in a medically trained individual. Tragically, the nurses I was with had never heard of a situation where a fetus that was positioned breech was born alive, in the hands of a traditional birth attendant. One of the main goals of the women’s health program begun by the American nurses is to gain trust in the communities, normalizing the idea of primary medical care and affording the opportunity for early detection of pregnancy complications which can turn deadly during labor and delivery, like preclampsia and malpresentation of the fetus. The nurses do not encourage any woman to deliver in a hospital, unless she is medically “high risk,” so in this way home birth traditions may still be safely embraced as long as the woman and baby are healthy.

The nurses I worked with were initially met with some suspicion as they started the women’s health program, but as I participated with them I was struck by their emphasis on building relationships with members of the community. It takes years of commitment and patience. They are deeply involved with spiritual life in the community, attending and participating in a church in a nearby town. One of the nurses is married to a local man and is very involved with her children’s education in the public schools, in addition to her work with the hospital. Because Honduran culture...
emphasizes family, friendship and community. I felt that this was an excellent model for bringing much needed health care to a group of women who would normally be uncomfortable receiving advice from an “outsider.” Another way in which the nurses have built trust in the community is through doing home visits, as a free and caring gesture to families with very limited resources. I was able to participate in these visits one afternoon. Wilson, the four-year-old pictured here, has a congenital disability similar to cerebral palsy. He has never had a complete neurological workup because his family does not have the financial resources to travel and visit a specialist. Wilson lives in a one-room cinderblock home with dirt floor and palm leaf thatched roof, in a rural area where supportive care for children with disabilities is nonexistent. The nurse does a brief physical assessment to assess Wilson’s neurological, cognitive, and nutritional status, and talks with his mother about strategies for keeping him healthy. For example, in this picture he is sitting in a padded high chair, but he needs to have a strap system put in place to keep him upright in the chair since he has poor neuromuscular control. Because of the relationship of trust that is developing between Wilson, his mother and the nurse, Wilson has the benefit of limited developmental support and he can be brought to the hospital if his condition deteriorates.

The time I spent with Wilson was one of my best yet most heartbreaking experiences in Honduras. I spoke to him in Spanish, and he recognizes his own name although he does not seem to understand anything else. He has such a pleasant temperament, and although he cannot speak he was very engaged and stared at my face, smiling, and reaching out to touch me. As I interacted with him, it hurt to see the health disparity between his situation and that of a child in the U.S. Here, Wilson would have a formal diagnosis for his condition, he would be taken to physical and occupational therapy sessions in little wheelchair, and he would receive developmental and educational support even if his family was poor. But those things are inconceivable in Honduras, and

Wilson is blessed to have a loving mother and the watchful eyes of the nurse. I wished I could bring him home with me and give him the care he needs to live the healthiest life possible, but I just had to give the child a kiss on the cheek and wave “adiós” as he started to cry.

My experiences in Honduras with the women’s health care program and the home visits now serve as a case study on trust building between nurses and patients in the community. This presents and open door for me to do future investigation in this area; I am currently writing two related papers on this topic, and I hope to tie my findings in with a broader study for my senior inquiry project.

A Lesson in HIV/AIDS and the Human Experience: Inspired Toward Nursing By Volunteering with the Kenya Network of Women With AIDS

Tiffany Holder

As I embarked on my trip to Nairobi, Kenya to volunteer with the Kenya Network of Women With AIDS (KENWA), I knew it would be an intense two and a half months. However, at that time, I could not imagine what I can now vividly picture in my mind after seeing, hearing, and experiencing HIV/AIDS in the slums of Kenya. The following quote was in the back of my mind as I traveled and recorded what I saw and did there: “Just as an observation is a form of control, so too is the process of writing and representing what has been observed.” So as not to further control the process of observation and recounting events, I am presenting excerpts of my journals that I kept during my time in Kenya, all of which propelled me on the path to a nursing career.

Excerpt 1
Addis Ababa airport

The night before I left, I watched a TV show about HIV/AIDS. In this TV show, a man from Sierra Leone went to Zambia to work as an orderly in the hospital. He dealt with dead adults, dead children, broken families, despair, and loss. If I see, in person, even half of what I witnessed on the documentary, my heart will break, although I am very emotionally together. As of tomorrow, my life will be devoted to those I meet dealing with AIDS in some way in Kenya.

If I wanted to be a doctor, this is most likely what I would do. I would be here as a doctor actually providing free or affordable medical care. Maybe I’d join Doctors Without Borders, but I am not a doctor — nor do I plan to be one. But I hope these roles get filled. We all have our place in life.

Excerpt 2

I met my first AIDS patients today as well as some orphans. Many of the people working with or volunteering for KENWA are HIV positive, but they are very healthy compared to the people they help. Today, I spent several hours with Grace. She is a 5-year-old girl who has Tuberculosis. Her mother just died of AIDS two weeks ago, and she is now alone. Luckily, she is HIV negative herself, but she is very small and malnourished for her age. She’s about the size of a two-year-old, and I am not exaggerating. While she is being treated for her Tuberculosis, she is staying at the KENWA clinic. Today, we drove her to get her treatment, and the hospital was overcrowded especially in the waiting areas. We went to the pediatric ward, where all the mothers were there with their children. The atmosphere wasn’t too bad, but it is such a clear difference from hospitals in the United States. I am not saying it is completely bad here, because they do very well, but appearances and processes are very different.

After taking Grace back to KENWA, she looked so sad — sad in the deepest possible way. Her face was downcast, and her eyes would meet mine and then look away. I spent time with her just trying to play and get her to at least smile and also saying “Unatuka kucheka?” or “You want to laugh?” Finally, she started playing and even smiled. A long time later, she finally laughed, and it made me so happy to see her and eyes light up.

Also, apparently, she is not at all familiar with milk,