ValleyCare Nurses
Making a Difference Worldwide
2010 International Year of the Nurse
Seasons Greetings and welcome to the second issue of the ValleyCare Nurse Magazine! Our first edition met with rousing success so our Advanced Practice Nurse Council is proud to do a repeat performance.

2010 is the International Year of the Nurse, as well as the centennial year of the death of the founder of modern nursing – Florence Nightingale. To celebrate, the 2010 International Year of the Nurse was established to engage the world’s nurses – estimated to be more than 15 million – in a celebration of their commitment to improve health in their communities. Service to community, both globally and locally is the theme of this edition of ValleyCare Magazine. Nurses, by profession, are patient and community advocates and ValleyCare Nurses are truly exceptional. It is truly amazing how many of our nurses serve at local, state, national and international levels. At churches, schools, scouting, homeless shelters, animal rescue shelters and many other organizations, ValleyCare Nurses can be found volunteering their time and expertise. Our nurses walk for heart health, colon cancer, breast cancer and arthritis so that cures can be found. Through leadership roles in these organizations we further the impact that Nursing has on the health of our patients and communities.

Many of us, believing we have been blessed in our lives and in our profession, want to share with those who need us, both at home and in other parts of the world. Community service starts with our Nursing Leaders: Marcy Feit, President and CEO, has served on a Critical Care Nurses Association delegation to China and Mongolia. Cindy Noonan, Chief Operating Officer, has helped to dispense wheel chairs in Mexico for the Wheelchairs for the World. I, myself, have been extremely fortunate to represent ValleyCare on three separate American International Health Alliance projects in Russia, Azerbaijan and Kosovo along with Dr. David Mertes, member of the ValleyCare Board of Directors. As you read further you will meet many other dedicated nurses who have had the adventure of a lifetime while serving humanity.

As the ValleyCare Nursing Division continues on our journey to Magnet Status, we know we have ample evidence to demonstrate our community involvement and our commitment to helping make our world a better place. As Mother Teresa said, “You can do no great things, only small things with great love.” That philosophy is alive and well at ValleyCare!

-Jessica Jordan

Front Cover: Patty Stowers RN holds the mirror as a 30 year old Ghanaian man sees himself for the first time after surgical repair to his cleft lip.
# ValleyCare Nurse Table of Contents

From the Chief Nursing Officer…  
Jessica Jordan RN, BSN, MS  

Meet the Nurse Practice Council  

Providing Care to Asia and Africa  
Patty Stowers BSN RN CPAN  

Healing Touch Program Reaches Out to Vets  

Grateful for Ethiopia  
Lisa Skafuri RN  

Improving the Health of Women and Children in Kosovo  
Christiane Maier RNC, SNM  

Haiti Relief Mission—“A Truly Humbling Experience”  
Rose Duncan RN  

Colon Cancer Walk: A Grassroots Project.  

Bringing Neonatal Resuscitation to Kosovo  
(Back Cover)

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Meet the Nurse Practice Council

The Nurse Practice Council consists of staff nurses and nurse educators whose purpose is to ensure an evidence based review and development of policy, procedures and nursing practice throughout ValleyCare Health System. Members were asked to share why they became involved in the Council and why supporting evidence-based practice is important to them. The Members:

Shannon Stewart: “I became a member of Nurse Practice because I wanted to be a part of the decisions being made that would affect the care I provided at the bedside. I believe that Nurse Practice is an empowering committee. We put patient safety as a priority in all of our decisions. We work collaboratively between the departments to provide the best possible patient care. We are the voice of the bedside nurse, and I am very proud to be a part of that.”

Mary K. Dunn: “I became a member to help facilitate cooperation between units; to better coordinate quality patient care. I believe in shared governance and feel that membership on councils empowers nurses to do the best by their patients, and their colleagues.”

Johanna Forrester: “I joined NPC to become involved and make a difference. As nurses on the floors, we are involved in every aspect of patient care and patient safety; therefore, I believe it is important that we have a voice in the changes to policies, procedures, and processes that impact what we do every day to keep our patients safe. We see first hand what works and does not work, and it is important to provide feedback so that our practices reflect what is truly in the best interest of the patient.”

Jolene Duffey: “Being a part of the Nurse Practice Council has been a great experience for me, looking at new policies and having input on what needs to be changed has been a great experience.”

Diane Hughes: “Participating in the Nurse Practice Council helps keep me current with issues that arise every day in other departments, some of which are applicable to the Ambulatory Surgery Center practices. Being a member allows me to anticipate changes in products, policies, etc. that affect our department.”

Heather Hazelwood: Heather started at ValleyCare as a nurse assistant. After finishing nursing school, she worked in the Pediatric ICU at Packard Children’s Hospital. She joined us back at ValleyCare in 2007. Heather has been an active member or the Nurse Practice Council for two years.

Lisa Scafuri: “I joined NPC to become more involved with the decisions that control our practice as nurses. The nurses I work with work very hard to offer the best care to their patients and I don’t want them to get discouraged by policies that make our job more difficult. I feel like I can offer a realistic perspective of nursing practice and help make policies that place reasonable expectations on us while keeping safety and evidence-based practice a priority. I also double as a cheerleader . . . GO NURSING!”

Angelina Daco and Marjorie Jolicoeur: “Majorie and I joined NPC as practice is essential to growth! Changes in Evidence-Based Practice and technique are integral parts of educating nurses. We seek to improve and reinforce the current practice of our Critical Care staff to deliver efficient, compassionate, and safe care daily!”

Sheela Stanley: “I joined npc because it’s the best place to discuss issues; to find solutions; and to create the best nursing practice for ValleyCare.”
Providing Nursing Care in Asia and Africa

Patty Stowers, BSN, RN, CPAN

It’s hard for me to believe that I am celebrating 40 years of nursing this year. Seems like only yesterday that I graduated from nursing school and immediately applied for work in the very small general hospital in Nome, Alaska. I was accepted and told that I would be responsible for a 2,500 square mile area, caring for tubercular Native American Indians and Eskimos. My only source of transportation would be a bush plane and dog sled. At that point, my responsibilities seemed a little daunting, so I reluctantly declined their offer, feeling that I would benefit more from a few years of general nursing to broaden my knowledge and skills.

I began my nursing career in 1970 in San Francisco in the Neonatal Intensive Care Unit at Mount Zion Hospital. After one year, feeling more confident, I traveled to Boston to work in the Surgical Intensive Care Unit at Beth Israel Hospital. I met my husband Irving on a blind date, when he was just finishing graduate school. After we were married, we moved to Columbia, South Carolina where he taught at the University and I took a head nurse position in the surgical ICU at Richland Memorial Hospital.

After 2 years of my being homesick for the west coast, my husband accepted a teaching position at UC Davis and we moved to California. I worked in the surgical ICU at Sutter General Hospital in Sacramento.

In 1976, we moved to Livermore when Irv accepted a position at LLNL. I replaced Marcy Feit at Valley Memorial Hospital as the night nurse in our little 3-bed ICU (now the SNF dining room). Marcy moved to the day shift (and the rest is history). Relocating just across the hall to our newly built 10-bed ICU, I worked many more years on the night shift. Always preferring surgical over medical patients (the more tubes and lines the better), I accepted the staff nurse position in the PACU in 1989. I have continually watched over the years, the steady improvements and innovations in surgical techniques, anesthesia, and pain management for our patients. When ValleyCare opened in 1991 in Pleasanton, I transferred there with the rest of the employees.

After working many years in Pleasanton, I transferred back to ValleyCare’s new Ambulatory Surgery Center PACU in Livermore, which was conveniently very close to home.

My husband, recently retired, has for many years been active in the Livermore Rotary Club. He told me of a new organization called Alliance for Smiles, a non-profit humanitarian organization, founded by the San Francisco Rotary Club. They send volunteer medical teams for 2-week long medical missions to third-world countries to repair cleft lips and palates for children. I was intrigued and impressed by the medical missions they were sponsoring and began to learn about the birth defect and the surgery necessary to correct the defect.

Cleft lip and palate, the incomplete fusion of the skull of the fetus, is caused by a combination of pollution, diet, genetics and low folic acid. One in 250 children in China are born with this abnormality and indigent families earning only $300-500 annually are unable to afford reconstructive surgery. In the U.S. the rate is one in 1,000 but all cases are treated surgically soon after birth thus children with this birth defect are rarely encountered.

For the past three years I have had the opportunity to be part of several Alliance for Smiles medical missions that traveled to Baiyin, Harbin and Wenzhou, China; Bangladesh; and Ghana in Africa. In association with the Rotary Club of Oakland, I was part of a polio vaccination mission to Cote d’Ivoire, Africa. Next year my husband and I will be participating in 2-week long medical missions to the Philippines and Tanzania, Africa. During these missions I will work in the PACU and Irv will be the medical photographer.

A medical mission consists of 4 plastic surgeons, 4 anesthesiologists, 2 pediatricians, 4 OR nurses, 2 PACU nurses, a medical records keeper, sterilizer, quartermaster, photographer, mission leader, dentist, dental assistant and several translators. Typically, we pack 30 large boxes of supplies and equipment for each mission. The biggest hold up on every trip is trying to get all the boxes through customs and immigration. The surgeries occur in established hospitals to maintain the highest possible sterility standards. Some hospitals cannot afford to give the team 4 surgical suites; therefore surgeries are performed two to a suite.

Most of the families hear of our mission by word of mouth and will travel many days on foot to reach the hospital. The first day after arrival, half of the team unpacks all of the boxes to set up shop. The other half of the team conducts a long Clinic Day - creating
medical records, interviewing, examining, photographing, and admitting patients. Up to 200 patients may be examined during this first day with a sub-selection down to 125 to 150 due to unrelated sickness, fever, or complications that cannot be handled in two weeks. Eligibility for surgery is based upon a 10-10-10 rule. The child must be 10 weeks old, weigh 10 kg, and have a hemoglobin blood count of 10 g/dL. The unfortunate children not meeting these criteria must be sent back to their villages or rescheduled for our next visit to their city the following year. That evening the lead surgeon and head nurse prepare a prioritized list for surgery to begin the following morning. Our goal is to perform 20-25 surgeries per day.

The team resides in a local hotel that is sometimes adjacent to the hospital and sometimes many miles away. Transportation to and from the hospital can be by foot, taxi, bus, or local Rotarians who are hosting the medical mission. Typically the day begins when the surgeons arrive at the hospital at 7 am and work until 6 pm. The day ends when the last child is recovered in the PACU and the nurses come back to the hotel, hopefully in time to join the others for a late dinner. The 15-16 day mission requires 2 days of travel, one day of leisure in the middle, and the remaining days working.

Each location is unique and varies with the size and location of the city. Harbin, in the northeast corner of China is a city of 4 million and close to the Russian border. It is known as the ice sculpture capital of the world in the winter. During our one-day off, we had the opportunity to visit the world's largest Siberian Tiger Preserve, which had about 600 tiger living on several hundred acres.

In 2008, I traveled to Baiyin in north-central China near Mongolia. Baiyin is a small city of 500,000 located in a mining area, where the air pollution from mining dust and sand storms from the Gobi Desert make it very difficult to see and breathe.

Dacca, Bangladesh, has a considerably higher population density than China (17 million people in the city of Dacca alone) and girls are expected to marry at the age of 12. Cows, goats, bicycles, rickshaws, cars, buses, and trucks all share the same roadway. Cockroaches and lizards run amok throughout the hospital. There was a civil war going on so we were not allowed out of the hospital or hotel rooms without an armed escort.

Wenzhou is in southeastern China and completely surrounded by mountains. Because of its geographic isolation, the people have developed their own dialect and culture. The city boasts of a prosperous downtown area and is considered the eyeglass capital of the world.

Cote d’Ivoire in Western Africa was a polio vaccination mission sponsored by the Oakland Rotary Club. The countless families in the village we visited had one dripping hose as their only source of water. Streams of raw sewage ran through open trenches where the children played. We gave vaccinations, deworming medicine, and mosquito netting to the appreciative families but there were no schools and apparently no work for the hundreds of inhabitants.

In Ghana, in Western Africa, three MASH-like tents were set up as our pediatric ward in front of the overcrowded hospital in which the surgeries took place. On this particular trip, there were many adults who had suffered with cleft lip and were given the opportunity to have surgery. The heat and humidity was brutal. Thank goodness for surgical scrub caps because every day was a “bad hair day.” Finding clean drinking water is always a challenge on our medical missions. And since I’m not adventurous when it comes to eating AUTHENTIC Asian and African food (e.g. jelly fish, duck eyes, scorpions, and cow hide for breakfast), I learned to always pack canned tuna fish, peanut butter, trail mix, and a water purifier in my suitcase.

Western toilets are a rare luxury; so strong thighs and a good aim are a definite advantage when using the Asian and African squatty potties. Language barriers are always significant. Translators traveling with us are always scarce, but were of great help when available. The medical mission staff is always mindful of respecting the religious and cultural differences in each country.

You will not find a PACU in most Third-World hospitals because the patient’s family is expected to care for the patient immediately after surgery. The nursing team usually finds an empty room close to the operating room to set up a makeshift PACU. There is also an absence of any disposable supplies in the hospitals, something we take for granted in the States. Nothing is thrown away, and oxygen masks, gloves, suction tubing... are cleaned and reused over and over. When there are no sheets for the beds, we use the autoclave paper that was used to wrap the sterile instruments. Sinks with running water are nearly non-existent, so we consume a lot of hand sanitizer. The most popular item I carry with me in the PACU is a mirror so the children can look at their “new face” right after surgery.

Many of our pediatric plastic surgeons are 70-80 years of age. They have retired from their regular practice but are eager to use their skills and talent for the good of these children.

Armed only with a stethoscope, blood pressure cuff, pulse oximeter, and
basic nursing skills, we are constantly amazed that despite deplorable sanitary conditions, we can provide quality-nursing care with good patient outcomes.

As soon as a child is awake after surgery and taking oral fluids they are presented to their very anxious and grateful parents waiting just outside the PACU doors. The parents are so thrilled that their babies will no longer be stared at or laughed at. They will be able to eat and drink normally and enjoy a happy childhood. Depending on the extent of their surgery, the child may stay in the makeshift pediatric ward for 1-7 days. Even though the children sleep in overcrowded conditions of 3-4 patients to a bed, with parents sleeping on the floor, there is no complaining, only laughter and gratitude. The beaming smiles on the faces of the children and their parents make it so worthwhile.

Recently, while in Nome to watch the completion of the Iditarod, I had the opportunity to take part in an amateur dog sled race. I mushed a small team of huskies right past the little hospital I would have been working in 40 years earlier. I wonder if they still have my job application on file. It took me forty years, but I guess you might say I’ve come full circle.

Healing Touch Program Reaches Out to Vets

By Katheryn Darlington BSN, CHTP, RN

I believe in Integrative Health Care. By providing the best of many types of supportive care along with our mainstream medical care, our patients can regain health more quickly. Health means more than just the absence of disease; it is a state of wellness that allows each person to function and feel at his or her absolute best. My studies in this area have included courses in Pain Management, Nutrition, Yoga, Reike, Chinese Medicine, Homeopathy, Guided Imagery and Healing Touch. I have become a certified provider in the latter two.

During 2010, I volunteered along with a group of 17 other nurses and Healing Touch providers at two Bay Area events held annually for our military veterans. In August this “Stand Down” event is held at the Pleasanton Fairgrounds, and in October at the Dixon Fairgrounds. These “Stand Downs” provide medical, dental, legal, and social services for vets that are unable to drive to the appropriate locations for their care due to distance, finances, mental health issues, or homelessness. We provided care to approximately 100 vets at each event. Each person received a 30-45 minute session of energy healing and we were voted the “most popular tent” by the vets and the staff in attendance.

Healing Touch is a light touch that helps to open and balance the natural energy flow in the body. This bolsters the immune system, helps to promote relaxation, and decreases pain. The client remains fully clothed and lies on a massage table. This technique is very helpful with chronic pain and is proving to be very effective with Post Traumatic Stress Disorder. Healing Touch is a nurse-based therapy. Nurses learn the technique through continuing education courses and become certified. Healing Touch is endorsed by the American Holistic Nurses Association.

During the “Stand Down” event it was heart wrenching to hear the stories and ails of the military men and women in my care. I felt honored to work with them and joyful to be able to provide care that alleviates some of their symptoms. Many of them will continue to receive this care at the Vet Center in Concord. I look forward to continuing this volunteer care twice a month at our Livermore VA hospital.
Grateful for Ethiopia
Lisa Scafuri R.N.

“Did you complete your monthly audit?” “Please remember to document strict I/O.” “Make sure your patient is on the correct mattress.” These are all statements that demonstrate how amazingly blessed we are to be nurses in the United States. I recently had the privilege of serving as a nurse in Ethiopia. Our team went to work with Ethiopians who are under-served and have sometimes never been to a doctor. Words cannot describe the stark contrast between their health care and ours.

Doctors Giving Back is a nonprofit organization that goes to Ethiopia every year in March. This past trip we started in Addis, which although it is the capitol, is filled with extreme poverty. For example, it is not uncommon to see children without shoes walking the streets. And though it is home to the best hospital and nursing school in Ethiopia, Chala, a nursing student I met who graduated from the school in Addis had never taken a blood pressure for lack of supplies.

In anticipation of this, we each gave up our one hundred pounds of checked luggage to bring supplies for these clinics including shoes, clothes, drugs, and sterile supplies for the hospital. We were unable to acquire anti-retrovirals which would have been a great help to the orphans we encountered at a make shift feeding program in Addis. These drugs are contraband coming into Ethiopia, very expensive and tightly controlled in the U.S. There are some political issues surrounding provision of these particular drugs in Africa, the details of which I do not entirely understand.

We did a few clinics in Addis, before arriving at our final destination, Assosa, about which people in Addis said, “Why would you go there?” It is truly a forgotten area. The only hospital in Assosa is under-staffed and poorly functioning; staff reuse everything for lack of sterile supplies. As an American nurse, all I could say was “Why?” and “Ew.”

The first day we visited I did not see any nurses or doctors attending the few patients that were in the hospital. The only attendants appeared to be family. There was a crying naked baby with flies on his face, just like you have seen on the “Just a dollar a day” commercials; no mosquito nets despite widespread Malaria; the few sinks that worked drained to buckets of stagnant water; and their “birthing room” looked like something from a horror flick. Basically, the sick do not go here to get well.

We had a construction team working on the hospital and improving conditions there, while the health care staff ran clinics out of a local church. Doctors Giving Back is a Christian organization and Assosa is a predominantly Muslim area with anti-American sentiments, but the goal was to take care of everyone that would come to the clinic and that is what we did. Each day of clinic went something like this: cram as many team members and translators in a van as possible; drive to the church trying not to run over the kids running beside the vehicle; squeeze through the crowd of people at the gate; lay people start on triage assessing vitals, histories and chief complaints; nurses and doctors (and one lay person believe it or not) see patients. Without labs or diagnostic imaging we would do the best we could to diagnose, hand patients any medications that would help, and teach them prevention and
treatment for the future. It was frustrating that our ability to accurately diagnose and treat was limited by lack of simple technologies that just were not available in this environment.

Visits to even more remote villages added some variation to the above schedule. It took at least 2 hours of unpaved, rough-road driving toward the Sudan border to get there. Many villagers had never seen Americans. At one such village residents did not understand that our motives were purely medical and their enforcer (with a large semi-automatic weapon) strongly encouraged us to leave immediately.

Another, more friendly village met us on the road when our tire went flat and played some impromptu soccer with us before they let us address their illnesses.

This trip gave me a whole new perspective on nursing. Here in the U.S., the patient population is mostly over the age of 60. Many of the illnesses we see are, to some degree, self-inflicted. Much of the time our chief concerns are liability, meeting deadlines, following protocol and making acronyms to remind us to do so. In my opinion, these activities prove that we’ve taken care of the big stuff. I am exceedingly grateful for the care that we have and are able to provide to our patients. How privileged we are to serve and learn here.
The Health of Women and Children in Kosovo

Christiane Maier RNC, SNM

In June of 2009, I became involved in ValleyCare’s international maternal/child health project in Kosovo. This project is organized through a three-year partnership with a nongovernmental organization based in Washington, DC, called the American International Health Alliance (AIHA). Due to my background, both in midwifery and obstetric nursing, I was asked to join the ValleyCare group, consisting of Jessica Jordan, RN, MSN, Shelley Barnhill, RNC, BSN, and former ValleyCare obstetrician/gynecologist Michael Ranahan, MD. All of these colleagues had participated in previous partnerships with AIHA.

My part in this project has been to serve as a resource to midwives in Kosovo, to provide insight and guidance from a midwifery aspect, and to assist in developing antenatal care programs in order to improve the health of women and children in this country. Although I am not licensed as a nurse-midwife in the United States, I am currently in my last year of graduate school pursuing a Master’s degree in Nursing and certificate in nurse-midwifery at the Frontier School of Midwifery and Family Nursing (FSMFN). I have been a licensed midwife in Germany since 1991 and have worked in maternity and obstetric care, both as a midwife and labor & delivery nurse, ever since.

My first trip to Kosovo was in September of 2009. During this visit I traveled to several different health care facilities mainly focusing on inquiring about the current state of perinatal care in the country. In addition, together with Shelley Barnhill RNC, BSN and Dr. Ranahan, I participated as a lecturer at Kosovo’s first ever health symposium, which was intended for physicians, midwives, and nurses involved in the provision of maternity and pediatric health care in the country. My talk specifically concentrated on how midwifery support during antenatal, intrapartum, and postpartum periods positively impacts maternal and neonatal outcomes.

The symposium was hosted through AIHA and the United States Agency for International Development (USAID). The location was at Camp Bondsteel, which is the main base of the United States Army under KFOR command in Kosovo. This United States military base serves as the NATO headquarters for KFOR (AKA the Kosovo Force), which is a “NATO-led international peacekeeping force responsible for establishing a
A number of barriers hinder the effective delivery of antenatal care (ANC) in Kosovo, which consequently adversely affects the health and wellness of mothers and children in this country. These barriers can be grouped into three categories: sociodemographic, system-related, and attitudinal (Centering Healthcare Institute, 2008). Sociodemographic variables include poverty, minority status, and to a certain extent the deficiency of academic education. Examples of system-related deficiencies include financial hardship, lack of coordinated services, poor communication among providers and staff, transportation challenges, and uncomfortable surroundings. Finally, attitudinal barriers, such as fear, ambivalence, apathy, and inadequate social support are portrayed both by many of Kosovo’s health care providers and by their clients. These factors all negatively impact the quality of maternity care in this country.

Perinatal health conditions in Kosovo are some of the most inferior found throughout Europe. The country has a “very high fertility rate and amongst the poorest maternal and child vital indicators in Europe” (Unicef, 2005). 35,000 children are born each year to a total population of about 2 million people (Unicef). The estimated infant mortality rate ranges between 35 to 49 per 1,000 live births; this is one of the highest infant mortality rates in Europe and is at least twice as high as those of neighboring countries (Unicef). Approximately 69 of 1000 children under the age of five die each year in Kosovo, which can mainly be attributed to “a lack of knowledge and awareness among communities and families about adequate home care management, child physical and cognitive development, and general reproductive health.” (Unicef)
facility > 95%), the maternal mortality rate in this country is still one of the highest in Europe (6.9 maternal deaths per 100,000 births) (Unicef, 2005). As in other developing countries, in Kosovo the majority of women die of perinatal causes that are due to hemorrhage, sepsis, unsafe abortions, preeclampsia, and obstructed labor (dystocia). Neonatal deaths can be usually attributed to infections, asphyxia, and preterm births (Unicef). Most of these deaths are preventable by giving women access to quality maternity care, improved nutrition, family planning, access to safe post-abortion care, or in some cases, simply transportation and education (Unicef).

This past April, I went on my second visit to Kosovo. During this time I not only visited various health care settings, but also spent a good portion of my time with local midwives accompanying them on antepartum and postpartum home visits. This provided me with a detailed impression of what day-to-day life in Kosovo actually entails. I was exposed to the local culture and traditions, and was privileged to meet and talk with many locals.

This time, I specifically concentrated on facilitating antenatal care in group settings. The care was based on the Centering Pregnancy Group Prenatal Care model that is offered at various settings here in the United States. This type of prenatal care is appropriate for most women and can be facilitated by trained personnel, in particular by midwives, in almost any health care setting. Providing prenatal care in groups would be a reasonable and beneficial option for family medicine centers throughout Kosovo. I encountered several midwives and gynecologists at Kosovo’s family medicine centers that showed interest and enthusiasm towards starting ANC programs similar to the Centering Pregnancy model. I feel very strongly that these facilities would be great places to initiate pilot programs offering group prenatal care to the women they serve.

I hope, of course, that some of the efforts ValleyCare and AIHA put into this cause will eventually be noticeable and make a difference in the lives of Kosovo’s women and children. However, I also have to remain realistic and remind myself that influencing the overall mentality of a country such as Kosovo cannot be simple nor quick. This endeavor will likely take more time for reasons related to socioeconomic conditions, a high incidence of poverty, high rates of unemployment (>50%), and poor preconceptional health, and other economic and social stressors, such as domestic violence. In addition, understanding the obstacles of Kosovo’s health care system might also provide some insight in finding solutions to wider life problems related to obstetric and newborn care. In order to improve the health of Kosovo’s population, the women and children of this tiny country need to have an opportunity to receive health care that is safe, acceptable, and sustainable despite having health care settings with limited resources.

History of Kosovo:

- 1400-1912 – ruled by Ottoman Empire (Turkey)
- 1912 – divided b/w Montenegro and Serbia, both of which became part of Yugoslavia in 1918
- 1943-1992: Yugoslavia, including Kosovo, was a communist country.
- During Balkan Crisis (1989-1999), Yugoslavia was divided into 6 republics - Kosovo became one of two autonomous provinces within Serbia.
- Kosovo War 1998-1999
- 1999: 10 years of Serbian repression and ethnic cleansing lead to the displacement of 855,400 Kosovo-Albanians, and up to 10,000 were killed
- NATO interfered in 1999 by bombing Serbian targets throughout Kosovo, Montenegro, and Serbia.
- June 1999 - Serbia withdrew from Kosovo
- Since 1999 Kosovo is under United Nations (UN) administration; Kosovo Force (KFOR) - NATO-led international force responsible for establishing and maintaining a safe and secure environment in Kosovo
- Declared its independence from Serbia in February 2008 - became the Republic of Kosovo.
Haiti Relief Mission—“A Truly Humbling Experience”

Rose Duncan, RN ER

Haiti is the poorest country in the Western Hemisphere and one of the poorest in the world. It is a nation of farmers who work small, privately owned areas of the land and depend on their own labor and that of family members. Only 30% of the land is suitable for agriculture as erosion is severe. In most rural areas, the average family of 6 earns less than $500/year. A tectonic fault runs through the country, causing occasional and sometimes devastating earthquakes. The island is also located within the Caribbean hurricane belt. The infrastructure is in very poor condition. International efforts to change this situation have been underway since 1915, but the country may be more underdeveloped today than it was 100 years ago. I believe this is partially due to the reoccurring natural disasters that strike and destroy all new efforts made to rebuild their society repeatedly sending them back to square one. For instance, a temporary wood structure was built by previous relief teams before us to house the orphans that were left homeless in the most recent earthquake, but just 3 weeks before our arrival a hurricane blew the top right off the building. The children were forced to sleep in a bus until our teams could re-roof the structure. International food aid, predominantly from the United States, supplies over 10% of the country’s needs.

The devastating earthquake of January 2010 left this already poverty-stricken country in even worse condition. Leogane (the epicenter of the quake) was home of the Dezman-Fluery Foundation Orphanage which, along with the rest of the city, crumbled to the ground. This left its 38 survivors traumatized and yet again...homeless.

I feel that the children of Haiti are the most innocent victims of this country’s tragedies. This summer, my 14 year old daughter and I were blessed with the opportunity to travel to Haiti with a team of 13 other volunteers from Cornerstone Fellowship Church. Our team had 4 areas in which to work: Medical Care, Orphan Care, Construction, and Discipleship. We all ended up working every category at some point during the trip.

Our journey began as we landed in the capital city of Port Au Prince. From one huge pile, we collected our checked suitcases (filled with donated clothing for the children) and boarded a big open back box truck lined with 2 benches for us to sit. We quickly learned that their only “rule of the road” consists of a quick beep of a horn followed by a high speed pass on either side, needless to say, it was quite a “white-knuckle” ride whenever we traveled the road. The crumbling 2 lane road is lined with numerous tent cities.

Pastor Kelly (brother of Dezman Fleury) together with Cornerstone Fellowship, had purchased a 2 acre lot in Leogane. On that lot now stands a small wooden structure (about 25 feet by 45 feet) built progressively by the 3 teams before us which now houses 50+ children (all girls and very young boys). The older boys have their own orphanage down the street in a very small tent city but they spend most of their day at the girls’ orphanage so they can join in on the activities and bible stories led by our team. Many of the kids are new to this orphanage as they recently lost their parents in the 2010 quake. They range from 7 months to 16 years old. As our vehicle entered the compound, all of the children (the big ones holding the little ones) gathered and greeted us with huge hugs as we climbed off the back of the truck. We were overwhelmed by the outpouring of love and gratitude we immediately received from these little ones.

Rose Duncan R.N.
so full of love for life that it was beyond humbling to our team! The team met with many challenges over the course of the next 8 days. The harsh hot, humid weather took its toll on us quickly, yet these amazing children remained playful and energetic. Their eyes lit up when we pulled out a ball and played soccer with them.

At the back of the “compound” stands a HUGE tree, we called it “the Giving Tree.” It provides the ONLY shade under which we spread three tarps on the ground to do crafts, activities and games each day. In the afternoon the children would throw rocks up into the tree and down would drop a seemingly never-ending supply of mangos (this was their lunch). These resourceful little ones would disappear into the surrounding field and return with sugarcane sticks—they were thrilled to teach us how to bang it on a rock, strip it down using your teeth and chew on it for sugar water. Their water source is a well in which they would drop down a 2 gallon bucket tied to a rope. Goats and chickens wander the grounds, but sometimes one would disappear—which explains our “mystery meat” for dinner.

The construction team (including several Haitian guys whom we hired to work alongside our crew to learn to build safe earthquake/hurricane proof structures furred the progress of the foundation for the permanent shelter. Cement pillars were poured and the septic tank was completed. Currently the children use a makeshift outhouse (cement hole in the ground). Their shower is a cement stall and a bucket of water. A cement building will soon replace their temporary wood shelter and the children will have an actual place to sit and eat at a table, as well as having a classroom/church.

Many of the children were very ill with various untreated medical conditions (e.g., infected wounds, upper respiratory infections and dehydration). We were able to resolve most conditions by the end of our stay using what to us is very BASIC health care interventions such as wound care, antibiotic injections or plain and simple Pedialyte! We found an abandoned supply tent filled with medical equipment brought in by the relief teams that came right after the earthquake. One of our goals on this mission was to teach the Haitians how to help themselves, so we collected a large box of medical supplies and set up a small clinic on the compound. We instructed one of the older Haitian girls on basic first aid. She was thrilled to take on this role as she told us she dreams of being a nurse someday. To have touched the lives of the people in this country in the smallest way was for me a “life changing” experience. It was extremely difficult to leave them; but knowing another team would continue where we left off made it just a little easier. In the words of my daughter, “Don’t be sad that it’s over, be happy that it happened.” The memories of their bright smiles will stay with us FOREVER. (If any readers are interested in traveling as part of a team on a medical/orphan care mission, I would be happy to get you connected with the Cornerstone Fellowship Haiti relief program.)
Colon Cancer Walk: A Grassroots Project
Katheryn Darlington, RN

The GI, Pre-Op, and PACU nursing staff in the Ambulatory Surgery Center (ASC) have sponsored Colon Cancer Awareness Walks for the past two years. The inspiration and leadership for this project began with Debbie Lewis, RN and Amber Barr Alton, RN. They attended a GI continuing education conference in 2008 and returned with the idea of using a walkathon to promote colon cancer awareness and prevention in our community. Colon cancer is the third most prevalent type of cancer in America and the third leading cause of cancer deaths, yet colon cancer is very preventable and treatable with appropriate screening and healthy lifestyle choices. The ASC is where most of the colonoscopies are done at ValleyCare. So staff see first hand the effects of this deadly, but largely avoidable disease. We are very sad when we discover an advanced disease when patients procrastinate about these screening exams or state they did not know of the importance. When Debbie and Amber presented their ideas it did not take much for all of us to get started.

Debbie and Amber obtained permission and support from our Director of Surgical Services, Carol Falcon, RN and from our Medical Director of Gastroenterology, Ralph Camacho, MD.

Fourteen of our staff nurses volunteered many hours each week for six months to prepare for the first colon cancer walk event. Permits were obtained, donations solicited, raffle prizes displayed in beautiful baskets, the route planned and set, snacks and beverages organized, and t-shirts ordered. The Marketing Department assisted with creating the brochures and Engineering provided the sound equipment and tables. On the day of the event 100% of our GI, Pre-Op, and PACU staff, along with many spouses, and other family members, turned out to volunteer their time in support of our cause. We encouraged families to attend and they did with strollers, wagons, and wheelchairs. We invited family pooches to attend and had water bowls, treats, and extra leashes available. The LifeStyleRx staff was very gracious and helpful. Our Olympus medical equipment representative provided educational models, videos, and brochures. Snacks included high fiber foods such as fresh fruit and bran muffins. The first year our goal was to recruit 50 participants and raise $1000. We exceeded that goal by having 125 participants and raising $5000! We educated many of our staff and community members, discovered new skills and talents among our nurses, and had a lot of fun working toward this common goal. The participants told us how much they appreciated the education, fun, and great prizes.

ValleyCare’s Second Annual Colon Cancer Awareness Walk took place in April, 2010. The event was expanded to include more support for fundraising from our ValleyCare Foundation and Doctor Camacho, and even included a BBQ lunch. The team worked with Gabrielle Chow RD, Anne Moselle, RD, and the Marketing Department to create and sell our Fiber of Life Cookbook. We had the same high level of support from our ASC staff during the months of preparation: many hours of soliciting donations, preparing raffle prizes, planning the snacks, compiling the cookbook, planning the route, and tending to all the details. The outcome was worth it. The Walk attracted more than 200 participants and raised $14,000! Again, the participants said they enjoyed the event, learned more about colon health and cancer, and loved the beautiful raffle prizes.

The funds we have raised have provided the money to produce the cookbook that continues to be sold through ValleyCare’s cafeterias and in some of the medical offices. Besides the nostalgia of recipes from so many colleagues at work, it is an excellent educational tool and resource.

Our goal now shifts to the walk for 2011 and new educational avenues. The planning has already begun – Come join us!
Bringing Neonatal Resuscitation to Kosova

In July 2009, over a five day period, Shelley Barnhill and Jessica Jordan provided training in Neonatal Resuscitation (NRP) to 150 nurses and physicians in 5 Kosovan regional hospitals.

Shelley and Jessica returned to do a “Train the Trainer” program for 80 midwives in June, 2010. They brought their expertise to regional "maternities", where they were able to observe the trainers working with their colleagues.

The team also provided equipment for NRP training as well as for two new ambulances. The ambulances are used to transport infirm infants from regional hospitals to the University hospital located in the capital city of Prishtina, where a higher level of care can be provided.