Contributions of Nursing and Midwifery Professionals to Women's Health

Reports from the Region of the Americas

PAHO
Pan American Health Organization
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Americas

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Reports from the Region of the Americas

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Last, thanks are also due to all those who, in one way or another, contributed their valuable stories to highlight the contribution of nursing and midwifery professionals to women's health.

Introduction

The State of the World's Nursing Report 2020: Investing in Education, Employment and Leadership, published by the World Health Organization (WHO), estimates that there are 28 million nursing professionals in the world, a number that represents more than half of all health professionals. The report also notes that there is a global shortage of 5.9 million nursing professionals, mainly in Africa, Southeast Asia, and the Eastern Mediterranean, as well as in some Latin American countries. To reduce the global shortage of these professionals, it is necessary to increase national investment, increase the number of graduates in nursing, improve employment options, and retain professionals in the health system (*1*).

The report also concludes that investing in nursing and midwifery professionals will not only enable improvements in the health field, but will also contribute to improving the quality of education, promoting gender equality, and ensuring decent work and economic growth. All these achievements are in line with the Sustainable Development Goals *(1)*.

WHO declared 2020 as the International Year of the Nurse and the Midwife. However, plans for the celebrations were affected by the intense work of professionals during the COVID-19 pandemic, declared by WHO on 11 March, 2020. Consequently, 2021 was declared to be the International Year of Health and Care Workers *(2)*.

The COVID-19 pandemic highlighted the inequalities and inequities that exist in health systems and in the countries of the Region of the Americas. Countries implemented non-pharmacological public health measures during the response to the pandemic, including lockdowns and school and business closures, with varying effects on the social, economic, and cultural conditions of different population groups *(3)*. In countries where access to health has been most affected by the pandemic, health professionals and caregivers have embodied one of the best responses to combat it *(4)*.

The task of health professionals has not been an easy one. They apply their knowledge, help their patients, and provide emotional and therapeutic support, while taking care of their own health. Despite the fear of falling ill, these people leave home every day to fight the virus, enduring long hours of work and often dealing with precarious working conditions, including a lack of supplies and personal protective equipment, which in turn contributes to an increased risk of infection.

As at 31 December, 2020, 2,262 nursing professionals from 59 countries around the world had died from COVID-19, according to the International Council of Nurses. Brazil, the United States of America, and Mexico were the countries with the largest number of deceased professionals. To date, these numbers continue to rise, as do infections in health care professionals, which are estimated at more than 1.6 million *(5)*.

In September 2020, the United Nations General Assembly recognized the critical role of human resources for health in the response to the COVID-19 pandemic. In addition, it highlighted the need to train and retain health professionals, stressing that investment is essential to promote decent working conditions and protect workers from all forms of violence and discriminatory practices *(6)*.

The pandemic has affected men and women in different ways. These differences involve, for example, the health workforce; social impacts and social protection measures; unpaid work, underemployment, and informal employment; food insecurity; sexual and reproductive rights; and violence against women. This is what the data show.

Analysis of COVID-19 infections and associated deaths in health professionals around the world points to a higher incidence of infection in women, although mortality is higher in men. Professionals aged 50 to 59 are at high risk of infection, while those aged 70 and older have a higher death rate. In relation to specialties, professionals who are frequently exposed to oronasal secretions are at greater risk, although the risk to other professionals is not to be underestimated. This suggests the need to adopt guidelines for monitoring, testing, and reporting infections in health care professionals. Consideration should also be given to assigning high-risk professionals to activities and sectors with less exposure, such as the care of patients without COVID-19, administrative positions, or telehealth *(7)*.

Overall, women have been greatly affected by the pandemic, either in their capacity as health workers or due to difficulties in accessing health services and care. They make up the majority of health personnel, so they are more exposed to occupational risks in the sector. These risks include COVID-19 infections at work, injuries associated with prolonged use of personal protective equipment, exposure to toxins from disinfectants, increased workload and working hours, violence, discrimination and stigma, chronic fatigue, psychological disorders and risks to mental health, and precarious facilities for sanitation, hygiene, and rest *(8)*. In the Region of the Americas, 86% of the nursing workforce is female *(1)*.

The pandemic has also negatively affected care during childbirth and the postpartum period due to the decrease in prenatal care services, health education, and research on maternal pathologies. A study published in October 2020 *(9)* estimated that there could be between 60,000 and 200,000 more stillborns over the following 12 months.

Widespread lockdowns in some countries have had a direct impact on family planning and gender-based violence. A study by the United Nations Population Fund (UNFPA) estimates

that, due to the pandemic, it could be 20% more difficult for adolescents to access contraceptive methods. This would lead to an increase in early pregnancy, in addition to increasing the exposure of girls and adolescents to violence and domestic abuse (*9*).

In Colombia, calls to the hotline for victims of gender-based violence have increased 91% since lockdowns were imposed; and 36% in Mexico. In Argentina, where seven out of ten cases of femicide in women and girls occur at home, emergency calls to report domestic violence have increased by 25%. In the Plurinational State of Bolivia, the city of Santa Cruz has recorded the highest number of cases of domestic violence to date. Along with Paraguay, Bolivia also has the highest rate of femicide in adults and girls in South America *(10)*.

The reduced capacity of health services combined with more limited access to immediate response services has made it difficult for women to seek help. Likewise, due to fear of infection, many women choose to stay home instead of seeking care from these services *(11)*.

These problems are intensified by socioeconomic factors and by inequalities and inequities within countries, such as unemployment, informal employment, lack of social protection, and limited access to health and education services *(3)*. It is foreseeable that the economic impact of the pandemic, including reduced income, will increase the vulnerability of women and children *(12)*. A decrease in resources and an overload of unpaid work for women has also affected the exercise of sexual and reproductive rights. In addition, the fact that resources are being focused on containing the pandemic tends to make it more difficult to access public health services *(13)*.

The COVID-19 pandemic has been a source of new challenges for everyone, including health care professionals. The changes in forms of care and in epidemiological realities, along with widening health gaps, have had strong negative effects. When responding to the pandemic, health systems must also focus on policies and strategies aimed at the care of women, with community-based responses and qualified professionals to offer a viable care plan *(14)*.

It is essential to present, highlight, and value the work and role of health professionals, who have made immense efforts to serve urban and rural communities, especially considering that 2021 is the International Year of Health and Care Workers.

The reports presented here focus on understanding comprehensive nursing and midwifery care for women from the point of view of health professionals and users. The ultimate goal is to highlight the initiatives of health professionals who work to ensure equity in health in order to achieve universal access to health and universal health coverage.

Purpose

The Pan American Health Organization (PAHO), in recognition of the fundamental role of nursing and midwifery professionals in health systems, has decided to publicize the initiatives and contributions of professionals focused on women's health as part of the International Year of Health and Care Workers in 2021.

This publication presents and summarizes activities, stories, and cases presented by professionals from different countries of the Region of the Americas. All these stories illustrate the role of nursing and midwifery professionals in advancing towards universal access to health and universal health coverage. They also show the contributions of these professionals to health systems, universities, and schools in the countries of the Region.

The following pages present reports on different types of health services, considering health care at different stages of the life course, with a focus on women's health, maternal health, and children's health. In addition, different innovative initiatives and strategies are presented in the context of tackling the COVID-19 pandemic.

These stories also highlight the crucial role of nursing and midwifery professionals in health systems and in their own communities. These professionals train the population and promote community health care, based on the guidelines for primary health care *(15)*.

The purpose of this publication is to disseminate the stories of different health professionals in the area of women's health and in the training of other professionals. It also focuses on the reality of women's health in different countries of the Region and the initiatives taken by professionals to guarantee humanized quality care, as well as professional training. It should be noted that the main interest of this publication is to present lived experiences, as communicated by the authors themselves.

Methodology

This document follows *Perspectives and Contributions of Nursing to the Promotion of Universal Health,* published by PAHO in 2020 *(16)*.

Initially, the project that culminated in the previous publication was developed in partnership with the University of Illinois School of Nursing (a PAHO/WHO Collaborating Center) with a compilation of case studies, initiatives, and activities of nursing professionals working in the United States of America. In 2019, PAHO joined the project and expanded its scope to the other Member States in the Region of the Americas. The Organization requested that PAHO country offices, nursing associations, heads of nursing, and social networks in the Region provide cases, stories, and activities involving nursing professionals. A template was then developed to outline the objectives of the service, project, or program described, the type of work involved, the results, and the population served.

By the end of this process, more than 400 stories were received. From these PAHO made a selection based on their relevance to the theme of the publication, the quality and consistency of their content, and the innovative practices they offered to the Region.

Perspectives and Contributions of Nursing to the Promotion of Universal Health included 41 stories. For the current publication, PAHO selected 17 additional stories from those received. Although not all countries in the Region are represented, the stories of these nursing and midwifery professionals provide experiences and contributions to women's health and address situations that are common throughout the Region. All the initiatives and stories presented here focus on the health of women, users of health services, health professionals, and their families.

PART I

Initiatives by Health Professionals at The Three Levels of Health Care

Breastfeeding in a First-level Health Service

Jeanneth Lourdes Madrid Lara

BOLIVIA (PLURINATIONAL STATE OF)

The Garcilazo Bajo Health Center was created in 2003 as a public institution at the first level of care, dependent on the Ministry of Health and Sports, the Department of Health Services (SEDES) of Chuquisaca, and RED I Sucre—District II Santa Bárbara Sul. The human resources working at the center are four doctors, two qualified nurses, a dentist, and a vaccination technician, for a total of eight professionals.

On 8 October, 2018, the center underwent an external evaluation for certification as a Mother- and Child-friendly Health Center below, as part of the process of awareness, training, and institutional strengthening to monitor the 11 stages of breastfeeding.

The evaluation process started in 2017. In the beginning, health professionals were not motivated and committed. Even so, local, departmental, and municipal authorities were invited to consider the experience of the Garcilazo Bajo Health Center above as a model that could be replicated in all health posts in the municipality of Sucre.

Policies to promote breastfeeding have been developed for all health professionals who have had contact with women in any way during pregnancy and the puerperium, during the care of women and newborns, or in the first months of life. It was considered essential to propose inclusive, intersectoral, and interinstitutional strategies in conjunction with the whole of civil society, in order to involve the health team, municipal authorities, and parents to achieve change and empowerment in the health of the population of the municipality of Sucre.

This led the health professionals to establish the general objective of designing policies to encourage breastfeeding at the Garcilazo Bajo Health Center. To this end, the following specific objectives were established: *1)* develop the Breastfeeding Promotion standard, in order to update and standardize the technical knowledge and skills of health professionals for the promotion, protection, and support of breastfeeding; *2)* sensitize and empower families and civil society to promote, protect, and support successful breastfeeding practices; and *3)* develop monitoring mechanisms and encourage breastfeeding promotion and protection.

Having defined the specific objectives, the Breastfeeding Committee was created, with the participation of all health professionals and with members of civil society as strategic allies. The committee held several meetings to define the baseline and carry out the analysis of scenarios

It was found that the time available for promotion and encouragement of breastfeeding in the different services was insufficient due to the high demand on the part of the users of the health center. Consequently, the intended message reached its recipients in an incomplete or distorted form, so it was decided to establish a Breastfeeding-friendly Center. At this location, the health team offered theoretical and practical education classes for pregnant women and mothers with breastfeeding children.

(strengths, weaknesses, opportunities, and threats—SWOT). Institutional standards were developed according to the socio-cultural context and the work plan was defined, which included scheduling, budgeting, supervision, and evaluation.

It was essential to train health personnel in topics such as early attachment techniques, breastfeeding techniques, late umbilical cord ligation, working mothers and lactation, composition of breast milk, and mastitis. In addition, it was important to make the team aware of the institutional standards and the application of the 11 steps to ensure successful breastfeeding. During the training process, the training of the team and its commitment to the institutional policy for the promotion of breastfeeding improved. Subsequently, the standards and their thematic content were delivered in digital and hard-copy format.

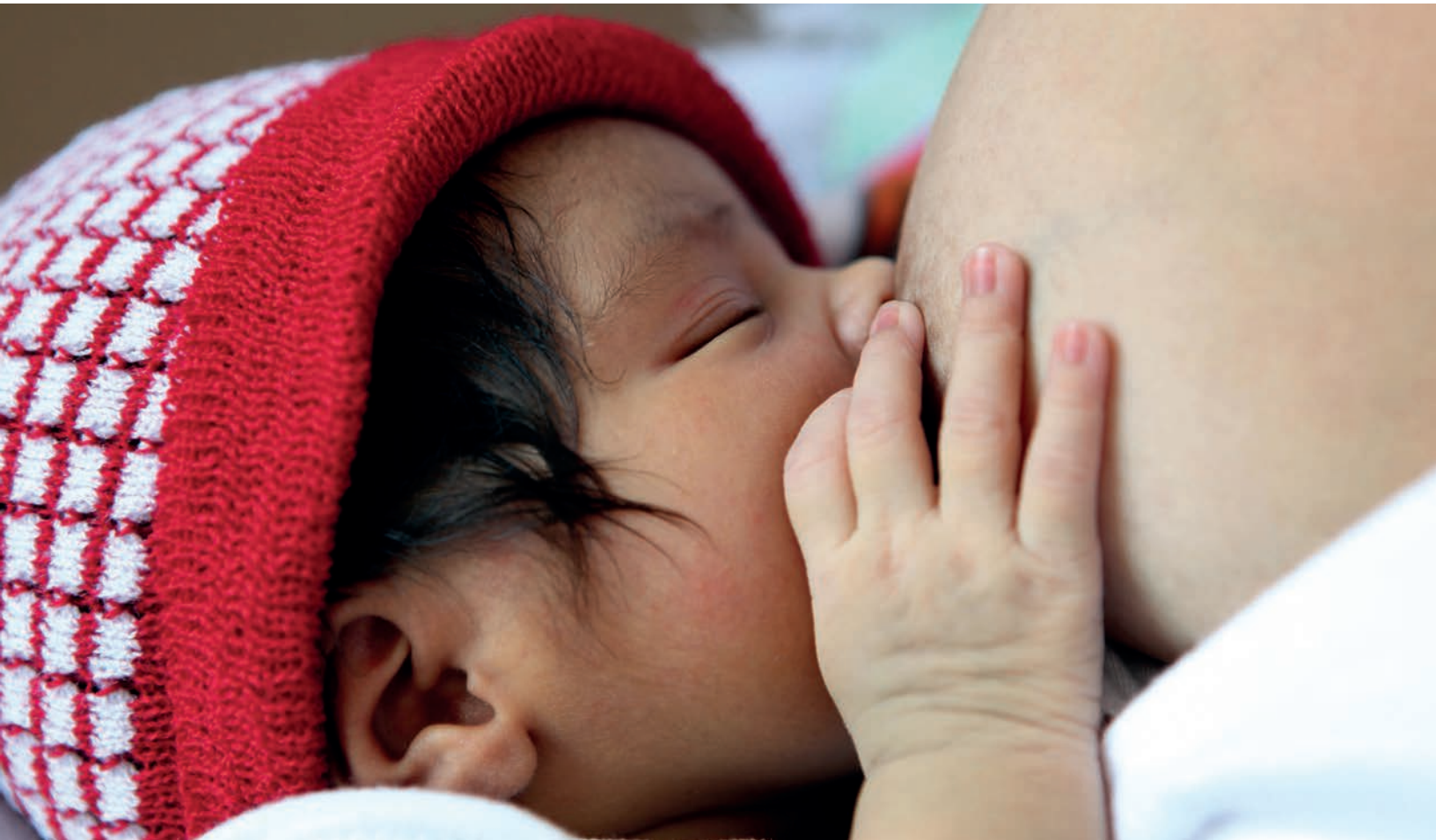
Some people made voluntary financial contributions and collaborated free of charge, ensuring that several activities could be carried out to promote and encourage breastfeeding, and helping achieve certification as a Mother- and Child-friendly Health Center. These financial resources also made it possible to design and standardize teaching material appropriate to the cultural context of the region to be used in educational activities aimed at mothers and organized groups from civil society, applying participatory dynamics techniques. It is noteworthy that the anatomical models of the breasts, mothers, and babies were prepared by the health professionals themselves.

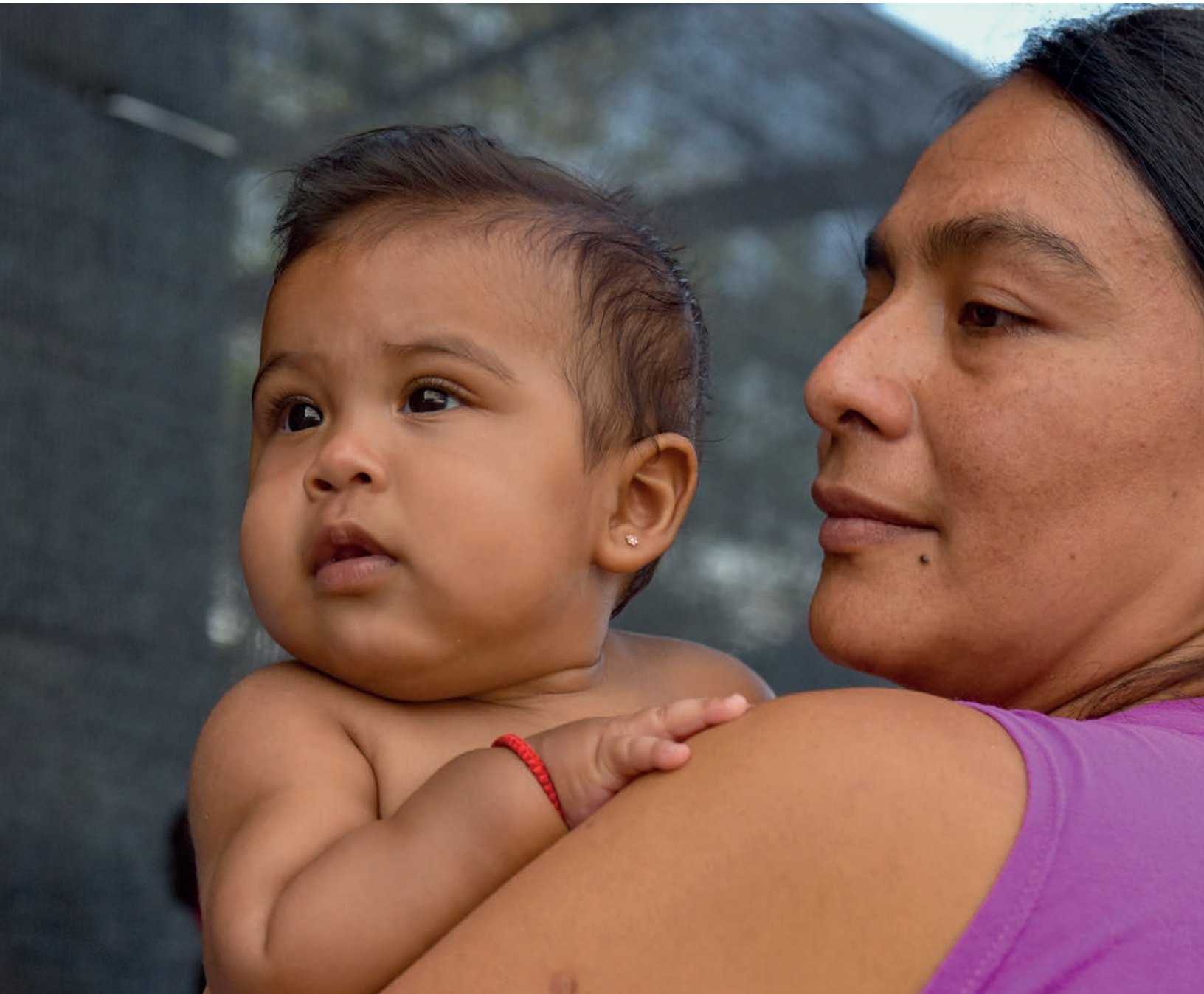
The awareness and empowerment of families and civil society with regard to the promotion, protection, and support of successful breastfeeding practices was developed during the process of assisting pregnant women and monitoring the health of children under 2 years old. However, it was found that the time available for promotion and encouragement of breastfeeding in the different services was insufficient due to the high demand on the part of the users of the health center. Consequently, the intended message reached its recipients in an incomplete or distorted form. Therefore, it was decided to establish a Breastfeeding-friendly Center. At this location, the health team offered theoretical and practical education classes for pregnant women and mothers with breastfeeding children.

Strategic allies to achieve the objectives included different members of civil society, who participated in lengthy meetings of neighborhood councils to inform, raise awareness, and train participants on the promotion and encouragement of breastfeeding to benefit children, mothers, and families. During the meetings, women from the most vulnerable neighborhoods who could act as “guide mothers” were identified and recruited for this role, helping to orient mothers about problems that put breastfeeding at risk, especially for adolescents and women in their first pregnancy.

The Garcilazo Bajo Health Center was evaluated to certify it as a Mother- and Child-friendly Health Center. This was done jointly by the SEDES Chuquisaca Nutrition Unit, the Ministry of Health and Sports, and UNICEF. The evaluation process was based on forms that developed the 11 stages of successful breastfeeding, and included interviews with health professionals and observation of mothers in the waiting room. The training programs and content were reviewed and all the services of the health center were visited. Finally, an analysis was made of the progress and pending tasks.

The evaluation committee gave the Garcilazo Bajo Health Center 97.3 points out of 100, and the Center received the certification of Mother- and Child-friendly Health Center.





Innovative practices in obstetric care with the MATCH program

Susana Ku, Jenna Bly,
Shezeen Suleman, Elizabeth Darling

CANADA

Although indigenous peoples have practiced obstetrics for centuries, it was only in 1994 that midwives were regulated or integrated into the Canadian health system, specifically in the province of Ontario. The original model of obstetric care is financed with public funds from the province and follows a continuity-of-care model led by midwives.

Ontario midwives work autonomously to provide community-based antenatal care and attend births. They maintain their skills inside and outside the hospital environment and provide early postpartum care at home. The profession's philosophy promotes normal childbirth and provides user-centered care, with a strong emphasis on continuity of care, choice of place of birth, and discussion of informed choice. In recent years, Ontario midwives have been looking for other ways to organize and practice, especially with the aim of addressing health care gaps in their communities and using their knowledge and skills in new ways.

In 2018, the Ontario Ministry of Health launched a call for proposals for alternative models of practice. In the previous three years, a task force that included midwives in hospitals and community health centers had been working to develop a vision for an alternative and integrated model of obstetric care. This work culminated in the Midwifery and Toronto Community Health Program (MATCH), an innovative initiative launched in Ontario in 2018 to meet the specific needs of the community, with the goal of serving people with significant difficulties in accessing high-quality perinatal care. The team consists of four midwives and a social worker, located in East Toronto, and is integrated into the programming of the South Riverdale Community Health Center. All are employees of the Center, provide health care, and work as a team and in direct collaboration with doctors, nurses, physiotherapists, nutritionists, health personnel specialized in risk management, and community health agents, among others.

The objective of the program is to reduce the significant gaps in care needs and poor access to health care for many people. During the first six months of the program, midwives met with shelters in the area, nurses who provide health care on the streets, public health nurses, neighboring clinical teams, and staff from early childhood education centers in order to conduct a needs assessment, examine existing services, and establish relationships and referral paths for users.

The program offers Ontario's original model for midwifery. Midwives provide on-call services 24 hours a day during pregnancy and for the first six weeks after delivery, participate in labor and deliveries in hospitals or in clients' homes, and carry out postpartum visits at home or in shelters up to two weeks later, in addition to providing continuous care to parents and newborns up to six weeks postpartum. The program offers discreet postpartum referral care, counseling on pregnancy options, medical abortion up to 11 weeks of gestation, early management of pregnancy loss with mifepristone and misoprostol (Mifegymiso), and case management referrals for late pregnancy terminations or surgical abortions. Together with the rest of the primary care team, midwives have access to a consulting psychiatrist during weekly meetings to discuss complex cases involving mental health problems.

During the pandemic, when a large part of the health team cut face-to-face services, the team continued to provide services to needy clients. They offered a telephone to clients who did not have one, in order to guarantee access to care continued to visit the city's shelter system, and even provided face-to-face care at the city's "COVID hotel" (emergency shelter for homeless people who tested positive for COVID-19) for several infected users and their babies.

Users have access to vaccines that require a prescription. Through collaborative practice with nurses and advanced practitioners, midwives can easily order laboratory tests that are often needed during perinatal care, but are not included in the list of tests they can order (such as hemoglobin electrophoresis, glycated hemoglobin or HbA1C test, TSH test, and vitamin B12 test), and access other common prescriptions that are not included in obstetrics pharmacotherapy. The team also receives referrals from other midwives to offer free access to vaccines to clients without provincial health insurance or without access to primary care. All patients are referred to primary care services before discharge from obstetric care, six weeks after delivery. All babies have access to routine vaccines, and parents can access contraception.

The program offers services to people who face barriers in accessing quality perinatal care. Of the current list of clients, 83% are indigenous or of African descent, 44% do not have

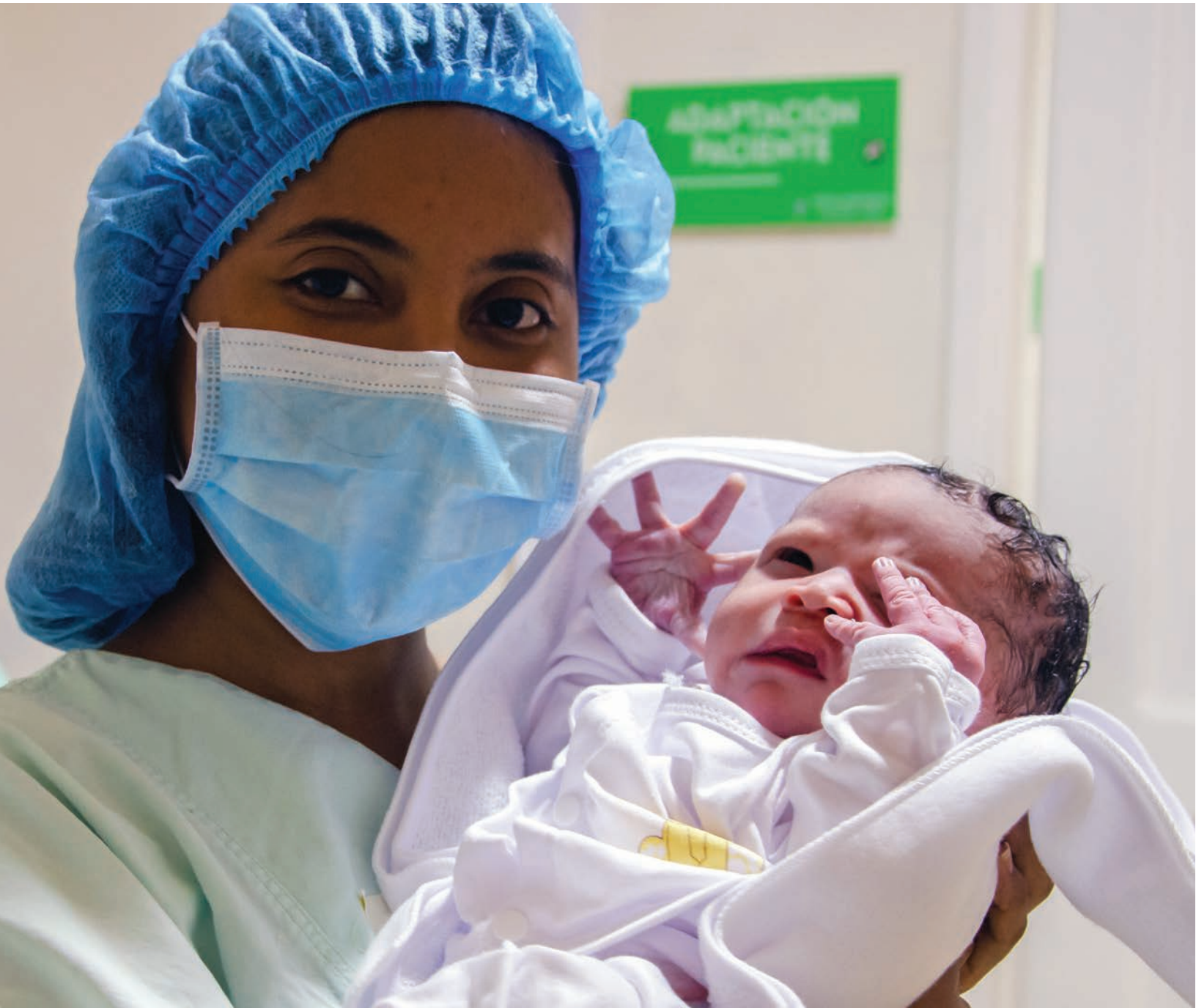
provincial health insurance, 80% live on low income, and 65% do not have a fixed address. During the midwives' initial needs assessment, they found that pregnant women who use drugs often do not have access to prenatal care or to substance use services. The project team immediately established a relationship with these women about substance use during pregnancy and worked to increase skills and knowledge in this area. Midwives serve clients for antenatal care, but they also have access to an advanced practice nurse specializing in addiction and abstinence treatment, and to the hospital's addiction medical staff. They also coordinate care with a multidisciplinary team from the hospital that includes obstetrics, nursing, pharmacy, and anesthesia professionals.

The social worker provides support to clients in English or Spanish. The social worker helps women with case management, housing, crisis intervention, individual counseling, access to social services, and other community resources, and purchases everything needed for pregnancy and parenting. The team can also provide phone terminals or SIM cards to people without a phone. The midwives on the team speak Cantonese, French, Gujarati, and Kachchhi and can provide a translator in any other language. All of its services are free of charge for people living in Ontario.

During the pandemic, when a large part of the health team interrupted face-to-face services, the team continued to provide care to needy clients. They offered a telephone to clients who did not have one, in order to guarantee access to care; they continued to visit the city's shelter system; and they even provided face-to-face care at the city's "COVID hotel" (emergency shelter for homeless people who tested positive for COVID-19) for several infected users and their babies.

Recently, midwives were trained to perform ultrasound exams during the early stages of pregnancy. Specifically, this plan is to streamline abortion care by offering ultrasound exams at the point of care, in the clinic.

In the two and a half years since the launch of the MATCH program, the team has continued to build a supportive and committed relationship with the leadership team and has established strong relationships with the hospital's obstetrics department. The salaried employee model also allows team midwives to prioritize changes in the system, leadership, and advocacy work, and to participate in a variety of leadership groups dedicated to the defense of uninsured or homeless people, including access to abortion, racial equality, inclusion of the lesbians, gay, bisexual, transgender, and intersex community, obstetrics and childbirth, infection prevention and control, and quality assurance, just to name a few.


ADAPTACIÓN
INCUBATE

Taking care of pregnant women, children, and families

Nada Natasha

GUYANA

People from different religious backgrounds, such as Christians, Hindus, and Muslims, live in the Plaisance area. Those of Indian origin believe that when a woman is in labor, she must let go of her hair and the baby will be born faster. They also believe that if the baby's head is not shaved, it will bring bad luck, and that if the woman brings three children of the same sex into the world and has a fourth child of the opposite sex, it will bring good luck and wealth to the family.

People of African descent believe that if a mother loses her child, she should not go to the cemetery or the rest of her babies will also die. If someone in the family dies, all small children in the household must move from one side of the coffin to the other three times. They call it "going over the dead" and they do it so that the dead don't go looking for the little ones at night.

People of African and Indian origin believe that a pregnant woman should not eat from the pepper pot because the baby can burn, especially its eyes. To avoid the evil eye (making the child sick), a black spot is placed in the middle of the child's forehead, which they call a *tika*.

In prenatal care, it is important to ensure that both men and women meet their physical, emotional, economic, social, and spiritual needs to have children and care for them. Respecting culture is an important issue. Therefore, prenatal counseling and advocacy provide women and their partners with important and necessary information to make informed decisions about their reproductive future.

If a woman arrives at the clinic because she thinks she is in full-term labor, she is evaluated. If she is indeed in the initial stage of labor, she is referred to the maternity ward accompanied by a family member.

In 2017, a Health and Wellness Clinic for teenagers was established, as well as a community support group for teenagers, men, and women in the community. One-hour educational sessions are held at the clinic once a month. The focus is on friendly relationships among young people, their activities in personal development, decreasing mortality and morbidity in this age group, reducing teenage pregnancy, and increasing family planning. In addition, the center seeks to increase the participation of parents in caring for their children and in supporting mothers. Referral services are provided when the need arises.

It is a successful program. The results show that it is beneficial for individuals, families, and the community, but it needs more day-to-day support. Men receive education and join continuing education programs without being discriminated against for being teenage parents or having had a child in their teens.

Pregnant women come to the clinic for health care. They are welcomed, registered, and advised on clinical procedures. They can stay in the clinic or be referred to a higher level of care, if necessary.

Mothers are advised to look after themselves and their fetus, and education is provided to fathers. The focus is on monitoring the growth and development of the fetus and identifying abnormalities that can interrupt the normal course of labor.

The importance of attending clinical appointments is also emphasized to the women. When registering, mothers receive a code that is used to register each pregnancy as soon as they use the public health service. The pregnant woman is examined to see if there is a risk of complications. A general history is obtained and measurements and results (height, weight, blood pressure, pulse, urine glucose level tests, and baseline proteins) are recorded at each follow-up visit.

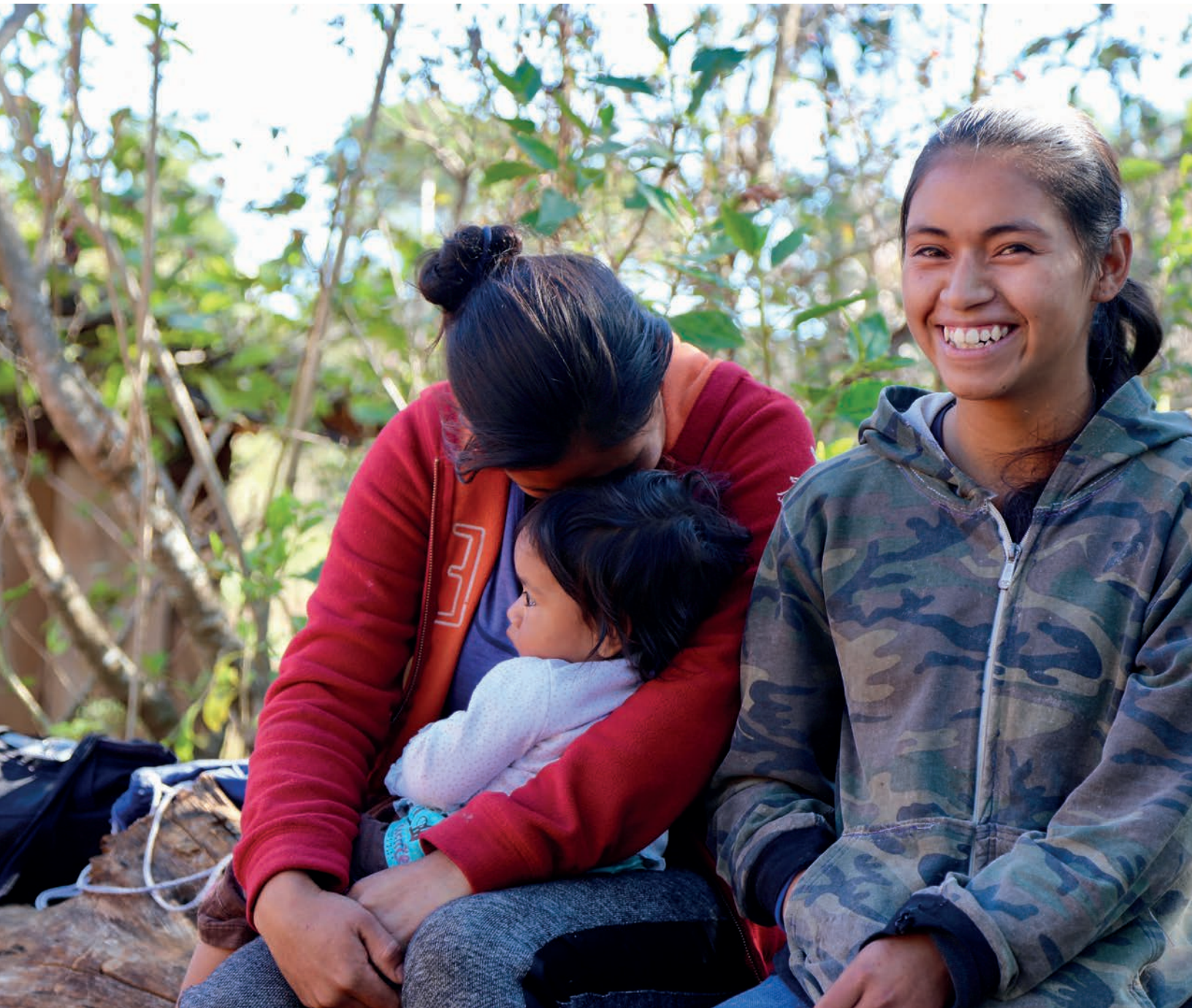
On her first visit, the expectant mother is examined from head to toe. The abdomen is palpated and the uterine height is evaluated to compare different gestational ages, as well as the fetal position and presentation if the pregnancy is far enough along, and the heartbeat of the fetus. Laboratory technicians also perform routine tests, including hemoglobin tests to assess anemia, HIV and syphilis tests, and tests to determine blood group and Rh factor. Blood smears are taken for malaria if the mother comes from the interior of the country, and parents and couples are invited to have tests for HIV, blood group, and Rh factor.

If a woman goes to the health center because she thinks she is in full-term labor, she is evaluated. If she is in the initial stage of labor, she is referred to the maternity ward accompanied by a family member. Monitoring is done through calls and home visits. All women with a high-risk precondition and complications that appear during pregnancy should be treated at the obstetric office. Some examples are anterior cesarean section, myomectomy, abortions or premature birth, pregnancy-induced hypertension, stillbirth, neonatal death, low birth weight babies, congenital anomalies, anterior cervical laceration, previous third-degree perineal lacerations, and HIV-positive mothers, among other situations.

Postnatal home visits take place after mothers are discharged. They are invited to visit the clinic with the baby within 28 days of delivery and are evaluated and observed. The mother looks for secretions, lochia, engorged breasts, involution of the uterus, and pain in the legs, and, in the case of cesarean section, the surgical site is evaluated. Mothers are encouraged to exclusively breastfeed their babies and the great benefits for the baby, mother, and family are highlighted.

Dietary and nutritional advice is provided to prevent anemia. Clients are encouraged to perform postnatal exercises to tone the abdomen and Kegel exercises to tone the pelvic floor and perineum muscles. Tips for caring for the perineum are provided if the mother had an episiotomy or if she had a rupture during childbirth. Guidance is offered on family planning to space births, the kind of care newborns need, and what vaccinations to give, among other topics.

The baby is registered at the clinic and examined from head to toe for possible abnormalities, reflexes, and the health of the umbilical cord. Any changes detected in the mother during the postnatal consultation and the baby's admission are referred to the doctor responsible for the outpatient clinic for further management. The mother is encouraged to attend all clinical appointments and keep the baby vaccinated.



Maternal and child health clinics and care for chronic patients

Duan Lewis-Garnett

GUYANA

I started my journey as a midwife in April 2011. The first years of work at the Buxton Health Center were very difficult. Friendship, the community twinned with Buxton, was suffering from years of violence. The residents of Friendship asked to be seen at neighboring health centers like ours, because, in that turbulent period, they were afraid to go to the clinics in their area. My task and that of the rest of the nursing team was to convince them to come to our health clinic. Most patients were satisfied with the service we provided, so much so that they encouraged other residents of Buxton and many other villages to use our services.

The Buxton Health Center primarily serves the health needs of residents in the area. But its doors are open to anyone, regardless of their area of origin, ethnicity, sexual orientation, profession, or religious belief. The target population is about 6,635 patients, to whom we offer a variety of services. We currently have a pharmacy, with dental care, phlebotomy, and ultrasound. I participate in all other aspects of care at the health center. Sometimes I see patients at the chronic disease clinic and I also spend days treating our outpatients for diabetic foot.

As for prenatal care, a typical day at the Center begins with the preparation of the medical records of the previous day. I spend most of the day in SMI (Safe Motherhood Initiative) clinics, where the four pillars of safe motherhood are addressed (family planning, prenatal care, clean and safe delivery, and integrated essential obstetric care), and growth and development are monitored. The ultrasound service is easily accessible. Thus, it is possible to correct the gestational age of the pregnant woman and make clear diagnoses, among other aspects of any ultrasound examination. I also do whatever it takes to get all blood samples from pregnant women on the same day as the consultation.

Mothers are advised to wear comfortable clothes, as they often participate in the Lamaze method classes for natural childbirth. In addition, it is customary to advise them on self-acceptance of their pregnant bodies, modified diets, breastfeeding benefits, family planning, mental illnesses in pregnancy and in the postpartum period, and signs of labor, among others.

Women and their partners are also encouraged to ask for sexual and reproductive health advice.

Adolescent mothers receive special attention through the Adolescent Support Group, which meets every third Wednesday of the month. In addition to discussing general issues related to pregnancy, participants are encouraged to discuss their difficulties as teenage mothers and to think of solutions to overcome them.

My life as a nurse and midwife is not limited to the health center building. I also work in the community, where I get first-hand information about my patients' living conditions. This allows me to understand why some babies always have a skin infection or why there are mothers with recurrent anemic values. I am motivated to continue to work hard as I enthusiastically enter schools to speak with parents and teachers during parent-teacher conferences and meetings. I take advantage of these moments to involve all participants in different aspects of health. I speak about the importance of cancer detection, vaccination, and even deworming. Because I am very convincing, I was also invited to carry out vaccination and deworming campaigns in these schools. We also distribute condoms regularly—more often just before the holidays.

One of the experiences I remember in my work as a nurse and midwife is helping to give birth in the back seat of a car. I was also a liaison officer for a non-governmental organization that wanted to work with teenagers and girls in our area of influence. It was a rewarding experience to see these young women acquire the necessary knowledge about vaccines against human papillomavirus (HPV), self-awareness, and financial stability.

Strengthening the first level of care with a focus on the community

Veyra Beckford Brown

PANAMA

The Regional Hospital Dr. Raúl Dávila Mena is located in Changuinola, in Bocas del Toro Province. It is a hospital at the second level of care and fifth level of complexity, being the only referral center in the province, receiving all cases referred to the provincial level. To access the province by land from Panama City, it is necessary to travel 626 kilometers, and it is 186 kilometers to the nearest province. There is no land access to the only regional referral hospital, so transfers must be made by air or sea, which makes it difficult to arrive in time.

The Comptroller General of the Republic of Panama reported a national maternal mortality rate of 39 and 36 per 100,000 live births for 2015 and 2016, respectively. In Bocas del Toro Province, it was 52 and 76 per 100,000 live births in the same years, respectively. In addition, across the country there were 7.2 and 7.7 perinatal deaths per 1,000 live births, and in Bocas del Toro Province, 10.5 and 13.2 per 1,000 live births in the same years. The figures for Bocas del Toro Province stand out for a significant increase that exceeds the figures for the country as a whole.

To strengthen the first level of care with a community approach, the community diagnoses presented in Chart 1 were performed with community participation, in response to the realities of the maternal-perinatal population.

To strengthen the first level of care based on the community approach, community diagnoses were carried out in response to the realities of the maternal-perinatal population, with community participation.

Chart 1. Participatory community diagnoses of reproductive-age populations in five geographical areas of Bocas del Toro Province

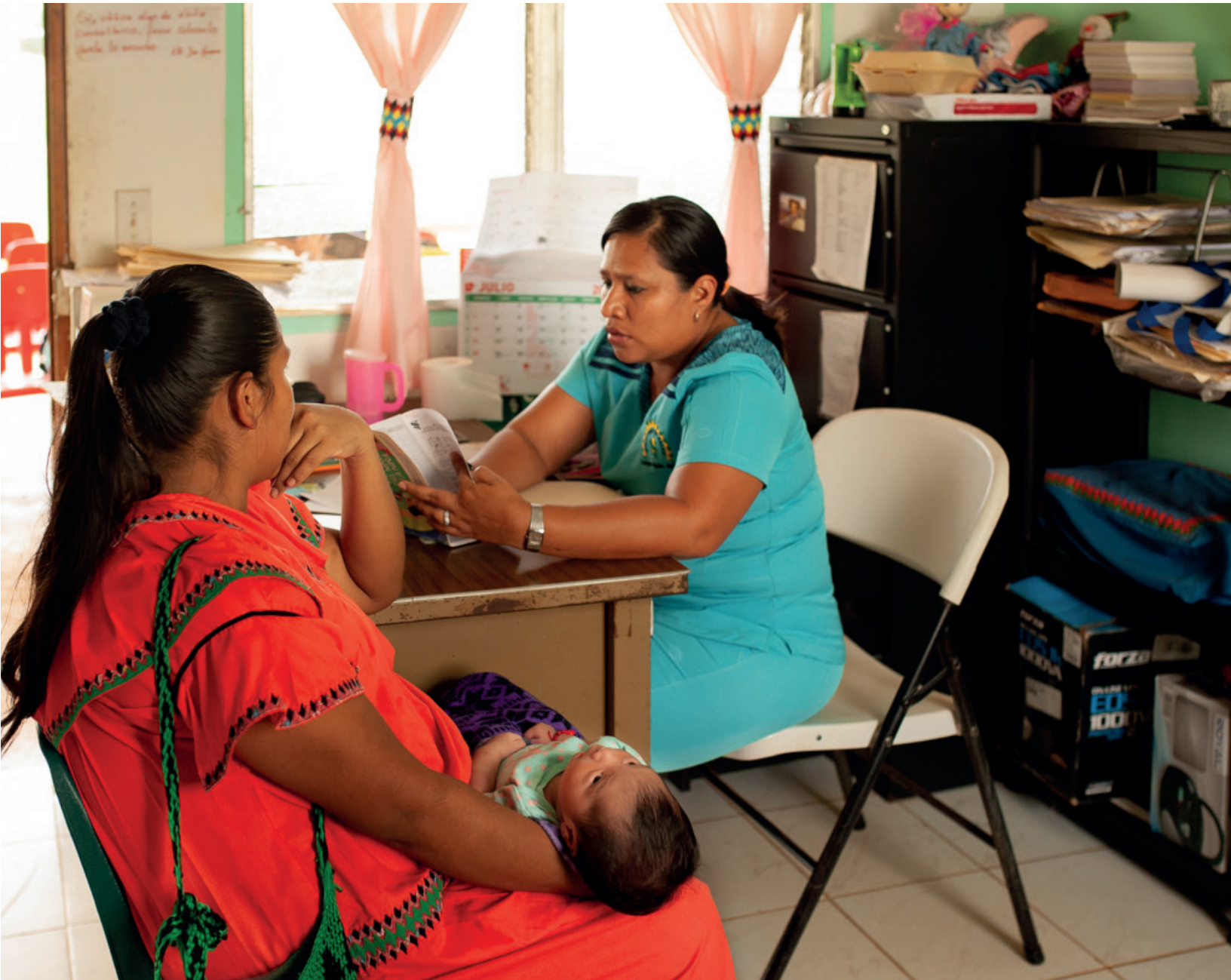
Geographic Zone	Community Diagnosis	Action Plan	Target Population
District of Chiriquí Grande	Onset of sexual life at a young age Multiparity	Formation of a team of peer educators and health promoters	13 high school teenagers from Chiriquí Grande, residents of the community of Chiriquí Grande
Municipality of Almirante	Teenage pregnancy	Formation of a team of peer educators	10 high school teenagers from Almirante living in the Almirante community
District of Changuinola	Failure to get a Pap smear	Formation of a team of health promoters	12 high school teenagers from Finca # 02 living in the community of Finca # 02
Municipality of Guabito	Teenagers with HIV	Formation of a team of peer educators	14 high school teenagers from Guabito living in the community of Guabito
Municipalities of Las Tablas	Teenage pregnancy	Formation of a team of peer educators	10 teenagers from the Nievecita School living in the community of las Tablas

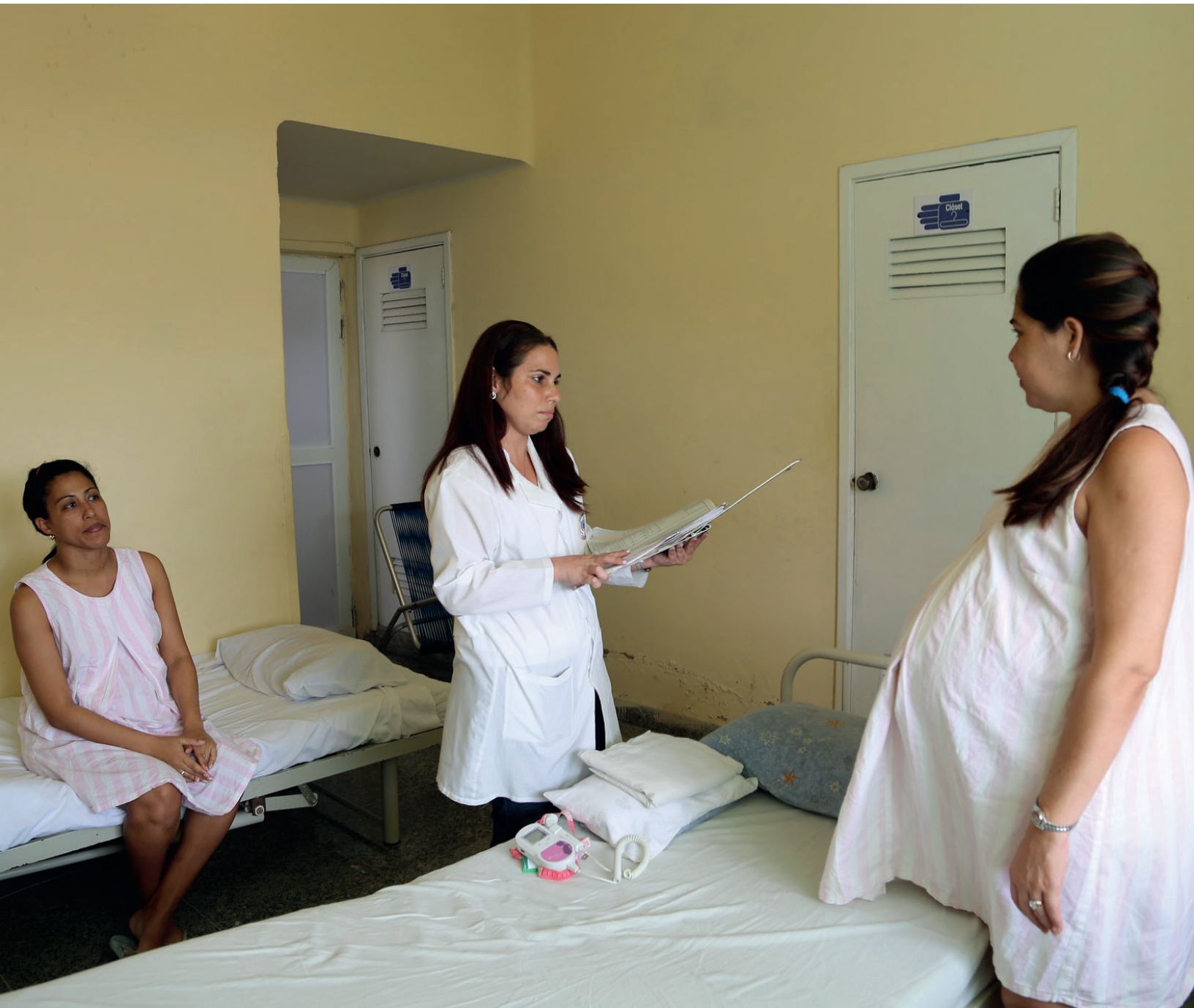
The results of community diagnostics reflect the expressed needs of members of these communities. This practice seeks to connect the social determinants of health, human security, and the renewal of primary health care from the perspective of community participation so that society in the target communities satisfies the needs of its maternal-perinatal population.

Each of the community diagnoses sought to fulfill the individual and collective rights of the community through the participation of its members. They expressed the main health problems they face, which allowed them to determine the inequities, inequalities, and social determinants that negatively affect their health.

When each of the action plans was established to respond to the community's diagnoses, several differences could be recognized. These involved the need for an intercultural approach to health, with equality and mutual respect, as well as competencies that facilitate the community's organization of interventions, in line with the established strategies and the results of the diagnoses.

Indicators of success were one hundred percent of community diagnoses were performed and 100% of action plans were implemented through the formation of three groups of peer educators on four topics: *1*) teenage pregnancy, *2*) HIV in adolescents, *3*) early sexual initiation and multiparity, and *4*) failure to get a Pap smear.




Closet

Humanized maternity and childbirth assistance

Mercedes Pérez

URUGUAY

The Maternal and Child Education Program was carried out in a private maternity hospital in Montevideo between 1979 and 2008, led by a nursing team. Most users of this institution are health professionals (especially in medicine), most of them with higher education. The number of pregnant adolescents was below the national average, coming from the middle and upper middle classes. During this experience, activities specific to the profession were conducted: care management, teaching the user population and professionals involved in the care of newborns and their families, early detection of complications, identification of growth problems, identification of environmental risks in family settings unknown to hospital teams, and extended exclusive breastfeeding.

Education for pregnant women and family members started in 1985 with a course that initially focused on preparing for childbirth. However, in view of the assessments and needs identified during its development, it was decided to implement a course coordinated by the nursing team that included activities involving several members of the institutional health team and families. These activities were accredited by ISO 9000-2000 standards.

The program was developed in 10 face-to-face sessions, in which pregnant women were accompanied by a companion, preferably their partner or whoever would be with them during childbirth. In all cases, relaxation, breathing, and stretching exercises were used to improve the body conditions of users, with the support and guidance of their companions who would be with them during labor. These exercises were led by midwives and physical therapists.

The activities were coordinated with professionals who defined the contents, methodology of working with users, and time needed to carry them out. The professionals who participated were:

1. Midwives, for advice on labor and delivery.
2. Nurses, for the workshops on newborn care, lactation, care during pregnancy, and the puerperium.

3. Oral hygienist.

4. Gerontology team, for an activity on intergenerational ties, role of grandparents, newborn care, and general health care.

5. Pediatricians and gynecologists, to answer the questions raised and reinforce concepts about natural childbirth, breastfeeding, the importance of medical check-ups during pregnancy and the puerperium, and newborn care.

The activities were carried out through participatory group dynamics to promote exchanges between pregnant women and their partners or family members. Activities were based on the knowledge and myths with which they arrived. Information based on scientific evidence was offered, promoting critical analysis of the information if it was confusing or did not reflect the individual situation.

Self-care and the strengthening of self-esteem were promoted, with a view to engaging in new family roles.

One of the important aspects of this educational activity was visiting the maternity hospital to get to know the hospital teams and delivery room, in order to eliminate unfounded fears and make the women feel more comfortable. During the visits, there were discussions with patients in different stages of hospitalization, especially puerperal women and their families.

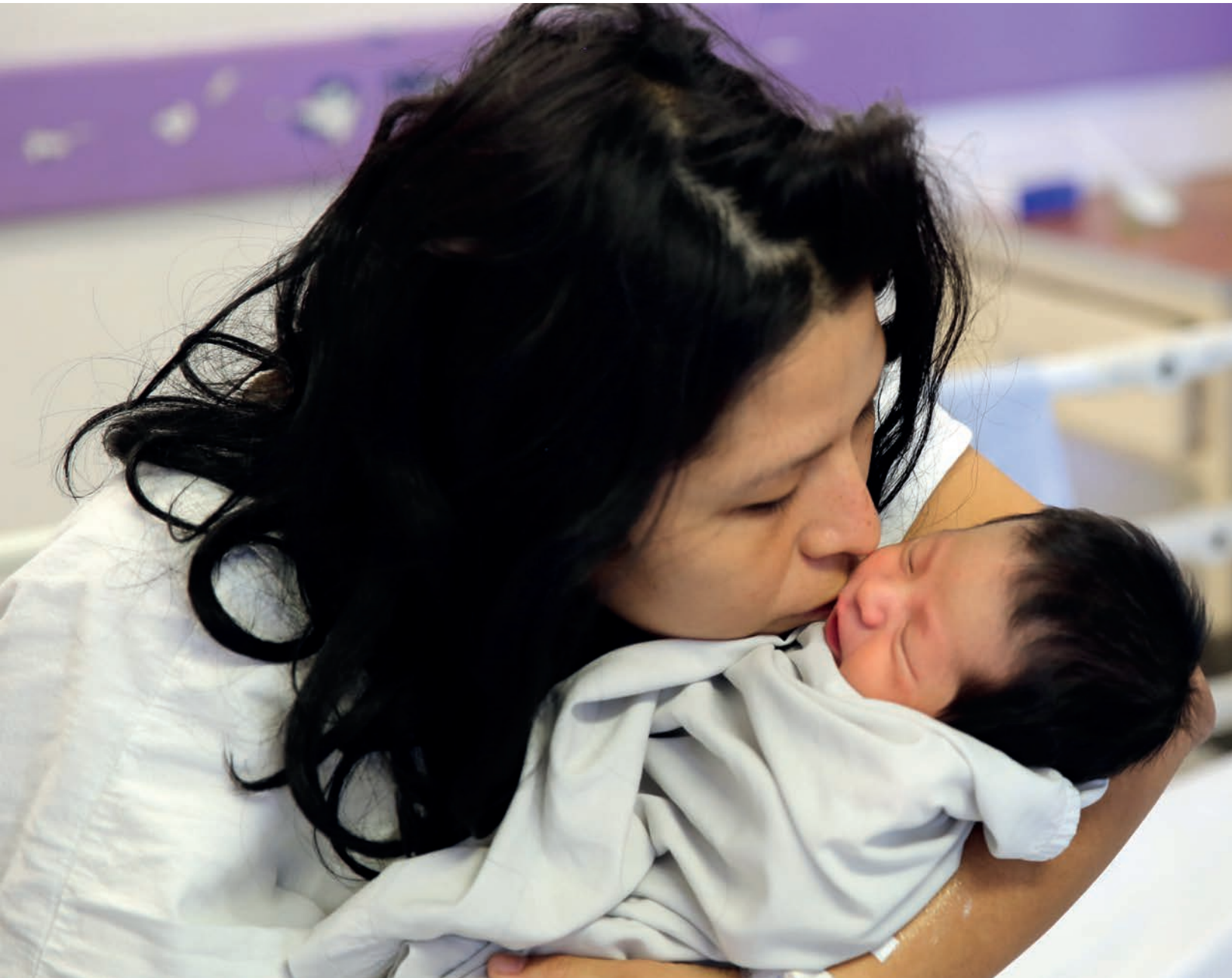
Activity records were stored permanently in Epi Info, a set of computational tools for researchers. This made it possible to keep statistics on the activities, number of users, and user profiles. The results were evaluated and some attempts were made to measure the impact of the activities.

The nursing team had a key role in monitoring the activities of the interprofessional team and in the organization and monitoring of activities. The team guaranteed the continuity of each activity for five weeks, with conversations between users and their families in each of the activities.

The evaluations showed that the activities were very rewarding for the users and fostered links with the health service and the team that exceeded initial expectations.

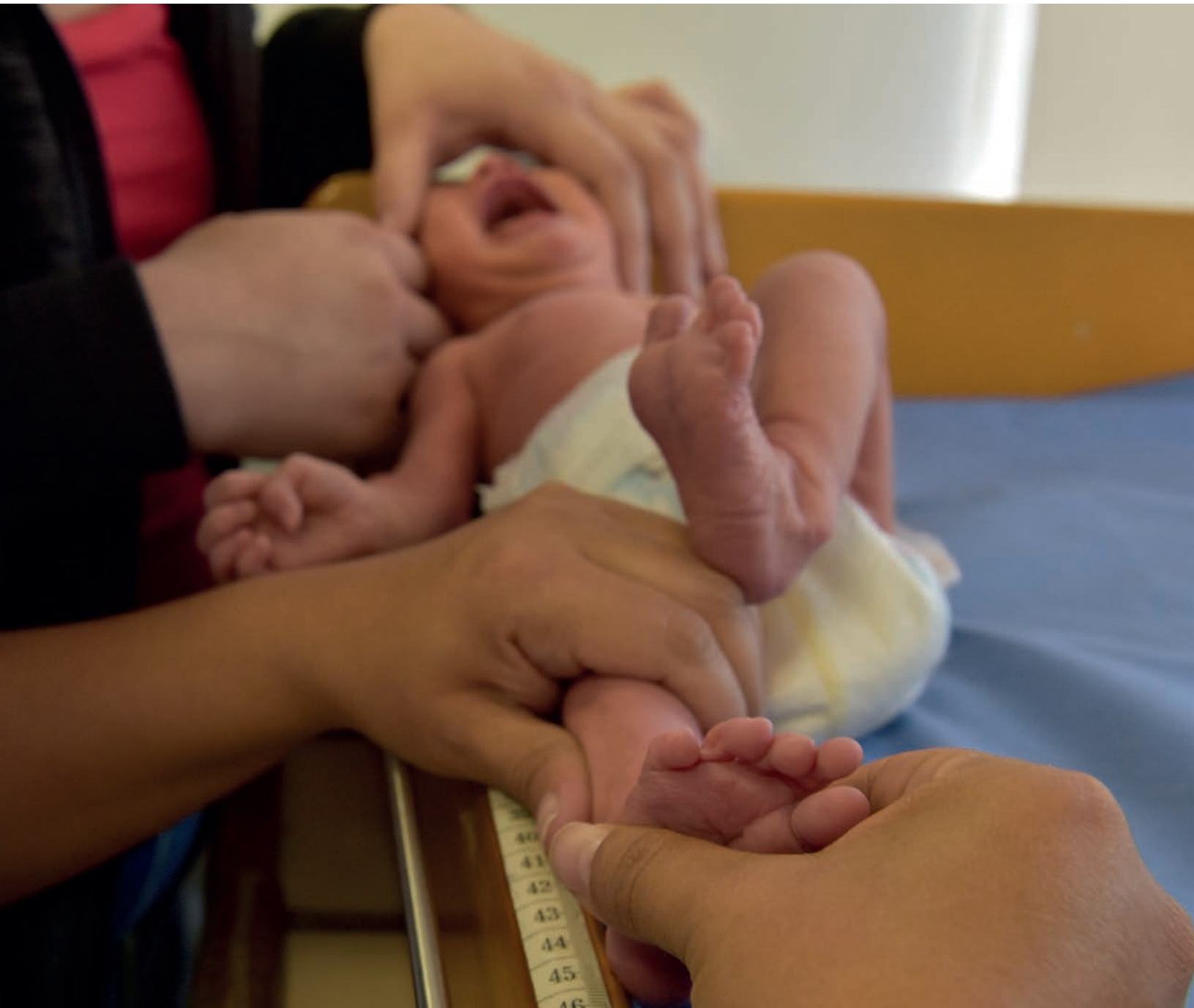
The team was very motivated and made constant proposals for the improvement of activities. They were highly valued by the institutional authorities and received recognition from different areas.

For the nurses, this was an autonomous program coordinated with other professionals, greatly strengthening their autonomous development in the profession.



PART II

Initiatives by Nursing and Midwifery Professionals in Remote Communities and Vulnerable Populations



Maternal and neonatal care in a remote community

Catarina Maldonado Sajbin

GUATEMALA

At the time this case occurred, in the Baldío Vergel community, in the Zona Reyna Uspantán Quiché, it was necessary to walk six hours on foot to reach the road, with a difficult-to-access one lane road that was only used in emergencies and a landing area that an airplane could use only if it was not cloudy.

The population is Qeqchi'-speaking and their educational level is low. This community is made up of 670 inhabitants and only 18% of adult men can read. The school has a wooden classroom where classes from various grades are taught. The community lacks drinking water and electricity, except for the most fortunate, who have a solar panel used for cardamom dryers. The phone signal is still not very good, although there are now more families with this service. The population is supplied with water from another community 25 minutes away. The community is entirely agricultural: planting and harvesting cardamom is their only source of income.

The Ministry of Public Health and Social Assistance conducts training in maternal and neonatal care for nursing staff working in primary health care services. It is based on the Health Care Standards, in which pregnant women are recruited before week 12 of gestation with the support of trained and active traditional midwives. Care is offered by a nursing professional who is in the area each month, often with the support of a nursing assistant.

When the pregnant woman cannot go to the health service, home visits are carried out to avoid obstetric risks. Prenatal care is provided monthly, accompanied by the midwife who will attend the home birth. These actions contribute to the reduction

The patient and the newborn were saved from a risky situation in a remote community thanks to the help of the family, who recognized the danger signs in time; and because the ambulance available to provide the service was in good condition and quickly reached the emergency site.

of maternal and neonatal mortality. As a rule, and taking into account that these are neglected and inaccessible communities, health professionals go from community to community, month by month, so that the entire population has access to health care.

RQ, a 28-year-old multiparous woman in the community of Baldío Vergel, had had regular prenatal exams at the Vergel Chimal health center since the 20th week of pregnancy, including an ultrasound. Her delivery was complicated because when the contractions started, vaginal bleeding began.

Realizing the complications, the family took her to the health center, which is half an hour's walk away. Placenta previa was identified, with active labor on a rainy day when the intravenous solution was not available. To initiate treatment, the patient was placed in a gynecological position with her legs elevated. At that time, there was radio communication and the health commission was called. An ambulance took three hours to arrive. In the meantime, the patient was given an oral rehydration solution, as it was the only one available at that time. The patient was transferred on a plank used as a stretcher when the ambulance arrived. She was in stable condition and immediately transferred to the National Hospital of San Miguel Uspantán.

The patient had a normal delivery upon arrival at the hospital. She received the necessary care, and both she and the newborn were saved from a risky situation in a remote community thanks to the help of the family, who recognized the danger signs in time; and because the ambulance available to provide the service was in good condition and quickly reached the emergency site. The work of the community organization continues to save the lives of mothers and newborns.

Respectful birth attended by midwifery professionals in cases of violence against women

Ameyalli Aide Juárez Orea

MEXICO

The population served at Casa Materna is made up of women of reproductive age and pregnant women who migrate to Chiapas to work in agriculture and coffee harvesting, and others who live in the Sierra Madre de Chiapas in the State of Chiapas. These places are usually difficult to access, and do not have health facilities close to the communities. The communication routes are rough roads or roads difficult to access and transit, and subject to extreme climatic changes.

Casa Materna has a 10-person supervisory team made up of two obstetric nurses, a perinatal nurse, and a team of nursing and midwifery interns. They are trained to provide care focused on professional obstetrics. Clinical supervision provides support during the evaluation of pregnant women, childbirth, the puerperium, and newborn care. Monthly clinical sessions on obstetric issues are also offered, organized and coordinated with the health team for quality care.

Some of the women who receive maternal care live in violent environments (physical, psychological, economic, or structural). Most of them are illiterate or have elementary education and do not know their rights.

It has been observed that men who attend the delivery are more receptive to family planning and value motherhood and their wives more.

The respectful model of care for childbirth with midwifery professionals at Casa Materna seeks to assist women beginning with obstetric screening to determine whether they are in labor or if they have any pathology. Then they move on to obstetric assessment and, if necessary, an obstetric ultrasound is performed. The psychological aspect is also assessed; if the patient is a candidate for a mental health assessment, she is placed in contact with the team for follow-up.

Various social aspects are assessed, including whether the patient has emotional and partner support, and whether she is

experiencing a situation of violence or food instability. If necessary, the patient is supported by pantries or food stamps until childbirth. One of the objectives of Casa Materna is for women to go there to await delivery to make sure they receive medical care, and for timely care to be provided in case of any complications during pregnancy or childbirth—or referral, if needed, to the second level of care, about two hours away. The future mother receives vouchers for fuel and supplies so that she can receive care she could not afford without such support. Pregnancy is evaluated and, if it is low-risk, it is attended at Casa Materna.

The patient is asked how she wants to give birth—on the obstetric bench, in four supports, lying down, or in a medical position. If she wants to be accompanied during labor and delivery. The working method is explained, since many of the women are coming into contact with the health system for the first time or have had bad medical experiences and have lost confidence in health professionals.

Women are allowed to walk around, eat, and drink without restrictions, considering the importance of keeping the body energized, so that the labor progresses properly. They are given explanations about how births are attended and practices for mother-child bonding, such as immediate skin-to-skin contact, and not immediately taking away newborns if they are born healthy. The importance of administering oxytocin to prevent bleeding is explained, and that it will be administered intramuscularly.

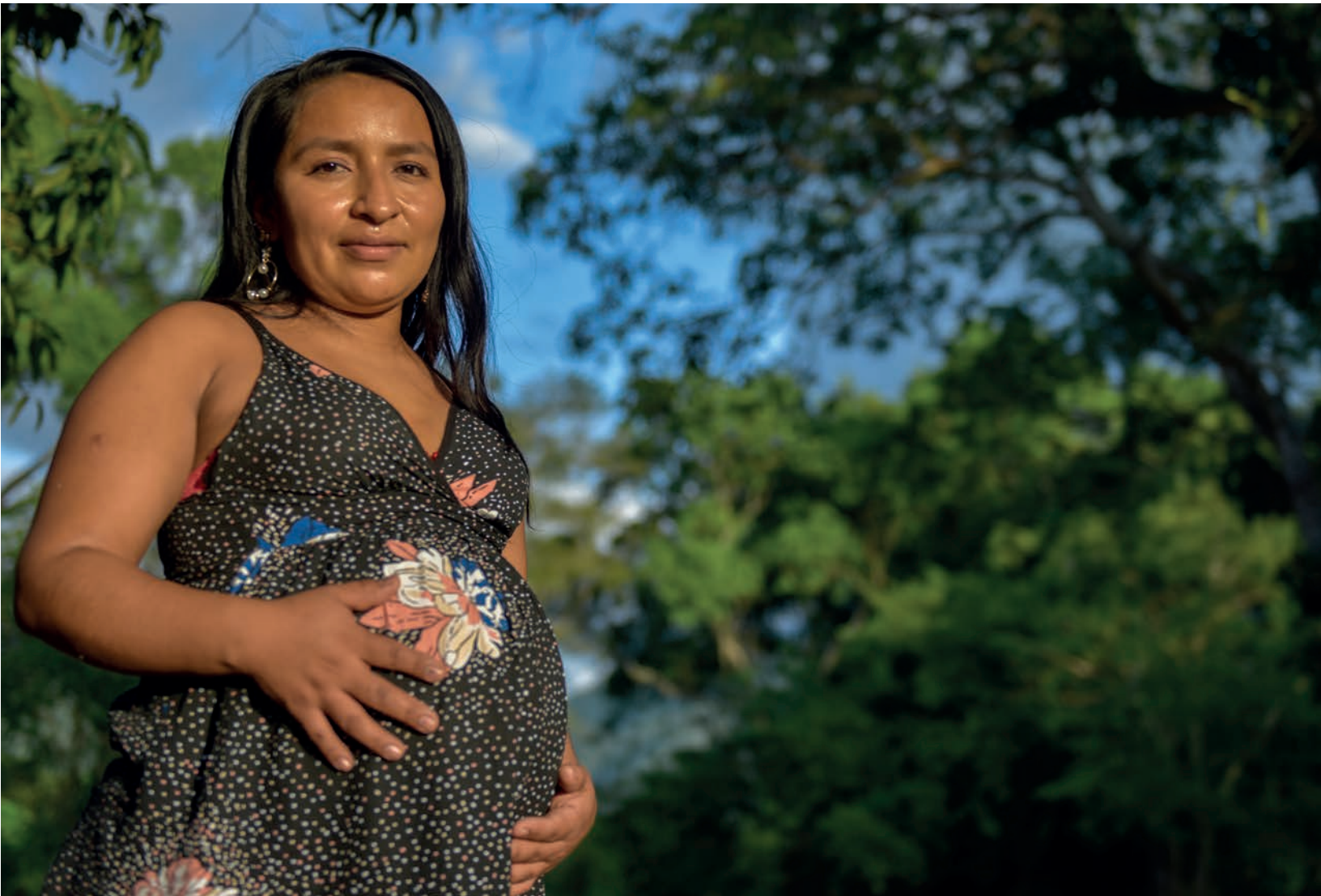
The approach to birth seeks to preserve emotional family bonds. It has been observed that men who go through childbirth with their wives are more receptive to a family planning method and value motherhood and their wives more. In the social context in which the community lives, there are beliefs and taboos about the adoption of a family planning method. Couples are advised and their doubts are addressed by adapting the advice to their beliefs and customs.

After delivery, breastfeeding is supported and counseling is offered, with teaching materials such as a hand-woven doll that represents a breastfeeding mother. Breastfeeding techniques are promoted and a breastfeeding pillow is available for use in the first hour after delivery. Other activities are organized for the community, such as check wording and giving lectures on care before, during, and after pregnancy.

The respectful delivery model offered at Casa Materna makes more women seek care. Those who did not perform prenatal surveillance and who present risk factors or pathologies that put the couple's life at risk are recruited. Work is done together with professional midwives, who carry out the first assessment. If the patient has a risk factor or pathology, she is referred to a general practitioner and an appointment is made with a gynecologist.

The Pregnant Women's Club holds one session per month working together with the local health center. Women receive topics of obstetric interest and preparation for labor and delivery. In psychoprophylaxis sessions, spherodynamics, aromatherapy, cold compresses, heat, shawls, and stretching positions are used.

To give continuity and follow-up to women in the communities that carry out prenatal surveillance at Health Companion clinics, a report is sent via WhatsApp to inform them that the women went to Casa Materna, and the care plan they were offered. After delivery, a new message is sent to report the findings and relevant data obtained during delivery, as well as information on the newborn.



PART III

Educational Initiatives for Professionals and Users of Health Services

University collaboration with a health unit to promote breastfeeding

Juliana Cristina dos Santos Monteiro, Carolina María de Sá Guimarães, Lilian Donizete Pimenta Nogueira, Márcia Cristina Guerreiro dos Reis, Flávia Azevedo Gomes

BRAZIL

The Brazilian Breastfeeding and Food Strategy (EAAB) is an initiative of the Ministry of Health of Brazil that began in 2012 to train professionals working in the Unified Health System (SUS), and in the promotion of breastfeeding and healthy eating in children under 2 years of age. EAAB's focus is to transform professional practices and reorganize the work process, with viable actions for each context in order to improve the practice of breastfeeding and healthy eating.

It is an innovative project because the actions are not imposed vertically. They are proposed and implemented specifically in each health unit to consider the demands of nursing mothers and their children and to assess the characteristics of health professionals who work in these units.

Since 2013 in Ribeirão Preto, the Municipal Health Department's Breastfeeding Program (PALMA) has gradually trained professionals from Basic Health Units (UBS) to act in accordance with EAAB proposals. Currently, the 42 UBS above in the municipality are part of EAAB and tutors are responsible for monitoring the actions of health professionals.

In each unit, educational groups were chosen as the most effective way of transmitting information and health education. Through the groups, women who use health services are free to express their doubts, concerns, and misconceptions about breastfeeding, which favors early and immediate intervention. With regard to breastfeeding support, support groups are the most common actions under EAAB. They are effective tools for successful breastfeeding and prevention of early weaning, as they help women to develop and maintain their confidence in breastfeeding.

The objectives of the project were to promote the identification of opportunities and difficulties in the promotion of breastfeeding and a healthy complementary diet in the UBS; promote the implementation, evaluation, and monitoring of EAAB actions; and help improve breastfeeding rates in the city of Ribeirão Preto.

The objectives of the project were to promote the identification of strengths and weaknesses in the promotion of breastfeeding and healthy complementary infant nutrition in the UBS; promote the implementation, evaluation; and monitoring of EAAB actions, and help improve breastfeeding rates in the city of Ribeirão Preto.

The project used active methods to promote the skills of nursing professionals, such as the continuous search for scientific and technical evidence, greater creativity and motivation, and improved communication and collaboration between health professionals and breastfeeding women. Nurses played a fundamental role in the development of activities and clinical care through nursing consultation during prenatal and puerperium, mainly in the clinical management of breastfeeding, identification of early complications, and prevention of early weaning. PALMA, in conjunction with the Breastfeeding Center of the Ribeirão Preto College of Nursing at the University of São Paulo, organizes workshops on the clinical management of breastfeeding and on the coordination of breastfeeding actions in the UBS, in order to promote training teams and encourage the participation of all health professionals in the activities.

In Ribeirão Preto, breastfeeding rates have increased over the years. In 2011, the prevalence of exclusive breastfeeding in children under 6 months was 11.4%. In 2017, this rose to 59.96% and in 2018 it was 54.66%. This is above the Brazilian index, which has stagnated at 37% since 2013. In the municipality, 41 tutors were trained to monitor breastfeeding promotion in the UBS. In addition, thinking about the continuity of actions beyond the health services, PALMA established new alliances and has worked with the School Meals Division since 2016, with the Childhood Education Centers of the municipality since 2018, and with the Municipal Secretary of Education and with Social Assistance since the beginning of 2019. PALMA provides training workshops for nutrition and education professionals to promote breastfeeding and healthy eating in schools.

In conclusion, EAAB recognized the specificities of each service and appropriate ways to achieve effective performance in the management of breastfeeding and diet, with a positive impact on the prevalence of breastfeeding in the municipality.

The university's collaboration with municipal programs and the health unit is important in health education. This partnership allows easier access to human and material resources to carry out activities, as well as access to the most recent scientific evidence and support for studies on the work done.

Teleobstetrics for the training of midwives during the COVID-19 pandemic

Daniela Rojas

CHILE

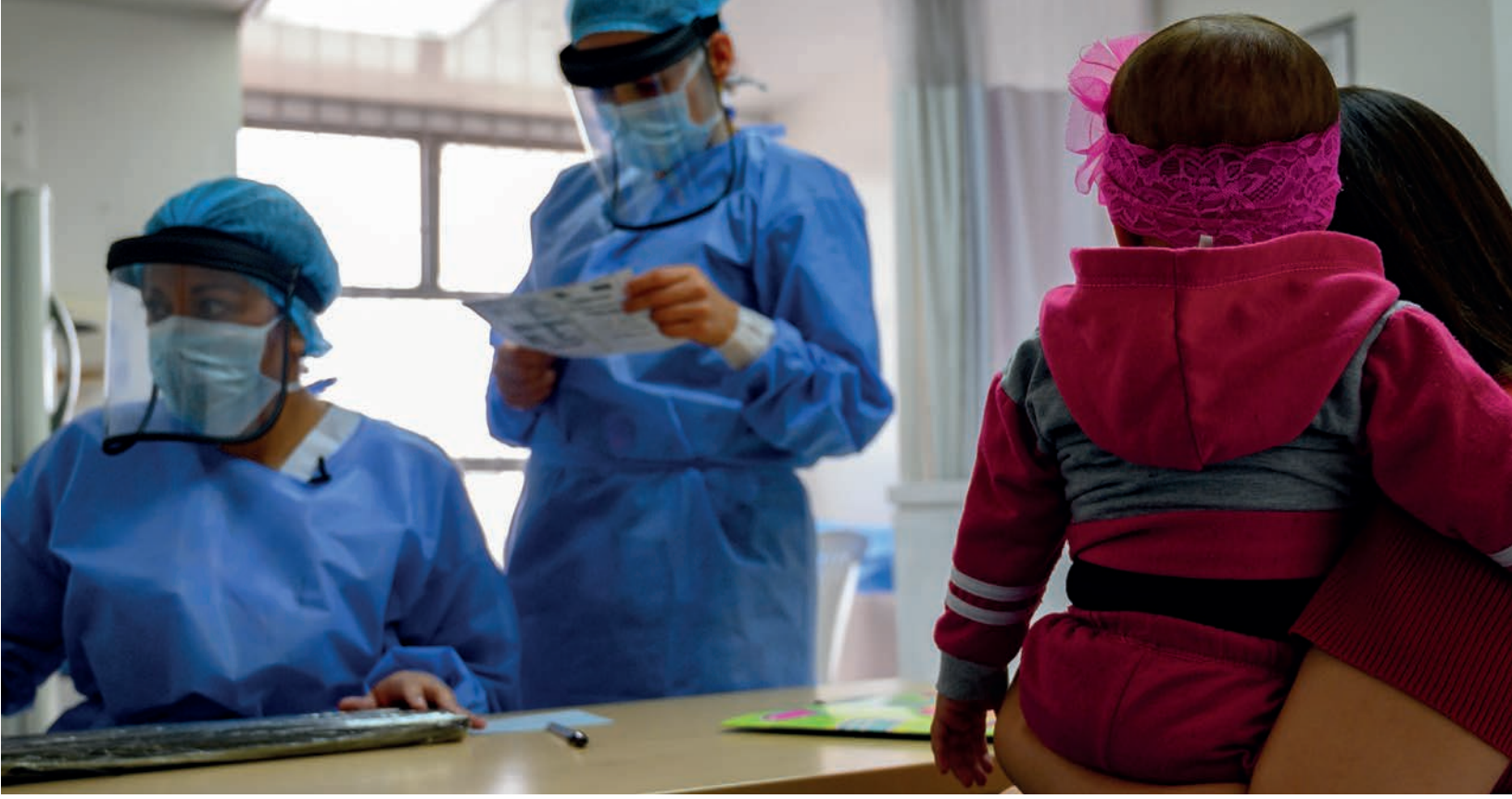
The pandemic has affected the entire population of the country physically, mentally, or socially. But the people most affected were those in the most vulnerable conditions, who were deprived of health care options.

Users with chronic illnesses, as well as monitoring of the various programs for women's health care, were affected when health teams at the first and third levels of care became overloaded. Gynecological and obstetric care were no exception; in addition to the need to solve specific problems that often require simple guidance, they have been hampered by the users' fear, anguish, and uncertainty.

However, even in this totally adverse and unusual scenario, it was essential to continue training new health professionals, ensuring that they acquire knowledge and practices, while ensuring safe health care for the population. The new situation provided opportunities for changes that took into account health care at different stages of the life course. Comprehensive training was provided to professionals who can communicate and resolve issues, encouraging them to develop critical thinking and educational activities, among other aspects. In this context, teleobstetrics proved to be a tool capable of responding to the situation.

The teleobstetrics project provided clinical assistance to users through video calls with three people (user, student, teaching professional), through the WhatsApp application (with an appointment, regardless of the user's location). The students who participated in the project were in the third and fourth years of Obstetrics and Childcare at Universidad de los Andes. The

The teleobstetrics project provided clinical assistance to users through video calls with three people (user, student, teaching professional), through the WhatsApp application (with an appointment, regardless of the user's location).



students fulfilled most of the learning objectives corresponding to their curricular level, with the exception of those related to the activities carried out during the user's physical examination. After the service, users and students were asked to complete a satisfaction survey on an online form using a Likert scale from 1 to 5, in which 1 was "totally in disagreement," and 5 "totally in disagreement."

The collected results reflected a high level of approval of teleobstetrics, both among students and users. In fact, in almost all consultations, the level of satisfaction of the interviewees was 5. In the case of questions about image and sound quality, 92.3% of the answers scored 5 and 7.7% scored 4. All users said they would use this remote service again. One of them said:

> I felt very comfortable and well looked after [...] I was able to present my health problem calmly and with a lot of time [...] I really liked the service because, despite not being [with me] in person, they took the time to ask me for a lot of information and gave me answers. I am very grateful to the health professional, the student, and the institution for the service provided to the community.

Teleobstetrics will be used with increasing frequency since its requirements are accessible (e.g., computer or smartphone, camera, and internet) and its benefits are many: improved access to health care, shorter waiting lists, smaller crowds, and lower costs than face-to-face service.

Nursing team initiatives to address the COVID-19 pandemic

Silvia Iris Tejada, Juana Solano

DOMINICAN REPUBLIC

On 11 March, 2020, the World Health Organization (WHO) declared that the coronavirus epidemic was a pandemic. That same month, the first case of COVID-19 in the Dominican Republic was confirmed and extraordinary measures had to be established in all areas of life. Nursing was no exception and important decisions had to be made, both to offer the best care to patients affected by the disease and to prevent infection. This situation required not only clinical knowledge, but also new initiatives that developed as things became more complicated. These were adapted to the level of complexity of each hospital for the care of patients with COVID-19. It is worth mentioning that the pandemic arrived when there was a significant shortage in nurses in the Dominican Republic.

In this context, several initiatives were launched to adapt work to the COVID-19 pandemic in the country. The measures implemented by head nurses for the care of COVID-19 patients included the following:

- 24-hour work shifts were scheduled;
- Nursing personnel with risk factors were released from service;
- Staff received training in donning and doffing personal protective equipment;
- Teams were trained in patient screening and use of ventilators;

The nursing team's attitude to the measures implemented was initially receptive and welcoming. In some hospitals there was resistance and many absences due to sick leave; in others, the reaction was anxiety, fear, and stress. Regarding the lessons learned, the value of teamwork and solidarity prevailed.

- The biosafety protocols recommended by the Ministry of Public Health were implemented in accordance with the guidelines of the Pan American Health Organization and the World Health Organization.

In addition, coordination was maintained with hospital management to replace necessary material (including personal protective equipment); nursing teams collaborated with other disciplines (such as pharmacy); and nurses were assigned to help pharmacy departments replace medicines, materials, and equipment, and to distribute and supervise the donning and doffing of protective equipment for all personnel.

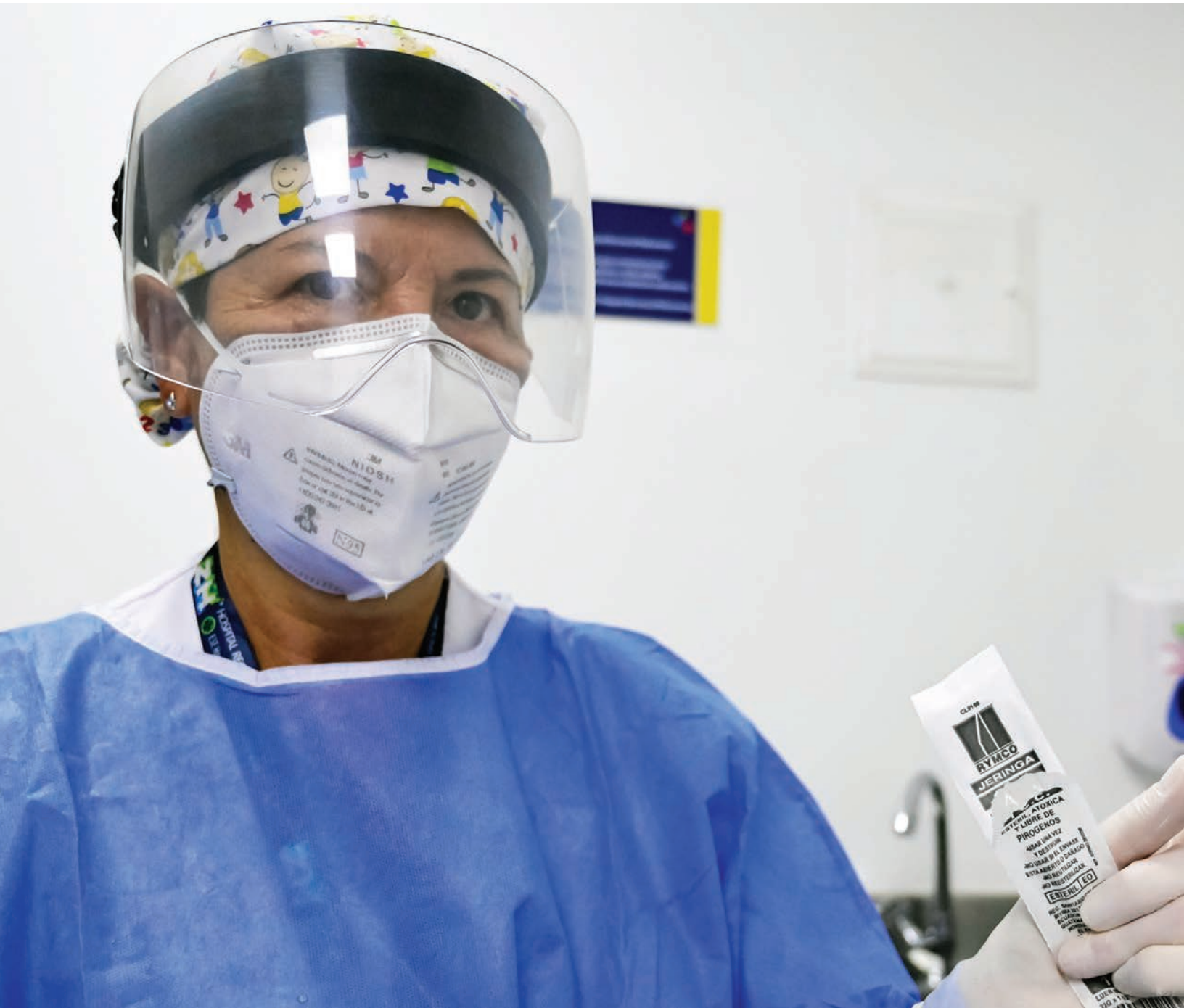
The initial attitude of the nursing team to the measures implemented was receptive and welcoming. In some hospitals, there was resistance and many absences due to sick leave; in others, the reaction was anxiety, fear; and stress. The value of teamwork and solidarity was prominent among lessons learned.

In the educational field, the situation evolved in a similar way, since nursing schools had to make sudden and unprecedented changes to end the term. The Dominican School of Nursing Professionals was forced to resort to measures aimed at preserving the health of its members, while maintaining care for patients and the population in general.

Nursing schools have adopted the following measures to adapt academic processes to the pandemic:

- All universities have launched virtual studies on different platforms;
- Learning strategies based on situations and case studies have been strengthened;
- Practicums and internships in hospital and community cycles have been suspended as a preventive measure for students and teachers;
- Simulation laboratories were used, following the protocols for physical distance, hand washing, and permanent mask use;
- In scientific research requiring the use of instruments in a hospital setting, surveys and questionnaires were conducted online.

The initiatives adopted in the field of nursing care and education have sought to alleviate the serious effects of the pandemic on the ability to provide health care and professional training. However, at the time of this writing, the significant shortage of nursing staff in the country has worsened as a result of the pandemic, and professional associations continue to ask authorities for more personal protective equipment, more nursing staff, and a guarantee of a sufficient supply of vaccines.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Repositioning midwifery education in line with international best practices

Arlene James Euin, Marcia Rollock,
Franka Olliviere Andrews, Oscar Noel Ocho

TRINIDAD AND TOBAGO

Midwives have played a central role in providing services to families at different levels of health care. Traditionally, midwifery education in the Caribbean Region has been and continues to be taught at the diploma level by the Ministry of Health. The only exception is the University of the West Indies in Mona, Jamaica, where the curriculum corresponds to pre-medical education. Regardless of the level of qualification, the region has a staff of highly experienced doctors who work independently and interdependently as members of interprofessional teams. Despite their levels of competence, highly qualified midwives have been developed in accordance with international best practices.

Well-trained midwives provide a wide range of services for the population of childbearing age and newborns and can make a significant contribution to primary health care and universal health coverage.

The World Health Organization (WHO) and the International Confederation of Midwives agree that the future of midwifery lies in the level of education and training that professionals receive, since the focus is on the development of competencies and not on the skills established within a specific framework. This is because more qualified graduates in a highly qualified workforce not only improve the quality of care, but save lives as well. Strengthening midwifery education globally is the key to meeting the Sustainable Development Goals, and schools must adopt a competency-based training program to standardize and strengthen midwifery education.

A report commissioned by the Ministry of Health on nursing and midwifery education in Trinidad and Tobago recommended that education in these disciplines be offered at the undergraduate level. This recommendation coincides with that of the Caribbean Regional Midwives Association and the Caribbean Nurses Organization to develop and implement undergraduate midwifery programs in the countries of the Caribbean Community.

According to WHO *(17)*, if midwives receive an education in accordance with international standards and midwifery includes the provision of family planning, more than 80% of maternal, stillborn, and neonatal deaths can be prevented. The benefits of midwives with adequate education extend across the continuum to improve the overall health of families and communities. This means that well-trained midwives offer a wide range of services for reproductive-age women and newborns and can make a significant contribution to primary health care and universal health coverage. However, the vast majority of them rarely have the opportunity to participate in policy decision-making for the population they serve. According to the International Confederation of Midwives, this may be related to the level of education in the profession.

The duration of midwifery education in the Caribbean Region varies, as does the quality of clinical experiences. This provides a window of opportunity to develop a comprehensive midwifery curriculum for Trinidad and Tobago that is consistent with global trends. The institution cannot work in isolation to develop educational programs and practicums in midwifery. Although there is a great need for midwives, they must act within the country's economic, political, and social context. Supportive partnerships and collaborations have been beneficial in strengthening the educational policies and guidelines needed to improve and update the curriculum to ensure that quality is maintained.

Recognizing the importance of collaboration, the University of the West Indies invited several key stakeholders from the Faculty of Medical Sciences, Ministry of Health, Ministry of Education, Nursing Council, Trinidad and Tobago Association of Midwives, PAHO, WHO, and private sector to develop a midwifery curriculum consistent with global recommendations and the highest standards.

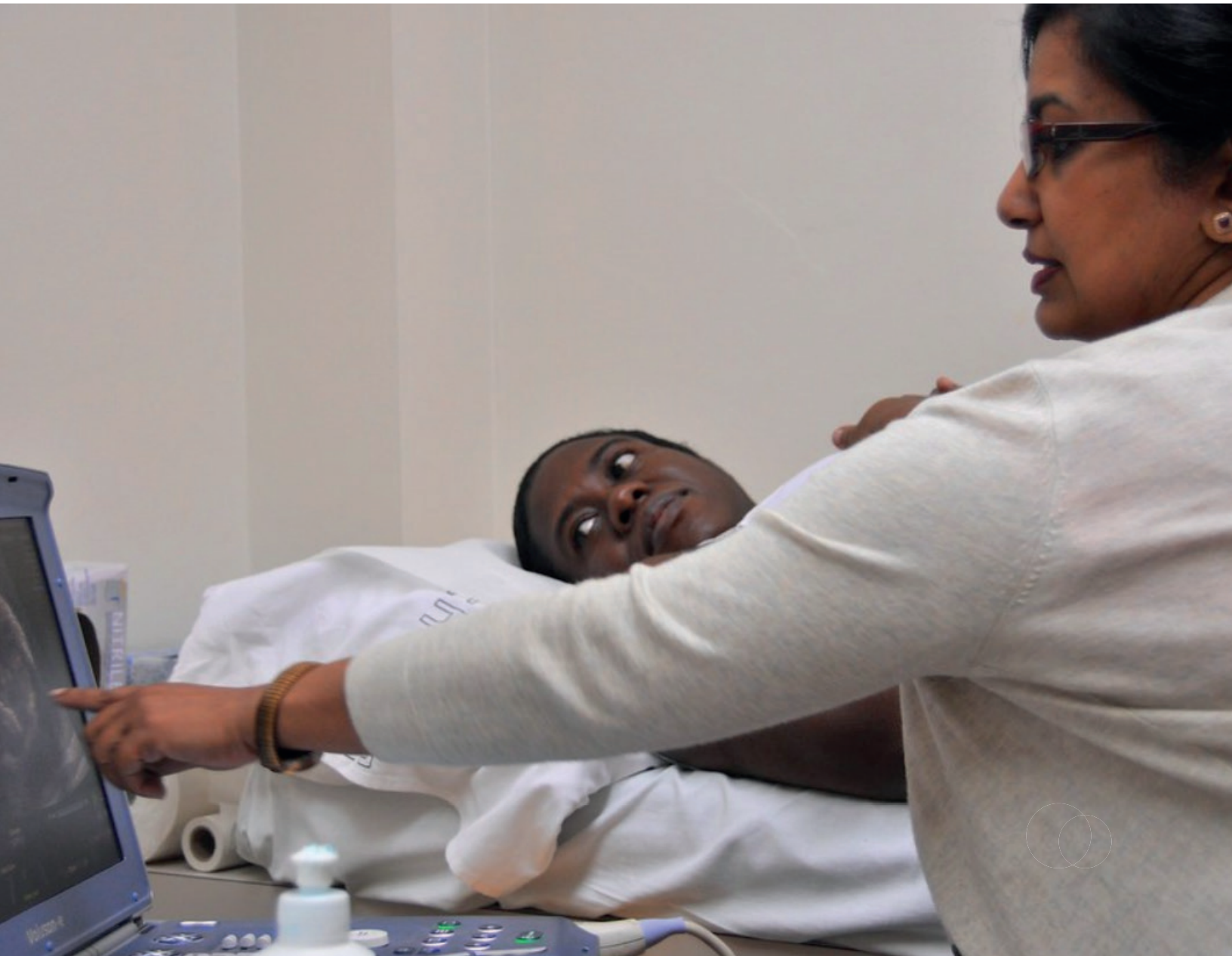
An important strategy used by the school was to organize an international symposium on midwifery in 2016. The meeting served as the foundation to strengthen midwifery education in the Caribbean Region in general, and in Trinidad and Tobago in general. During the first meeting, in April 2016, stakeholder awareness was raised and a new midwifery committee was created. The parties recognized that it was a crucial moment to bring midwifery back as a key health care practice. At that meeting, the terms of reference with background information, roles, and responsibilities were provided to the committee for its consent.

Discussions during the meeting focused on the development of essential competencies for the standards of midwifery practice, as stipulated by the International Confederation of Midwives, the nursing councils of the Member States of the Caribbean Community, and the laws of Trinidad and Tobago. The level of certification that the University of the West Indies must propose to the Faculty Council for consideration was also discussed. After obtaining the authors' consent, the most recent data were analyzed and based on the findings, there was considerable debate, since the professionals defended the value of midwifery as an autonomous practice and wanted to see this reflected in the study plan.

Committee members were divided into teams and each team was responsible for developing study plans according to the core competencies identified by the International Confederation of Midwives. The midwifery component was delivered to the team of the Trinidad and Tobago Association of Midwives, which was supported by other midwives for comprehensive evidence-based content. The teams continued to work for some time and monthly meetings were held during which questions were raised, clarifications were given, and rewriting began, with the aim of developing a strong, culturally sensitive, and internationally recognized curriculum.

The curriculum was completed and received the support of the Faculty directors. At the time of this writing, it is in the process of final approval by the University of the West Indies at St. Augustine for effective implementation during academic year 2021/2022.

Since the development of midwives depends on the implementation of a robust and culturally sensitive curriculum, based on an internationally recognized competence structure, it is imperative that the principles of interprofessional collaboration be followed as an effective strategy to make this a reality.



Challenges for nursing and midwifery education during the COVID-19 pandemic

Ruth E. Zielinski, Nora Drummond

UNITED STATES OF AMERICA

The COVID-19 pandemic has presented several challenges for the educational processes of the new generation of health professionals. No one could have predicted its reach, but educators quickly realized the impact that the coronavirus would have on their ability to teach students. Since many educational programs were designed to take place in person, rather than remotely, when lockdown orders were issued in the United States of America, teachers had to mobilize quickly to deliver content online. Although clinical learning is an important part of nursing and midwifery training, in mid-March 2020, with only one month left in the semester, it was decided to interrupt clinical practice for all students in these courses.

Knowing that the challenges faced by the students were part of a broader narrative, we sought to study their impact on the experiences of midwifery students throughout the United States. Through professional and personal contacts and using open questions, students from different midwifery programs across the country were asked to share their experiences in midwifery studies during the pandemic.

The pandemic has increased feelings of loneliness and isolation. Some students have lost family members and their social relationships have been disrupted.

Some midwifery students are caregivers of children. With schools and daycares closing, they had to manage new and rapidly evolving changes in their children's lives while attempting to adapt to changes in their own academic programs. For some students, the impact of the pandemic on the economy meant the loss of their parents' or partners' income, which also implied a financial cost. Some health professionals, such as nurses and paramedics, lost their jobs in some parts of the country. Since certain midwifery study programs had to be canceled or postponed, there were students who were struggling, without financial aid or sufficient help to cover the costs of their study program.

Many students in the country are professionals with on-site jobs, which makes exposure to COVID-19 in the workplace a very real possibility, especially with the scarcity of personal protective

equipment. Students who contracted the virus mentioned difficulties in concentrating on academic tasks during recovery, tiredness in the neck and back, as well as eye strain and headache from prolonged use of the computer. Mental tension and fatigue affected their studies; some had lower grades; others reduced their course load or did not complete some courses. They also reported negative effects on their mental health, including increased feelings of isolation, anxiety, and depression. In order to deal with the situation, some resorted to the use of medication, practiced meditation or yoga, prioritized sleep, or took vitamin supplements.

With the worsening of the pandemic, both outpatient clinical centers and hospitals removed students from their practicums in an attempt to reduce the number of people present in the clinical areas. Students across the country reported a major gap in their clinical learning, with some still unable to return. Those who returned to clinical centers found that they had to provide more emotional support to patients due to restrictions imposed on family and visitors. In some midwifery programs, the difficulty of finding clinical preceptors has become an added burden that has led to delays in graduation. Students have struggled to balance mandatory extra work shifts as nurses with their clinical education. Those completing the program were mainly concerned with gaining the experience to acquire the necessary skills in time to graduate. Some felt that their skills were being impaired and that the transition to practice would be more difficult.

Although students understood the need for physical distance, they expressed disappointment and frustration with the move to online teaching. They said they missed face-to-face classes and clinical simulations and that they felt less motivated when they were not with their teachers and colleagues. For them, connecting by video call, phone, or text message was not the same as meeting in person. Students with children at home mentioned that frequent interruptions affected their ability to focus on learning.

The pandemic has increased feelings of loneliness and isolation. Some students have lost family members and their social relationships have been disrupted. One of them wrote:

> Missing classroom teaching, interactions with colleagues, and face-to-face clinical simulations has made me feel less connected and lonelier. I miss people without masks.

Although the pandemic has posed significant challenges for education, there are opportunities for growth that will strengthen curricula in the future. Students have shown resilience and flexibility during the pandemic. Those who shared their stories were from the United States, but the impact of the pandemic has been felt by students around the world, who need support at this difficult time. As teachers and clinical preceptors, we must reach out to students, especially those who are experiencing difficulties. We need to explore support possibilities, such as more flexibility with deadlines and creative ways to socialize safely, in addition to preparing students academically and clinically. Different and innovative forms of education are emerging that can continue to be part of professional training and we must be better prepared in the event of a future pandemic.

Benefits of including a partner in a woman's prenatal care

Monica Isabel Alves, Geraldo Duarte

BRAZIL

In 2019, the estimated population of the municipality of Franca, in the State of São Paulo, was 339,925 inhabitants, of whom 173,753 were women. The projection of women of childbearing age (10-49 years) for the same year was 101,103 and there were 4,633 births. The total number of men who attended prenatal care with their partners in 2019 was 2,357, between 16 and 61 years of age.

The Prenatal Partner Program is an innovative strategy created in Ribeirão Preto (São Paulo) in 2006. It is being progressively implemented by the Ministry of Health to provide several health benefits to pregnant women and their partners and children.

Studies show that when a pregnant woman's partner is present and participates in prenatal care, puerperal depression is reduced, as is the use of analgesics during delivery. Also, the bond between mother and newborn is strengthened, adherence to breastfeeding improves, and vertical transmission from mother to child is reduced, among other benefits.

One of the objectives of participating in the program is early diagnosis of different conditions in the father and mother, such as dyslipidemia, arterial hypertension, and diabetes, and integrating them into the health network for disease prevention and health promotion actions.

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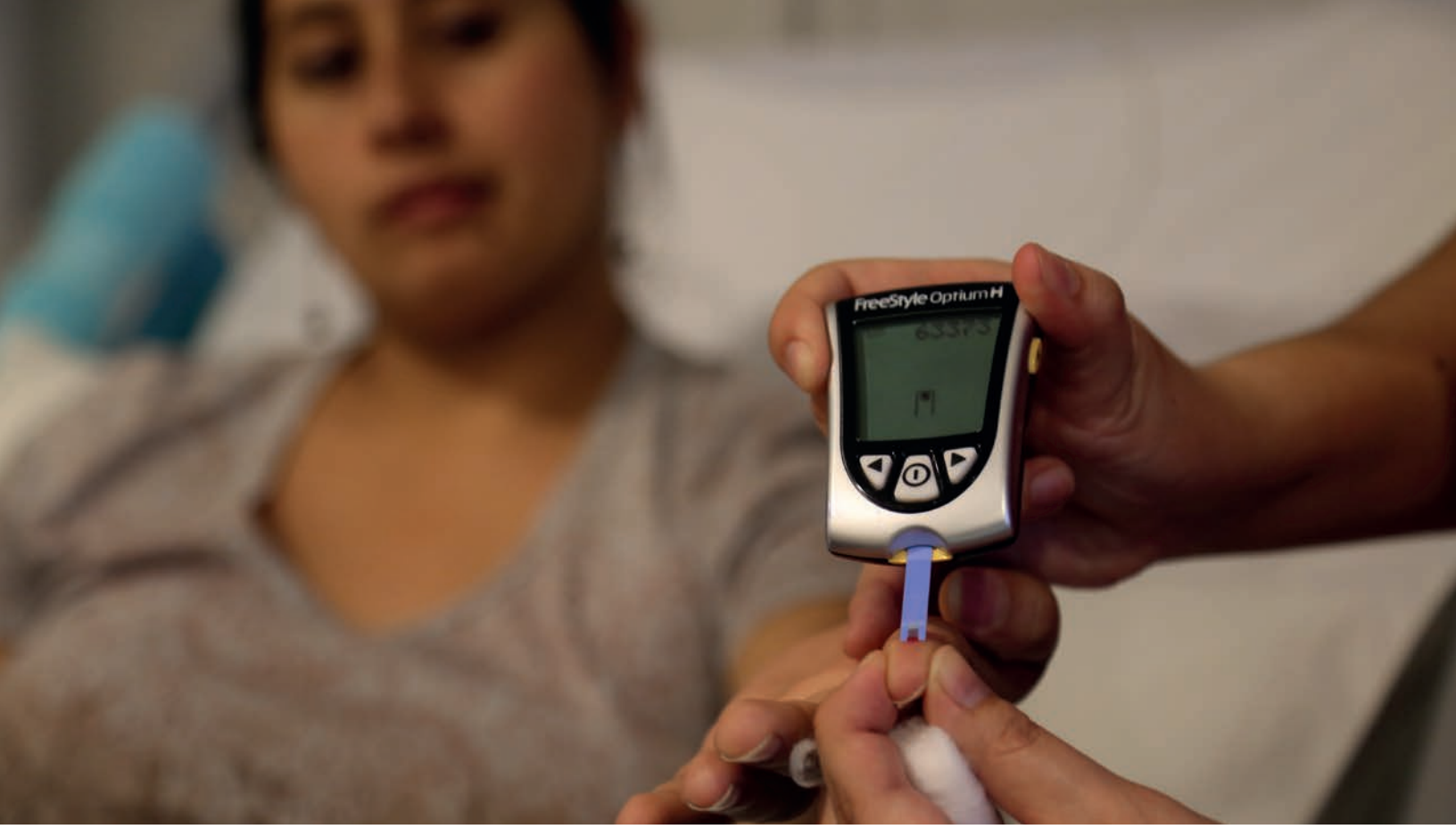


The program was implemented in the municipality of Franca in 2015, with training for health teams. Training in prenatal care for partners included receptionists, a gynecologist, a general practitioner, nurses, nursing assistants and technicians, a social worker, and a community health worker.

Primary care nurses were in charge of initial care for pregnant women and their companions, and subsequent consultations were provided by doctors. The nurse saw women who wanted a quick urine test to detect pregnancy. Women who arrived with their companion were also welcome.

If the hCG result was negative, information about sexually transmitted infections (STIs) and contraceptive methods was provided and questions were answered. If the test confirmed pregnancy, prenatal care was started and the partner was invited to participate. Serologies were then requested from the research laboratory for venereal diseases, hepatitis B and C, anti-HIV, glycemia, lipid profile, and blood pressure.

The program made it possible to diagnose dyslipidemia, hypertension, and diabetes in several users, enabling early diagnosis of cardiovascular diseases. The serology results identified HIV-positive men and pregnant women, allowing rapid screening to interrupt vertical transmission.

When the blood pressure values were elevated, the couple was instructed in physical activity and diet, and medical care was provided. Upon receiving the results of the laboratory tests, the pregnant woman could present them to the gynecologist and, depending on the result

of HIV serology, the couple was referred to the specialized HIV/AIDS care service or to the clinician for further tests.

As part of comprehensive assistance to the couple, guidance was given on the right to paternity leave under Brazilian law and the physical and psychological changes that occur during pregnancy. Couples feel welcomed and develop a bond with the health team. They are motivated to seek care for themselves, ask questions, and participate in groups of pregnant women.

Couples also express gratitude for being able to be together during consultations, in groups, and during childbirth. This helps to refute the idea that men are not able or do not want to participate.

The practice of welcoming pregnant women's partners to prenatal care helped to facilitate the access of men to primary care. These units are the gateway to care in the Unified Health System, and are often mistakenly considered places for the care of women and children.

One of the benefits of the program was to provide men with access to health facilities and, consequently, to the diagnosis and treatment of communicable diseases such as syphilis. This benefit is clear in the response from one of the participants to the question about what they thought of their inclusion in the Prenatal Partner Program:

> It was good. I went to the exams, and for the prevention of sexually transmitted diseases. It was good for my health, her health, and the baby's.

Humanization of childbirth care with psychoprophylactic measures

Ana Lisia Alfaro

EL SALVADOR

Nossa Senhora de Fátima National Hospital, in the city of Cojutepeque, is a departmental hospital offering second-level care, with a 90-bed capacity, of which 27 are for the obstetrics service. In 2018, 2,595 women were served. To reduce the complications of childbirth and cesarean sections and improve the humanization of childbirth care, good practices have been promoted for the implementation of psychoprophylactic measures in childbirth care. These measures were implemented among women and their companions in the hospital, while reducing medical procedures for childbirth without jeopardizing maternal and neonatal safety.

The application of good practices of obstetric psychoprophylaxis prepares the pregnant woman and her partner to establish a family in an integrated way (physically, cognitively, and psychologically). These practices are accomplished through educational activities, techniques for neuromuscular relaxation, respiratory activity, gestational exercises, analgesic positions, self-help techniques, and prenatal stimulation to achieve tranquility and safety during childbirth, postpartum, and breastfeeding.

Obstetric psychoprophylaxis works in four dimensions:

1. Attitudinal and emotional at each stage of the birth process.
2. Behavioral, which includes the development of skills to competently face the process of childbirth and puerperium.
3. Cognitively, in terms of the birth process and its implications in the different stages of pregnancy, childbirth, and postpartum. In addition, women are advised on warning signs, specialty care, signs of onset of labor, postnatal recovery, and the birth plan, among other aspects.
4. Strategies for managing fear, discomfort, and pain, such as relaxation techniques, relationship skills, and communication.

Psychoprophylactic measures bring benefits to mother and newborn, the family, and even the health team. The advantages for the mother are: *1)* lower anxiety, which allows her to develop and manifest a positive and calm attitude; *2)* adequate response during uterine contractions, with adequate use of relaxation, breathing, massage, and other self-help techniques; *3)* greater likelihood that she will be in labor when entering the health center, with a more advanced dilation; *4)* shorter dilation phase compared to average; *5)* shorter expulsion phase; *6)* shorter total working time; *7)* less drug use; *8)* lower risk of obstetric complications; *9)* stronger emotional bond with the baby; *10)* less chance of cesarean section; *11)* faster and more comfortable recovery; *12)* greater ability to breastfeed; and *13)* lower risk of postpartum depression.

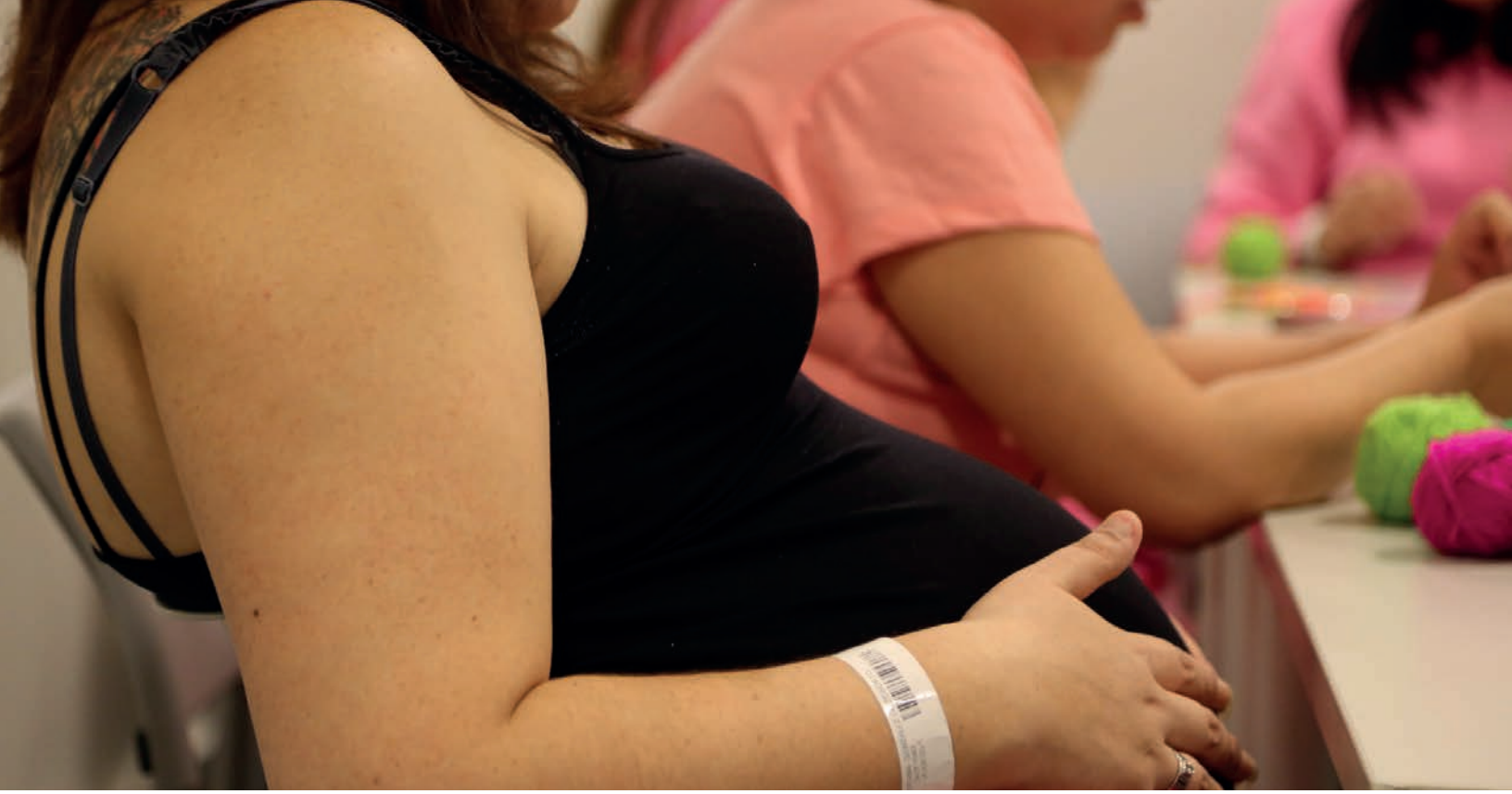
The advantages for the newborn are: *1)* reduction of acute fetal distress; *2)* decrease in perinatal complications; *3)* better Apgar score; and *4)* better breastfeeding.

The advantages for the family are: *1)* reduced complications during delivery and in the newborn, which shortens the hospital stay and facilitates early incorporation into the home and family; *2)* reduced economic cost to the family, since the couple does not need to travel frequently to the hospital due to the short stay; *3)* stronger social and psychological bond with the partner, since the partner experiences the delivery process and feels part of it; and *4)* the individual is returned to her family and community as quickly as possible.

The advantages for the health team are: *1)* working in a climate of greater harmony; *2)* greater confidence, understanding, and collaboration with the pregnant couple; *3)* reduction of maternal and perinatal risks; and *4)* promotion of institutionalized delivery in safe conditions in a timely and humanized way.

The general objective of this initiative was to help reduce maternal and perinatal morbidity and mortality by strengthening care for normal childbirth through the application of psychoprophylactic measures with the participation of the family at the Nossa Senhora de Fátima National Hospital, from January 2016 to December 2018. The specific objectives were: *1)* implementation of psychoprophylactic exercises in pregnant women (latent and active phase) with indication of uncomplicated delivery; *2)* achieve emotional support for pregnant women by implementing actions for the active participation of the couple and family in the childbirth care process; *3)* improve women's satisfaction with childbirth care; *4)* strengthen exclusive breastfeeding; *5)* improve users' empathy with the hospital delivery assistance process; and *6)* promote institutional delivery.

The general objective of the initiative was to help reduce maternal and perinatal morbidity and mortality by strengthening care for normal childbirth through the application of psychoprophylactic measures with participation of the family.



Good practices were implemented in four phases:

1. **Planning:** Documentary analysis was carried out and the project was developed, including an action plan and teaching plan, which was approved by hospital management. Workshops were planned for the medical and nursing staff, with the aim of training and involving human resources in project execution.

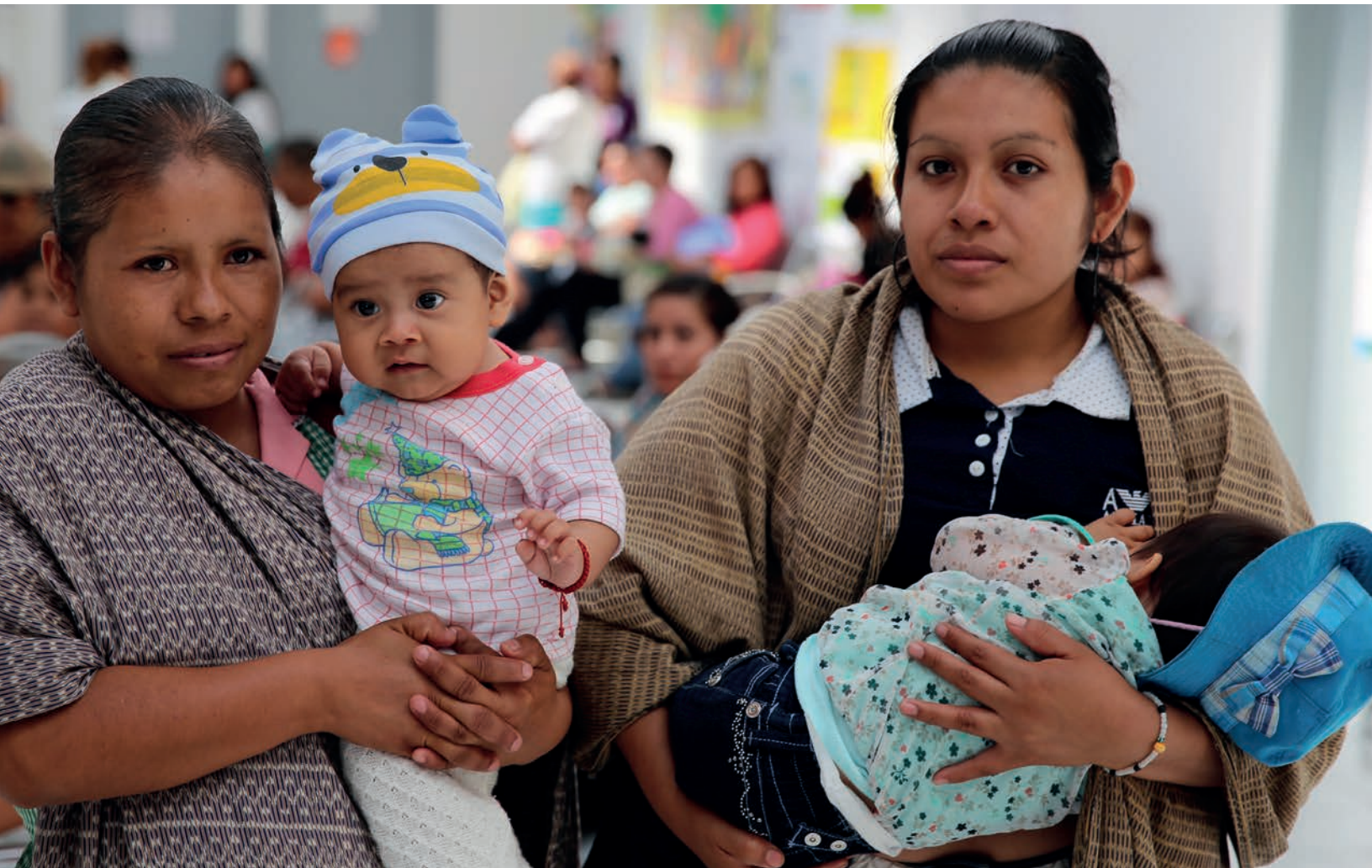
2. **Execution:** The coordinating team started the training workshops in phases, first involving the heads of units and then moving to operational personnel from the maternal and other hospital services. These trained team members became facilitators for the different services that participated in the project. In this phase, actions were undertaken to improve the area's infrastructure, including placing curtains between the parturients' beds to respect their right to privacy, acquiring the material and supplies necessary to execute the strategy in the areas of attention, recruiting users and their partners to participate in the application of psychoprophylactic measures during hospitalization, and applying these measures to all parturients with planned uncomplicated delivery.

3. **Monitoring and evaluation:** Evaluation of good practices followed two methodologies. Observational methodology was used to verify the application of psychoprophylactic exercises in users; the second methodology consisted of satisfaction surveys to users who participated in the program.

4. **Project replicas:** Several maternity hospitals in the country were trained through similar workshops.

Multiprofessional participation from different areas of the hospital achieved the objectives proposed by the improvement team. The areas were management, sub-management, and hospital administration; institutional financial unit; laundry and sewing; maintenance; cleaning; and medical services in the areas of epidemiology and internal medicine. Thanks to the participation of all these areas, each of the activities outlined in the work plan was carried out in a timely manner and with the necessary materials, personnel, and supplies.

Evidence of good practice included participatory visits with pregnant women to disseminate best practices; dissemination of best practices in the 28 maternity hospitals and the Salvadoran Social Security Institute; training workshops on childbirth psychoprophylaxis; implementation of good practices in other maternity hospitals in the country; and dissemination of good practices among the population and institutional strengthening of childbirth care.



Companion Family Program to promote the bond between father, family, and newborn

Vanessa Naupari Carreño, Lady Horna Cabanillas,
María de Fátima Ballón Rendón

PERU

The Neonatological Nursing Service offers immediate care for high-risk newborns whose mothers are transferred to the hospital due to its greater response capacity.

The service proposed the Companion Family Program in order to establish a work team for newborns, mothers, fathers, and families. Current trends show that the birth of a child has implications for the family that make it an object of care. Childbirth is a time when a wide range of needs arise for both the newborn and the parents. Therefore, it is essential to provide effective responses to ensure the health, well-being, and development of families, making each situation a learning opportunity.

This innovative program aims to train and encourage companions to adopt actions for the care and promotion of breastfeeding and establish a strategic alliance with professionals. This is a key point in health promotion, disease prevention, recovery, and timely discharge.

It is important to strengthen the father and mother's self-esteem so that they feel able to act as such with responsibility and autonomy. From the first contact with the parents, the nursing team offers care and continuing education, so that they gain security and confidence in the care of their baby. Giving guidance on breastfeeding requires considerable time; team members must remain at the mother's side until she develops her confidence, while fostering continuous comprehensive care at home.

Nursing professionals use care strategies that are not limited to the hospital setting but also include the home. This provides continuity in the care of the mother and the newborn, while the family is involved. The family acts as a support network and takes on the challenge of participating in the process of disease prevention and the promotion of neonatal maternal health, ensuring well-being while minimizing risks.

The program allows the family—including the mother, father, grandparents, and aunts and uncles, among others—to participate in the process of caring for the newborn, through training in basic skills. They acquire knowledge, skills, and aptitudes to participate and collaborate in

care, feeding, prevention of complications, and detection of warning signs during adaptation to the extrauterine life of the newborn. They will be able to put all this into practice at home after discharge, improving the bond between the nurse and the family through an integral therapeutic relationship.

The general objective of the program is to promote the participation of family members in comprehensive care for newborns in order to avoid preventable adverse events and irreversible complications in their growth and development, contributing to their health, and achieving optimal care and recovery at home and in society. The specific objectives are to:

1. Strengthen the bonds between the family and nursing staff.

2. Integrate family members in newborn care during hospitalization.

3. Facilitate knowledge, skills, and abilities that allow family members and companions to participate in basic care related to biosafety, diet, maternal lactation, hygiene, vaccines, warning signs, and emotional and spiritual support.

4. Train the accompanying family member in the care required by the newborn, including the prevention of adverse events and complications during hospitalization and at home.

5. Identify any relatives or companion with excessive stress and provide them with interdisciplinary psychosocial support.

6. Assess the skills and abilities acquired by the family member or companion at the end of the program.

7. Assess the impact of the program.

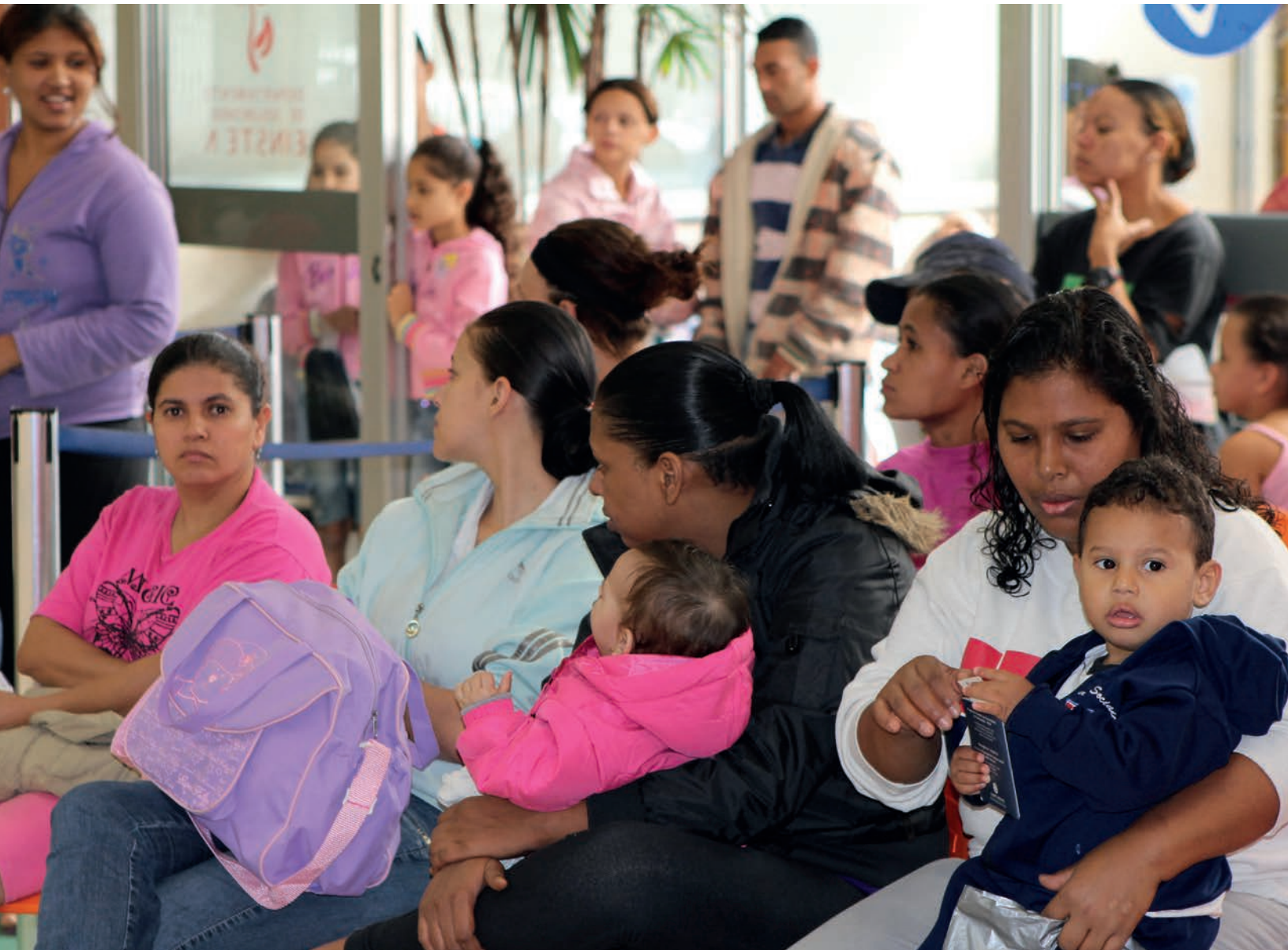
The program allows the family—including the mother, father, grandparents, and aunts and uncles, among others—to participate in the process of caring for the newborn, through training in basic skills.

Evaluation of the program was based on the number of accompanying family members who: *1)* participated in the program for the entire month; *2)* obtained a good score during the program; *3)* were satisfied with the program; *4)* provided satisfactory care at home; and *5)* demonstrated sustainable results.

The program's effectiveness was evaluated according to the results expected in the different activities, expressed in the fulfillment of the established objectives. A pre-test measured changes in the obtained levels. Changes in attitudes and

behaviors and skills development were also evaluated, evidenced by participation in self-care during the newborn's hospitalization.

The expected results were: users satisfied with the program; practices performed correctly by the family companion; and reduction of adverse events due to falls associated with a lack of prevention measures. The indicators used were: *1)* percentage of accompanying family members who participated in the program during the month; *2)* percentage of activities completed; *3)* percentage of users rated "good" in patient care; and *4)* percentage of users satisfied with the Companion Family Program.



Experiences of the Trinidad and Tobago Association of Midwives in childbirth education classes

Marcia Rollock, Debra Lewis, Arlene James Euin, Franka Olliviere Andrews, Oscar Noel Ocho

TRINIDAD AND TOBAGO

The Trinidad and Tobago Association of Midwives is an organization of midwifery professionals who work in public and private practice. Childbirth classes are considered essential to the family's childbirth experience. The association started prenatal education classes to guide women who, together with their families, seek information on activities related to motherhood and raising children.

Historically, classes were designed to prepare potential mothers for childbirth and to teach them techniques to control pain during labor. Over the years, the scope of this education has expanded and now includes preparing for pregnancy, labor, and delivery; caring for the newborn; and adapting to family life with a baby. The duration, content, membership criteria, and economic cost of courses varies. While some are organized through hospitals, others are offered by community organizations.

Although the structure and content of these classes vary, there is a consensus that they can be beneficial for women and their partners. The results of research done by one of the authors on the value of education in childbirth, specifically the Lamaze method classes and the presence of the future father in the delivery room, showed that the exposure of future parents to classes or Lamaze can serve as essential support for women during pregnancy and childbirth *(18)*.

Historically, most male partners were not included in prenatal classes. The association has sought to provide this support to parents through childbirth classes that focus on the needs of the pregnant woman and her partner.

However, there is a need to establish standards of practice for Lamaze classes. This will promote structured programs that are culturally sensitive and adapted not only to the needs of the pregnant woman, but also those of the future father.

Including the father is vital, since learning is a shared experience with the unborn child, while the bond is being built between them. The World Health Organization recommends interventions to promote male participation during pregnancy, childbirth, and postpartum. This facilitates and supports better personal care for women, as well as better home care practices for mothers and newborns, and better use of specialized care during pregnancy, childbirth, and the puerperium for women and newborns *(19)*.

Most male partners historically have not been included in prenatal classes. The association has sought to provide this support to parents through its childbirth classes, which focus on the needs of the pregnant woman and her partner. To this end, the classes were designed to create a relaxed atmosphere that encourages the participation of women and their companions.

Classes adapted for men started in 2005 with a small group. They are divided into eight sessions that form a cycle. Women and their companions can join at any point in the cycle to get the information they need. Midwives speak on various topics every Saturday morning for two hours. These include good health practices during pregnancy; clothing and bathing the baby; pre- and postnatal exercises; childbirth and delivery; the role of the companion; breastfeeding; the postnatal period; and baby massages.

In the period from January to December 2019, six cycles were concluded, with 68 women and their respective companions. In the first three months of 2020, eight clients participated with their companions. The restrictions resulting from the COVID-19 pandemic forced the cancellation of face-to-face classes and the availability of classes on the virtual platform. As a result, from January to September 2020, there were four cycles with 18 couples. At the end of each cycle, feedback was requested, which resulted in an increased number of topics. User feedback has been positive, and 97% of participants said they perceive the benefits of classes in their own experiences.

In small group interactive classes over eight weeks, women and future fathers have the opportunity to feel comfortable, relaxed, and safe enough to share thoughts, fears, and feelings, and they have conversations with the midwife and other group members. The association's birth preparation classes have facilitated interaction and education, since the sessions allow practical experiences for women and their companions.

The association continues to fulfill its mandate to inform and advise women and their families about the need for continuous and responsible education in reproductive health. It is necessary to continually evaluate classes to ensure that they continue to include families and improve information for women and their partners.

Conclusions

The purpose of the stories in this book is to highlight the initiatives of nursing and midwifery professionals and the important work they do at different levels of care and professional settings in the different countries of the Region of the Americas.

Through the health programs launched by nursing and midwifery professionals or promoted by ministries of health, quality work is offered to communities, barriers to health are reduced or eliminated, and many health programs reach the most remote places.

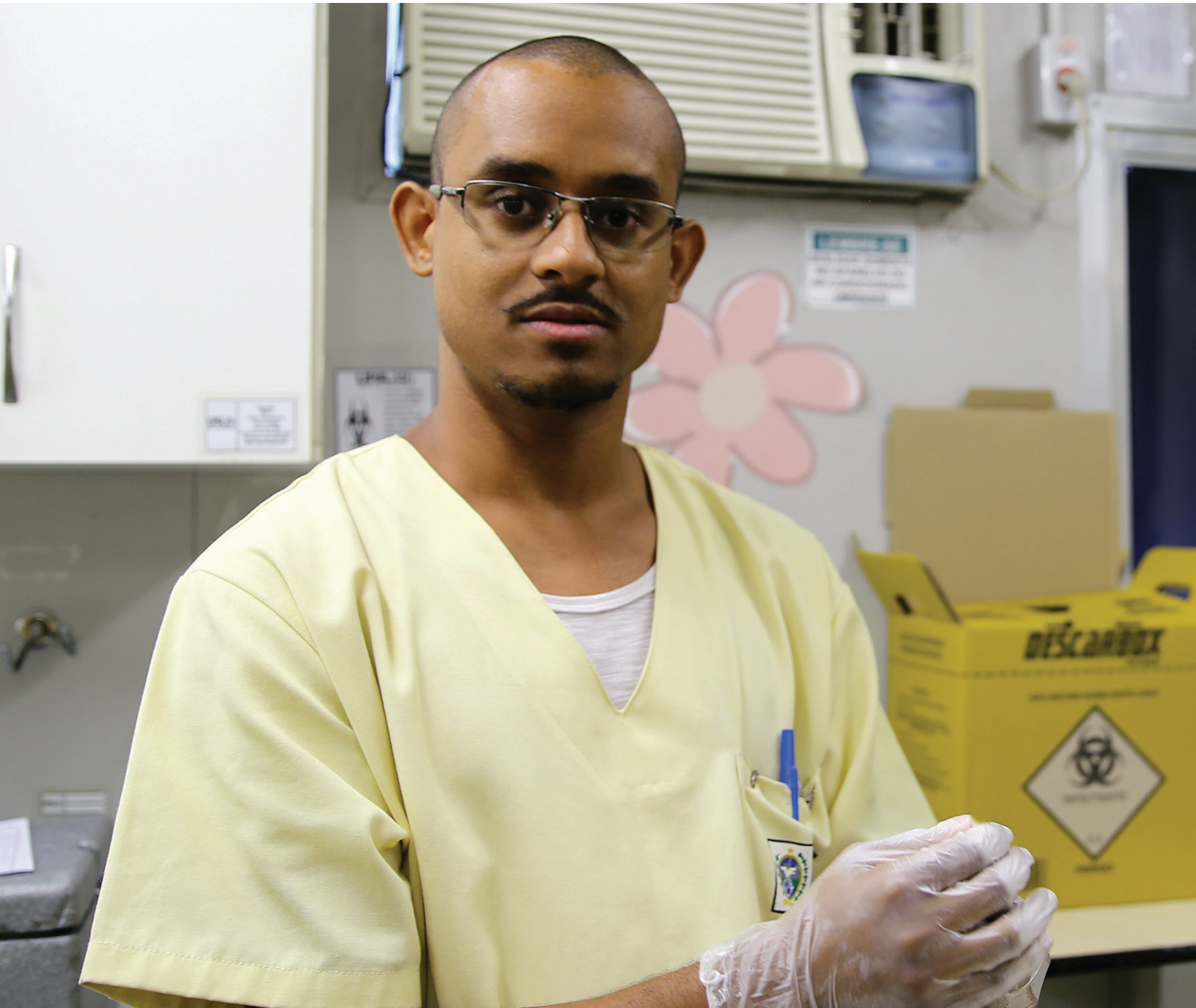
These programs are based on disease prevention and health promotion, and are comprised of interdisciplinary teams. One of their main approaches is to get to know the community, identify its needs, promote the education of family groups through different activities and initiatives, involve other health professionals, and evaluate the results—which are subjective, since no scientific or research process is followed.

Professionals face multiple difficulties and the COVID-19 pandemic has been one of the most complex. The pandemic has had devastating consequences worldwide with health, social, and economic effects. And although the crisis is affecting the entire population, the current situation exacerbates pre-existing risk factors, which mainly affect the most vulnerable populations in each country. Women are severely affected because they constitute the majority of health professionals and users of health services.

Furthermore, the pandemic has not only affected professionals and patients, but also future professionals, with profound consequences. Educational processes had to be modified during the pandemic because most programs were designed to be face-to-face, especially in health centers. At the peak of the pandemic, these centers decided to withdraw their students from clinical practice. Some of the stories reveal the reality of students and educators, and the effect that the pandemic had on training, with a wide gap in clinical learning. Presumably, the cases described here that were in operation before the pandemic were also affected in some way.

However, countries cannot win the battle against outbreaks or achieve universal access to health and universal health coverage without investing in training, employment, and regulation of human resources for health. The pandemic has shown that nurses and midwives are

central to health systems and services. We recommend that the initiatives presented in this publication be disseminated and replicated and that investment in and appreciation of the work done by health professionals in general and by nursing and midwifery professionals in particular be promoted. We believe that respecting and valuing these professionals, disseminating positive experiences, promoting collaborative practices, and strengthening primary health care are essential factors for achieving equity, universal access to health, and universal health coverage.



References

1. World Health Organization. State of the World's Nursing Report 2020: investing in education, jobs and leadership. Geneva: WHO; 2020. Available at: https://www.who.int/publications/i/item/9789240003279. Last accessed on: 18 August 2020.

2. World Health Organization. 2021 designated as the International Year of Health and Care Workers [internet]. Washington, D.C.: WHO; 2020. Available at: https://www.who.int/news/item/11-11-2020-2021-designated-as-the-international-year-of-health-and-care-workers. Last accessed on: 29 December 2020.

3. Pan American Health Organization. Guidance for implementing non pharmacological public health measures in populations in situations of vulnerability in the context of COVID-19. Washington, D.C.: PAHO, 2020. Available at: https://iris.paho.org/handle/10665.2/52955. Last accessed on: 23 November 2020.

4. World Health Organization. WHO and partners call for urgent investment in nurses [internet]. Washington, D.C.: WHO; 2020. Available at: https://www.who.int/es/news/item/07-04-2020-who-and-partners-call-for-urgent-investment-in-nurses. Last accessed on: 21 January 2021.

5. International Council of Nurses. Update of the International Council of Nurses on COVID-19. Geneva: International Council of Nurses; 2021. Available at: https://www.icn.ch/sites/default/files/inline-files/ICN%20COVID19%20update%20report%20FINAL.pdf. Last accessed on: 9 February 2021.

6. World Health Organization et al. Managing the COVID-19 infodemic: promoting healthy behaviours and mitigating the harm from misinformation and disinformation. Geneva: WHO; United Nations; UNICEF; PNUD; UNESCO; ONUSIDA; ITU, UN Global Pulse; IFRC; 2020. Available at: https://www.who.int/es/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation. Last accessed on: 21 January 2021.

7. Bandyopadhyay S, Baticulon RE, Kadhum M, Alser M, Ojuka DK, Badereddin Y, et al. Infection and mortality of healthcare workers worldwide from COVID-19: a systematic review. BMJ Global Health. 2020;5(12):e003097. doi.org/10.1136/bmjgh-2020-003097.

8. World Health Organization. COVID-19: occupational health and safety for health workers. Geneva: WHO; 2021. Available at: https://www.who.int/publications/i/item/WHO-2019-nCoV-HCW_advice-2021.1. Last accessed on: 5 February 2021.

9. United Nations Children's Fund. A neglected Tragedy: the global burden of stillbirths. New York: UNICEF; 2020. Available at: https://data.unicef.org/resources/a-neglected-tragedy-stillbirth-estimates-report/. Last accessed on: 22 January 2021.

10. World Bank Group. Closing Gender Gaps in Latin America and the Caribbean. Washington, D.C: WBG; 2020. Available at: http://documents1.worldbank.org/curated/en/484401532010525429/pdf/Closing-Gender-Gaps-in-Latin-America-and-the-Caribbean.pdf. Last accessed on: 8 February 2021.

11. World Bank Group. Gender dimensions of the COVID-19 pandemic. Policy note, 26 April 2020:1.29. Available at: http://documents1.worldbank.org/curated/en/618731587147227244/pdf/Gender-Dimensions-of-the-COVID-19-Pandemic.pdf. Last accessed on: 8 February 2021.

12. United Nations Food and Agriculture Organization, Economic Commission for Latin America and the Caribbean. Food systems and COVID-19 in Latin America and the Caribbean N° 7: the role of social protection measures. Santiago: FAO; 2020. Available at: https://repositorio.cepal.org//handle/11362/45721. Last accessed on: 5 February 2021.

13. Economic Commission for Latin America and the Caribbean. Los riesgos de la pandemia de COVID-19 para el ejercicio de los derechos sexuales y reproductivos de las mujeres. Santiago: ECLAC; 2020. Available at: http://hdl.handle.net/11362/46483. Last accessed on: 8 February 2021.

14. Kimani RW, Maina R, Shumba C, Shaibu S. Maternal and newborn care during the COVID-19 pandemic in Kenya: re-contextualising the community midwifery model. Human Resources for Health. 2020;18(1):75. doi.org/10.1186/s12960-020-00518-3.

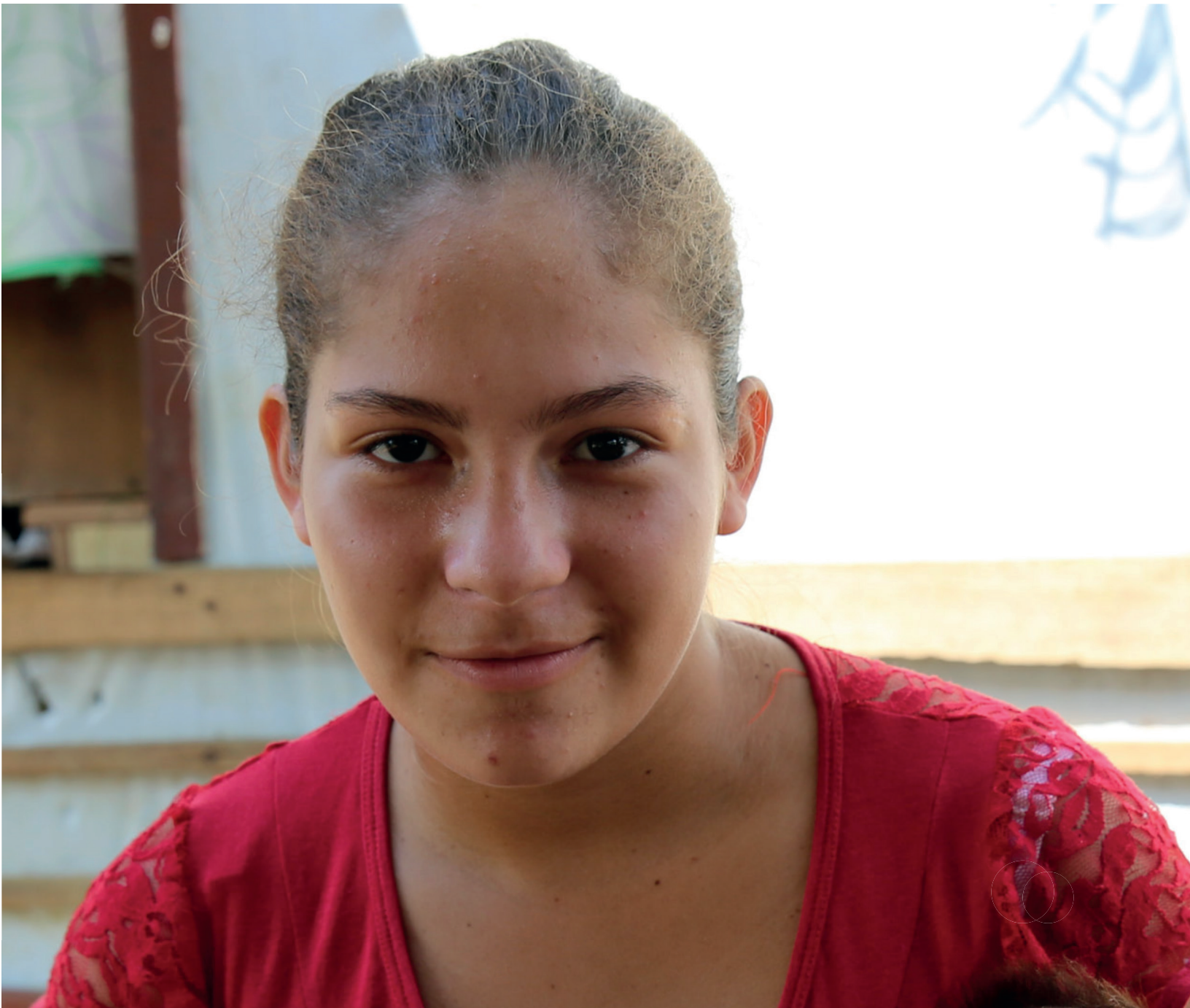
15. Pan American Health Organization. Compact 30 • 30 • 30 PHC for Universal Health. Washington, D.C.: PAHO; 2019. Available at: https://www3.paho.org/hq/index.php?option=com_docman&view=download&alias=50477-brochure-30-30-30-eng2019&category_slug=health-services-access-1965&Itemid=270&lang=en. Last accessed on: 18 August 2020.

16. Pan American Health Organization. Perspectives and Contributions of Nursing to the Promotion of Universal Health. Washington, D.C.: PAHO; 2020. Available at: https://iris.paho.org/handle/10665.2/52115. Last accessed on: 28 August 2020.

17. World Health Organization. Strengthening quality midwifery education for Universal Health Coverage 2030: framework for action. Geneva: WHO; 2019.

18. Ocho ON. Perceptions of registered nurses/midwives and obstetricians on having males as expectant fathers present in the delivery room at public hospitals in Trinidad and Tobago: implications for women and their partners. Sexuality & Culture. 2018;22(2):541–554. doi.org/10.1007/s12119-017-9482-2.

19. World Health Organization. WHO recommendations on health promotion interventions for maternal and newborn health. Geneva: WHO; 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742tables_eng.pdf;jsessionid=C84DDAD6E212FBBD6E9F69E82D423B37?sequence=2. Last accessed on: 13 April 2021.



The Pan American Health Organization, in recognition of the fundamental role of nursing and midwifery professionals in health systems, brought together reports from different countries to highlight the initiatives and contributions of these professionals with a focus on women's health. This publication helps to highlight the important work they do at different levels of care and professional settings, as well as the reality of women's health in the countries of the Region of the Americas. The related activities, stories, and cases illustrate the role of nursing and midwifery professionals in promoting universal access to health and universal health coverage, as well as their important contribution to health systems, universities, and schools in the countries of the Region.

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