

THE GLOBAL NETWORK OF
WHO COLLABORATING CENTERS FOR
NURSING & MIDWIFERY PRESENTS:

ISSN: 2175-4144

JUNE 2021 LINKS MAGAZINE

WELCOME

June 2021

Welcome to the June 2021 edition of Links Magazine!

As the six regions of the WHOCC experience various stages of evolution in the pandemic, the universal commonality has been continuous change. It is said that change is the only constant, and rapid change has certainly become the norm since the last edition of Links in December 2020.

Since that time, we have collectively witnessed a vaccine rollout that has demonstrated both the highest innovative achievements of medical science, as well as the complex social injustices that still prevail globally. As many nations began to gain traction for the first time since the onset of the pandemic, we watched in horror as India fell into the depths of loss and suffering at the hands of Covid-19. The WHO communities activated emergency initiatives to assemble support and relief efforts with urgency. Misinformation swept across the internet posing a threat to public health, and Nurses and Midwives continued on at the edge of innovation in practice and education.

All regions of the Collaborating Centers are represented in this June edition with insight into the global health experience as Nurses, Midwives, Students, and Educators over the past six months. Progressive programs for better supporting the dedicated Nurse are explored. Our international colleagues are celebrated and honored; as well as mourned.

In honor of those who lost their lives during the Covid Pandemic, and those who continue to forge on in the face of loss, we offer a heartfelt representation of solidarity in the form of voices from Collaborating Centers across the globe, from our community to yours.

Warmly,



Nancy Reynolds, PhD, RN, FAAN
Co-Secretary General



Patricia M. Davidson, PhD, MEd, RN, FAAN
Dean Emeritus
Co-Secretary General

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Contact Info

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WHO COLLABORATING CENTERS

AFRO

- **University of Botswana**, WHO Collaborating Centre for Nursing and Midwifery Development
- **University of Malawi, Kamuzu College of Nursing**, WHO Collaborating Centre for Interprofessional Education and Collaborative Practice
- **University of Natal, School of Nursing**, WHO Collaborating Centre for Educating Nurses and Midwives in Community Problem-solving
- **University of South Africa (UNISA), Department of Advanced Nursing Sciences**, WHO Collaborating Centre for Postgraduate Distance Education and Research in Nursing and Midwifery Development

AMRO

- **University of São Paulo** WHO Collaborating Centre for Nursing Research Development
- **McMaster University** WHO Collaborating Centre in Primary Care Nursing and Health Human Resources
- **University of Chile** WHO Collaborating Centre for Development of Midwifery
- **Pontificia Universidad Católica de Chile** WHO Collaborating Centre for Health Services and Nursing Development for Noncommunicable Disease Care
- **The UWI School of Nursing, Mona (UWISON)** WHO Collaborating Centre for Nursing and Midwifery Development in the Caribbean
- **Escuela Nacional de Enfermería y Obstetricia, Universidad Nacional Autónoma de México** WHO Collaborating Centre for the Development of Professional Nursing
- **University of Illinois at Chicago** WHO Collaborating Centre for International Nursing Development In Primary Health Care
- **University of Pennsylvania, School of Nursing** WHO Collaborating Centre for Nursing and Midwifery Leadership
- **University of Alabama at Birmingham, School of Nursing** WHO Collaborating Center for International Nursing
- **Columbia University, School of Nursing** WHO Collaborating Centre for Advanced Practice Nursing
- **University of Michigan, School of Nursing**, Office of International Affairs WHO Collaborating Centre for Research and Clinical Training in Health Promotion Nursing
- **Johns Hopkins University School of Nursing** WHO Collaborating Centre for Nursing Information, Knowledge Management and Sharing
- **New York University Rory Meyers College of Nursing** WHO Collaborating Centre for Gerontological Nursing Education
- **University of Miami, School of Nursing and Health Studies** WHO Collaborating Centre for Nursing Human Resources Development and Patient Safety
- **University of West Indies School of Nursing** WHO Collaborating Centre in Nursing Policies and Leadership

EMRO

- **College of Health Sciences, University of Bahrain** WHO Collaborating Centre for Nursing Development
- **Jordan University of Science and Technology** WHO Collaborating Centre for Nursing Development

EURO

- **Paracelsus Medical University, Institute of Nursing Science and Practice** WHO CC for Nursing Research & Palliative Care Education
- **Katholieke Universiteit Leuven, Research Unit, Institute for Healthcare Policy** WHO Collaborating Centre for Human Resources for Health Research and Policy
- **Nursing Research Foundation** WHO Collaborating Centre for Nursing
- **Lithuanian University of Health Sciences** WHO Collaborating Centre for Nursing Education and Practice
- **Nursing School of Coimbra** WHO Collaborating Centre for Nursing Practice and Research
- **Glasgow Caledonian University, Department of Nursing and Community Health** WHO Collaborating Centre for Nursing and Midwifery Education, Research and Practice
- **Cardiff University, College of Biomedical and Life Sciences, School of Healthcare Sciences** WHO Collaborating centre for Midwifery Development
- **Public Health England, Chief Nurse Directorate** WHO Collaborating Centre for Public Health Nursing & Midwifery

SEARO

- **Christian Medical College and Hospital** WHO Collaborating Centre for Nursing and Midwifery Development
- **National Institute of Nursing Education, Postgraduate Institute of Medical Education and Research (PGIMER)** WHO Collaborating Centre for Nursing and Midwifery Development
- **University of Nursing, Yangon** WHO Collaborating Centre for Nursing and Midwifery Development
- **Faculty of Nursing, Mahidol University** WHO Collaborating Centre for Nursing And Midwifery Development
- **Ramathibodi School of Nursing - Mahidol University** WHO Collaborating Centre for Nursing and Midwifery Development
- **Chiang Mai University - Faculty of Nursing** WHO Collaborating Centre for Nursing and Midwifery Development

WPRO

- **University of Technology Sydney (UTS)** WHO Collaborating Centre for Nursing, Midwifery and Health
- **James Cook University** Australia WHO Collaborating Centre for Nursing and Midwifery Education and Research Capacity-Building
- **The Hong Kong Polytechnic University (HKPU) School of Nursing**, WHO Collaborating Centre for Community Health Services
- **Peking Union Medical College School of Nursing** WHO Collaborating Centre for Nursing Policy-Making and Quality Management
- **St. Luke's International University, College of Nursing** WHO Collaborating Centre for Nursing Development in Primary Health Care
- **University of Hyogo, Research Institute of Nursing Care for People and Community** WHO Collaborating Centre for Disaster Risk Management for Health
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- **The Catholic University of Korea, College of Nursing, Research Institute for Hospice/Palliative Care** WHO Collaborating Centre for Training in Hospice & Palliative Care
- **University of the Philippines Manila** WHO Collaborating Centre for Leadership in Nursing Development

On May 6, 2021, Antonia M. Villarruel, PhD, RN, FAAN, Margaret Bond Simon, Dean of Nursing at the University of Pennsylvania School of Nursing, received the *Ohtli Award (Reconocimiento Ohtli)*, "the highest honor bestowed by the Government of Mexico to individuals and organizations that have stood out for their work in favor of the empowerment of the Mexican diaspora and helped to 'open the path' for the new Mexican American and Latino generations." [Click Here to video of the award ceremony that took place in Philadelphia, Pennsylvania, USA](#)



*The Consul of Mexico in Philadelphia
Carlos Obrador Garrido
cordially invites you to attend the*

2020 Ohtli Award Ceremony

honoring

Antonia M. Villarruel, PhD, RN, FAAN
Professor and Margaret Bond Simon Dean of Nursing
University of Pennsylvania School of Nursing

The Ohtli Award is the Government of Mexico's highest recognition to individuals that have opened pathways to enhance the future of generations of Mexicans abroad.

On Friday, November 20, 2020

6 PM–8 PM

Inn at Penn

**Sansom Common, 3600 Sansom St.
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Please R.S.V.P. by November 10th

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tomcavag@nursing.upenn.edu

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**Please note: capacity is limited, and the event
will meet all health and safety guidelines.**



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2020
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Developments In Midwifery Education

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NOVEMBER 18, 2020

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Fran McConville



Pragati Sharma



Marie Klingberg-Alvin



Jama Ali Egal



Fran McConville SRN, SCM, BSc, MA Econ, Technical Officer
Midwifery WHO HQ

Pragati Sharma RNM, MPH, MPP, Midwifery Consultant, WHO India
Office

**WHO-UNFPA-UNICEF-ICM Framework for Strengthening Quality
Midwifery Education for UHC 2030: Achievements in India**

Marie Klingberg-Alvin RNM, PhD, Professor in Global Sexual and
Reproductive Health, Dalarna University, Sweden and Adjunct
Professor, School of Nursing, University of Michigan, US.

Jama Ali Egal RNM, PhD student, Dalarna University, Associate dean
in Midwifery, University of Hargeisa, Somaliland.

**Crosscultural Capacity Building in Midwifery Education Using
Net Based Learning- Partnership Between Somaliland and
Sweden**

Ruth Zielinski PhD, CNM, FACNM, FAAN Clinical Professor &
Midwifery Graduate Program Director University of Michigan School
of Nursing

**Midwifery Education in the Time of COVID - Challenges and
Opportunities in Clinical Learning**

Fran McConville SRN, SCM, BSc, MA Econ, Technical Officer
Midwifery WHO HQ

Introduction to WHO MCA Project 'Sustaining Midwifery':

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THE MIDWIFERY NETWORK PRESENTS

WHO COLLABORATING CENTRES' MIDWIFERY NETWORK WEBINARS 2020-2021

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DEVELOPMENTS IN MIDWIFERY EDUCATION

NOVEMBER 18, 2020
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JANUARY 20, 2021
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THE QUALITY OF CARE NETWORK AND MIDWIFERY

MARCH 17, 2021
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LEADERSHIP IN MIDWIFERY: CLAIMING AND SUSTAINING A PLACE AT THE TABLE

APRIL 28, 2021
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ADDITIONAL DETAILS AND NAMES OF
KEYNOTE SPEAKERS TO FOLLOW



Webinar
11 May 2021
10:00 a.m. - 12:00 p.m. (EDT)

International Nurses Day

The need to invest in nursing: lessons learned from the pandemic



PAHO

Opening remarks:



James Fitzgerald, Director,
Health Systems and Services
Department,
PAHO/WHO



Moderator: Silvia Cassiani,
Advisor on Nursing and
Allied Health Personnel,
PAHO/WHO

Panelists:



Rear Admiral Susan Orsega, Director of
Commissioned Corps
Headquarters, USA



Oscar Ocho, Director/Senior
Lecturer of University of the
West Indies School of
Nursing, PAHO Collaborating
Center for Nursing, Trinidad
and Tobago



Ethel Maciel, Associate
Professor, School of
Nursing, Federal
University of Espirito
Santo, Brazil



Ana María San Martín Venegas, Director of
Nursing, Ministry of
Health, Chile



Gloria Lucia Arango Bayer, Associate
Professor, Faculty of
Nursing, National
University of Colombia

WEBINAR RECORDINGS BY LANGUAGE:

- ENGLISH
- PORTUGUESA
- ESPAÑOL
- FLOOR



Webinar
11 May 2021
10:00 a.m. - 12:00 p.m. (EDT)

International Nurses Day

The need to invest in nursing: lessons learned from the pandemic



PAHO

Profile on CoVax & the Profound Impact on Healthcare Workers Worldwide: Q&A with Pandora Hardtman and Howard Catton



Pandora Hardtman
Chief Nursing and
Midwifery officer for
Jhpiego



Howard Catton
CEO International Council of
Nurses

WATCH
THE Q&A
HERE!

Featuring Insight On:

- The vaccine roll-out & distribution
- Challenges & achievements for LMIC in particular
- Future planning to better support the Nurses and Midwives of the world



Moderated by: Karli McGuinness, LINKS Magazine Editor,
Johns Hopkins School of Nursing MSN Student

The Links Magazine team is grateful to have had the opportunity to gather insight from two Nurse and Midwife Global leaders in our community.

Resources referenced in the panel can be found here:

**National Nursing Associations
which are ICN members**

Keep in Touch:



@ICNurses

@HowardCatton

@PandoraHardtman

COVID Vaccination – An Update: India Scenario

**With a fast-moving
pandemic, no one is safe,
unless everyone is safe.**

COVID Vaccination – An update: India Scenario

Joy Priyadharishini J (1), Aruna G (2), Vathsala Sadan (3)

1. Reader, Community Health Nursing Department, College of Nursing, CMC, Vellore

2. Reader, Psychiatry Nursing Department, College of Nursing, CMC, Vellore

3. Professor and Dean, College of Nursing, CMC, Vellore



The pictures were taken in a secondary hospital called "CHAD" (Community Health and Development) which is attached to Christian Medical College, Vellore. .

This is a team of interdisciplinary staff with Mrs. Priya the nurse manager leading the vaccine program

The global pandemic has already caused the loss of hundreds of thousands of lives and disrupted the lives of billions more. Introduction of vaccines will reduce the loss of lives and help getting the pandemic under control. Equitable access to vaccine among the front line health workers and the at-risk group will reduce impact of the pandemic on public health and economy [1].

During the initial times of pandemic, just like the other countries India, was also left scrambling for protective gear and medical equipment to manage the crisis. The first mass vaccine program in India started in early December 2020 and as of 19 April 2021, a total of 130,027,370 vaccine doses have been administered. There are three vaccines available in India now; Covaxin, Covishield and Sputnik V.

Covaxin is an inactivated vaccine which means that it is made up of killed coronaviruses, making it safe to be injected into the body. Bharat Biotech, a 24-year-old vaccine maker with a portfolio of 16 vaccines and exports to 123 countries, used a sample of the coronavirus, isolated by India's National Institute of Virology. When administered, immune cells can still recognize the dead virus, prompting the immune system to make antibodies against the pandemic virus [2].

Covishield or the Oxford-astrazeneca vaccine is being manufactured locally by the Serum Institute of India, the world's largest vaccine manufacturer. It says it is producing more than 60 million doses a month. The vaccine is made from a weakened version of a common cold virus (known as an adenovirus) from chimpanzees. It has been modified to look more like coronavirus - although it can't cause illness [2].

A third coronavirus vaccine has been approved for use in India amid a deadly second wave of infections. Russia's Sputnik V has been deemed to be safe, and works in a way similar to the Oxford-astrazeneca which is being made in India as Covishield. Sputnik V gives around 92% protection against Covid-19, late stage trial results published in The Lancet. Sputnik V's approval came as India overtook Brazil to become the country with the second-highest number of cases globally. The vaccine, developed by Moscow's Gamaleya Institute, initially generated some controversy after being rolled out before the final trial data had been released [2].

COVID Vaccination – An update: India Scenario

Distribution:

The speedy distribution of vaccine across the country is a biggest challenge to any government (3). Healthcare and frontline workers are the targeted group for the vaccination at first level followed by the high risk people like above 60 years of age and then persons between 45 and 59 years with co morbid conditions. [4]

The digital track and trace system is adapted to ensure that everyone in India is vaccinated. This system helps in identifying the contacts of the COVID positive persons and prevents the spread of infection by notifying them to keep them isolated. [5].

Challenges

The challenges in administration of the vaccine are Vaccine supply to huge population:

As India is the second populous country in the world, vaccinating the huge population is a biggest challenge. India aims to immunize 300 million people in the first phase of vaccination, by July including health care workers, people aged 50 and above and those with comorbidities.

The maintenance of the cold chain:

The management of cold chain is a major challenge in Vaccination programs. Most of the Vaccines are to be kept in a low temperature from the time of preparation time till the time of administration. Super cold freezers that are required to ship vaccines from one continent to another are short in supply. Hence, maintaining the required temperature during transporting, stocking, distributing and at the vaccination centers is a real challenge. There are trials by pharmaceutical companies to create a vaccine box for transportation

Work force to administer the vaccine: In a country with 1.35 billion populations, larger health care work force is required to ensure that everyone is vaccinated especially when it is a two-dose vaccine [6].

Monitoring the adverse reaction:

Establishing a public-public partnership, public –private partnership and IT- enabled supply chain transparency to plan, organize and co-ordinate the vaccination program would help overcome the challenges [6]

Vaccine hesitancy:

Vaccine skepticism thrives on social media, and the quick development of covid vaccines has deepened fears about their safety. In India, the controversy sparked by the nod to Covaxin when its efficacy data is awaited has not helped the matters.

Keeping all the challenges in mind, the large amount of funding required to ensure everyone is vaccinated at free of cost is a bigger challenge. Yet another major concern regarding the long term protection by these vaccines will be known only after 2-3 years from now.



COVID Vaccination – An update: India Scenario

Achievements:

Globally as of 25 April, 2021, there have been 146,054,107 confirmed cases of COVID-19, including 3,092,410 deaths, reported to WHO. As of 21 April, a total of 899,936,102 vaccine doses have been administered. In India, from 3 January 2020 to 25 April 2021, there have been 16,960,172 confirmed cases of COVID-19 with 192,311 deaths, reported to WHO. As of 19 April 2021, a total of 130,027,370 vaccine doses have been administered. (7)

The Electronic Vaccine Intelligence Network (eVIN) developed in 2015 to address the few challenges of transporting, storing and deploying the vaccines used in India's Universal Immunization Program, provides real-time monitoring of the vaccine supply chain in India[4]. The eVIN system has been expanded in response to the pandemic to check the journey of vaccine along with the recipient of the vaccine and the due date to receive the next dose[5].

The tracking system is launched not only to track the vaccine but to ensure utilization of the service by the target group. The aim of introducing the tracking system is to boost the vaccine safety mechanism and the safety surveillance. This also helps in tracking if a person has had any adverse reactions and the vaccine safety can be then investigated [5].

India has shipped 64 million doses of vaccines to 86 countries in Latin America, the Caribbean, Asia and Africa. The recipient countries include UK, Canada, Brazil and Mexico. Both Covishield and Covaxin have been exported - some in the form of "gifts", others in line with commercial agreements signed between the vaccine makers and the recipient nations, and the rest under the Covax scheme, which is led by the World Health Organization (WHO) and hopes to deliver more than two billion doses to people in 190 countries in less than a year. But in March, India placed a temporary hold on all exports of the Oxford-AstraZeneca vaccine. The government said rising cases meant domestic demand was expected to pick up and so the doses were needed for India's own rollout [2].

Herd immunity is what expected after the vaccination program (3), however it is equally important to control the spread of infection. The most mentioned term in 2020 was COVID 19, but the year of 2021 is all about COVID vaccine.

[References can be found on page 69-73]



**Spiritual Well-Being,
Attitude, Involvement,
Perceptions &
Competencies:
Measuring the Self-Perception of
Nursing Students During 2018, 2019 &
the First Wave of COVID-19 in 2020**

Spiritual Well-being, Attitude, Involvement, Perceptions and Competencies: Measuring the Self-Perception of Nursing Students During 2018, 2019 and the First Wave of COVID-19 in 2020

*Cornelia Brandstötter, Firuzan Sari Kundt, Priv.-Doz. Dr. Piret Paal,
Institute for Nursing Science and Practice, Paracelsus Medical
University, Salzburg, Austria*

What is spirituality and how important is it for nurses?

There are many definitions, but in essence, spirituality is an element of human life that connects the way individuals experience, express and seek meaning and purpose to every aspect of their individual life, such as the moment, self, others or the sacred. Spirituality, particularly in the workplace, has shown to have positive effects on job commitment, satisfaction, and performance all the while increasing self-career management, self-esteem, involvement, retention and ethical behavior, and reducing inter-role conflict and frustration. In other words, enhancing spirituality and spiritual care competencies promotes nurses' overall well-being, and hence, facilitates patients' safety, well-being and satisfaction.

Methods:

In June 2018, June 2019 and May 2020, a single six-hour interactive lecture entitled "Spirituality and spiritual care in nursing" was included in the curriculum of second year Bachelor-level nursing students in Salzburg, Austria. The session concentrated on the theoretical aspects of spirituality, such as definitions, and its importance for health and nursing practice. To measure spirituality and spiritual care competencies in undergraduate nurses, we used a preconstructed questionnaire containing demographics and validated scales to measure spiritual well-being (JAREL), spiritual care attitudes and involvement (SAIL), spirituality and spiritual care perceptions (SSCRS) and competencies (SCCS). Data was collected in 3 consecutive years (2018, 2019, 2020) from students attending the "Spirituality and spiritual care in nursing" lecture with a completion rate of 50-60% (total sample=191). In addition, we also collected data on students' positive and negative life events as well as their spiritual practices.



Results and Discussion Demographics:

A majority of participating students were female, between 21 and 25 years of age, and classified themselves to be Christian. Spiritual Practices: The percentage of daily spiritual practices during the COVID-19 lockdown in 2020 increased in almost every category (practice prayer, practice meditation, read religious books, practice art and seek rest in nature), as compared to 2018 and 2019. Significant Life Events: In all 3 years, between 35% and 45% of students experienced significant life events (both positive and negative). Scales: Regarding the self-assessment tools, all 3 groups show on average high levels of spiritual attitude and involvement (SAIL), with the 2020 group scoring the highest. In contrast, on the JAREL spiritual well-being scale, all three groups have different results. Compared with international data, the results of all three Austrian groups regarding spiritual well-being are lower. Especially in the 2020 group, 17.2% reported low spiritual well-being, 82.8% medium well-being, and none of the students attained scores in the high spiritual well-being range. Comparing these numbers to the ones from 2018 and 2019, 0% and 1.8%, respectively, scored low on spiritual well-being. Keeping in mind that spiritual practices are carried out most often by the 2020 group, this outcome is of particular interest, confirming the lack of, and hence, greater need for spirituality. One explanation for these findings could be the COVID-19 pandemic and the impact of its associated lockdown measures. Regarding the Spirituality and Spiritual Care Rating Scale (SSCRS), all 3 groups achieved similar scores. The 2020 group reached the highest scores, indicating a broader view of spirituality. Students in all 3 years perceived to have a strong spiritual competence (SCCS), however, students from the 2020 group indicated to have the highest spiritual competence of all 3 years.

Implications for Teaching Spirituality and Spiritual Care Online:

Up until 2020, only a small proportion of spiritual care courses took place online. In 2020, due to the pandemic, classroom teaching at the tertiary level was entirely replaced by distance and online lecture formats. Although this change came out of a necessity, it turned out that students were more engaged during online lectures than during a six-hour classroom session with more than a hundred students. That might be one of the reasons why the scores on the perception of spirituality are broader in this group.

Conclusion:

Students argue that spirituality and spiritual care are an integral part of professional nursing, which should serve as an indicator to educators, academic leaders and nursing associations to include the topic in further discussions. The findings of our study indicate that during the COVID-19 lockdown students suffered from low spiritual well-being. It remains unclear whether the COVID-19 pandemic will have any long-term effects and whether it is the only reason for such outcomes. If nurses are to educate people to manage their own health, including educating patients about the importance of spirituality and spiritual care, nurses' self- and healthcare practices need much more attention. Even if the students rated their competencies in delivering spiritual care as high, their care giving may be affected if their own spiritual well-being remains low for an extended period of time.

Conclusion:

Students argue that spirituality and spiritual care are an integral part of professional nursing, which should serve as an indicator to educators, academic leaders and nursing associations to include the topic in further discussions. The findings of our study indicate that during the COVID-19 lockdown students suffered from low spiritual well-being. It remains unclear whether the COVID-19 pandemic will have any long-term effects and whether it is the only reason for such outcomes. If nurses are to educate people to manage their own health, including educating patients about the importance of spirituality and spiritual care, nurses' self- and healthcare practices need much more attention. Even if the students rated their competencies in delivering spiritual care as high, their care giving may be affected if their own spiritual well-being remains low for an extended period of time.

Interested in spiritual care education? Consult these freshly published reviews!

- McSherry; Boughey, Attard (Eds), Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care ISBN 978-3-030-65887-8
- Jones KF et al. (2021). The Content, Teaching Methods and Effectiveness of Spiritual Care Training for Healthcare Professionals: A Mixed-Methods Systematic Review. Journal of Pain and Symptom Management, <https://doi.org/10.1016/j.jpainsymman.2021.03.013>
- Prinds C et al. (2021). Characteristics of existing healthcare workforce education in spiritual care related to childbirth: A systematic review identifying only two studies. Midwifery, Volume 97, <https://doi.org/10.1016/j.midw.2021.102974>

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THE FUTURE IN HEALTHCARE POST-COVID FOR MENTAL HEALTH

The Future in Healthcare Post-Covid for Mental Health



*Dr. Monique A. Lynch (right) DSc, MSc., BSc.,
The UWI School of Nursing, Mona*



*Dr. Andrea Pusey-Murray (left)
Associate Professor & Coordinator Graduate
Studies, Research & Entrepreneurship, College of
Health Sciences, University of Technology, Jamaica*

The coronavirus disease 2019 (COVID-19) is an infectious disease caused by SARS-CoV-2 that mainly affects the respiratory system, as interstitial pneumonia, and acute respiratory distress syndrome (ARDS) (Landi, Barillaro, Bellieni et al., 2020). To prevent the spread of this contagious virus, national governments have introduced 'lockdown' measures with infection control strategies including 'social distancing' and 'self-isolation' guidelines which severely restricts the movement of people and affects their daily life (WHO, 2020; Haleem, Javaid, & Vaishya, 2020).

Lockdown and strategies to prevent COVID-19 viral transmission has caused significant economic, geopolitical and health consequences all over the world (World Economic Forum, 2020). To reduce the number of 'face to face' consultations, the way out-patient services are delivered has completely changes during the pandemic. Remote consultations including telephone and Video platforms have evolved significantly to provide a continuity of care (NHS England & NHS Improvement 2020).

The healthcare industry worldwide post-pandemic might be distorted due to the crisis' spurt of disruption and hence the future of healthcare will possibly be shaped by technology and innovation. As a fact, it has catalyzed technology, innovation, and growth in healthcare such as increased usage of medical devices, medical apps, touch-free technology, and virtual services. Among them is virtual mental healthcare, which has seen a precipitous increase in demand for all ages, but especially in the teen and young adult demographic (Laker, 2020). Many studies show that the psychological impact of isolation, social distancing and accessing support during crises is widespread and substantial and can include depression, anxiety, misuse of drugs and alcohol, and other serious effects, especially for at-risk populations like what we have here in Jamaica (Deschutes County Behavioral Health, 2020). This has created the opportunity for teletherapy, which can be a lifesaver. Other innovations such as improving the coordination and electronic health records will contribute to the improvement in health care for the caregiver's post COVID. Telehealth will improve access to behavioral health care and improve effectiveness by helping to support patients and caregiver's during their visits. For example, virtual home health services can boost the patient's and caregiver's experience where they participate in virtual sessions to improve their strength, balance, and endurance, and to advise them how to avoid physical hazards to reduce risk of falls.

The Future in Healthcare Post-Covid for Mental Health

The epidemic has worsened existing issues around the mental health of populations globally and post-pandemic, healthcare providers will need to create an integrated framework which supports overall well-being. This more widespread, better integrated mental health framework represents a change from the current level of mental health provision, care and treatment for the population, and as such, providers will need additional funding and resources from both public and private sectors.

Education, self-care, and family support forms part of mental health prevention strategies, which should involve multiagency collaboration. As a region there should be a thrust to garner support from the non - governmental organization, public and private sectors. These agencies should continue to mobilize social support networks and work with local communities to help address identified stressors and encourage those in need to seek help from the mental health services.

There is no simple one-size-fits-all solution but there are, however, some fundamental principles for a new healthcare framework such as:

- Creating a sustainable mental health and well-being programme that supports persons on all socio-economic levels.
- Create new structures within the public and private sectors' organizational model to prioritize mental health and holistic well-being.
- Integrate mental health and resiliency training throughout education at the early childhood, primary, secondary, and tertiary levels.

[References can be found on page 69-73]

Minimum Nurse-to-Patient Ratios Policy Saves Lives and Lowers Costs



Minimum Nurse-to-Patient Ratios Policy Saves Lives and Lowers Costs

*Ed Federico, Associate Director of Public & Media Relations,
Penn Nursing*

A new study published in The Lancet on May 11, 2021 showed that a policy establishing minimum nurse-to-patient staffing ratios in hospitals in Queensland, Australia saved lives, prevented readmissions, shortened hospital stays, and reduced costs.



Left: Penn Nursing - QUT team presenting findings to Queensland Health

(L-R) Shelley Nowlan, Chief Nursing and Midwifery Officer - Queensland Health; Professor Patsy Yates, Queensland University of Technology School of Nursing; Steven Miles, Minister for Health and Ambulance Services - Queensland; Professor Matthew McHugh, University of Pennsylvania School of Nursing

The study, by the Center for Health Outcomes and Policy Research (CHOPR) at the University of Pennsylvania School of Nursing, and the Queensland University of Technology School of Nursing, evaluated legislation enacted in 2016 as a safety measure. The new policy limited the average number of patients per nurse to four, similar to pending legislation in New York and Illinois. "The positive results in Queensland should inform policies in the U.S. and elsewhere," said lead-author Matthew McHugh, PhD, the Independence Chair for Nursing Education and CHOPR Director.

The researchers collected extensive data before and after the legislation from about 17,000 nurses and analyzed of outcomes for more than 400,000 patients. They found that: The researchers collected extensive data before and after the legislation from about 17,000 nurses and analyzed of outcomes for more than 400,000 patients. They found that:

- **There was a clear need for a safe hospital nurse staffing standard.** Before the policy was in place, nurse staffing levels varied significantly across Queensland hospitals. In some facilities, nurses cared for as few as three patients on adult medical and surgical wards, while nurses at other facilities were responsible for as many as 10 patients each.
- **The policy led to better nurse staffing in the intervention hospitals.** While staffing levels remained the same before and after the policy in comparison hospitals, the medical-surgical nurses at the intervention hospitals saw average reductions in their workload of nearly one patient per nurse, with some having three fewer assigned patients after policy implementation.
- **The staffing improvements stimulated by the policy led to better outcomes for patients.** The researchers estimated that intervention hospitals had 145 fewer deaths, 255 fewer readmissions, and 29,222 fewer hospital days than if they had not implemented the policy.
- **The policy yielded a good return on investment for the public.** In addition to better quality of care and patient outcomes, the savings due to fewer readmissions and shorter lengths of stay in hospitals was about \$70 million (AUD), more than twice the cost of the additional nurse staffing.

Minimum Nurse-to-Patient Ratios Policy Saves Lives and Lowers Costs

The findings are consistent with a substantial body of evidence on the positive effects on patient outcomes when nurses have a reasonable number of patients in their care. There is similarly strong evidence that when staffing levels improve, nurses experience less burnout and job dissatisfaction, which are key drivers to costly turnover and result in nurses leaving their careers at the bedside. The study's release coincided with International Nurses Day.

McHugh, who is also a Senior Fellow at the Leonard Davis Institute of Health Economics at Penn, said "These results are all the more relevant in the context of COVID-19, which has pushed an already strained and burned-out hospital nurse workforce to the brink. Minimum safeguards to ensure that there are enough nurses to provide high-quality care to every patient is a simple but effective public safety measure."

QUT Faculty of Health Executive Dean, Distinguished Professor Patsy Yates, said the publication illustrated the value of research that had real-world impact. "This research is a clear example of good public health policy in Queensland being derived from evidence-based research," said Professor Yates. "The result benefits the health system, nurses, patients and the public at large."

The study was carried out by the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing in partnership with the Queensland University of Technology. Funding and support for the study was from Queensland Health, the National Institute of Nursing Research/NIH, and the Leonard Davis Institute of Health Economics at the University of Pennsylvania.



Above: Matthew McHugh, PhD, the Independence Chair for Nursing Education and Director of the Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing



Above: Distinguished Professor Patsy Yates, Faculty of Health, Office of the Executive Dean, Health, Queensland University of Technology School of Nursing

Building Capacity Through Partnerships During the Pandemic



Building Capacity Through Partnerships During the Pandemic

Ada Markaki, Co-Director & Lisa Theus, Program Manager

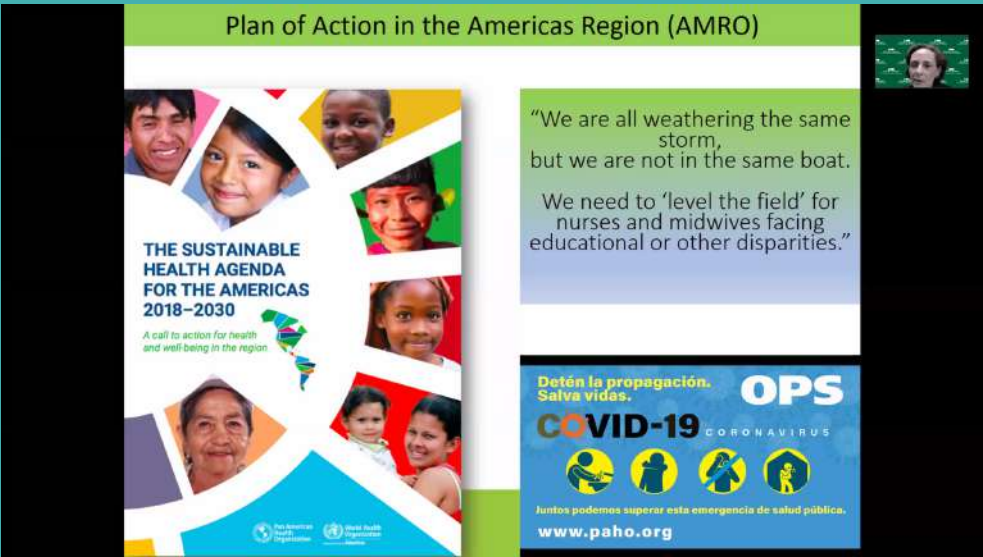
Creating the next generation of nurse leaders, capable of reaching and caring for underserved populations, has been central to the University of Alabama at Birmingham (UAB) School of Nursing's education mission. The unprecedented changes, brought on by the COVID-19 pandemic, have further accelerated the School's global focus by re-conceptualizing the ways we teach, practice, and build capacity through partnerships.

The School's emphasis on "thinking globally, acting locally", also known as a "glocal" approach, has been threaded throughout the undergraduate and graduate programs to offer student exposure and engagement in global health, early on. Similarly, the adopted



(Above) 2019 International Visiting Scholars, Chinwendu Agu of Jamaica and Ong-on Prajankett of Thailand, making connections at UAB.

UAB SON Framework for Global Health Action, not only captures faculty activities that meet the WHO's sustainable development goals, but also identifies growth opportunities for leadership. This approach and framework underpin the Model of Sustainability in Global Nursing which guides the School's PAHO/WHOCC for International Nursing activities.



(Above) Image from a presentation on sustainable partnerships in the Americas given by PAHO/WHO CC Co-Director, Dr. Ada Markaki.

Building Capacity Through Partnerships During the Pandemic

Through program/course development, delivery, and evaluation, the UAB PAHO/ WHOCC has continued to build capacity in education quality improvement and leadership. Two new distance-accessible courses, PUB-201 (English) /PUB-202 (Spanish), were developed in 2020 to target the growing need for well-trained and qualified nurse and midwifery educators worldwide, especially in Latin America and the Caribbean, which existed well before the COVID-19 pandemic. These self-directed courses strengthen competencies on quality monitoring, evaluation and improvement plans; expand use of clinical simulation and virtual training; and promote experiential learning for complex and systemic thinking and evidence-based decision making. UAB School of Nursing faculty, and staff with expertise in clinical and global partnerships, simulation, and innovation came together with partners from the PAHO/WHOCCs at the University of West Indies in Jamaica, and the Pontificia Universidad Católica in Chile to develop, pilot test and evaluate the courses in English and Spanish. Both courses were officially launched in November 2020 during an international webinar entitled, Quality Improvement in Nursing Education: Future perspectives in the post-pandemic era. This event included a panel of expert speakers from PAHO, Latin America, and UAB who spoke on how education has adjusted during this period and offered insights for the future. The webinar was live-streamed to 3,000 participants, representing 40 countries, and is available through the School's YouTube channel.

Furthermore, in response to COVID-19 travel restrictions, the UAB SON International Scholars Program was expanded to offer two alternative virtual options for greater flexibility. The virtual international scholar experience is a semester-long program, which includes a selected PhD level course and mentoring from UAB faculty. There is also a shorter-term option which provides intense mentorship for research proposal development and guidance from a UAB faculty member. Both programs include regular virtual meetings between the faculty mentor(s) and the scholar, opportunities for virtual observing, and classroom teaching. The program enables select international faculty, post-doctoral fellows, PhD students, clinicians, and nursing administrators to gain valuable short-term experiences in advanced nursing education, research, and practice through individualized mentorship. In the last ten years, over 30 international scholars have been mentored on projects ranging from palliative care, to clinical simulation, to quality of life for persons with chronic diseases. Interactions between international mentees and mentors have been particularly rewarding and enriching, especially during a time of social isolation and diminished opportunities for travel.

Through the above initiatives, the UAB PAHO/WHOCC is making a difference in reducing disparities, leveling the field for nurses and midwives, while underscoring their role and contributions during the pandemic across the globe.

WHO SEARO Nursing Workforce Project



WHO SEARO Nursing Workforce Project

Chiang Mai University WHO CC Collaborating Center in Nursing and Midwifery Development

In 2010, The Lancet published the landmark report “Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World” which described a global need for more health professionals, including nurses, to ensure that population health needs were met. The report called for educational reforms to improve competency based training, better coordination between educational institutions and local needs, pedagogy. The multifaceted roles that nurses take on from midwife to nurse practitioner uniquely positions them to address several facets of the healthcare shortage to meet existing needs.

Ten years later, WHO designated 2020 as the International Year of the Nurse and Midwife and the importance of nursing was highlighted through their role in the COVID-19 pandemic. WHO released the State of the World’s Nursing 2020 report providing up-to-date information on that current state of the global nursing workforce and the role of nurses in meeting the Sustainable Development Goals. This comprehensive report provides an important overview of the global nursing workforce, however, the WHO SEARO office wanted to gather in-depth information regarding the nursing workforce in the SEA region. This resulted in the current collaboration between WHO SEARO and the Chiang Mai University Faculty of Nursing WHO CC Collaborating Center in Nursing and Midwifery Development.



(Left) Image from the WHO SEARO Workforce Webinar with Ai Tanimizu and colleagues from Timor-Leste

The collaboration is focused on better understanding the nuances of the nursing workforce within SEARO through an in-depth questionnaire. WHOCC staff and WHO SEARO have been developing a questionnaire to follow-up on an earlier 2017 WHO SEARO initiative on nursing workforce. The questionnaire will also build upon the recent 2020 State of the World’s Nursing report.

Throughout April 2021, the project will gather data on nursing education curriculum, production capacity, nurse deployment, scope of work, and career development from all 11 SEARO countries. Data validation and analysis will take place in May. The results will be submitted as a report to WHO SEARO. Dean Thanee Kaewthummanukul, Director the Chiang Mai University Faculty of Nursing WHO CC Collaborating Center in Nursing and Midwifery Development hope that this project will provide useful information on the state of the nursing workforce in the SE region that can be used to further strengthen nursing in the region.

Basic Psychosocial Skills Training for COVID-19 Responders: Online Training



Basic Psychosocial Skills Training for COVID-19 Responders: Online Training

As a World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development, University of Technology (WHO CC UTS) has continued to provide support for nurses and midwives across the Pacific during this challenging and difficult time that the pandemic has presented the world. WHO CC UTS has delivered a number of projects over the last 12 months, including a scoping review of the pediatric and birthing facilities at the ANGAU Hospital in Papua New Guinea (PNG). This review provides continued professional development of midwives at the ANGAU Hospital. Another initiative includes the publication of the Vital Role of Nurses and Midwives in the Western Pacific Region report. The Centre was also recently awarded a contract with the Department of Foreign Affairs and Trade, Australia, to review and update the Diploma of General Nursing and Certificate for Community Health Workers in Australia



Basic Psychosocial Skills Training for COVID-19 Responders

As part of our ongoing support in the region towards the COVID-19 response WHO CC UTS has launched a new [free online](#) course called 'Basic Psychosocial Skills Training for COVID-19 Responders', to provide individuals with the necessary skills to support their own and others' mental health and emotional well-being during this difficult time.

The Basic Psychosocial Skills Training for COVID-19 Responders online training is a free program for anyone affected by the COVID-19 pandemic, and/or offering support to family, loved ones and the community during this challenging time. The training recognizes that many people may feel higher levels of stress than normal during the pandemic, due to the additional demands and stresses associated with responding to the pandemic. The training is designed to strengthen basic psychosocial skills that are essential to identifying the needs of self and others, building resilience and promoting mental health well-being for first responders and frontline health and care staff and equipping them to support others.

Basic Psychosocial Skills Training for COVID-19 Responders: Online Training

The training enhances an individual's ability to support themselves from workplace stressors and help others feel supported through their interactions. The course comprises of a number of highly interactive training modules designed to maximise participant engagement through the use of diverse learning materials inclusive of videos, quizzes and online activities. The training also includes case scenarios, which acquaints the learner to real-life situations and enhances critical thinking skills along with facilitating application of learning. The course allows the learner to reflect on their context and challenges them to try new strategies for supporting others. There is also the opportunity to interact with other learners, allowing an insight into new perspectives and engagement in shared experiences. At the end of the course, participants will receive a certificate of completion.

The online course emphasises five key elements:

1. Focus on personal well-being
2. Exploring supportive communication in everyday interactions using verbal and non-verbal communication, as well as active listening
3. Providing a practical framework that enables first responders to support others to problem-solve and encourage them to make healthy autonomous decisions
4. Examining how to recognise emotional patterns and provide tools that can be used to relieve distress
5. Recognising the vulnerable and marginalised, and providing help with specific considerations.

For more information, please see the below links:

- [View a detailed video on how to sign up](#)
- [Enroll for this FREE online course](#)
- [Read instructions on how to sign up](#)
- [Read more about the basic psychosocial skills course](#)
- [Access to the IASC Guidance on Basic Psychosocial Skills- A Guide for COVID-19 Responders](#)

FAQs

1. How many resources are provided in the Basic Psychosocial Skills training program?
A. The program provides 3 resources. Guidance report, short online course and presentation with facilitation notes.
2. How many languages is the guidance offered in?
A. While the online course is only in English, the guidance report is provided in 28 languages.
3. Is the online course time-bound?
A. No. The online course is self-paced and takes an average of 3 hours to complete with a short quiz and a certificate awarded.
4. What platform is best to access the course on?
A. It is recommended that the course be accessed using google chrome.

Penn Nursing Collaborates with Partners In Health to Support Global Nursing



Penn Nursing Collaborates with Partners In Health to Support Global Nursing

*Nancy Biller, MA, MPH; Assistant Dean
Global Health Affairs
University of Pennsylvania School of Nursing*

Making A Connection

Weeks before the world understood that COVID-19 was a pandemic, Penn Nursing, a WHO Collaborating Center for Nursing and Midwifery Leadership, had connected with nursing leadership at Partners In Health (PIH) to invite them to consider how we might contribute to the impactful work for which PIH is known and celebrated. Many excellent ideas were considered and then the world changed.... PIH needed to shift significant focus to the COVID-19 response, globally and locally. Months later the conversation continued, and a project was identified.

The Project

Launched in 2017, Partners In Health's Global Nurse Executive Fellowship (GNEF), formerly the Nightingale Fellowship, is a twelve-month program that facilitates the development of culturally humble and confident nursing and midwifery senior and executive leaders who address current and emerging global health challenges by transforming health systems and, ultimately, improving population health.

The fellowship has four core components: 1) three week-long intensive learning sessions; 2) ten-month self-directed online learning program; 3) individualized executive coaching and mentorship; and 4) implementation of a capstone leadership project. The program's curriculum is rooted in current pedagogical approaches and is divided into three broad categories that deal with "leading self," "leading others" and "leading systems." Leading self focuses on the fellows establishing a better understanding of themselves as leaders, leading others focuses on acquiring skills and knowledge to better lead and manage others and leading systems focuses on leading at an organizational and systems level.

Penn Nursing Collaborates with Partners In Health to Support Global Nursing

Collaborating through Penn Global Nursing Fellowship

To collaborate with Partner In Health's Global Nurse Executive Fellowship (GNEF), we utilized our Penn Global Nursing Fellowship (PGNF) program. This had been designed several years earlier, in response to the desire of our graduates (alumni) to engage in meaningful global health work. The PGNF program would provide financial and Penn faculty mentoring support that allowed Penn Global Nursing Fellows to commit a significant amount of time (usually a minimum of three months) to a worthwhile global effort. The mechanics of the PGNF program involve matching of host-organization-specified needs with skills that our alumni Fellows, along with a Penn Nursing Faculty mentor, can provide.

Through the wonders of the virtual environment, we have been obliged to operate in, in early 2021, Partners In Health (PIH) became a host organization for not one, but two Penn Renfield Foundation Global Nursing Fellows* (not to be confused with PIH's Global Nurse Executive Fellows, GNEF). Once PIH had specified their needs, Penn Nursing built a team made up of Faculty Mentor, Hanne S. Harbison, MHSPH, MSN, WHNP-BC, the Director of our Women's Health Gender Related Nurse Practitioner Track;; Alumna Fellow, Barbara Doyle, RN, MSN, PMP, who had previously served as a healthcare Peace Corps Volunteer in Gabon; and Alumna Fellow, Luca Koritsanszky, RN, MPH who had worked for more than five years with Lifebox Foundation, a non-profit for safety of global surgery.

The Penn Nursing Team was incorporated into PIH's core Global Nursing Executive Fellowship team, working with ten global fellows from six different countries – five in Africa plus Haiti. The Penn Team was initially called upon to provide support developing a mid-term evaluation survey using accepted monitoring and evaluation (M&E) best practices, feedback on curriculum content, as well as teaching assistance and one-on-one support with fellows.

The Expansion

At the end of March, 2021, given the skills the Penn Renfield Foundation Global Nursing Fellows and their mentor had demonstrated over the prior weeks, in the areas of curriculum review, monitoring and evaluation, and mentoring, the PIH GNEF co-lead, Melissa T Ojemeni, RN, PhD, asked the Penn Team to also lend support to a pressing need of their Zanmi Lasante (ZL) team at the Hôpital Universitaire de Mirebalais (HUM) in Haiti. The ZL team requested this assistance for a critical care curriculum that will be conducted for nurses across Haiti. The Penn Nursing Team has been tremendously agile in moving across projects. They are enthusiastic and gratified to be able to collaborate with Partners in Health to support the enhancement of global nursing. The Fellowship period will continue through October 2021.

*Fellowships available through the Penn Global Nursing Fellowship program have been made possible through the Beatrice Renfield Foundation and individual funders.

Nursing Innovation: Time for a Global Revolution



Nursing Innovation: Time for a Global Revolution

Michelle Munro-Kramer, University of Michigan School of Nursing Office of Global Affairs & Olivia Lemberger, Rush Copley Medical Center

Acknowledgements: Megan Eagle, Li Gao, Mercedes Guiterrez, Dean Hui Yang

Over the last few years, there has been an increasing focus on nursing and midwifery innovation. (1) This has resulted in the development of innovation centers in hospitals, innovation education programs in universities and colleges, and even fellowships in nursing innovation (Johnson & Johnson Nurse Innovation Fellowship, Betty Irene Moore Fellowship for Nurse Leaders and Innovators). However, the focus on nursing and midwifery innovation has largely been contained within high-income countries, such as the United States. There has been little focus on nurturing innovation in low- and middle-income countries (LMICs) or in reverse innovation, where successful innovative approaches from LMICs could be used to transform healthcare systems in high-income countries. (2) The global COVID-19 pandemic has harkened the need to highlight, promote, and expand the role of nursing and midwifery innovation around the world.

During the early months of the COVID-19 pandemic, at the Nursing College of Shanxi Medical University in China, Dean Hui Yang stepped up to implement innovative processes to streamline patient care and protect nurses. She implemented an innovative scheduling model called the “three-legged” closed-loop scheduling that ensured each shift had nursing management personnel, infection control personnel, and quality control personnel. This scheduling model took into account nurses’ experience, professional titles, and ability levels to ensure a diverse nursing workforce as well as interdisciplinary teamwork across shifts.

In Ann Arbor, Michigan a group of engineering students collaborated with nursing mentors from the United States and Mexico to create a simulator for nursing students in Mexico who were unable to access campus resources or clinical rotations during the pandemic. This device can be built with inexpensive local materials and has the potential to train healthcare providers and volunteers around the globe as we see an uptick in COVID-19 vaccinations and a need for more individuals to be trained to deliver IM vaccinations.



Above: Photo of the IM Simulator

Nursing Innovation: Time for a Global Revolution

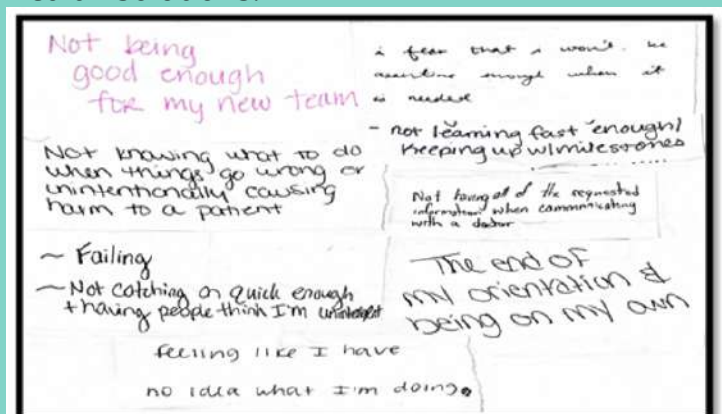
In Chicago, Illinois - Olivia Lemberger, the hospital coordinator of the new graduate nursing residency program, notes my role is to provide the resources, tools and experiences for the successful transition to practice. New graduate nurses often feel overwhelmed by the complexity of the healthcare system, intimidated by the unfamiliarity of working with interprofessional health care providers, and exhausted by the enormous responsibility of providing timely, safe, and quality care. During the COVID-19 pandemic, many nursing students were unable to have clinical experiences in hospital settings. For the first time ever, new graduate nurses who had not set foot in a clinical setting for over a year were hired. Our approach to onboarding new graduate nurses had to change which meant we had to be innovative to meet the needs of this unique group of nurses. Expected timelines needed to be adjusted, resources needed to be scaled, and support needed to be maximized to facilitate a successful transition to practice. We quickly realized the importance of providing nurse-centered onboarding, which allowed the new graduates to be thoroughly involved in their onboarding experience.

Innovation relies on recognizing existing gaps and creating solutions to effectively negotiate the spaces where innovation is needed. We innovated by providing additional interprofessional education offerings on self-care and well-being by having a Psychologist and Chaplin work with the new grads on creating a wellness wheel and talking through scripted examples of how to communicate with patients and families during end-of-life scenarios. We innovated by providing increased opportunities for peer support, and by creating a transparent environment where new graduates were open to sharing their feelings regarding their experiences. We incorporated an exercise called "fear in a bucket" where new graduates had the opportunity to anonymously write down on a slip of paper what they were afraid of. Each slip of paper was then read aloud and we collaboratively discussed as a group how to address each concern. Some of the fears included "not learning fast enough or keeping up with milestones", "not being good enough for my team", "failing", "not being ready to come off orientation", "not knowing what to do when things go wrong", "causing harm to my patient", "not being assertive enough, when it is needed". The COVID-19 pandemic provided an opportunity to reexamine our onboarding process, and create innovative solutions to improve educational offerings, enhance peer support and openly address fears related to patient care delivery. As nurses, we have the ability to leverage innovation practice in order to meet the needs of new graduate nurses, patients, healthcare systems, community members, and interprofessional healthcare practitioners.

These examples illustrate the natural skill and creativity of nurses and midwives to find solutions to complex problems by creating more efficient work processes, developing new products, or even creative training methods that prioritize the learner's needs and experiences.

Nurses are the largest and most trusted frontline health professionals that deliver the majority of primary healthcare services around the world. (3) It is essential that we continue to elevate and support the profession by educating nurses and midwives about innovation (e.g., design thinking, prototyping, establishing an evidence-base), providing funding and support to scale-up innovative ideas, and elevating the status of nurses and midwives on a global scale.(4) There is much to be learned from nurses and midwives around the globe. We believe now, more than ever, that the COVID-19 pandemic has demonstrated the need to elevate and emphasize the role of nurses and midwives in creating innovative global health solutions.

[References can be found on page 69-73]



Right: A handwritten example of the fear slips

The Parallel Pandemic:

**Widespread
Misinformation Causes an
Infodemic, Posing a
Threat to Global Health**



The Parallel Pandemic: Widespread Misinformation Causes an Infodemic, Posing a Threat to Global Health

Karli J. McGuiness

*Johns Hopkins University School of Nursing,
MSN Candidate, Editor WHOCC Links Magazine*

The year 2020 brought the Covid-19 pandemic to our doorsteps and into our homes, while in the same year, the World Health Organization (WHO) identified an Infodemic in response to misinformation related to Covid-19. When reliable information was needed most, the onslaught of content caused a parallel pandemic to Covid that proved to be just as contagious as the virus itself: dangerous misinformation that undermines lifesaving, evidence-based scientific data.

“The Covid-19 pandemic occurs in the social media era, allowing for swift propagation of unproven clinical care guidelines and overt misinformation. Proposed treatment strategies have been amplified and distorted according to testimonials rather than scientific rigor” (Love et al., 2020). This phenomenon has elevated mis- and dis-information to the level of an urgent public health issue. Plainly stated, the Infodemic poses a threat to global health.

The term Infodemic, was coined to categorize some of the common features of rumors, stigma, and conspiracy theories during public health emergencies. It is an overabundance of information (some accurate and some not) that makes it hard for people to find trustworthy sources and reliable guidance when they need it. (Islam et al., 2020). In the early days of the pandemic, the U.S. federal government offered little in the way of a unified front that exuded confidence in scientific fact around public health. This ignited a digital wildfire of falsehoods including dangerous pseudo-medical advice.

While the Biden Administration made the grand gesture to defend the scientific community amid a global health crisis by appointing a Coronavirus Task Force in early 2021, the topic of misinformation has gone largely overlooked. According to the Washington Post, “the task force [has] subgroups that focus on issues related to the response, including testing, vaccine distribution and personal protective equipment” (Abutaleb & McGinley, 2020). However, “no U.S. agency [has been] tasked with leading a unified response [as it relates to misinformation]” (Sell et al., 2021).

For the sake of clarity, both mis- and dis-information play a role in this issue, and it is necessary to establish common definitions for each term. Misinformation refers to false information that is spread, regardless of intent to mislead. Disinformation is understood as deliberately misleading or biased information, manipulated narrative or facts, and propaganda. For the purposes of this piece, the two together will be referred to as MDI.



Photo Credit and more details can be found at: [The W.H.O. Call for Action: Managing the Infodemic](https://www.who.int/campaigns/infodemic)

The Parallel Pandemic: Widespread Misinformation Causes an Infodemic, Posing a Threat to Global Health

The insidious nature of MDI is more prevalent than may be apparent. Since its arrival, the internet has democratized medicine. “In 2013, 72% of U.S. adults looked online for health information” (Swire-Thompson & Lazer, 2020). This means that individuals were finding their own answers to complex health questions, without the guidance of a trained and accredited professional with little discernment for where the information was coming from. A 2020 annual public health review found that when asked to search for a series of health questions, 96% of individuals in a sample used an unaccredited source for at least one question (Swire-Thompson & Lazer, 2020). Just as it would not be considered wise to take medical advice from an untrained individual, the unaccredited websites are not sound platforms on which to make healthcare decisions.

This democratization has also left the door open to digital echo chambers being built around medical falsehoods, which undermine the facts, leading to a distrust in news and science. A 2021 study by Cornell University’s Alliance for Science found that with regards to Covid-19 conspiracy theories, nearly 85% of a representative U.S. sample of 3,019 individuals believed that at least one Covid-19 conspiracy theory was “probably” or “definitely” true (Agley & Xiao, 2021). Public trust in media is difficult to attain in the first place, and even more difficult to re-build once lost. This leads to hazardous outcomes when it comes to loss of trust in science.

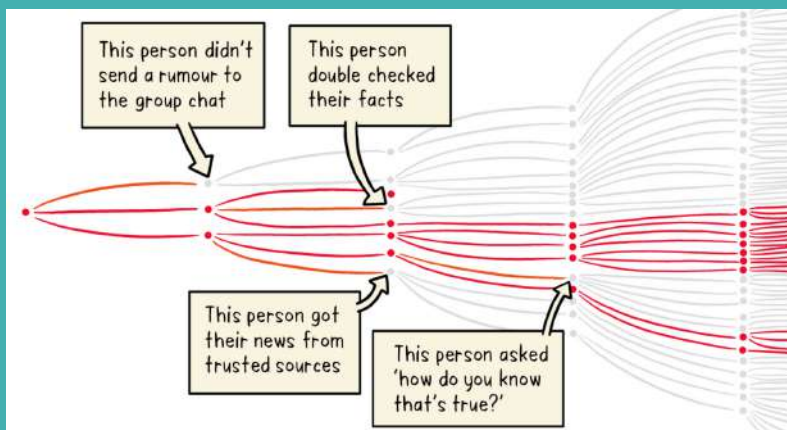


(Left) Factual accuracy of rumors, stigma, and conspiracy theories linked to Covid-19 causes of disease, illness, treatment, and control measures. (Islam et al., 2020)

The financial cost of this distrust is enormous. An economic study by Tel Aviv, Israel-based cybersecurity firm CHEQ and the University of Baltimore have revealed that fake news is “costing the global economy \$78 billion each year. The report analyzes the direct economic cost inflicted by fake news, alongside the growing price paid by businesses and governments to counter misinformation. Other varied costs include economic losses from health misinformation (\$9 billion per year in losses), financial misinformation (\$17 billion), reputation management (\$9 billion), platform safety efforts (\$3 billion per year), and loss of brand dollars advertising next to fake news (\$235 million)” (Brown, 2019).

The Parallel Pandemic: Widespread Misinformation Causes an Infodemic, Posing a Threat to Global Health

Unfortunately, the dissemination of misinformation is not a new concern. Manipulating the narratives around public health policy, information, and access can have dangerous consequences. The morbidity and mortality of COVID-19 are already being compounded by the parallel pandemic of medical misinformation. Fear and desperation prevail as in the 1918 influenza pandemic, but with the added swiftness of rumor propagation by social media. Models of how rumor spreads demonstrate similarities to the spread of an epidemic. Like an infectious disease, a rumor may have a basic reproductive rate and individuals may be susceptible or resistant. Social media allows a rumor to be broadcast to a large potentially susceptible audience and has been shown to spread rumors contagiously. Some rumors propagate because they are scientifically plausible or have preliminary supportive data (e.g., convalescent plasma), others because the [source of the rumor] is charismatic or famous. (Love et al., 2020)



Much like "Flattening the Covid Curve", The WHO has begun to look into the "Infodemiology" of how the spread of false information can be curbed.

Though it is difficult to state exact morbidity and mortality rates associated directly with MDI, the pervasiveness of the detrimental effects of using media platforms in this way cannot be underestimated. Quantifiable data is in part why this policy is of such urgent importance. More data must be collected to determine direct correlation, but we can use history to inform us of repetitive trends. While this analysis references the Covid-19 pandemic as a relevant example, it is important to understand that the same challenges have been faced during public health crises throughout history:

- Misinformation was linked to violence, mistrust, social disturbances, and targeted attacks on healthcare providers during the Ebola outbreak in the Democratic Republic of Congo in 2019 (Islam et al., 2020).
- Polio vaccines were suspended in Pakistan after MDI spread on WhatsApp which triggered an attack on vaccine clinic staff (Tanner, 2020).
- During the SARS outbreak in China in 2002–2003, fear and anxiety about contracting the disease caused social stigma against Asian communities.
- Similar accounts are linked to HIV/AIDS denial, and the ongoing Anti-Vaccine movement.

This pattern is important to consider as it provides foresight into the notion that without addressing the MDI issue, it is bound to repeat itself in the future. We cannot be certain of the long-term effects of misled beliefs about COVID-19 on the landscape of US politics, treatment of vulnerable populations, and other longer-term outcomes. Lessons from prior viral epidemics such as those listed above are our best projection for morbidity and mortality rates associated with MDI. "Using history to inform our present gaps in research can result in avoidable morbidity and mortality" (Agley & Xiao, 2021).

The Parallel Pandemic: Widespread Misinformation Causes an Infodemic, Posing a Threat to Global Health

Though MDI has long been an issue in modern media, social media has served to exacerbate the problem. Traditionally, in order to reach the public, an individual or organization had to pay for print space or airtime. Modern day media gains access to the public's ear free of charge and, in many cases, uncensored. What was once touted as an inherent right, has begun to pose a critical threat. International health agencies, including the WHO and NIH, have "recognized rumor, stigma, and conspiracy theories as emerging threats to pandemic preparedness and control, and, therefore, recommended systematic monitoring and control measures" (Islam et al., 2020). The United Nations (UN) secretary-general identified COVID-19-related rumors as a global enemy. Just as the U.S. would with any global threat, we must mount a defense.

Looking at potential interventions, a multiagency approach to a national security response effort could prioritize management of public health MDI as a national security issue (Sell et al., 2021). This will prioritize public health risk communication at the federal, state, and local levels.

The first step in data collection is to prioritize epidemiology to describe the size of the problem by isolating it from confounding factors. In addition to data collection to more clearly define the quantifiable statistics of the issue, basic local listening programs can be established as a means to realign constituents with local media.

Listening programs and case studies will fuel data collection to better understand the values of regional constituents in order to tailor media messages to resonate with those values in a nation as polarized as the U.S. This is a very powerful tool especially in terms of a topic such as vaccination. A liberal city will be receptive to much different language around vaccination than a conservative town would. When reaching for the common goal of public health and safety, it is important to address each with care, in terms that are meaningful to them. Tara Kirk Sell is a Senior Scholar at the Johns Hopkins Center for Health Security who promotes the idea of making the public health message "stickier than misinformation" using these tools: Capture Attention, Easy = True, Be Credible, Motivate, Tell Stories (Simpson, 2021).

Top tips for navigating the infodemic





1. Assess the source:
Who shared the information with you and where did they get it from? Even if it is friends or family, you still need to vet their source.



2. Go beyond headlines:
Headlines may be intentionally sensational or provocative.



3. Identify the author:
Search the author's name online to see if they are real or credible.



4. Check the date:
Is it up to date and relevant to current events? Has a headline, image or statistic been used out of context?



5. Examine the supporting evidence:
Credible stories back up their claims with facts.



6. Check your biases:
Think about whether your own biases could affect your judgment on what is or is not trustworthy.



7. Turn to fact-checkers:
Consult trusted fact-checking organizations, such as the International Fact-Checking Network and global news outlets focused on debunking misinformation.

Education is a long-term goal in what can be called Protection from Deception. The goal is to build immunity to misinformation via media literacy through public education.

Tips from the WHO to build MDI resilience

The Parallel Pandemic: Widespread Misinformation Causes an Infodemic, Posing a Threat to Global Health

Much of the Infodemic can be distilled to the fact that once “fake news” goes viral, it is nearly impossible to conduct effective damage control. An additional approach will be not only to provide reliable information, but to counteract falsehoods. There is a tipping point theory at play here. When debunking a news item that is already very obscure, one may inadvertently be giving oxygen to that topic. For this reason, the rumor should be required to hit a predetermined viral level prior to defensively intervening.

Two pillars of education around this topic include helping the public understand why misinformation is useful to companies. Similarly, understanding the psychology of why people believe such misinformation will be addressed in the aforementioned listening programs.

Finally, in an encouraging sentiment of hope, and recognition of the importance of the role of nurses during this time: “While trust in the institution of medicine seems to have slowly declined since the 1970s, nurses as individuals continue to be at the top of nearly all scales for public trustworthiness” (Swire- Thompson & Lazer, 2020).

[References can be found on page 69-73]

MIDWIFERY NETWORK UPDATE

Over the past year, WHO CC Midwifery Network members have engaged in many activities promoting the role of the midwife in global maternity care, including working with WHO HQ in developing education resources and co-ordinating an exciting series of midwifery webinars celebrating the Year of the Nurse and Midwife.

The Covid-19 pandemic has created huge challenges for midwifery programs worldwide. In response, WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA) commissioned 'Sustaining midwifery education during the COVID-19 pandemic', a project gathering and analyzing evidence and best practice for use by member states. Midwifery Network members have participated in a Project Technical Advisory Group and contributed case studies and resources. The Report will be launched at ICM Triennial Congress in June 2021.

Midwifery Network members also contributed to the WHO MCA Department Inter-Professional Midwifery Education Toolkit for Maternal New-Born, Sexual Reproductive and Mental Health, for example Cardiff University WHO CC provided expert input into Safe Medical Abortion and Essential Childbirth modules.

The Webinar Series has been a huge success! As we go to print, four out of five webinars have been held. Attendance has risen each time: 157 participants from 52 countries (Webinar One) to 548 participants from 115 countries (Webinar Four). Audience members have included midwives, doctors, nurses, and representatives from governments, NGOs and UN agencies, representing all WHO regions. Huge thanks to all our speakers, to our collaborators in GNWHOCC Secretariat, JHU and MCA dept, WHO HQ - and to you as the audience.

The webinars explore key issues in global midwifery today and how can they best be tackled. The series aim is to:

- Promote and celebrate midwifery developments in the Year of the Nurse and Midwife - and beyond.
- Facilitate dialogue between Midwifery Network members and global midwives, and with other agencies and leaders.

In the last LINKS magazine, we reported on Webinar 1 '*Developments in midwifery research*' (23/9/20). In this issue, we share the next two webinars, focused on education and midwife-led care.

'Developments in midwifery education' (18/11/20) was chaired by Prof Jody Lori, WHO CC UMICH. High-quality midwifery education is critical for the provision of high-quality midwifery care, however programs vary widely worldwide, and the pandemic has created new challenges. The speakers discussed responses to these concerns. Fran McConville, Technical Officer Midwifery, WHO HQ, introduced the highly important publication 'WHO-UNFPA-UNICEF-ICM Framework for Strengthening Quality Midwifery Education for UHC 2030, the seven-step action plan'. With Pragati Sharma (Midwifery Consultant, WHO India Office), Fran described how the action plan is being used to support midwifery education development in India. Next, Prof. Marie Klingberg-Alvin, Dalarna University, Sweden and Jama Ali Egal, PhD student/ Associate Dean, University of Hargesia, Somaliland presented their inspiring capacity-building partnership to develop a net-based learning midwifery education program. Finally, Prof. Ruth Zielinski, Midwifery Graduate Program Director, University of Michigan spoke from the heart as she shared the challenges and opportunities of delivering midwifery education during the Covid-19 pandemic.

The third webinar 'Implementing midwife-led care globally' (20/01/21) showcased the work of three experts in midwife-led care in various global settings. Professor Address Malata, Vice-Chancellor of Malawi University of Science and Technology, supported by Prof Jane Sandall, Kings College London, set the scene by describing the benefits of midwife-led continuity of care for women and their babies and how this model of care is being introduced in Malawi. As acknowledged by WHO in its recommendations, when a woman can get to know her midwife/ a small group of midwives who provide care throughout her entire pregnancy and birth, there are a range of improved outcomes. Next, two European region speakers described how midwife-led care can also be achieved by creating midwifery-led birth centre environments. Whilst this may not offer continuity of care, it does offer cost-effective, holistic care for women with an uncomplicated pregnancy and labour, using a philosophy of care that focuses on relationships and support. These stimulating talks focused on how to make change happen. Natalie Sedlická described establishing the first midwife-led birth centre in the Czech Republic and gave some very interesting insights into the challenges she and her colleagues had experienced, as well as the opportunities. A key message was the importance of collaborating with parents, doctors and journalists, lobbying and 'seizing the right moment' in order to make change happen. Finally Dr. Lucia Rocca-Ihenacho, Lecturer & Researcher, Centre for Maternal and Child Health Research, City, University of London, described the important work of the Midwifery Unit Network (MUNET) which she founded. MUNET aims for midwife-led birth centres to be a mainstream option for women and families. For midwives such as Natalie who want to set up birth centres, it offers support via its MU Academy and MU Standards. For further details please see www.midwiferyunitnetwork.org.

A large teal circle with a lighter teal border, partially visible on the left and top edges of the page.

EFFECTING POLICY CHANGES TO MIDWIFERY PRACTICES IN THE CARIBBEAN

Effecting policy changes to Midwifery Practices in the Caribbean

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Echoed in the International Competencies for midwifery practice is the autonomy of midwives and the accountability accompanying that is integral to professional practice. It is the expectation that midwives practice within their scope autonomously to promote the health and wellbeing of women and their families (ICM, 2019). Within Jamaica and the wider Caribbean region, midwifery students are prepared to provide safe, responsive care by ensuring that the focal point of care are the needs of women and their babies. To support and maintain appropriate safe care strong leadership in midwifery practice is required to facilitate the role of midwives to create safe environments that is appropriate for care.

Within the Caribbean, single trained/ direct entry midwives are hindered by government policies that do not allow them to provide leadership in their areas of expertise. One such policy is, the Sister in Charge or the Charge nurse working on the areas must be a registered nurse and a trained midwife. In addition, direct/ single trained midwives do spend a significant part of their professional lives making decisions, many routine and predictable, and others pertaining to life or death. Whilst collaborative working across the health service is essential, it is equally important that single trained midwives are not undervalued but given the opportunity to lead by sustaining practice environments, communicating shared vision and influence the sharing of skills and knowledge.

The vision for midwifery practice in the Caribbean should be focused on midwives' knowledge, skills and expertise. This is of importance as their daily roles involves initiating and responding to changes as they provide holistic individualized care whilst focusing on being safe within the constraints they are working. Due to this complex and dynamic way of working, it is imperative that each midwife understands his or her own accountability irrespective of having a nursing qualification. Furthermore, commitment to leadership should not be driven by policies that demotivate midwives but by encouraging professional development and providing support.

Leadership must be encouraged and strengthened by identifying and developing next generation leaders. For instance, leadership in midwifery should never equate to having a nursing qualification. It is argued that to be able to meet the challenges of providing high quality maternity care, there need to be objective, effective succession planning and career development to support current midwifery leaders, build capacity and grow new emerging leaders (NHS Scotland, 2004). At the same time, it does not require seniority to assert changes in midwifery leadership (Hewitt et al., 2021). Utilizing shadowing and supportive mentorship will facilitate this process. This will foster an organizational culture of humanism where there is an attitude of lifelong learning, an appreciation of midwifery leadership and a safe organizational structure to develop and enhance leadership abilities of midwives.

Effecting policy changes to Midwifery Practices in the Caribbean

The roles of the midwife have expanded and the policies that guide midwifery practices require review and changes. Notably, it will require not only midwives practicing clinically to do so but also midwifery educators and stakeholders from each country in the region. Furthermore, to effect changes to midwifery preparation and practice in the Caribbean, require a comprehensive review of the global standards that guide practices and use these to make national policies in each country. Similarly, having national policies on practice facilitates accountability as well as it leads to the formulation of guidelines to produce audits that will measure the quality of midwifery services. Additionally, there needs to be a comprehensive political approach driven by the local midwifery associations to agitate and initiate for changes to local policies in the profession. At the same time, pushing the agenda for the acceptance of midwifery as a profession separate and apart from the nursing profession.

Finally, the public through political agitation will become knowledgeable about the role and function of midwives and their contribution as part of the health sector. For example, the Caribbean is now collectively working at transferring midwifery preparation to universities. Therefore, it is essential that the expanding roles of midwives in the Caribbean are captured and education pathways created to foster these roles. The thrust is then on midwifery educators to lead on this improvement in educational programmes to empower midwives in achieving the Millennium Developmental goals.

[References can be found on page 69-73]

Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A South African
Perspective**



Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: South Africa

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University of KwaZulu-Natal WHOCC Faculty and Nursing students.

In March 2020, the global crisis created by the Covid-19 pandemic led to the declaration of a national state of disaster in South Africa. The crisis, which demanded sudden changes, was multifold and enveloped the education sector with uncertainty (Bozkurt et al., 2020). Neither the country nor, more specifically, the Department of Higher Education had an established emergency plan to deal with national or global disasters that interrupt teaching and learning.

An abrupt suspension of all on-campus activities ensued in an attempt to reduce the risk of exposing the students to the virus, SARS-CoV-2, affecting classroom and clinical teaching and learning. There was no lead-time nor period for adjustment and adaptation for what lay ahead. The University had to adjust within a short period to the changing circumstances, clichéd as the 'new normal.' Academics continued without a recess and began to familiarize themselves with online platforms, developing emergency plans for remote online teaching and learning to a student body who had predominantly returned home to rural areas.

The adjustment plans focused on amending materials to be suitable for remote online learning, capacity building for faculty and students, and mobilizing resources to support remote teaching and learning. The motto of "No student is to be left behind" blazed the trail in the mobilization of digital resources for the students, mindful of the funding of different students, ranging from giving laptops to government-funded students to a loan arrangement for the self-funded. In addition, to facilitate the transition to online teaching and learning, modems for internet connection for faculty and data for the students were organized, negotiating zero-rating of databases used by students, and developing catch-up plans for clinical teaching and learning. All of these actions required shifting of the budget to prioritize the implementation of the emergency recovery plan.

Besides institution-based preparation, the South African Nursing Council (SANC) provided supportive guidance to Nursing Education Institution on managing interrupted teaching and learning activities while meeting the stipulated clinical requirements (SANC, 2020a). It allowed for flexibility and creativity in delivering theory content using online learning platforms to avoid losing more teaching time. There was, however, no flexibility concerning clinical learning, and students were expected to meet the prescribed theoretical and clinical/practical requirements (SANC, 2020a). Institutions developed recovery plans for lost clinical time, making provision for more time for clinical teaching and learning on campus students' return.

Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: South Africa

Meeting the stipulated clinical requirements meant extending the period of training, which had cost implications, creating a sense of panic and uneasiness. Stakeholders approached SANC requesting some flexibility with meeting the clinical requirements, especially for the final year students. SANC allowed the institutions to extend the training period and increased the simulation laboratory's duration to 20 percent of the allotted clinical hours (SANCb). The leeway of a fifth of clinical time is less than Upper-Income Countries' allocation of up to 50 percent where the state of the art simulation laboratories are available to students (Fogg, et al, 2020).

Clinical teaching was not without challenges, but in part, eased through a legislated concession to nursing and medical students to return early to campus to meet the requirements (SA Government 2020). Unfortunately, counter to the concession, health facilities reduced numbers of students to be placed in the facilities in line with facilities' Covid-19 management protocols. The senior nursing students were assigned to resume clinical learning. Although students returning to the health facilities at the peak of the first wave involved high health risks, they consented to be placed on either day or night duty and work longer hours because they wanted to complete their studies.

The University strived for the safe re-entry of students in clinical facilities. During the precautionary quarantine period, all students completed the re-orientation program, including COVID-19 knowledge, psychological safety, and personal protective equipment (PPE) proficiency. All students were tested for SARS-CoV-2 and offered the influenza vaccine. The provision of PPE was facility-dependent, with the University bridging the supply gap to ensure students' protection. About 15 students contracted SARS-CoV-2, but they all recovered. High levels of anxiety and uncertainty couched the return to the facilities; however, with support from clinical staff, faculty-driven WhatsApp groups, and virtual student support services, the students demonstrated self-agency and adjusted.

Adjustments to assessments included reviewing academic rules and waivers to ensure that students were not compromised due to challenges beyond their control. Online assessments and moderation minimized contact between faculty, students, and moderators. Following SANC's recognition of the extension of education and training (SANC, 2020b), all final-year students completed their studies and have started their one-year internship.

The University has adopted the "new normal". Moving to digital teaching and learning was part of the University's plan, and the pandemic has fast-tracked the process, and we are embracing the change.

[References can be found on page 69-73]

Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A Jamaican
Perspective
Part I**



Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: Jamaica



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Covid 19 Pandemic has caused disruption in many activities worldwide. The public health of the world and its people have been brought to the forefront. Education on all levels have been affected in the way it is delivered and thus impact the way teaching and learning is done. March 10, 2020 saw the first case of Covid 19 confirmed in Jamaica. This led to the government of Jamaica closing all schools on March 14, 2020. Nursing and midwifery education is no exception with the forced rapid closure of face-to-face teaching has thrown the academic staff and students into what is for many, unfamiliar terrain.

The nursing and midwifery students were withdrawn from the clinical areas and face to face didactics cancelled. This led to the nursing and midwifery heads of schools, programme directors, coordinators and lecturers sought to identify and configure new ways of facilitating the teaching and learning experiences for learners. Coupled with this was the “fear factor” expressed by student who felt that they were unprepared to gain experiences where there were potential Covid 19 patients. Some facilitators even spoke about the “safety” of students and wondered what measures were in place to protect them from contracting this new virus that had suddenly arrived on the shores of Jamaica. These questions led to many meetings and conversations regarding the personal and protective equipment, preceptorship, completion of the stipulated curriculum hours and students lobbying to the Nursing Council of Jamaica to forego the requirement of the curriculum and allowing them to sit the qualifying nursing examination. Undergraduate nursing was now seeing an incremental shift towards e-learning providing a flexible student-centred model of learning contrasting with didactic transmission models of education (Betihavas et al., 2016).

Students are prepared for the profession of nursing and midwifery guided by curriculum content built on the foundations of the International Confederation of Nursing and the International Confederation of Midwives. The students would have then gone through the rudiments of infection control and transmission-based precautions and equipped with the knowledge and skills to provide safe care with support from clinical stakeholders.

Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: Jamaica

How do we go about meeting educational needs of Nursing and Midwifery during the pandemic?

Nursing and midwifery education is a practice-oriented curriculum where an emphasis is placed on the integration of theoretical knowledge and psychomotor skills integrated (Eyikera & Baykara, 2017). The use of simulated teaching may be used at all levels of the curriculum as a teaching and learning tool (Omer, 2016). As such, the use of technology enhanced simulation is essential to prepare nursing and midwifery students for practical experiences and future career.

It is recognized that although simulated learning environments are well established in the fields of nursing and midwifery there is no standardization of its use in education and as such will require comprehensive development for effectiveness (Zitzelsberger et al., 2017). Effectiveness the authors suggested may be enhanced if there is an increased support for utilization of simulation as a method of evaluation for the learners especially within our region. On the other hand, simulated experiences should not replace real life experiences but to be used alongside each other in the teaching and learning process (Omer, 2016).

The use of technology enhanced simulation should not be underestimated but form part of the teaching learning process in the preparation of nursing and midwifery students for their future careers. It encourages development of skills, build student confidence and will benefit employers.

Innovative teaching during this Covid 19 pandemic is therefore essential and must be done to involve all learners. This is achieved by identifying the needs of each learner and making a conscious effort to change from traditional pedagogical methodologies to student centered teaching. Activities for learner outcomes with the use of technology as with face-to-face teaching should be learner focused, reflect a direct content, determine teaching strategies and learning experiences, developed from the assessment criteria and should inform the evaluation process. A technology enhanced simulation-based approach to learning can be incorporated in the nursing and midwifery curriculum in Jamaica to achieve these learning outcomes as it engages students, encourage participation and allows for formative feedback.

[References can be found on page 69-73]

Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A Jamaican
Perspective
Part II**



Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: Jamaica



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The evidence is strong that the COVID-19 pandemic has impacted every facet of our lives (Haleem, Javaid, & Vaishya, 2020). The health care system worldwide as well as in Jamaica, and by extension the nursing profession, has been largely impacted (Shah, et al, 2020). While evidence abounds concerning the impact on the provision of healthcare to the populace, the effect on the education of healthcare workers have come under significant strain during the COVID-19 pandemic. The clinical rotations, which form the foundation for all professional health care programs, were halted due to inability of the clinical sites to safely accommodate students (Bayham, & Fenichel, 2020). Notwithstanding, tremendous efforts are still being undertaken to minimize the impact on students and facilitate their clinical training and skill development.

The current clinical challenges are complex in both developed and developing countries. Some countries have cited insufficient numbers of clinical sites to accommodate the cohorts of nursing students (Bayham, & Fenichel, 2020). Internationally, regulatory frameworks are malleable enough to anticipate and guide the novel situations of a pandemic (Reimers, & Schleicher, 2020). Globally, discussions and actions have begun to facilitate development of clinical competencies where students are able to deliver quality care while substituting actual clinical experience with simulated experiences (Jiménez-Rodríguez, 2020). Regionally, in the Caribbean, and locally in Jamaica, virtual and simulated substitution has not yet been accepted as suitable replacements for clinical experiences (Crew, 2016). The resulting clinical picture is a delay in completion of healthcare programs as clinical sites institute public health measures such as lower student numbers, no access to some clinical spaces and national public health measures which restrict movement.

Nationally, Jamaica continues to be affected by significant rates of migration which reduces the pool of clinical preceptors. While not yet assessed locally, lower available numbers of preceptors have been associated with poorer quality of clinical training (Phuma-Ngaiyaye, Bvumbwe, & Chipeta, 2017).

Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: Jamaica

Schools of Nursing have attempted to pivot in response to the pandemic and its impact on training and education. Nationally, the theoretical components of the programs have been offered virtually using many platforms supported by standardized practice videos which have led to increases in self-directed learning. Laboratory and clinical practice have seen significant changes as well, with small group training and learning. One such change is the use of Objective Structured Clinical Examination (OSCE) type training and assessment which allows rotation through several controlled clinical experience options in a single session. Schools have made several adjustments to maintain the standards of the programs including, curricular changes, an expansion of the clinical sites, peer teaching with mature clinical students supporting junior clinical students and staffing rotation and inter group teaching.

While the world grapples with the impact of the pandemic, the Universities and agencies that educate and train healthcare professionals have had to be resilient and agile in maintaining the standards of the regulatory body while providing a continuous supply of new graduates for the workforce. The balance is tenuous but possible with shifts in the regulatory framework, evidence-based practice and adopting international best practices that have been successful. The education of healthcare workers, especially student nurses, must be robust and dynamic utilizing sound evidence to maintain quality learning environments and ensure continuity even in the face of a changing clinical and theoretical milieu. These ideal outcomes are best achieved through research and information sharing. Locally, regionally, and internationally, the health sector and the education systems must continually adjust to the fluidity of this and future pandemics.

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Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A United States
Perspective**



Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: U.S.

*Deborah Ziff Soriano, Writer,
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College shows agility by swiftly converting classes and clinicals to virtual formats and finding other creative ways to replace in-person experiences.

When word came down from the University of Illinois System in mid-March 2020 that all in-person classes would migrate online to prevent the spread of coronavirus, it presented a special challenge for nursing clinical instructors.

How do you give nursing students a clinical experience without being in a clinic?

Susan Kilroy, PhD, RN, CHSE, knew part of the solution could be virtual simulations of clinical experiences. As Director of the UIC Nursing Clinical Learning Resource Center, Kilroy, oversees simulations for the College's six campuses. "With the way everything unfolded, we had to quickly transition from in-person clinical to virtual simulation experiences," Kilroy said.

The university system added a second week to the annual spring vacation, affording faculty an extra week to transition their classes to a virtual format. Kilroy worked with each campus's lab coordinator to scour the Internet for evidence-based resources on virtual simulation, then uploaded the resources to a free online library for faculty and staff.

"Our goal was to use virtual software to replicate the experiences our students would typically receive in clinical settings or the lab, and for our graduating seniors, to give them the skills they needed to graduate and enter the workforce," says Catherine Vincent, PhD, RN, Associate Dean for Academic Affairs.

Using a virtual simulation computer package, more than 400 bachelor's degree students and 280 graduate-level students have been able to practice skills on an avatar patient. The students can read the patient's chart, ask questions, and even check the patient's heartbeat by putting their cursor over the patient's heart. Via videoconference, faculty can 'meet' with students before seeing the patient and a debrief after, just as they would in a typical clinical situation.



PPE Supplies, Photo by Susan Kilroy

Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt and Move Forward: U.S.

Creative Clinicals

The Clinical Learning Resource Center donated necessary materials and equipment such as gowns, gloves, masks, eye protectors, thermometer covers and hand sanitizer for healthcare workers to use.

Telehealth is another way some graduate students have been able to get clinical hours. Mental health nurse practitioner students, for instance, are able to use videoconferencing software to call standardized patients in their homes.

Janey Kottler, DNP, FNP-BC, who is an instructor for the community health course, says some of her students are gaining clinical hours by creating public education materials for different populations. For instance, one group created fliers on hand hygiene. Another created a pre-recorded video and a PowerPoint presentation for an elderly LGBTQ group. "Because this is a public health emergency, this is a perfect opportunity to do public health teaching from a safe distance," Kottler says.

As useful as virtual experiences are, certain clinical hours cannot be replaced with simulation. For instance, neonatal nurse practitioner students have to spend at least 500 hours of direct care working with a neonatal nurse practitioner or physician in a Neonatal Intensive Care Unit. Kilroy says special skills days have also been offered for students who wanted extra practice or needed to demonstrate competency in front of their instructors.

In the meantime—while students are not on campus—physical materials in the simulation labs are being put to good use. Gowns, gloves, masks, eye protectors, thermometer covers, and hand sanitizer were donated to hospital workers. Three mid-fidelity manikins from the simulation laboratory are also loaned to the university's hospital to cross-train outpatient clinic nurses to care for patients in the inpatient setting.

The COVID-19 pandemic has changed the way we deliver clinical simulations and some of the techniques we learned in 2020 will continue to supplement our future in-person learning practices. For example, the evidence-based online simulation cases can be used as pre-work to be completed before the students arrive for their in-person simulations. Students have also expressed that they enjoy the smaller in-person simulation groups, a byproduct of COVID-19 restrictions, and would like to see more simulation days organized in this fashion. The past year has enabled us to build collaborative working relationships with external vendors as evidenced by our work on a joint manuscript describing our experiences during COVID-19 and by UIC Nursing becoming a testing site for updated simulation cases. We believe online virtual patients utilized through online simulation cases will enhance our simulation education well into the future.

Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A Chilean
Perspective**



COVID-19 Nursing Internship: Strategy Developed by a Chilean School of Nursing During Sanitary Alert

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On March 18, 2020, the Chilean government decreed a constitutional state of emergency to face the health crisis generated by the coronavirus pandemic (Covid-19).

In this context, the Ministry of Health issued a call for health professionals to meet the care demands of Chileans infected by Covid-19. The School of Nursing of the Pontificia Universidad Católica de Chile responded by creating a Certificate of Academic Specialty (CAE) in "Nursing in Health Crises" for students in the last year of their degree program. The Certificate required students to complete an average of 40 theoretical hours (taught remotely) and 580 clinical hours (in person).

The main learning objectives of the CAE were to demonstrate: a) the ability to collaborate with a health team in adapting to the care needs of the population; and b) more complex patient care skills during a health crisis.

The CAE thus constituted an innovation that was integrated in the curriculum to help students achieve the disciplinary and interdisciplinary competencies required for graduation, while deepening their professional nursing experience and responding to the health care needs of the country.

At the peak of the pandemic in Chile (April 15 to July 31, 2020), 74 nursing students (64.3%) voluntarily enrolled in the CAE in the last year of their program of study.

The acquisition of theoretical knowledge was facilitated through online activities and evaluated with a test of 36 items (72 points). The disciplinary and transdisciplinary skills acquired by the student in clinical practice were evaluated using "Guidelines for the Evaluation of Clinical Experiences in Nursing Internships related to Health Crises", which was completed separately by a nurse preceptor and by the student. These guidelines were used to rate student competency in 8 areas: a) care skills, b) management, c) research, d) education, e) integrity and ethical consistency, f) leadership, communication and teamwork, g) critical thinking, and h) professionalism. In addition, the guidelines provided a space for comments where students could report relevant aspects of their clinical experience.



(Above) Nurse interns in sanitary alert

COVID-19 Nursing Internship: Strategy Developed by a Chilean School of Nursing During Sanitary Alert

Preliminary results show that 87% of students completed the CAE. The most frequent causes of dropouts were health problems or the loss of employment by a family member. The percentage of approval on the test, and the clinical experiences evaluation completed by the guide nurse, was 92.5% and 91.4%, respectively. The self-evaluation of the students' clinical experiences reached 94.2%.

These results show that the students in the last year of their program of study successfully acquired competencies in different areas of the nursing role. The skills with the highest level of achievement were healthcare skills and those with the lowest level of achievement were research skills. The voluntary participation of the students in these internship experiences was a great learning opportunity since the students achieved the proposed CAE objectives.

In their comments, the students described the perceived value of their achievements in the areas of ethics, professionalism, teamwork, communication, and the ability to provide emotional support to patients directly and to their relatives, often remotely by phone. In addition, they highlighted their progress in developing perseverance and confidence in their own professional judgment as supported by current scientific evidence. They perceived themselves as making a significant contribution to national efforts to cope with the pandemic.



(Above) Nurse interns in sanitary alert

Education: Covid-19 Pandemic Interrupts Didactic Learning & Clinical Practice for Nursing Students: Universities Adapt & Move Forward

**A Middle Eastern
Perspective**



Online Learning Broadens Clinical Learning Horizons in Nursing Education -The Pandemic Challenges in Bahrain

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The spread of COVID-19 pandemic has provoked widespread societal disruption with recursive impacts within higher educational institutions and practical learning contexts. The United Nations Educational, Scientific and Cultural Organization (UNESCO) estimates that over 90% of the world's students are not currently attending schools in the response to the pandemic, with over 1.5 billion learners affected. Nursing schools are bracing for unique challenges and opportunities to successfully meet the evolving educational needs in the context of this pandemic and thus developing the next generation of health care providers (Dewart G., et al, 2020).

The online learning emerges as a promising alternative in the nursing education, however, the sudden transition from face-to-face instruction to an online learning platform presented the faculty and students with several challenges including technology infrastructure, technology support, time management, learning space, family, and work (Carolan et al., 2020). Moreover, nursing profession is a discipline based on practice and thus the key challenge is how to provide students with concrete, realistic learning experience to master the nursing competencies effectively. Therefore, nursing educators in higher education institutes were immersed in exploring the online learning culture, navigating the online landscape, learning new technologies and teaching methods and adapting the clinical education arena to work with the on-site instructors.

Nursing faculty worldwide have taken the advantage of variety of available online educational programs and resources that would improve the performance-based skills of nursing students (Gerkin et al. 2009; Gaza et al., 2017). Online learning at its core involves electronic means of communication, education, and training and can be viewed as a resource that has the potential to influence all dimensions of nursing to create a professional practice environment for future nurses. Many institutions of higher education reconsider the best utilization of the online learning in the context of the pandemic particularly in nursing education which has broadened the clinical learning horizons.

The College of Health Sciences and Sport (CHSS) at University of Bahrain (UoB) as a World Health Organization Collaborating Center (WHOCC) for Nursing Development in EMRO always ensures meeting the ongoing demands and challenges associated with the teaching and learning processes to support attaining program aims. By the end of 2019, COVID-19 pandemic provoked the need to deploy online and virtual learning modalities through various formats and platforms to maintain the continuity of learning for all nursing students. The UoB took proactive measures to protect the health and ensure the safety and wellbeing of faculty, staff, and students and has supported the shift into online learning environment. "Exemplary learning environments prepare, support, and inspire all involved in health professions education and health care to work toward optimal health of individuals, populations, and communities" (Macy, 2018).

Online Learning Broadens Clinical Learning Horizons in Nursing Education -The Pandemic Challenges in Bahrain

CHSS provides an exemplar of such conducive learning environment that foster the shift into online learning and since the nursing profession is a competency-based discipline, it was highly crucial to provide the students with a substantial realistic learning experience. Therefore, various measures were taken by Nursing faculty to adopt online teaching and learning strategies to fulfill the theoretical and practical requirements such as the utilization of virtual Objective Structured Clinical Evaluation(OSCE), Elsevier clinical skills, online case studies, video recording and audios of skills and online case scenarios.

A digital transformation committee was established to support the transformation of nursing education by means of meeting the emerging learning of students and faculty through training videos, virtual workshops, illustrations, instructions and technical assistance to enhance the teaching and learning process. These initiatives allowed the students to engage with the e-learning content and created a positive and supportive learning environment to attain the intended learning outcomes. Nursing faculty encountered paramount challenges during this critical period and teaching foundation courses in nursing which emphasize mostly on the mastery of clinical skills pose the utmost challenge as students are not yet exposed to the clinical area. Providing a sound method of instruction for teaching competency skills is vital to improve the student's practical performance.

According to a widely regarded research paper, a robust online community keeps students engaged with content, helps them to think critically and articulate their ideas in a more secure atmosphere (Glasgow et al., 2017). The use of video based instruction has proven to be a successful, cost-effective, and time-saving educational tool, allowing students to practice skills effectively (Moemennasab, 2002). Henceforth, nursing faculty actively engage the students in a virtual learning environment of classroom, lab and clinical settings by developing various instructional videos, e-skills manual, using simple simulation ideas such as monitoring BP-medium fidelity, and utilize various electronic clinical educational platforms to teach and assess the fundamental nursing skills successfully.

The students have appreciated the convenience of studying online and to actively engage with the virtual learning environment to master the nursing competencies efficiently. The Nursing faculty has demonstrated thier preparedness to explore and adapt with the emergency teaching methodologies. The faculty are being involved in conducting various research studies to examine the impact of the sudden transition into online learning on students, faculty and to assess the efficacy of online learning in nursing education to provide more concert evidence to guide further improvement.

In conclusion, the online learning is an added décor to the next phase of digitalized world for acquiring knowledge and is offering a promising alternative for clinical skills acquisition in nursing education, however, it needs to tame through effective evidence based methods. At the moment we are looking forward to a move towards blended learning among healthcare students as the COVID-19 lockdown eases.

[References can be found on page 69-73]

Confronting the Pandemic: Experience as Managers



Confronting the Pandemic: Experience as Managers

(A reminder of the resilience of Nurse Leaders in the height of the pandemic)

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Ms. P. Mary Jenifer, Reader, CMCH, Vellore

COVID-19 has severely demobilised the global economy. To restrict further transmission of the disease in the community many of the affected countries have decided to undergo complete lockdown. This has impacted every segment of life like commercial establishment, education, economy, religion, transport, tourism, employment, entertainment, food, security, sports etc. The outbreak was a major destabilizing threat to the global economy.

Many hospitals have scaled back or postponed non-emergency care. This has medical consequences for the people served by the hospital, and it has financial consequences for the hospital. Health facilities in many places were closing or limiting their services.

Meanwhile, the media portrayed corona virus as a deadly disease, a nightmare for all, including the healthcare workers. The same nightmare was among us as nurse managers trying to safeguard ourselves, our colleagues and staff nurses from this deadly disease as well as taking adequate precautions to prevent the transmission of the virus to our loved ones at home. Nurse managers were insighted to perform beyond the call of duty.

As nurse managers we hold many roles: educator, collaborator, advocator, counsellor and so on. As educators we had to familiarize ourselves with policies and procedures that were changing every day. We also shared the knowledge with our subordinates which involved training related to donning and doffing that was considered as the cornerstone for the frontline workers to face the pandemic with confidence.

During this time, we learned that four patients in a family has been tested to be positive and one of them was an antenatal who would deliver at any moment. We were worried and troubled at heart as we have not completed the formulation of policies and procedures and none of our subordinates were trained to take care of a Covid-positive woman about to deliver. Our one unifying commonality was fear of facing the challenge.

We built courage within ourselves by motivating each other and quickly started to set up the things needed for delivery in the isolation ward where the patient was admitted. Staffing was another part of preparedness where we must train staff quickly in the method of donning and doffing and keep a standby at every shift so that any time she delivers, there is a midwife to attend to her. The first delivery was conducted successfully without any agitation and with all precautions.

Initially when the number of COVID affected parturient women were few, the staff from the labour room were scheduled to work in the isolation ward when the women went into labour. As the number of COVID positive women increased and separate wards allocated regular staffing for all shifts had to be arranged. Staff from the obstetric wards were also called in to help. Many wards of varies departments closed. Obstetric wards were completely functional all through the COVID crisis. Thus, staff from those areas were also shifted to the obstetrics wards to help us.

Confronting the Pandemic: Experience as Managers

(A reminder of the resilience of Nurse Leaders in the height of the pandemic)

Slowly we understood that isolation ward was not enough as an increasing number of parturient women were diagnosed to be COVID positive. Hence, we moved on to a separate ward which was away from the obstetric unit. We created a separate triage area for our suspect and positive pregnant women. We had to set up a whole ward with all the items needed for the care of pregnant women (cardiograph to monitor the fetal heart rate and uterine contraction, delivery cots, cardiac monitors, infusion pumps etc). Two separate wards, one for suspects and the other for positives was setup. We also identified place to set up neonatal resuscitation, identifying separate room to keep the newborn babies out of COVID area, organizing and maintenance of staffing for each shift as well as on call personnel in case of demand or emergency.

Our institution graciously granted 14 days of special leave for COVID for all category of staff. We planned the leave and ensured that all staff were able to avail it. Complete lockdown was announced throughout the nation. This caused even the government transport came to a standstill. This caused problem in transport for many staff. Thus, additional leave needed to be arranged for few along with the special COVID leave. This affected the staff available for work in all the wards. Each day had its challenge staffing help was received from all over the department and the institution.

We joined hands with the obstetricians and were very careful in formulation of procedures and policies for the women with obstetrical and gynecological condition as well as safeguard our work force as per the government policy since we were dealing with two lives.

We also acted as a coordinators and collaborators, working in teams with the obstetrician, neonatologist and other team workers in creating policies on place for suspect parturient, delivery conduction policy, personal protective equipment, training of nursing personnel, advocating for their needs (adequate supply of PPEs, food, and water), visitors, showing the newborn to the relatives etc.

Life was not easy with COVID which put forth many daunting challenges. Managing the emotions of the women admitted in the COVID area was difficult where many presented with psychotic symptoms as they were isolated. Managing and answering the queries of the husband and their relatives was one the main challenge where some were even agitated and unable to accept that the women was COVID positive and their need to be isolated. They do not want to leave the women alone as they are vulnerable and need the care of somebody. The other major challenge which we confronted was managing the staffing amid the policy of arranging leave for the nursing personnel which was asked to be given by the institution.

Though we needed to cross many hurdles in the journey of COVID, we felt that we were in control because of the grace of God, guidance of our Head of the Department and the Nursing Superintendent. The team spirit yielded by the administrators of our institution, the effort and willingness of our nursing personnel who were the frontline workers. Though corona virus may be deadly, had killed many and posted many challenges to the global economy, it has also taught us the value of being together which can help us to overcome anything as deadly as COVID-19.

Strengthening Infection Prevention & Control in Scotland During the Coronavirus Pandemic: The Nursing Contribution



Strengthening Infection Prevention & Control in Scotland During the Coronavirus Pandemic: The Nursing Contribution

Glasgow Caledonian University WHO Collaborating Centre for Nursing & Public Health Education and Research

Globally, the coronavirus pandemic has challenged governments, healthcare policy makers & providers, communities, and individuals to respond at pace to a new and evolving threat. In an uncertain and frequently shifting evidence landscape, strong and effective nursing leadership has been core to informing and supporting the actions necessary to develop and implement new policies to strengthen infection prevention and control (IPC) practice across all sectors.

In Scotland, nursing leadership starts with the Chief Nursing Officer, who has national policy level responsibility for infection prevention and control within the Scottish health service and a team of HAI policy advisors including nursing and IPC Nurse specialist advisors supporting the policy effort nationally. Our CNO established the Scottish COVID-19 nosocomial review group, connecting professionals and organisations across Scotland to inform IPC policy and guidance and to wider UK and international colleagues to share emerging issues and solutions. Our national IPC effort in Antimicrobial Resistance/Healthcare Associated Infection (ARHAI) Scotland is led by a nurse consultant in infection prevention and control and supported by a wide range of multidisciplinary professionals in the IPC response, working in collaboration with NHS Education Scotland, Health Improvement Scotland, and the Scottish Government Health & Social Care Directorate in reviewing international evidence, analyzing national data and generating guidance and advice.

When the scale of the crisis in long term care facilities (LTCF) became apparent, additional leadership was provided by Nurse Directors in each regional board area in Scotland to provide nursing care assurance, supplementary staffing and support with additional IPC specialist nursing input to LTCF. Activities such as learning from root cause analysis, and policy enablers such as IT infrastructure and context specific guidance, have all been supported via CNO and wider adult social care policy leadership in Scottish Government Health & Social Care Directorate. A national adult social care winter plan was published for the first time by Scottish Government last year and legacy considerations from the response, such as a national manual for IPC in care homes and monitoring IT tools, should support future preparedness efforts.



Right and Left: Glasgow Caledonian University School of Health & Life Sciences Students donning PPE



Strengthening Infection Prevention & Control in Scotland During the Coronavirus Pandemic: The Nursing Contribution

Recognizing the need for ongoing focus on IPC capacity and capability building in the community and social care sector, the CNO commissioned a review to generate recommendations for strengthening workforce development within nursing, midwifery and other allied health professional roles at generic, specialist and consultant level. The recommendations in this review offer further opportunities for transforming nursing roles, integrating IPC more effectively in public health and health protection services for LTCF, care-at-home, and the wider community.

The Glasgow Caledonian University Safeguarding Health through Infection Prevention (SHIP) Research Group, is contributing to the COVID-19 management agenda by providing leadership and expertise to Scottish Government, UK and International groups and academic support in the development of evidence. This has included undertaking systematic reviews to support IPC measures such as hand hygiene and leading research to inform the response, such as SIREN study, which is analyzing COVID-19 immunity among healthcare workers, year to see if previous COVID-19 infection or vaccination protects healthcare workers from further covid-19 infection.

This brief snapshot of the influence and impact of nursing leaders in Scotland - from CNO, policy advisors, clinical-academic Professors, Nurse Consultants and Specialist IPC nurses (nationally and locally), and crucially, frontline nurses - highlights the vital importance of the nursing contribution to a fundamental aspect of nursing care, infection prevention and control, particularly in this time of pandemic.



Left: Glasgow Caledonian University School of Health & Life Sciences Student donning PPE

Links to guidance mentioned above:

[Covid 19 Nosocomial Review Group](#)

[The Guidance \(All IPCN Nurse Led\)](#)

[Care Home IPC: a New National IPC Manual Created , Led by ARHAI](#)

[SIREN Study](#)

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The International Confederation of Midwives (ICM) supports, represents and works to strengthen professional associations of midwives throughout the world, to achieve common goals in the care of mothers and newborns.



Operated by nurses and leading nurses internationally, the International Council of Nurses (ICN) works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.



Jhpiego works to prevent the needless deaths of women and their families by developing strategies to help countries care for themselves by training competent health care workers, strengthening health systems and improving delivery of care.



Sigma aims to advance world health and celebrate nursing excellence in scholarship, leadership, and service.



AFREhealth is an interdisciplinary health professional forum which seeks to improve health care in Africa through research, education and capacity building. It seeks to build on the achievements of MEPI and NEPI, as well as the President's Emergency Plan for AIDS Relief (PEPFAR), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA).

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