AWHONN
OREGON
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

OREGON SECTION

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The International Edition

by Deb Castile, MN, RNC, CNS, NE

Welcome to the summer 2015 edition of the Oregon AWHONN Newsletter. I am excited for this newsletter. The United States and other advanced countries focus a lot of healthcare energy on patient safety, medical and nursing care, medical technology and developing advancements for healthcare. Meanwhile, other countries struggle to keep up with healthcare demands as their population grows. Yet, other countries are struggling with their high neonatal mortality rates purely from a lack of knowledge of "basic" neonatal resuscitation or stabilization skills. This newsletter provides you an opportunity to experience international nursing and volunteering through the eyes of fellow Oregon AWHONN members.

Kendra Crawford (Membership), Linda Veltri (Southern Oregon Chapter), Nancy Irland (Women's Health) and Pat Scheans (Neonatal Health) have offered articles regarding their international traveling experiences. Each of these ladies has had different experiences either volunteering or working abroad. It reminds me that there is a large world outside the borders of the continental United States. There is so much that can and needs to be done across the globe and even here near home. If you have a sense of adventure or just need a change of pace, don't hesitate to look into international nursing opportunities.

Happy readings and my best to all of you. §

IN THIS ISSUE

"Once a year, go someplace you've never been before." – Dalai Lama

Calling All Leaders

AWHONN members, don't forget to let your voice be heard. Oregon Section Chair and Secretary/Treasurer are up for elections this year. Look for an email in September from AWHONN Headquarters for the qualifications.

Are you a natural-born leader? Do you know someone who is a great leader? Nominate someone or apply yourself at oregonawhonn.org/section-elections. Deadline for applications is August 1.§

Oregon AWHONN Leadership Team

Section Chair
Deb Castile, MN, RNC-OB, CNS, NE
chair@oregonawhonn.org

Secretary/Treasurer
Becky Moore, RN
treasurer@oregonawhonn.org

2014 Oregon Section Conference Co-Chairs
Nancy Alt, BSN, RNC-OB
conference1@oregonawhonn.org

Robin Cothrell-Tubbs, MN, RN
conference2@oregonawhonn.org

Chapter Coordinator
Robin Cothrell-Tubbs, MN, RN
conference2@oregonawhonn.org

Portland Metro
Leona Logue, MN, RN, CNS
pdxmetro@oregonawhonn.org

Southwest Willamette Valley & Vicinity
Becky Moore, RN
swillamette@oregonawhonn.org

Southern Oregon
Linda Veltri, PhD, RN
soregon@oregonawhonn.org

Central Oregon
Mara Kerr, MN, RN
coregon@oregonawhonn.org

Northeast Oregon
Trish Alexander, RNC, BSN
neoregon@oregonawhonn.org

Mid-Willamette Valley
Open Positions

From the Editor's Desk

Welcome to our International Edition of the Oregon AWHONN newsletter. I've had fun putting this edition together for you, and hope you enjoy reading it as much as I have.

For the next edition, I want to know what YOU do to keep your nursing practice up-to-date. Send in your tips at oregonawhonn.org/contact. We'll publish the best tips. The best one will win a gift card!

Donna Talain

Oregon came out strong to Convention last month in Long Beach California. There were over 55 Oregon nurses who attended Convention. It was good to see old friends and to meet many new ones. I hope to see many of you at 2016 convention June 11-15th in Grapevine, TX. §

Oregon AWHONN Joins Facebook

Oregon AWHONN is now on Facebook! Get the latest news and happenings with Oregon AWHONN, women's health, obstetrics, and neonatal care. We are set up as a private group on Facebook, so you'll need to go to facebook.com/groups/AWHONNOregonSection and request to join. This is not limited to AWHONN members, so feel free to forward this link to friends and colleagues who are interested in keeping up to date with the latest in evidence-based practice. We'll even throw in some fun posts because you what they say about all work and no play. §

Volun-"Tour"-ism in Vietnam

by Pat Scheans, DNP, NNP-BC

We've all heard the old adage of "*Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime.*" (attributed to various authors)

To that end, training trainers can be an extremely rewarding endeavor because it enables you to add this extra line to the above quote: "*... train a man to teach others to fish, and you feed a community.*"

Instead of providing clinical care to a group of patients, or teaching a cadre of providers to administer care, I have been lucky to have had several opportunities to train trainers in Vietnam, and so have seen this process in action. I was part of a team that trained instructors to teach the Neonatal Resuscitation Program (NRP) in 2010 and 2011, and the S.T.A.B.L.E. Program® in 2015. This methodology allows these instructors to go on to teach their colleagues on a continuing basis. In the case of NRP, the instructors we trained have now trained over 5000 NRP providers!

Neonatal mortality in Vietnam (death before 28 days of life per 1,000 live births per year) ranges from 13-19 per 1,000. Compare this to the U.S. with a rate of 4, Somalia with a rate of 46 (CIA, n.d., World Bank, 2015). Globally, almost 41% of deaths under five years of age occur in the newborn period. The most common causes of neonatal mortality are preterm birth complications (12%), birth asphyxia (9%), sepsis (6%), and pneumonia (4%)(Black et al, 2010). Instruction in neonatal care may be able to help impact these outcomes.

The volunteer organization I worked with, International Relief Teams (IRT), collaborated with another organization, Project Vietnam, to bring trainers to several cities and hospitals in Vietnam including Hanoi, Saigon/Ho Chi Minh City, Ben Tre, and Can Tho. In the case

A new NRP instructor trains her colleagues in Can Tho, Vietnam.

I find that working side by side with colleagues in another country allows me to get to know people, understand cultural aspects first hand, and make new friends, while potentially making a difference in the health of others.

of NRP, we trainers taught the instructors the NRP course, then how to administer the course, and then stayed with them to provide mentorship while they taught their first class. IRT provided manikins and supplies, and funded having the materials for both NRP and the S.T.A.B.L.E. Program® translated into Vietnamese, a lengthy process due to the dialect differences between the north and south regions of the country. The instructors can then continue to teach using the Vietnamese slides and learner manuals to train their colleagues. Translation can really help to ensure the sustainability of the teaching programs.

Teaching with a translator does slow down the process, just as you would expect. It takes time to have your words repeated, student questions translated, and then the back and forth to be sure that the questions are thoroughly answered. One nice thing about NRP is that there are plenty of hands-on skills demonstrations (positive pressure ventilation, compressions, intubation, line placement), so we could stand back and watch whether the students were doing things correctly i.e. were taught the content correctly. It was so satisfying to see a room full of knowledge expand before your very eyes.

Part of the impetus to have trained NRP and S.T.A.B.L.E. Program® providers available in the provinces of Vietnam is to encourage families to have their babies in their local hospital instead of going into the major cities of Hanoi and Saigon/Ho Chi Minh City. Over 40% of the population is under 30 years of age (median age of 29), 24% is under 14 years of age, and the birth rate is around 13 per 1,000 (1.8 children per woman). The urban hospitals are extremely busy; one of the hospitals we taught at in Saigon/Ho Chi Minh City has 300 births a day (300 a DAY!), with a 50% c-section rate. There were 15 operating rooms going at any one time...and you think YOU are busy at work!

We learned from our students as well as taught them. Some parts of the programs had to be modified based on resource accessibility, culture, and even genetics. One example is the use of O-negative blood for emergency transfusion. Interestingly, in Vietnam over 99% of the people have Rh-positive blood. When our students were puzzled by our information and pointed this fact out to us, we realized we needed to amend the program content.

We ate meals with our students provided by the hospital cafeteria or local catering. Sometimes we were entertained at restaurants by the staff or hospital administrators. We sang Karaoke with the students and were even invited to their homes. These unique opportunities for cultural exchange

and socializing may not come up during a guided tour, or during shore leave from a cruise ship.

There are lots of ways to see the world, but my favorite way is traveling to volunteer teach. I find that working side by side with colleagues in another country allows me to get to know people, understand cultural aspects first hand, and make new friends, while potentially making a difference in the health of others. I find it rewarding, worthwhile, and a gratifying way to spend a vacation.

The idea of leaving a lasting effect is very invigorating, renewing my outlook on life, and even my energy for my regular job. (I joke that I work to support my volunteer habit). It is like making rings emanate from a drop of water in a pond that go on forever. Check out the following websites to learn more about international volunteer opportunities!

- Health Volunteers Overseas: hvousa.org
- Helping Babies Breathe: helpingbabiesbreathe.org
- International Relief Teams: irteams.org
- Medical Teams International: medicalteams.org §

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Registration Now Open for the Oregon AWHONN Fall Conference

The stage is set for the 2015 Oregon AWHONN Fall Conference September 9, 10, and 11. We are excited to be visiting scenic southern Oregon and the Rogue Valley for the first time. This location offers a wealth of attractions both indoors and out. The venue is the Inn at the Commons in downtown Medford which offers easy access to Ashland and the Shakespeare festival, historic Jacksonville and the Britt Festival, Crater Lake and many wineries just to name a few.

We are thrilled to have several national speakers this year including Lisa Miller, CNM, JD and Roger Freeman, MD who are well known experts in fetal monitoring, Harvey Karp, MD, FAAP, a pediatrician and child developmentalist who has done landmark work on infant calming and sleep, and Karen Harris, MSN, RN, WHNP-BC who is the current AWHONN National Chair. Additionally there will be several local experts providing hands on education through simulation on Wednesday and evidenced based, innovative lectures on Thursday and Friday.

Don't forget that the Fall Conference Program Committee is seeking posters for display at the conference. Learn more and submit your poster at oregonawhonn.org/posters.

Register for the conference at oregonawhonn.org/registration. We hope to see you there! §

A Visit with "The Dublin Midwives"

by Nancy Irland, DNP, RN, CNM

This is a painfully honest statement: "Prolonged labour presents a picture of mental anguish and physical morbidity which often leads to surgical intervention and may produce a permanent revulsion to childbirth, expressed by the mother as voluntary infertility . . ." This is how Irish researcher Dr. O'Driscoll begins his landmark 1969 article on Active Management of Labor (AMOL). Shortening labor and promising every first-time mother 1:1 care with a midwife, and a delivery within 12 hours was the goal of "The Dublin Study" in the 1960s. That research gave us the Active Management of Labor (AMOL) protocols that we used in the 1970s. Those protocols included oxytocin inductions that started at 6 mu/min, were increased by 6 mu/min every 15 minutes, and then were scaled back if necessary due to tachysystole or a non-reassuring fetal heart rate. The term "pit to distress" was often used in reference to the AMOL practices. Yet, we didn't blink an eyelash as we did that, thinking it was best practice. Irish outcomes indicated a lower cesarean rate as well as reduced hemorrhage and chorioamnionitis rates, without increased neonatal morbidity. (I find AMOL uncomfortable, now. But, in our defense, I warn obstetric newcomers that in the future, some of our current practices might be challenged as well, and we'll have to own up to them, too. Yet, we can't think of any that should be altered currently... right?). For anyone practicing obstetrics in the 1970s, the "Dublin Midwives" were icons, having been active players in the research by Dr. O'Driscoll, et. al (1969).

In February of this year I was fortunate to tour the very hospital where the AMOL research was done, and to meet some of the Dublin Midwives who participated in that research. I had been invited to present podium and poster presentations at the annual convention of the Royal College of Surgeons (RCSI) in Dublin, Ireland. In preparation for my visit to Dublin, I emailed hospital administration at the National Maternity Hospital (NMH), to request a tour of their birthing unit. When I received a return email with an invitation to meet and tour with Ann Rath, senior midwife/manager at the NMH, I was thrilled.

The front doors of the hospital opened directly from a busy street (see Photo 1), looking much like the hospital in London, England, where Princess Kate recently gave birth to baby Charlotte. Ann met me in the small hospital lobby and took me down the

white, echoing halls and up some worn, wooden stairs to her office, an ancient, wood-paneled library of sorts.

I told Ann I was honored to be talking to one of the Dublin Midwives. She got right down to business and was quick to point out, "Everyone thinks the AMOL protocol is high oxytocin. However, Active Management of Labor means we recognize dystocia early and intervene actively when it happens. Patients are those having their first baby."

From my reading, I had learned that the Dublin Protocol defines labor as regular painful contractions at least every 5 minutes. In addition, before starting the protocol, the patient should have at least one of the following three criteria:

- spontaneous rupture of membranes
- complete cervical effacement, or
- the passage of bloody show.

Active Management of Labor has been modified significantly over time but the core principles remain:

- Early diagnosis following strict criteria by a senior midwife.
- Vaginal examination hourly for three hours, then every two hours, at least. This allows the rate of progress to be plotted on the partogram to avoid falling off the grid.
- Amniotomy one hour after admission if no SROM. (Amniotic fluid is referred to as "liquor", pronounced "ly-kur").
- Augmentation with oxytocin if not dilating at rate of 1 cm/hour.
- Women not in labor are sent home. 50% are re-admitted within 24 hours.
- Personal, psychological support for the woman.
- Liberal use of epidural anaesthesia (67% epidural rate).
- Regular rounds by the obstetrician (called a "Consultant") to determine the need for c-section.
- Antenatal education classes. All prenatal care is given at the hospital clinic, where 200 patients are seen per day. Beginning at 30 weeks, patients receive group classes of 1-hour duration. They discuss signs and symptoms of labor, active management of labor, breast feeding, and newborn bathing. An exciting and upcoming improvement in prenatal care was the establishment of outreach clinics in outlying towns, taking the clinic to the patients.

The evaluation of labor is carried out within one hour of the arrival of the patient to the unit (see Photo 2). Ann said, "When she comes in and says she is in labor, we believe her and get started. We do a vaginal exam. If there's no cervical (pronounced "cer-vy-cul") change in an hour, and she's not in labor, she goes home. We don't have them walking on the floor for an hour or two and re-check, as you do. We can't staff for that," Ann said matter-of-factly (see Photos 3, 4 and 5).

Photo 1. Front entrance. National Maternity Hospital, Holles Street, Dublin 2, Ireland

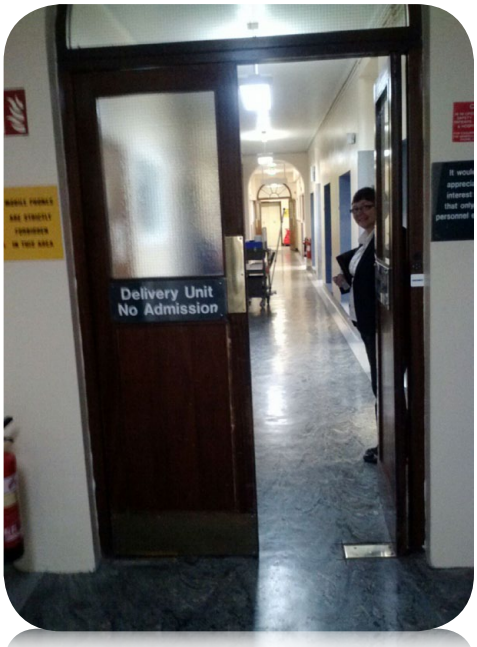

Photo 2. Delivery unit. Ann holding the doors open. Note the long hallway and arches.

Photo 3. Triage room.

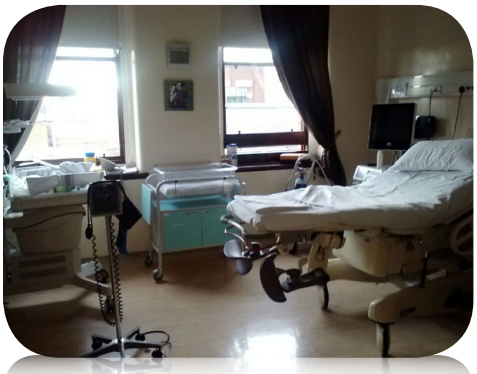

Photo 4. Familiar-looking delivery room.

Photo 5. Big, bright bathroom with birthing stool at the ready.

The statistics she shared were interesting: There are 19 maternity hospitals in the small country of Ireland. In the three hospitals in Dublin, each hospital has 9,000 to 10,000 births per year. In NMH, they have only 10 delivery rooms, all care is 1:1, and midwives (called "sisters") labor the patient and do all the deliveries, unless a patient has private insurance. In that case, something very interesting happens: the sister still does the delivery, and the patient's private physician attends as a courtesy, but only as an observer.

I asked, "Why doesn't the physician do the delivery?"

Her quick reply, "Because the sister is the one with experience! Physicians do the surgeries."

The cesarean rate for government-insured patients who see a midwife at the hospital clinic during their pregnancy, is 7%. Total cesarean rate for all patients is 35%.

My tour included a stop in the sisters' office on the unit. There, Ann introduced me as "a midwife from America!" The sisters were struggling to learn computer charting, which is being used for order entry as a first step in implementation. An obstetrical early warning score is done on paper before transfer from the labor and delivery unit to the postnatal unit.

I had told Ann how computers calculate early warning scores on the medical-surgical unit at St. Vincent Hospital.

Ann told her peers, "Nancy's told me of some amazing things our computer charting will do for us."

"It better!" one of the sisters said with a twinkle in her eye, "or I'm going to throw it across the room!"

Ann pulled three NMH partograms from the cupboard. Each was color-coded for a different patient population: primips, multips, and VBACs (see Figure 1). "You'll see there are only 10 boxes to record cervical dilation. There are only 10 centimeters to go, so we only need 10 boxes at 1 cm per hour. After up to two hours of pushing, the delivery is accomplished. Twelve hours total." Then she turned professorial. "What's different about these partograms?"

"They're different colors?" I said, stating the obvious. "You'll have to help me here."

Ann tapped a finger on the bottom of the VBAC partogram. "There's the line for oxytocin, but it's not pre-printed. It must be written in by hand when it's given. That makes them aware they are using oxytocin for the VBAC patient. That avoids mistakes in their management. AMOL is not used for VBACs."

After the patient is delivered, she is recovered for an hour, then has "tea 'n toast 'n breastfeedin' and off to the postnatal unit on another floor," Ann explained. With only 10 delivery rooms, the delivered patient sometimes is not allowed to stay in the delivery room for recovery if another labor patient needs the room. The delivered patient is moved to a stretcher and taken to the anteroom just outside the delivery room (see Photo 6), for that hour of recovery. The sister's time is divided between both patients for an hour.

On the postnatal unit, a midwife will care for up to six patients with the help of a nurses' aide. "The public patients are in wards of six beds, so it makes it easy for the sister to care for six. Private insurance patients have private rooms," Ann said.

After our tour, Ann said, "Will we have tea, then?" It was so reminiscent of the dialogue in the books of Maeve Binchy, one of my favorite Irish authors, it surprised me, but shouldn't have. "I'd love that!" I said, and enjoyed tea and crumpets with Ann and other midwives in the private staff cafeteria (see Photo 7). Student sisters with epaulets on their shoulders to indicate their year of education, chattered around me. One of them came to our table to tell Ann she was dealing with an unhappy husband who had a complaint about his wife's care. "I'll chat with him and give him a food coupon," Ann said.

No matter where you go, the fundamental challenges and goals for patient care are the same. With thanks to "The Dublin Midwives," Ann Rath and our kind colleagues at National Memorial Hospital, here's to "tea 'n toast 'n breastfeedin'."

NOTE: The Royal College of Surgeons in Ireland welcomes abstract and poster presentation submissions for their annual February conference. For more information on submission contact information, you may drop a line to Nancy Irland at womens@oregonawhonn.org. §

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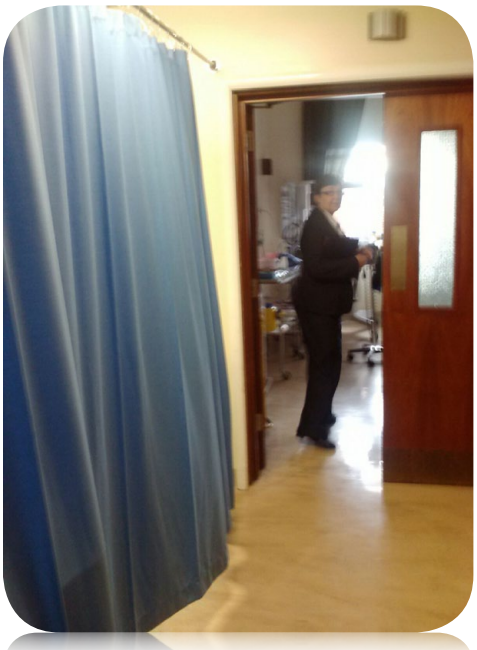

Photo 6. Anteroom with blue curtain for recovery, if necessary, and doors into the delivery room.

No matter where you go, the fundamental challenges and goals for patient care are the same.

With thanks to "The Dublin Midwives," Ann Rath and our kind colleagues at National Memorial Hospital, here's to "tea 'n toast 'n breastfeedin'"

Photo 7. Neighborhood view out the window from inside the staff cafeteria.

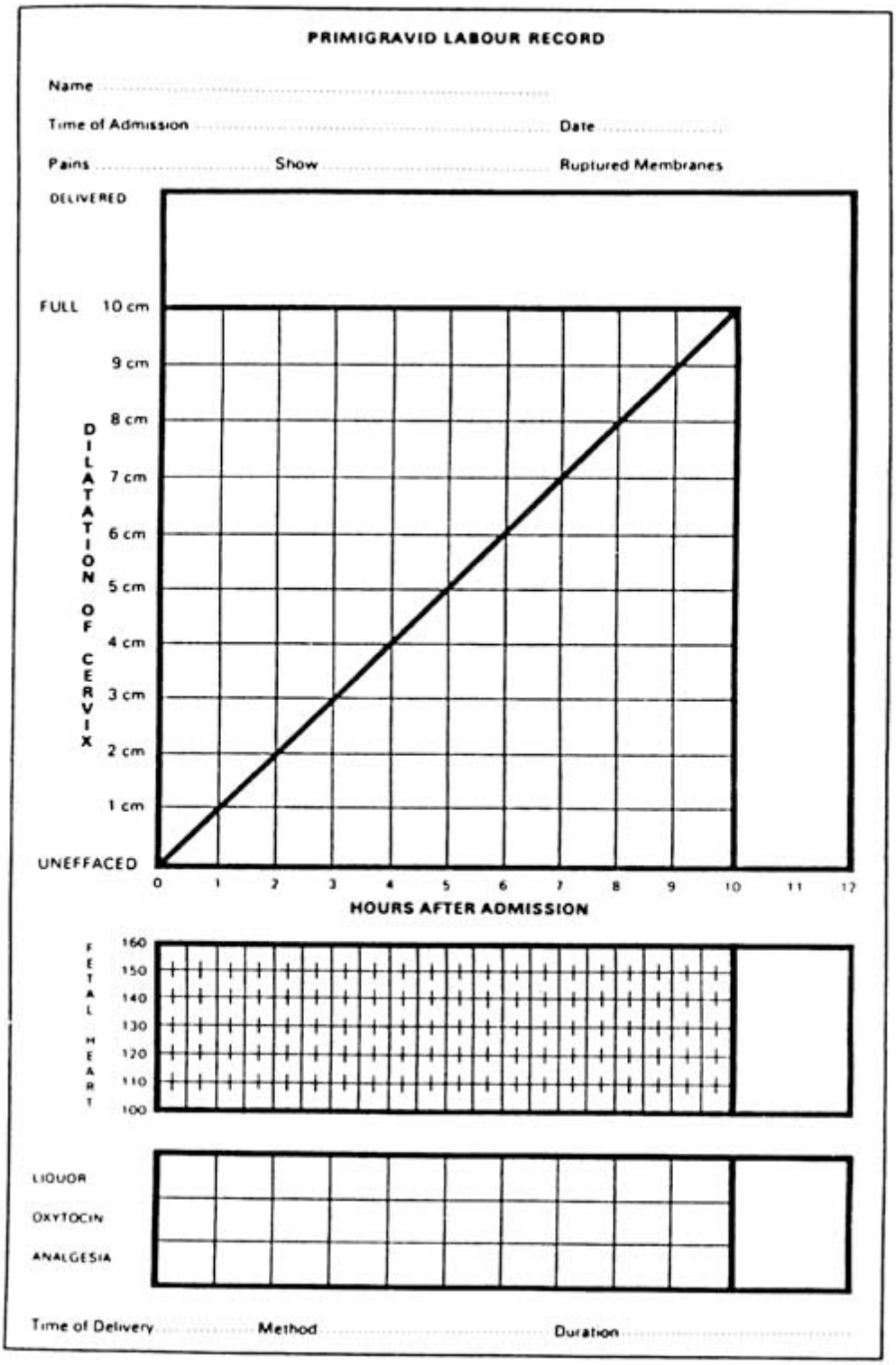

Figure 1. Partogram with 10 hours allowed for progression from 1 cm to 10 cm.

Enjoying the Experience of Working Abroad

by Kendra Crawford, MS, BSN, RN, NE-BC

Working abroad as a registered nurse was not something I considered as part of my career path. When the opportunity presented itself, I had to give it a shot. So I applied for a position, interviewed and was awarded the position... And I have been on the journey of a lifetime since leaving the United States in August 2014.

My journey has taken me to the country of Qatar, a peninsula adjacent to Saudi Arabia. Qatar has experienced vast growth in a short span of time and is currently the wealthiest country per capita in the world. Its major source of income is oil (Dobbs, 2014).

As the country experiences rapid growth, its leaders have also recognized the need to plan and set a vision for the country. Documents released a few years ago outline Qatar's Vision for 2030 which is founded on four pillars: Human Development, Social Development, Economic Development and Environmental Development. Under the pillar of Human Development resides the development of the healthcare system. The goal is to provide "a comprehensive world-class healthcare system, whose services are accessible to the whole population, including:

- Effective and affordable services in accordance with the principle of partnership in bearing the costs of health care
- Coverage of preventive and curative health care, both physical and mental, taking into account the differing needs of men, women and children
- High quality research directed at improving the effectiveness and quality of healthcare" (General Secretariat for Development Planning, 2008)

Qatar's population increased from 224,000 in 1980 to 1.8 million in 2010 (United Nations, 2012) and at the end of 2014 had a population of 2.27 million (World Population Review). As you can imagine, with such rapid growth comes an increase in births. Between 1980 and 2010 Qatar births increased from 2,500 to 7,500 (Greer, 2013). In 2014, the major hospital network delivering babies in Qatar, Hamad Medical Corporation (HMC) reported a 4.5% increase in births resulting in more than 21,00 births in 2014. The major women's hospital accounts for more than 15,000 of those deliveries (JustHere Qatar, 2015)! The country has recognized this increase in deliveries and has plans to open more hospitals to accommodate the volume.

One of the most fascinating things about the health of women and babies in Qatar is that they have improved outcomes over time. As the country has developed, so has their healthcare system. They have decreased their infant mortality from 23.2 per 1,000 births from 1980-1985 to 7.5 per 1,000 births from 2005 – 2010. Additionally, the estimated maternal mortality rate decreased from 15 per 100,000 live births in 1990 to 7 per 100,000 live births in 2010 (United Nations, 2012). While the country is heading in the right direction with the improved outcomes, they agree that there is still work to be done.

Learning a new culture and the ins and outs of a healthcare system in a new country has been enthralling. One of things that I have appreciated most is the work that I get to do on a daily basis with healthcare professionals and ancillary staff from all over the world: Germany, New Zealand, The UK, Australia, Philippines, Nigeria, Ireland, and many more. The people here are passionate about the care of women, neonates, and children. We have great discussions and debates about the delivery of care in our respective countries. Every day is a learning experience and every country believes in their delivery model. What is truly amazing is that when it's all said and done, as healthcare professionals, we always go back to the evidence. That alone is refreshing.

I share a little about my experience to encourage each of you to take a chance. If you have an opportunity to travel in any capacity as it relates to healthcare, whether it's a mission trip, a humanitarian trip, a new job, or a temporary assignment, you will be better for the experience. Healthcare is delivered in so many ways, and with our knowledge and training we can always deposit some good into the lives with which we come into contact. §

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From Medford, Oregon to Kerala, India: The Adventure of a Lifetime

by Linda M. Veltri, PhD, RN

- ✓ Obtain India visa and U.S. passport
- ✓ Update immunizations; fill Cipro prescription
- ✓ Pack bags (max weight 49.5 kg)
- ✓ Stow Neo-Natalie and other necessities in carry-on bag

December 2, 2014

After months of anticipation and planning it was time to go. I caught up with my traveling companion in Seattle following the short flight from Medford. From there we flew for 12 hours to Dubai, United Arab Emirates. I spied the Golden Arches (McDonald's) and stopped in for my "last American-style supper" which consisted of a burger, fries, and an ice cold diet coke. Following, we boarded yet another plane headed to Kochi International Airport. We arrived in India on December 4th at 0330 where we cleared customs, retrieved luggage, and caught up with team members for the short cab ride to a local hotel for a shower and breakfast. Feeling refreshed and excited our team of 44 volunteers, which hailed from the U.S. and Canada, boarded buses for the final leg of our journey into the Spice Hills. At the beginning of the ride we drank in the sights, sounds, and smells of India - so colorful, lush, congested, warm, and exotic all at the same time. Leaving behind the traffic and congestion of the big city, the buses began to climb a windy, two lane, well-traveled mountain road. The lack of sleep finally caught up with us – it was hot, we were tired and thirsty, yet the journey dragged on for six long hours. Finally, we arrived at the Spice Grove Hotel which would be our home base for the next two weeks. After a hot vegetarian Indian meal and shower we fell into bed.

The next few days were very busy. The first order of business was to travel to the Kerala hospital and School of Nursing (which was a one hour bus ride back down the mountain!) where we were scheduled to provide the Helping Babies Breathe (HBB) training to local nurses, nursing students, and faculty. Following a meeting with the hospital administrator and a tour of the hospital, we were taken to the classroom where we provided HBB training for the next four days. It was a large room filled with red plastic chairs, long, narrow, rough wooden tables, and many large windows. There were no electric lights in this room which meant we needed to complete the training and be packed up by 1700 because it would be pitch dark one hour later. Next, a HBB training session was held for the American nurses who provided training to the locals and a plan made about how to organize and run the training session for the anticipated 30-plus students scheduled to arrive at 0900 the following day.

Photo 1. HBB trainers.

HBB Training Session, Day One

HBB trainers arrived early to set up the registration area, classroom, and supplies. The first group of students, dressed in beautiful saris or punjabis with their long, black hair flowing down their backs, also arrived early and waited patiently outside for the classroom doors to open. As students entered the classroom, they were seated in groups of eight at the long wooden tables on which Neo-Natalie and other training equipment was placed. Despite a language barrier, instructors assigned to each group of students got to know those she would be teaching for the next several hours. Students were excited about the opportunity to learn and fascinated by the equipment on the table. All of a sudden, the room became deathly quiet - the silence broken only by the sound of red plastic chairs scraping the floor. Every student stood up, almost at attention, when the hospital administrator (and priest) entered the room. The priest welcomed students and offered a prayer. We were now ready to begin our first HBB training course.

It was a long, hot, rewarding day. All students successfully completed the training. What a joy to see them engaged and eager to learn, helping each other, sharing information about maternal-newborn practices in their own country, and becoming proficient with skills necessary to successfully assist babies transition from intra- to extrauterine life. I am vividly reminded of why I am a nurse and teacher. It was a great day - one that was repeated three more times. As the last students left, we readied the room for the next day, closed the wooden shutters on the windows, locked the classroom doors, and boarded the waiting bus for the one hour drive back to the Spice Grove.

Photo 2. HBB trainers with students from Kerala School of Nursing.

Graduation Day

The red plastic chairs were set in rows, facing a stage while the wooden tables were pushed to the side of the room. Students began to arrive, once again dressed in their beautiful, colorful saris and punjabis. They were talking, laughing, and greeting their HBB instructors. The ceremony began. Short speeches were made, the hospital administrator congratulated the newly trained students and called each one to the stage to receive a certificate of completion, flower lei, a hug, and words of encouragement from their instructors. After the ceremony, there was much laughter, words of thanks and gratitude, and of course, pictures! When it was all said and done, 98 Indian nursing students, nurses, and faculty completed the HBB training. We boarded the bus for the long drive back up the mountain. Our work, for now, was done.

Getting Involved

There are many ways you can make a difference in the lives of moms and babies around the world. Consider taking one of the training courses (Helping Babies Breathe, Helping Mother's Survive, or Essential

Photo 3. Graduation!

Care for Every Baby) developed through the collaborative effort of organizations like the American Academy of Pediatrics, Save the Children, and Laerdal Global Health to provide frontline healthcare workers with knowledge and skills needed to reduce maternal and newborn mortality at birth. Once you have completed training the next step is to join a group of healthcare professionals on an international training trip. Check out the following resources and opportunities for training and travel:

- Perinatal Rescue Network, a non-profit organization located in Talent, Oregon. Go to perinatalrescue.org or facebook.com/perinatalrescue to learn more about training courses as well as work in Rwanda and India.
- Visit the Perinatal Rescue Network vendor table during the fall conference to connect with AWHONN members who have taken HBB and other programs around the world.
- Project C.U.R.E. (projectcure.org/serve/helping-babies-breathe) collects medical supplies and equipment to donate around the world. You can find information about HBB training courses and opportunities available for international travel.
- Check the following websites: Helping Babies Breathe at helpingbabiesbreathe.org and Helping Mothers Survive at helpingmotherssurvive.org. §

What do three, triple, tres, and Oregon have in common? "3" – the number of times in a row Oregon can win the Every Women, Every Baby donation challenge. However, we can't do this without your help. We need you to donate today at awhonn.org/donate.

Improving the Health and Care of our Most Precious Patients

every WOMAN every BABY

AWHONN.org/donate

Welcome Oregon AWHONN New Members

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Rima E Bodasingh
Megan Bortnem
Rose Buchanan
Tami Ann Busse
Erin Chow
Elexise Danielle Chung
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Nancy Doneganm
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Don't forget! Recruit three new members and receive a free membership!

NW PRN
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2015 SAVE THE DATES

Perinatal Conference: Antepartum/Intrapartum/Mother-Baby Care

Offered twice yearly as 7 classroom days:
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Conference content is grouped for nurses with focus on Labor and Delivery, Antepartum or Mother-Baby Care. Refer to brochure for selection of applicable content focus.

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