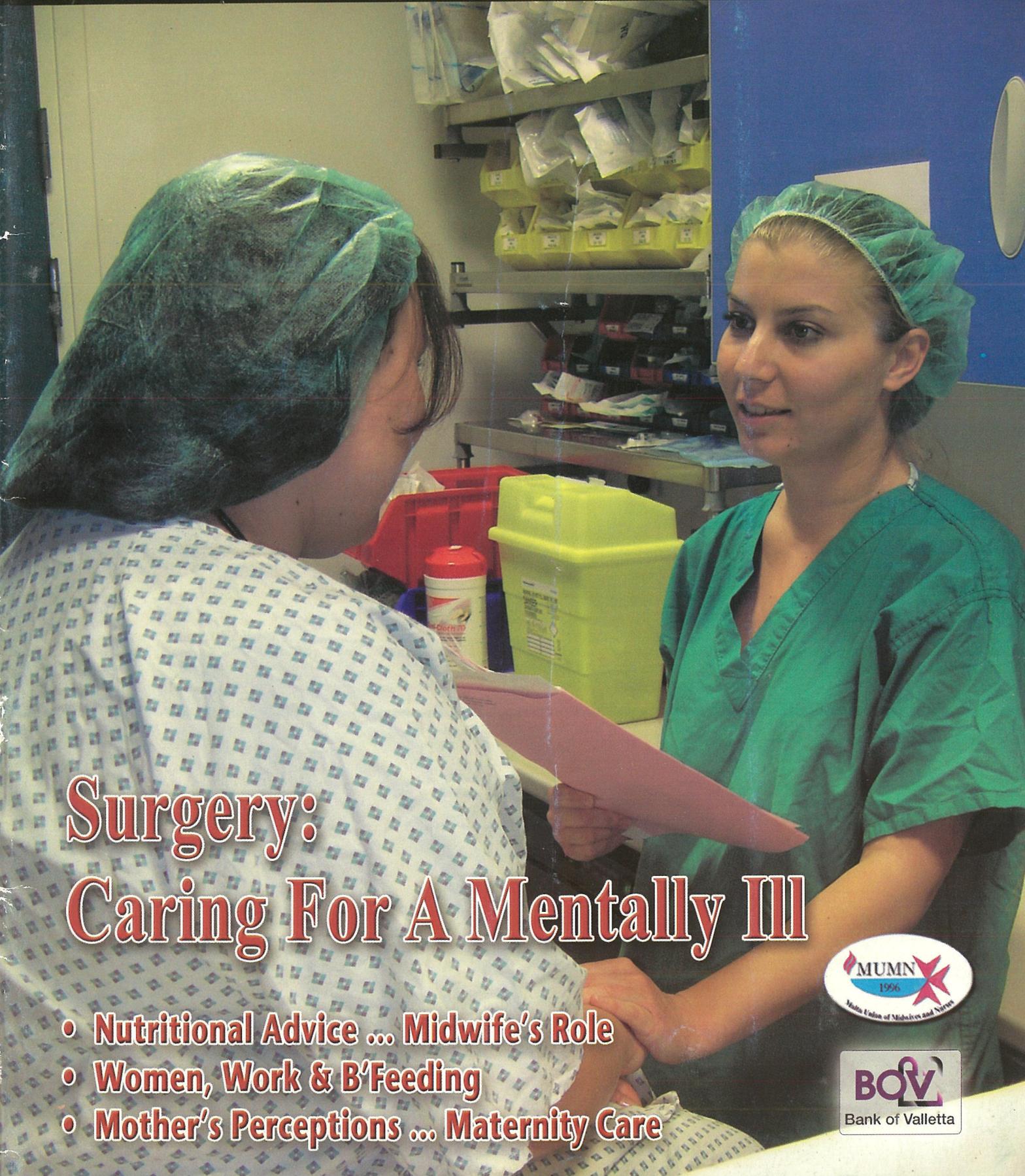


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MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

Harġa Nru. 39 - Ġunju 2008



Surgery: Caring For A Mentally Ill

- Nutritional Advice ... Midwife's Role
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References: 1. Jenkins C et al. BMJ 2004. Vol. 328; Issue 7437. 2. Szczeklik A et al. Am J Ther 2002;9:233-43. 3. MIMS. Panadol Prescribing Information. 2003. 4. Jenkins C. Am J Ther 2000; 7:55-61. 5. Lamb C et al. The Pharmaceutical Journal 1995;254:802-4. 6. Settapanne RA et al. J Allergy Clin Immunol 1995;96:480-5.



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Nurse Prescribing-Għala le?

F'dawn l-aħħar għoxrin sena rajna tibdiliet sinifikanti fir-rwol u l-funzjoni tan-Nurses f'hafna pajjiżi. Ix-xogħol fin-Nursing sar aktar tekniku fin-natura tiegħu. Żdied ukoll l-importanza tan-Nursing bħala parti integrali tat-*team* multidixxiplinarju bl-għarfien ta' esperti f'dan il-qasam u l-*management* ta' kura lill-pazjent. Dawn l-iżviluppi seħhew meta fil-kura tas-saħħa qegħdin nitkellmu kif tnaqqas l-ispiza u fl-istess ħin hemm zieda fid-domanda għal trattamenti ġodda u għoljin. Għalhekk, gvernijiet u professjonisti fis-saħħa qed jagħtu importanza kbira fuq effiċjenza tar-riżorsi

F'hafna pajjiżi, in-Nurses qed jiżviluppaw rwoli innovattivi u anke dawk innejha *expanded/extended roles*. Fil-fatt l-awtorita' li tippreskrivi (prescriptive) tista' tissejjaħ aspett wieħed ta' dawn l-avvanzi fil-professjoni tan-Nursing. Fl-2000 l-ICN stabilixxiet l-Internatiunal Nurse Practitioner/Advanced Practice Nursing Network waqt li fl-2002 ħabbret il-posizzjoni tagħha fuq rwoli fin-Nursing avvanzat.

L-interess biex in-Nurse t/jippreskrivi inħass biex: Tiġi ipprovduta kura aħjar lill-pazjent, b'mod immedjat fil-komunita'/postijiet rurali; il-ħin u r-riżorsi jiġu wżati b'mod effettiv; il-bżonn li n-Nurses jimxu fl-istatus professjonali tagħhom waqt li x-xogħol li diġa qed jagħmlu jiġi rikonoxxut bil-liġi; jitjiebu r-relazzjonijiet bejn professjonijisti fis-saħħa; jonqos l-ammont ta' xogħol tal-istaff mediku.

Hemm min għalhekk jiddibatti li bl-introduzzjoni ta' rwoli fil-prattika avvanzata tista' tifred il-professjoni tan-Nursing f'dawk 'elitisti' li għandhom *extended role*, u dawk ġenerali.

Bin-Nurse *prescribing* mhux biss il-professjonisti u l-*managers* għandhom x'jirbħu jew jitilfu, iżda l-pazjent iħossu li iggwadanja minn dan kollu.

Aspetti importanti biex wieħed jakkwista l-introduzzjoni tan-Nurse *prescribing* huma: Żvilupp ta' relazzjoni posittiva fuq il-post tax-xogħol ma professjonisti oħra fis-saħħa; *lobbying* sistematiku ma' politiċi u gvernijiet; argumenti posittivi fuq gwadann lejn il-kura tas-saħħa; krejazzjoni ta' alleanza ma organizzazzjonijiet li jirrapreżentaw lill-pazjent u l-konsumatur.

Nurse prescribing hija terminologija minnha nfisha li tista tintuża biex tiddekrivi aktar minn tip wieħed ta' Prattika f'pajjiżi differenti. Differenzi li jirreflettu d-diversita' fis-sistemi tal-kura tas-saħħa, id-distribuzzjoni tal-popolazzjoni tal-pajjiżi, u l-posizzjoni tan-Nursing f'dak il-pajjiż. Fil-fatt huwa evidenti li mhux ċar x'hinu r-rwol tan-Nurses li jippreskrivu meta niġu għal-xi tip ta' konsistenza fil-pajjiżi li applikawha. Għandhom ikunu awtonomi, jew dipendenti fuq it-tobba? Anke Midwives f'ċertu pajjiżi għandhom is-setgħa li jippreskrivu waqt il-qadi tal-professjoni tagħhom.

Hafna mid-dibattitu rigward *nurse prescribing* idur fuq ir-rwol tan-Nurses. Dan dejjem huwa abbinat ma dibattu ġenerali fuq Prattika tan-Nursing avvanzat. Fil-fatt isir diskors fuq *Nurse practitioner, Nurse consultant u clinical nurse specialist* meta nittrattaw dan is-suggett. Għalhekk tqum l-*issue* ta kif jiġi regolat Prattika avvanzata u kif din tinfilsa fl-edukazzjoni tan-Nurse. Hemm min għalhekk jiddibatti li bl-introduzzjoni ta'rwoli fil-prattika avvanzata tista' tifred il-professjoni tan-Nursing f'dawk 'elitisti' li għandhom *extended role*, u dawk ġenerali. Dibattitu relatat biss ma status u mhux salarju, għax ziediet fir-rwoli u responsabbilitajiet abbinati ma Prattika avvanzata mhux neċessarjament jirriflettu avvanz finanzjarju.

Hemm min se jiddibatti li n-Nursing se jaħtaf/jinvadi l-ispazju tar-rwol professjonali tat-tabib. Allura min hu r-regulatur ta' din l-*issue*? Min għandu monopolju tal-kontroll professjonali fil-proċess kurattiv u tad-dijanjozi? Kemm l-Istat kif ukoll il-professjoni medika għandhom rwol importanti li jiddefinixxu min huma dawk il-professjonijiet li qed jaspiraw li jippreskrivu.

M message from the President

General elections are over and the Maltese elected a government which has a five years legislation ahead of him. The elected government has high lighted the major “projects” within the health sector for this legislation. The extensions and new services should include the opening of the new rehabilitation hospital, the development of the primary health care, the renovation of the oncology hospital, the opening of elderly wards within SVPR and Mt. Carmel and the full utilization of mater Dei hospital.

As President, I took it in my stride to prepare a document (which has later been approved by the MUMN Executive Council) on the present issues which are effecting the nursing and midwifery profession on both national level and also on each and every health care setting on our islands. The document offers more than just that. The document highlights the main problems causing nursing and midwifery shortages and offers solutions which are need to be adopted for future recruitment. It also relates on how the nursing and midwifery professions should develop and the trends which needs to be introduced in order to achieve the standards required for our aging population.

The document relates to:

- 1) Shortages of Nurses and midwives
- 2) A Man power plan which should include the present staff vacancies and the projections needed for future projections. The man power plan should also include the number of nurses and midwives needed to be recruited to meet the demands envisaged by the plan.
- 3) Supporting staff of Mater Dei Hospital and SVPR.
- 4) Midwifery Services
- 5) Nurse/ Midwifery specialization and Nurse/ Midwifery practise development.
- 6) Primary Health Care
- 7) Mental Health Care
- 8) Oncology Care
- 9) The systems proposed for nursing and midwifery promotions.

The document ends by delivering this message **“MUMN is proposing that a consultative approach with a bi lateral agreement beneficial to both sides be in place in this legislature to avoid any dispute and that management by crisis which should not be the norm of the day.**

MUMN is prepared to contribute and propose various options on the different challenges, present in this document. The depleting work force would be strengthened and nurses and midwives should not be allowed to suffer more due mainly due to lack planning. One has to keep in mind that our nursing and midwifery staff are so stretched in number that any predications of extending the health care services would not be accepted to this union. MUMN has high lightened all major challenges and made it clear that objectives have to be met to increase and improve our health care facilities. These challenges if tackled with the proposed initiatives would result in better services and care to our patients.”

Paul Pace
President

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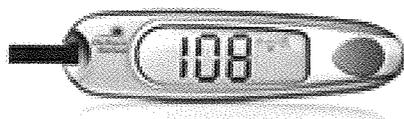
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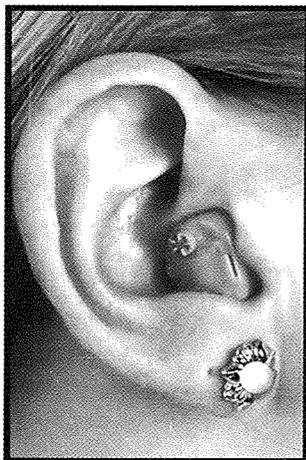
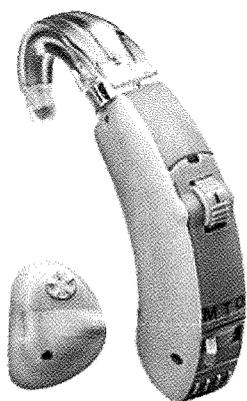
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Kelmtejn mis-Segretarju Ġenerali

Kemm ilhu li fetaħ l-isptar Mater Dei il-problemi ma waqqfux. U mhux biss f'dan l-isptar. Id-diffikultajiet tan-Nurses qegħdin f'kull sptar u fiċ-ċentri tas-saħħa.

In-numru ta' Nurses li ntbagħtu fl-isptar Mater Dei sar għas-spejjeż ta' sptarijiet oħra. Kull post tax-xogħol qed ibagħti minn nuqqas ta' Nurses. U dan mhux biżżejjed. Il-workload qiegħed dejjem jizdied. L-indipendenza tal-pazjenti qegħda kontinwament tonqos speċjalment fl-istitutizzjonijiet ta' l-anzjani. Il-klijent fiċ-ċentri tas-saħħa qiegħed jistenna aktar servizzi. Problemi ma kull fejn tmiss. Taqta' nifsek tejdhom aħseb u ara tkun f'nofshom!

Mela d-diffikultajiet qegħdin fuq żewġ binarji. Nuqqas ta' Nurses u żieda fix-xogħol. Ma dawn imbagħad issib nuqqas ta' *supporting staff*, nuqqas f'ċertu sistemi bħal *pay slip* tal-paga fejn l-ebda Nurse u Midwife ma jkollha tagħrif dwar il-paga tagħha (u dan għal għieħna qegħdin fis-sena 2008!), bħal l-ikel fl-isptar Mater Dei, biex tieħu ġurnata *vacation leave* trid tagħmel wegħda u bosta affarjiet oħra li jekk nibqa nsemmi nimla l-artiklu bijhom biss. In-Nurse u l-Midwife tkun diġa mifnija bil-problemi 'normali' u hekk kif tibda tħoss il-mewġ u r-riħ dejjem jizdied u ġej kontra tagħha, ma tijiex tort li taqbad tiġri l-bogħod mis-sistema kollha.

Dawn is-sitwazzjonijiet ilna ħafna li ntiċipajnihom. Kien hemm min kien jitbissem meta konna ngħidu li aħjar ma jiftaħ xejn għalissa l-isptar Mater Dei. X'jiswa billi ftaħna bini sabiħ? Qegħdin kuljum inżidu l-problemi. Barra d-diffikultajiet ta' nuqqas ta' riżorsi għandna problemi akbar bin-nuqqas ta' spazju fejn joqgħodu s-soddod għall-pazjenti. Mhux sew li kwazi s-swali kollha qed jagħtu kura lill-pazjenti li suppost qegħdin f'sala oħra. L-anqas ma jagħmel sens li pazjent wara li jiġi operat irid jistenna s-sieġhat sakemm tinstablu sodda. Mhux sew li pazjenti jistennew sieġhat twal fid-dipartiment ta' l-emergenza. Kellna ndawwru nofs id-*Day Surgery Unit* f'sala tal-Medicina u l-ftit Nurses barranin li ġew f'pajizna nbelaw f'dan il-post. Minflok il-*management* qiegħed jara kif ser itejjeb is-sitwazzjoni fl-interess tal-pazjenti u l-istaff, qiegħed ta' kuljum jipprova jsolvi kriżi wara oħra. Kemm aħna kapaci nifilhu għal dan kollu qabel ma l-bomba tispodi f'wiċċna?!

Il-Ministru Dalli sab dan kollu ma wiċċu. Veru li huwa ta' l-istess partit politiku però kull individwu huwa differenti. L-MUMN tapprezzah dan però mhux dejjem tkun tista' tistenna. F'Ġunju tas-sena l-oħra bdejna t-taħdidiet dwar Pakkett ta' Incentivi Ġodda. Meta f'Ottubru wasslet il-migration, il-Gvern kien talab lil Unions għal ċertu kawtela sabiex it-*transition* iseħħ kemm jista jkun mingħajr skossi. Wara ftit tħabbret l-elezzjoni u l-MUMN toqgħod ħafna attenta li ħadd ma jużha għal xi skoppijiet ta' politika partijjana. Wara ġie maħtur Ministru ġdid u allura trid tagħti ċans sakemm dan isib saqajh. Jekk tikkalkula dan kollu isib li kwazi hemm sena sħiħa fejn l-MUMN kienet b'mod diskrett qed tintalab biex tipposponi l-ilmenti tagħha. Però hemm limitu għal kollox. Minn jista' jlum lil dak in-Nurse jew lil dik il-Midwife li qegħda fl-infern tax-xogħol u ma tistax tissaporti aktar? U jekk l-MUMN ma tijiex ħajt tal-kenn minn ser jgħejna? Il-Ministru jrid japprezza li hemm ċertu problemi li ma jistawx jistennew aktar. Huwa mportanti li npoġġu madwar mejda u niddiskutu imma mhux biżżejjed. Jekk veru l-Ministru iridna nkunu *partners* miegħu hemm bżonn li niġu trattati ta' hekk. L-ebda *partner* ma tgħidlu 'jien imexxi, jien il-*management* u int zomm postok u oqgħod hemm'. *Partners* ta' veru jisimgħu lil xulxin u fejn wieħed għandu esperjenza aktar mill-ieħor allura jtieħ widen speċjalment fejn is-servizz lejn il-klijent ikun ser jitjeb. Però kulħadd bl-istil tiegħu.

Punt ieħor li qiegħed iwegġa l-irjus huwa dwar il-Ftehim li ffirmajna f'Ottubru. Hemm ċertu punti li għaddom mhux indirizzati u oħrajn li d-Divizjoni tas-Saħħa għadha lura fuqhom speċjalment dak tal-*Bridging*. L-amministrazzjoni ta' kull sptar hija responsabbli għas-sezzjoni tagħha. Jekk l-affarjiet ser jibqgħu kif inhuma, l-MUMN ser ikollha timxi bil-ponn tal-ħadid. Perwsaz li tmien xhur kienu biżżejjed sabiex il-punti kollha jiġu mmaterjalizzati.

Nispera li nibdew naraw ftit dawl fit-tarf tal-mina għax s'issa dlam ċappa hemm.

Nieħu l-opportunità sabiex niringrazzjakom tas-support kontinwu li tagħtu lil din il-Union u lili b'mod personali. Grazi mill-qalb.

Colin Galea
Segretarju Ġenerali

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Chaplaincy charting

It is not unusual in a hospital that a staff member approaches one of us chaplains and tells us: "Father, can you visit that patient because s/he needs help". Experience has taught me that talking beforehand with the nurse from whom I have been given referral before I actually meet the patient is crucial. But this is step one of pastoral care. If in our hospitals we are moving towards an interdisciplinary healthcare team in care, in what way can we as chaplains be involved in this endeavour?

In this short article I want to suggest what is called outcome-oriented chaplaincy. By the latter I mean that the pastoral intervention which is carried out by the chaplain is documented in the patient's notes. Such chaplaincy charting helps in giving an account of the spiritual aspect of the person, thereby providing its share towards holistic view of the progress or regress of the patient's entire well being.

The first step is to state the reason of the chaplain's encounter with the patient or relatives. The chaplain needs to ask herself/himself the following questions in order to clearly present the reason of her/his presence with the person/s involved. Why am I making this visit? Is it because I have been referred to this person? Is it because I am doing my usual round? Is it due to a request for ritual or religious literature? Is it because I am doing a follow up visit?

The second step consists of the chaplain explaining the interventions s/he is offering. The chaplain asks: What am I doing to help this person? The chaplain can be enlightened in her/his response by asking herself/himself if s/he is being empathic in her/his listening, encouraging, offering prayer, giving grief support or ethics consultation.

The third step in chaplaincy charting is commenting on the outcome of the hospital visitation. Here the chaplain asks: Did my interventions bring any difference within the patient and her/his family? In writing her/his report the chaplain can include phrases like: appeared more relaxed as visit went on; stated s/he felt less frightened; expressed grief and sadness with tears; stated that s/he appreciated support; or stated that s/he felt better.

The fourth step is doing a brief assessment statement. Here the chaplain asks: How would I summarise this person's existing emotional/spiritual/relational state to the remaining interdisciplinary healthcare team? S/he might give the following responses: "patient worried about dying during procedure;" "family appears to be coping well at present;" "patient remembering death of spouse at first anniversary;" "patient concerned about who is providing care for parents;" "patient states strong support from family and faith community;" "patient described feeling of guilt about lapse of religious practices;" "spouse expressed confusion regarding prognosis".

The final step is offering a number of suggestions for continued care of the person. The chaplain asks: What do I intend to do further or recommend to the interdisciplinary health care team? Examples can include: no follow up at this time; will continue with supportive care next week; suggest social work service; etc.

The model of chaplaincy charting is: Reason, Interventions, Outcomes, Assessment, Plan. In order to remember it easily, some chaplains like to refer to it with the mnemonic phrase: "Run In On A Prayer". The relevance of this model can be seen in two ways. First, it helps the chaplain to be more intentional regarding the care s/he is providing. In charting a visit the spiritual carer is more conscious of the quality of her/his work. S/he builds herself/himself up by replying to self evaluating questions like: How did the visit go? What were the needs I was called to respond to? Are there any other ways I could have been more helpful? Is this visit assisting me to become a more caring chaplain? Second, this charting model bridges our work as chaplains with that of the rest of the healthcare team. The more they understand our work the more they appreciate and make use of our services more adequately.

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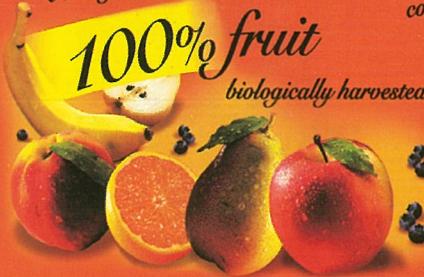
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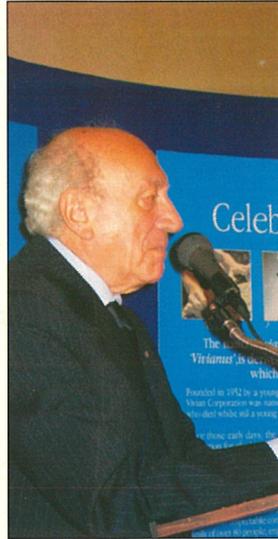
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From left to right: Ms Denise Borg Manche, Mr Frankie Mifsud, Prof. Guido de Marco, Hon Minister John Dalli and Mr Paul Pace



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The Malta Union of Midwives and Nurses (MUMN) award for excellence in the nursing and midwifery profession started in 2005 and is now an established event in the calendar of the MUMN.

The event was held at The Palace Hotel in Sliema on the 5th of May 2008.

Amongst the audience and distinguished guests to attend the ceremony were Hon. Minister Mr. John Dalli and Hon. Parliament Secretary Mr. Mario Galea who the organisers thank for their presence.

At this year's ceremony, the MUMN President Mr. Paul Pace presented awards to the 6 nominees from the following health institutions ; Mater Dei Hospital, Mount Carmel Hospital, Primary Health Care Dept., Zammit Clapp Hospital and St. Vincent de Paule Residence . All nominees were selected by their colleagues for their outstanding assistance to their patients and their carers through out the year.

The nominees were adjudicated by a panel chaired by H.E President Emeritus Prof. Guido de Marco, Director Nursing Services Mr. Jesmond Sharples and MUMN Hon. Presidents Ms. Antionette Calleja and Mr. Rudolph Cini. Mr. Frankie Mifsud Nursing Officer at Mount Carmel Hospital was proclaimed the winner of this year's award and presented with a special trophy.

A lovely reception with the MUMN bands for entertainment followed.

Mr. Pace thanked Vivian Corporation Ltd the sole sponsors of this event for their valuable support. Vivian Corporation is an established leader in the marketing of various brands with one unifying goal – that is to improve the quality of life of all the residents in Malta and Gozo.

Caring for a Seriously Mentally Ill Individual Undergoing Surgery



This is an adaptation of a paper presented by Ms Josanne Drago Bason at the Royal College of Surgeons in Ireland 10th Overseas Meeting on the 17th March 2008 at the Hilton Hotel Malta

ABSTRACT: Admission to the hospital is stressful for anyone, but for someone with a serious mental illness, such as schizophrenia or obsessive compulsive disorder, it can trigger fears that cause him to break with reality in one or more ways. Seriously mentally ill individuals may exhibit a range of symptoms, such as hallucinations, delusions, difficulty with communication, a threat to their own safety and that of others and angry or dependent behaviours. Unfortunately, because of the existent stigma towards mental illness, many a time these patients are either feared or not taken seriously by healthcare professionals.

This paper will discuss, using examples, the necessary skills required by general nurses, in order to overcome their own fears, so that they will be able to care for the patient's surgical condition as well as dealing effectively with his psychiatric presentation.

"All you need is love, love. Love is all you need".

So goes the song written by John Lennon in 1967. This hardly sounds scientific ... However, as a professional nurse I believe that caring for our patients should not be reigned solely by science. There is also the artistic side of nursing which deals

with the way we deliver our caring. So much so, nursing has long been described as both an art and a science (Gage, 2003).

As highlighted by Gage (2003), the art of nursing is often practiced in situations that are

unpredictable and spontaneous, requiring the nurse to be creative in her/his response to individual patient needs. And the admission of seriously mentally ill persons to a general hospital is certainly one of these instances.

Admission to the hospital is stressful for anyone (Brewer and Melnyck, 2007; Wichowski, 2004), whilst research over the past half century shows that preparation for surgery triggers stress that can be documented even physiologically (Kiecolt-Glaser, 1999). Therefore for people who already suffer from a serious mental illness, such as schizophrenia, bipolar disorder or obsessive compulsive disorder, such an event may trigger in them fears that may cause them to break with reality. These people may exhibit a range of symptoms, such as hallucinations, delusions, difficulty with communication, a threat to their own safety and that of others and angry or dependent behaviours (Wichowski, 2004), which pose a greater challenge to the nurses caring for them.

Unfortunately, because of the existent stigma towards mental illness, many a time these patients are either feared or not taken seriously by healthcare professionals. So much so, it has been demonstrated by several research that people with mental illness receive poorer healthcare (Beales, 2001; Chaplin, 2001; Corker, 2001; Thornicroft et al, 2007). Knowledge about such research obliges us, as nurses, to be proactive in order to provide the best possible care for this cohort of patients.

In order to be able to talk about caring for the seriously mentally ill undergoing surgery, which ultimately is the topic of this paper, I would like to briefly describe, both from my experience of working with mentally ill patients and from the available literature, what being mentally ill means to the person.

Though not completely absent, there seems to be a dearth of research which endeavoured to discern the world of mentally ill persons from their perspective. Yet, insight into the lifeworld of people suffering from mental illness gives nurses the opportunity to venture into the lives of their patients, which may enlighten them to be more empathic and gives a more benevolent direction for nursing care (Johnson, 1998; Hayne and Yonge, 1997).

The research studies which specifically addressed the question of what it means to be mentally ill, that were identified for the purpose of this paper, are all in agreement about the intense suffering of these people as they constantly battle against their symptoms to maintain control over themselves (Chafetz, 1996; Hayne and Yonge, 1997; Johnson, 1998; Koivisto et al, 2003). However, for me, the

most poignant comment about the experience of mental illness comes from Hayne and Yonge's study. One of their respondents described her experience of mental illness as one causing "psychic pain ... tangible, soundless, screaming pain entombed somewhere deep inside my body".

Working with mentally ill people made me aware of the continuous struggle which they have to face day in day out. Their first thought in the morning, as they struggle to get out of bed, is their inexplicable deep, inner sorrow which arises from unfounded fears or sometimes from nowhere, or their intense anger directed at all those with whom they come in contact, at life, at God and at themselves. Many of those who have insight into their illness, often ask themselves "Why me?", "Why did it have to be me?", "Why am I mentally ill?", "What wrong did I do to have merited such a fate?" Questions, questions, questions, for which there's hardly an answer.

Well, knowing what these people have to endure throughout their lives should instigate in us nurses, the will to care for them and help them to the best of our abilities. So, in the light of all this, what should we do, if we're faced by a seriously mentally ill patient on our ward?

The aim of this paper is not to discuss the surgical care that nurses should give to patients. That is something we all know. My aim is to write about how we can deliver care from a mental health nursing point of view, in order to give these people holistic care.

It has been well documented, that establishing a therapeutic nurse-patient relationship is an important goal for working with individuals in most nursing situations (Forchuk and Reynolds, 2001; Peplau, 1952/1990). Indeed, Forchuk and Reynolds (2001) suggested that the crucial elements in nursing situations are the nurse, the client and what goes on between them. Thus it is inevitable to care for any patient, let alone a seriously mentally ill patient, if this nurse-patient relationship is not established. This relationship is the first step towards making patients feel at ease and welcome in a ward and thus ease some of the stress they may be feeling.

I acknowledge that this is not an easy task to accomplish, when faced by seriously mentally ill individuals. In front of us we see "normal" persons who are not behaving "normally", because mental illness doesn't manifest itself in physical appearance, but shows itself in the person's behaviours. These persons may appear to be talking to themselves, they may appear frightened or suspicious of our each and every move, they may repeat themselves or certain rituals over and over again, they may

take a long time to provide us with the necessary information about themselves, they may seem dejected and withdrawn, or on the other hand they may be over-excited and talk non-stop about every detail of their lives. Well, the intangibility of mental illness brings to our mind stereotypes such as that of: Psychokiller / maniac; Indulgent, libidinous; Pathetic sad characters and Figures of fun (Byrne, 2001).

Therefore, as Peplau highlighted in her classic writings about the therapeutic nurse-patient relationship, we as nurses should be aware of ourselves, our attitudes and the stereotypes we hold of these people, in order to be able to shield ourselves from adopting a judgemental attitude towards our patients. This self-awareness process is a life-long process which may be achieved through reflective practice. It is the first step towards establishing a therapeutic nurse-patient relationship with our patients. Indeed, Peplau called this step as the Pre-Interaction phase of the therapeutic relationship. It is the foundation of the nurse-patient relationship which enables us to deal with who we are, with our fears, attitudes and prejudices, thus be able to deliver optimum care to our patients.

Before I write about what we, nurses, should do when caring for the seriously mentally ill on a surgical ward, I would like to call attention to what patients want from us nurses. In a research study, which compared Scottish and Canadian psychiatric patients' reflections on their relationships with nurses, carried out by Forchuk and Reynolds (2001), both groups of patients described a positive nurse-patient relationship as the cornerstone of their hospitalisation. They pointed out respect, closeness, genuine likeness and trusting the nurse as key characteristics of a nurse-patient relationship which went well, whilst describing a painful experience when it did not work well. In addition, the Canadian participants identified listening, availability and a friendly approach as critical in the nurse-client interaction. Consistently, the Scottish ones wanted nurses and to sound warm and genuine.

A more recent study carried out by Shattell et al (2007) about mentally ill patients experience of the therapeutic relationship, confirmed these findings by its three emergent themes, titled using the participants own words of "relate to me", "know me as a person" and "get to the solution".

These research studies shows exactly what mentally ill people expect from us nurses. They expect us to talk to them, involve them in their care and treat them like "normal" people. And this can be achieved by making it clear that we are available for them. Our approach to them should be warm and not hurried and even evidently scared.

We should find time to sit down by their bedside and talk with them to see if anything is troubling them. You might tell me "But the patient won't talk back to me" or "This patient only talks about being followed by the policemen". As I said in the beginning, the illness of these people manifests itself in the way they behave and communicate. However, this should not be a deterrent to the way we approach them. A practical thing which a surgical nurse can do is talk to the relatives or the community psychiatric nurse and sees how they cope with certain behaviours. This would give the nurse the opportunity to deal with them in a way which is not new to the patient, thus ensures continuity of care.

You might also add that it's practically impossible to find time to sit down by a patient's bedside when working on a busy surgical ward. ... And I tend to agree with you, because it is easy for me to write about this subject, when it is only you who know your reality. However, all I am suggesting is that we, as nurses, become aware of the impact we have on the patient with a mental illness.

All in all, we should show them that we're not avoiding them and that we are there to listen to what they say and help them with all their needs. We should accept them as they are, regard what they say and take action upon their complaints. In other words, these people should not be treated like crazy, but just like any other patient. Their communication needs and the way they interact with us might differ from a so called "normal" patient, but at the end of the day, we still have a person in front of us, a fellow human being who is in need of our care and deserves our best.

As Reynolds and Scott (1999) put it: "The focus on the whole person involves a recognition that patients are more than the disease or illness condition which urges them to seek nursing and health care."

That is what I meant in the beginning of this presentation, when I said that "all you need is love". By love I do not mean the "love-dovey" love of St.Valentine's day! It's the attitude with which we approach our patients, our unconditional acceptance of them, our availability for them. Yes, all we need is love to care for and about the patient in front of us, but above all, all we need is love to see a person in the seriously mentally ill patient who may be disruptive to our surgical ward.

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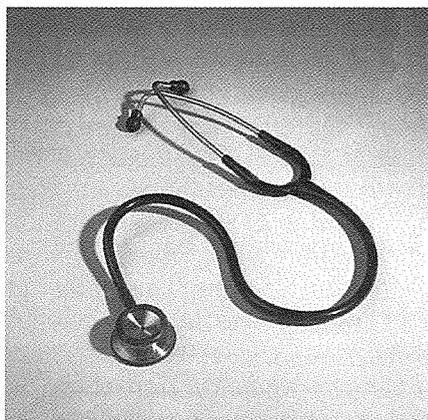
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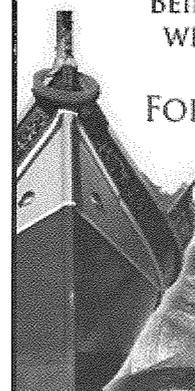
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The Significance of Nutritional Advice given by the Nurse/Midwife to a Woman Prior to Conception, during Labour, and the Postnatal Period

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Introduction

The enjoyment of the highest standard of health is one of fundamental human rights of every human being. Health is a pre-condition for well being and the quality of life (World Health Organization Proclamation, 1998). Health education is an important aspect of the midwife's role through advice given to prospective parents especially on nutritional aspects which are an integral component of good health (Shetty, 2002).

Advice on nutritional prior to conception

Nutrition during childhood and adolescence influences a woman's pre-conceptual nutritional status, which eventually influences the outcome of pregnancy and the health of her child (Dewey, 2003). Furthermore, nutrition around the time of conception may be the most important (Doyle, 1992) therefore nutritional advice may help the woman prepare herself for the prospective pregnancy. The best time to teach a woman about prenatal nutrition is before she discovers that she is pregnant (Cagle, 2002). Malnutrition and eating disorders, such as Anorexia nervosa and Bulimia nervosa may cause deterioration of the overall health and may also threaten reproductive health (James, 2002). Pre-conceptual counseling should aim at discouraging women from restricting their food intake for cosmetic reasons and those women who are of low weight which is unrelated to slimming should be referred professional dietitians on increasing weight. Retrospective evidence from shortages of food during the Second World War in Europe indicated maternal nutrition during pregnancy had less impact than the nutritional status of the women around the time of conception (Doyle, 1992). Woman should take care of their health before pregnancy and their nutritional status is important in relation to pregnancy outcome (Oakley, 2002). Changing to a healthier way of eating does not mean making sweeping changes, it means eating a variety of food to make to get a variety of nutrients. Doyle (1992) emphasize that by advising women to drastically change their diet, will make them less compliant. Advice should be given on what food to eat more or to eat less. It is becoming clear through many research studies that women planning pregnancies should be advised to take additional folic acid prior to conception and to continue this throughout the first trimester of the pregnancy (Persad et al, 2002). Furthermore, because half of pregnancies

are unplanned, Forest (1994) recommends that women capable of becoming pregnant should be advised to take folic acid supplement. Botto et al (2005), note that supplements containing folic acid, a B vitamin, when consumed from before conception can reduce spina bifida and other neural tube defect by 80% or more. Neural tube defects which also include anencephaly, are severe and often lethal conditions that annually effect at least 300,000 newborn world wide (WHO, 2000: Botto et al, 2005). This is supported by Persad et al.(2002) that state that folic acid fortifications of cereal grain is rapidly followed by a remarkable reduction in the incidence of spina-bifida and anencephaly. Wald et al (2001), in a study on quantifying the effect of folic acid, suggest that folic acid fortification levels should be increased, with women planning a pregnancy should take 5mg folic acid daily. Pregnancy outcomes can be improved by following recommendations for personal health maintenance prior to pregnancy (Dewey, 2003).

The harm that maternal alcoholism on the fetus and the potential damage that alcohol may have on maternal nutrition status of a well known fact (Doyle, 1992). Wright et al (1983 cited in Doyle, 1992), found that an alcohol consumption of more than a 100g a week around the time of conception carries an increased risk of low birth weight. They concluded that health education must be directed at reducing alcohol consumption before pregnancy. Conversely, Forrest et al (1991) noted that there was no significant difference in the child physical and mental development with an excess of 100g of alcohol before or during pregnancy. Furthermore, they suggest that women need not to abstain from alcohol in pregnancy but not to consume more than one drink a day. However as problem drinkers are not readily identified by appearance, pre-conception advice is needed to identify such problems

and during counseling, it is the midwives' duty to avoid guilt provoking criticism (Doyle, 1992). This is supported by Cagle (2002), where she states that it is important that alcohol intake should be reduced or stopped altogether around the time of conception and throughout pregnancy to minimize the risk of alcohol syndrome.

Intrapartum Nutrition

The debate over providing oral nutrition to women in labour has persisted since the 1940s. Mendelson (1946), identified aspiration of stomach contents as the cause of post-aspiration pneumonia and subsequent maternal mortality. However little scientific data exist about the influence of food and drink on the outcome of labour (Scheepers, et al. 2001). Baker (1996) supports this and states that there is insufficient evidence to support the practice of starving women in labour, therefore, if there are no risk factors which might indicate the need of a general anaesthetic, women should be allowed to eat and drink if they wish to do so.

The practice of restricted intake, and in some cases, fasting during labour has become common practice in many hospitals (Baker, 1996: RCM, 2005) including in the local practice. However researchers are questioning the wisdom of such practice. Although women are encouraged to take a more active role in decision making regarding labour, the decision regarding the nutritional intake during labour is made for them (Baker, 1996). If each woman during labour is looked upon as an individual, one may notice that some will be more physical than others. Likewise, some may want to eat and drink and others do not (Champion & McCormick, 2002). Therefore advice is important, based on the midwife's knowledge of the digestive system and the effects of different food stuffs on it, in order to provide those women who chose to eat and drink the correct information (Dumoulin & Foulkes, 1984). The desire to eat, however, would appear to be most common in early labour, with the decline in the desire as labour progresses and it is inappropriate to be encouraging them to do so against their natural instinct (Frye, 1994). This is an area in which we as health professionals should be responding to what the woman feels she needs, and therefore allowing her to make the decision and take control.

Fasting during labour is intended to decrease or eliminate stomach contents in order to prevent vomiting or regurgitation of gastric contents into the airway during obstetric anaesthesia (Newton & Champion, 1997). This may be brought about due to the delay of gastric emptying which is due to the effects of progesterone on the smooth muscle and also to the increased use of narcotic analgesia used to alleviate pain during labour (Bevis, 1984 cited in Baker, 1996). However, it is believed that withholding food and drink during labour does not automatically ensure a reduced volume of gastric contents or an empty stomach (Holdsworth, 1978: Nimmo et al, 1983). However, Ludka & Roberts (1993) argue that opposed to the time of Mendelson's (1946) study, where anaesthesia was

administered via face masks and cricoid pressure was not routinely performed, today anaesthesia is being administered by experienced anaesthetist using a cuffed endotracheal tube.

The energy needs of a woman intrapartum, was compared to those of athletes in a competition. When glucose is not available, fat supplies are utilized, resulting in a release of free acids into the blood and tissues (Newton & Champion, 1997). Domoulin & Foulkes (1984) reported a relationship between ketonuria and prolonged labour. This was supported by Broach and Newton (1988) where they stated that severe maternal ketosis increases the need for active management and this combined with starvation and fatigue can lead to inefficient uterine action. This in turn may lead to instrumental deliveries. A common response to the problem of ketosis in labour wards (including the local labour ward), where eating and drinking is restricted, is the use of intravenous infusion (Johnson, et.al. 1989). However, Johnson et. al (1989) advice that the effects of such practice, should be carefully weighed against allowing women, to eat and drink, as they wish. Domoulin & Foulkes (1984) noted significant hazards to both fetus and mother when administering intravenous fluids, such as hypoglycaemia in the newborn and hyponatraemia in the mother, especially with the administration of 5% Dextrose. Baker (1996) argues that in view of such evidence there appears to be a good reason for adequate assessment before administration of intravenous infusions to intra-partum women. In view of the continuous improvement in anaesthetic techniques, and the increase in the amount of experienced anaesthetist for the administration of obstetric anaesthesia, women must be given the information to help them make informed choices in all aspects regarding labour including the issue of food and drink. Our advice as midwives should be to help women in labour listen to their own bodies, and decide what is right for them during their labour, by empowering them in acting as their advocates (Baker, 1996).

Postnatal nutrition

After the giving of birth, the body of the postpartum female will pass through a period of stress. This stress is the result of more or less constantly overdriving the body, especially with little sleep and caring for the newborn. Moreover, pregnancy and the birth process can be both traumatic and wonderful experiences, which can be addressed with a healthful diet, with the right combination of nutritional supplements (Rafflelock, 2005). Advice to the postpartum woman at this stage is of significant importance as it may be beneficial to help her through this period of life safely. We are what we eat, and the food we eat is what enables us to get up in the morning and do what needs to be done. Sleep deprivation, managing life with an infant, and even perhaps returning to work within a matter of weeks all collaborate to further deplete nutrient reserves (Martin, 2002). Stress itself uses up more of all the essential fatty acids, and key minerals like zinc and magnesium (Dewey, 2003). A lot of advice is given

on the continuation of the vitamins for several months after the birth of the baby, mostly iron supplement as the nutritional status, such as iron deficiency anaemia, may affect the degree and quality of child caregiving. Advice on nutrition is given importance from many researchers, who found a link between fetal and early postnatal nutrition and chronic health problems in adult life, such as the risk of hypertension, obesity, diabetes and heart disease. Also, there are numerous linkages between adequate prenatal and postnatal nutrition and a child's physical, cognitive, emotional, and motor development (Dewey, 2003). There is an increase in awareness of the need for replenishment and recovery from childbirth and pregnancy. Dewey (2003) argues that, maternal dietary practices and weight status are strongly related to a child's risk of being overweight, a condition that can have lasting consequences on emotional and physical development later on (Dewey, et. al. 2001).

Mothers who breastfeed their infants, have also is a continuous drain on the protein, fat and mineral reserves of their body (Raffelock, 2005). Many women breastfeed their babies for more than six months even up to a year. Duration of breastfeeding has been positively associated with a child's cognitive and motor development (Dewey, 2003). When a woman is breastfeeding, many substances that enter her body can also travel through her breast milk to her child. Therefore, a woman who is breastfeeding should be advised to take certain actions to protect her baby. Food, medicines, and activities such as smoking may affect the nursing child (Martin, 2002). Alcohol passes easily through breast milk to the nursing child. The more alcohol a woman consumes, the greater its effect on the baby. Having a drink once in a while is fine, but larger amounts of alcohol can make the baby drowsy. Advice should be given to limit alcohol intake to just after nursing, rather than just before. Martin (2002) note that also caffeine intake may affect the newborn's behaviour, in that it may have sleep problems. Therefore, a nursing mother may be advised to decrease her caffeine intake. Breastfeeding mothers need to have a healthy, balanced diet. They should eat a variety of foods at regular mealtimes with nutritious snacks are best for between meals. Breastfeeding mothers need extra calories but should be careful not to overeat. The new mother should wait to start a weight-loss program until at least 6 weeks after delivery especially if she is nursing her baby. During this early period, it is important that her baby gets a high level of nutrients from her breast milk. After that, Martin (2002) argues that she could focus on gradual weight loss, while making sure to balance a healthy diet with moderate exercise.

Conclusion

Improving maternal nutrition requires multiple strategies, with interventions aimed at various critical points during the life cycle. Ensuring adequate diets prior to pregnancy and lactation, and during early childhood, particularly the first two years of life is essential (WHO, 2002). Such interventions may enhance

child development, as well as the general health of the women (Dewey, et. al.2001).

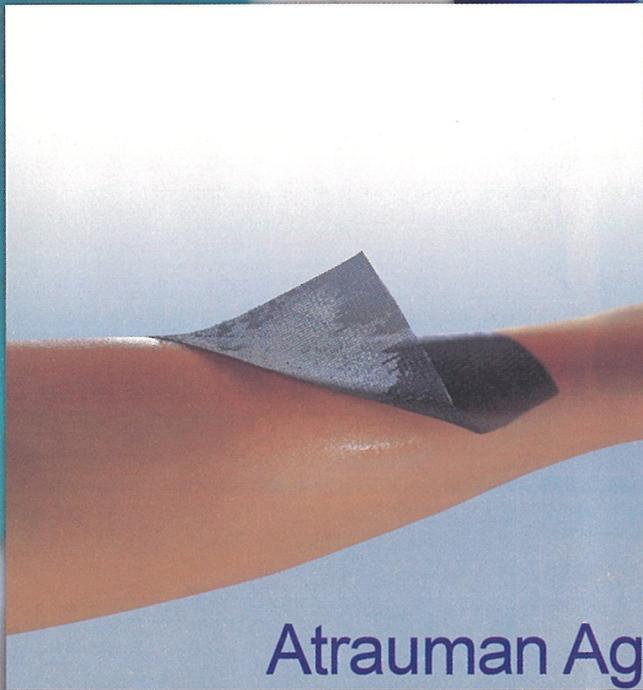
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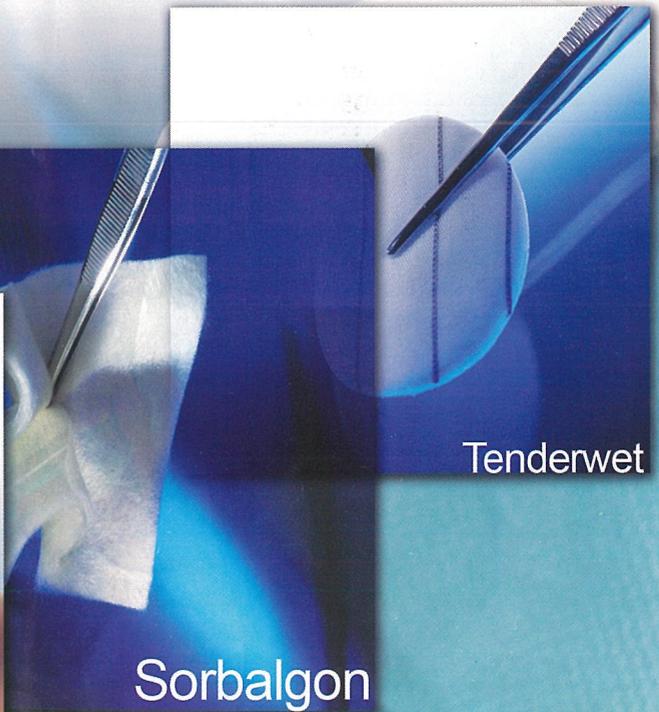


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FROM MID-DJARJU TAGHNA...





4



5

1

1 MUMN Council met with Health Minister On. John Dalli and Parliamentary Secretaries On. Mario Galea and On. Joe Cassar to present a Memorandum on a 5 year plan regarding Nurses & Midwives in our country.

2 A group of Maltese Nurses travelled to Lourdes on a voluntary basis under the auspices of the Knights of Malta to assist the sick. In the photo these Nurses are accompanied by the H. E. Archbishop of Malta, Mons. Paul Cremona.

3 Paul Pace and Colin Galea, MUMN President and General Secretary respectively, are discussing with other European counterparts, in one of the European Federation of Nurses Association's meetings.

4 Last April the 7th European Commonwealth Nurses Federation Conference was held in Malta where Cypriot, British and Maltese Nurses met together over a two day period. Paul Pace welcomed the delegates while On. Mario Galea made his first public address after being nominated as the Parliamentary Secretary responsible for Elderly and Mental Care.

5 The winner of this year's MUMN Award is Frankie Mifsud, Nursing Officer, Mount Carmel Hospital. The number of nominations was six and the adjudicating panel under the Chairmanship of H. E. President Emeritus Prof. Guido de Marco met to decide the winner. Vivian Corporation Ltd sponsored the whole event. In the photo Ms. Denise Borg Manche, Healthcare Marketing Executive of the company is seen accompanying the winner.

6 During the MUMN Award Ceremony two different groups and a solo singer (all Nurses) performed to the guests present. In this photo we can see one of the groups made up of Student Nurses.



2



6



3

YOU CAN HELP PREVENT PNEUMOCOCCAL DISEASE

Children under five years of age are the most vulnerable to suffer serious consequences from pneumococcal disease including death or disability.

- Meningitis
- Septicaemia
- Pneumonia

The introduction of routine vaccination for all infants and of a catch up campaign for all children under the age of 2 years targets the age group who suffer the majority of this disease. PREVENAR, the pneumococcal conjugate vaccine, has been recommended by the World Health Organisation who also recommended that all countries should give priority to the inclusion of PREVENAR in national childhood immunization programs.

VACCINATE HELP STOP IT



Wyeth

Prevenar
Pneumococcal Saccharide Conjugated Vaccine, Adsorbed

Pneumococcal saccharide conjugated vaccine, adsorbed. Presentation: Each 0.5ml dose of Prevenar contains 2 micrograms of each of the following saccharide serotypes: 4, 9V, 14, 18C, 19F, 23F and 4 micrograms of saccharide serotype 6B. Each saccharide is conjugated to the CRM197 carrier protein and adsorbed on aluminium phosphate. Indications: Immunisation against invasive disease (including sepsis, meningitis, bacteraemic pneumonia, bacteraemia) caused by Streptococcus pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F and 23F. Dosage and Administration: For intramuscular injection. Infants 2-6 months: Two doses with at least a 1 month interval between doses. A third dose is recommended in the second year of life. Infants 7-11 months: Two doses with at least a 1 month interval between doses. A third dose is recommended in the second year of life. Children 12-23 months: Two doses with at least a 2 month interval between doses. Children 24 months-5 years: one single dose. Contra-indications: Hypersensitivity to any component of the vaccine or to diphtheria toxoid. Warnings and Precautions: Do not administer intravenously. Appropriate treatment must be available in case of anaphylaxis. Impaired immune responsiveness may affect antibody levels. Prevenar does not replace 23 valent polysaccharide vaccine in at risk children > 2 years of age. Prophylactic antipyretics recommended when vaccinating children with history of seizure disorders, or when vaccinating simultaneously with whole cell pertussis vaccines. Delay vaccination in acute moderate or severe febrile illness. Data are limited on vaccination of children in high-risk groups for invasive pneumococcal disease. Side Effects: Very common: Decreased appetite, vomiting, diarrhoea, injection site reactions (e.g. erythema, induration/swelling, pain/tenderness), fever equal to or over 38 degrees C, irritability, drowsiness, restless sleep. Common: Injection site swelling/induration and erythema larger than 2.4cm, tenderness interfering with movement, fever over 39 degrees C. Uncommon: rash/urticaria. Rare: Seizures including febrile seizures, hypotonic hyporesponsive episode, injection site hypersensitivity reactions (e.g. dermatitis, pruritus, urticaria), hypersensitivity reactions including face oedema, angioneurotic oedema, dyspnoea, bronchospasm, anaphylactic/anaphylactoid reaction including shock. Very rare: Lymphadenopathy localised to the region of the injection site, erythema multiforme. Legal Category: POM Package Quantities: Pack of 1 single-dose vial. Marketing Authorisation Numbers: Pack of 1 (vial): EU/1/00/167/001 Marketing Authorisation Holder: Wyeth-Lederle Vaccines S.A., Rue du Bosquet 15, B-1348 Louvain-la-Neuve, Belgium. For full prescribing information see the Summary of Product Characteristics. Further information may be obtained from: Wyeth (Malta) Sanitas Building, Tower Street, Msida MSD 1824. Telephone: 800 73102 Date of preparation: January 2008

Il-pożizzjoni tal-Organizzazzjoni Dinjija tas-Saħħa fuq il-Mard ikkawżat mill-Pnewmokokkus

L-Awtorità dinjija tirrakomanda tilqima kontra dan it-tip ta' mard qerriedi

Skond l-Organizzazzjoni Dinjija tas-Saħħa il-mard mill-pnewmokokkus, li wieħed jista' jittlaqqam kontri, huwa l-ikbar kawza fid-dinja ta' mwiet fit-tfal taħt il-ħames snin. Issa, l-Awtorità mhux talli rrikonoxxiet li dan il-mard huwa theddida serja għat-tfal żgħar, iżda wkoll ħadet pożizzjoni biex tħares lil-tfal minn din il-mard qerriedi, billi qed tirrakomanda li t-tilqima kontra l-pnewmokokkus ssir parti integrali mill-programmi nazzjonali tat-tilqim mad-dinja kollha. L-Organizzazzjoni għamlet din ir-rakkomandazzjoni f'dokument, hekk imsejjaħ *position paper*, fil-*Weekly Epidemiological Record*, li huwa mfassal għall-użu minn ufficjali pubbliċi tas-saħħa nazzjonali u *managers* tal-programmi tat-tilqim.

"L-*Streptococcus pneumoniae* huwa l-kawza ewlenija tal-pnewmonja fil-bniedem, li tista' ġġib magħha kumplikazzjonijiet serji, kif ukoll tkun il-kawza ta' ħafna mwiet fid-dinja kollha," qal il-Professor Paul Cuschieri, konsulent fil-mikrobijologija, fid-Divizjoni tas-Saħħa. "Huwa wkoll kawza primarja ta' mard fil-widna, magħruf bħala *acute otitis media*, li jekk wieħed ma jikkurahx, jista' jwassal għal mard iktar serju bħal mastojdite u l-meningite, kkawżati mill-istess mikrobu. Fid-dawl ta' dan, il-*position paper* ta' l-Organizzazzjoni Dinjija tas-Saħħa hija rakkomandazzjoni importanti biex tgħin fil-ħarsien tat-tfal żgħar minn mard pedjatriku komuni kkaġunat mill-*Streptococcus pneumoniae*."

Mill-inqas 20 pajjiż fid-dinja diġà daħħlu t-tilqima kontra l-pnewmokokkus fil-programmi nazzjonali tat-tilqim ta' rutina għat-tfal. Dawn jinkludu l-Belġju, Franza, il-Ġermanja, il-Greċja, l-Italja, l-Olanda, Ċipru u r-Renju Unit. F'Malta, wieħed jista' jixtri t-tilqima privatament, peress li din għadha mhijiex inkluża fl-iskeda nazzjonali tat-tilqim b'xejn.

Għall-Organizzazzjoni Dinjija tas-Saħħa, it-tilqima kontra l-pnewmokokkus fil-programmi nazzjonali tat-tilqim għat-tfal, hija prijorità għas-saħħa. It-tnaqqis fir-rata tal-mard ikkawżat minn dan il-mikrobu jkun ukoll pass importanti biex jintlaħaq l-Għan għall-Iżvilupp tal-Millennju tal-Ġnus Magħquda, li jitnaqqsu l-imwiet tat-tfal b'żewġ terzi sa l-2015.

Skond l-Organizzazzjoni Dinjija tas-Saħħa, mill-1.6 miljun li kull sena jmutu kawża tal-mard mill-pnewmokokkus, bejn 700,000 u miljun minnhom huma tfal taħt il-ħames snin, li ħafna minnhom jgħixu f'pajjiżi li qed jiżviluppaw. Mill-banda l-oħra, dawk l-iktar vulnerabbli għal dan il-mard fil-pajjiżi industrijalizzati, huma tfal taħt is-sentejn u l-anzjani. Kif tenfasizza l-Organizzazzjoni Dinjija, l-urġenza tat-tilqima hija akbar illum minn qatt qabel għaliex qed tiżdied ir-resistenza ta' dan il-mikrobu għall-dawk l-antibijotiċi li jintużaw spiss, għall-fejtan ta' infezzjonijiet komuni.

It-tilqima li qed tkun irrakomandata hija PCV-7, li toffri protezzjoni kontra 65 sa 80 fil-mija kontra l-mard imsemmi hawn fuq, speċifikament dak ikkaġunat minn seba' tipi differenti tal-pnewmokokkus, li jattakkaw t-tfal żgħar fil-pajjiżi industrijalizzati. Hemm tilqima oħra li tkopri 23 tip differenti, imma din mhijiex addattata biex tingħata lil tfal taħt is-sentejn, li huma kkunsidrati bħala l-grupp l-iktar vulnerabbli u għaldaqstant l-iktar irrakomandati għat-tilqim bil PCV-7.

Skond id-dokument ta' l-Organizzazzjoni Dinjija tas-Saħħa, il-PCV-7 hija ittollerata sewwa u effettiva fl-etajiet kollha, imma hija awtorizzata li tingħata biss lit-tfal taħt il-ħames snin, inklużi t-trabi taħt it-12-il xahar. L-ewwel doża, mit-tlieta rakkomandati, tista' tingħata sa mis-sitt ġimgħa tal-ħajja.

MOTHERS' PERCEPTIONS

of

MATERNITY CARE

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Introduction

Maternity care commences as soon as the woman finds out that she has conceived and continues throughout the woman's pregnancy, during labour and birth and finally to the postpartum period (Wiegers, 2006). Changing Childbirth (1993) addressed the importance that the woman must be the 'focus' of maternity care, be in control of what is happening to her and be able to make decisions regarding her care. An important aspect in maternity care is good communication between the woman and her carers (Garcia, Redshaw, Fitzsimons & Keene, 1998). However studies revealed that issues such as lack of information and lack of involvement in decision-making seemed to be the cause for women to be dissatisfied with the maternity care received (Kabakian-Khasholian, Campbell, Shediak-Rizkallah & Ghorayeb, 2000; Gready, Newburn, Dodds & Gauge, 1995; Soltani & Dickinson, 2005; Churchill & Benbow, 2000).

In view of this, the author carried out a study that aimed to examine the Maltese mothers' perceptions of the maternity care that they received throughout their pregnancy, childbirth and the postnatal period. The objectives of this study were to describe the mothers' experiences of the maternity care, to determine if the maternity care they received reached up to their expectations, to assess if the women were given the information that they needed and to examine if the women were involved in decision making. Ethical approval was granted by the Nursing/ Midwifery Dissertation Panel Board of Studies; the Research Ethics Committee of the Institute of Health Care, University of Malta and from the Director of Primary Health Care.

To fulfill the study's aim, a self administered structured questionnaire was used. Thirty Maltese female clients who had given birth to a healthy baby, had a normal vaginal delivery, were primagravida or multigravida, and were attending for their postnatal visit at a Primary Health Centre were included in this study. A 100% response rate was obtained. Results revealed that the majority of the women perceived the overall maternity care received as reaching up to their expectations. Yet, several responses were given regarding care at each phase of maternity care.



Discussion

The Mothers' experiences of Maternity Care

Data collection was carried out when the women were in their sixth, seventh or eighth week or over postpartum. Such timing which is similar to that used by Churchill & Benbow (2000) and Kabakian-Khasholian et al (2000) allowed the women to be less dependent on the maternity services and gave her appropriate recall of the maternity experience.

Findings show that all 30 participants visited a general practitioner when they found out that they were pregnant. Similar findings emerged in a local study by Baldacchino (1994), in a study carried out in United Kingdom by Gready et al (1995) and in a study carried out in Lebanon by Kabakian-Khasholian et al (2000). These women preferred to have their maternity care managed by doctors or obstetricians. Such a finding may either indicate that women follow the contemporary perception that they should visit a doctor when they find out that they are pregnant, even if the pregnancy is normal, or else are not aware that the midwife is the expert and lead caregiver in normal pregnancy and childbirth (Fraser & Cooper, 2003).

Presently, women have various choices of where to attend for their antenatal visits. All participants attended the Hospital antenatal clinic at some time or another, however this could be due to the reason that it is advisable for the mother to attend at least once for the booking visit at the Hospital and then she chooses herself where to attend for subsequent visits (Department of Health Malta, 2001). Eight from the 30 participants visited the Hospital Antenatal clinic combined with visits at the General Practitioner, 17 out of the 30 participants attended the Hospital Antenatal clinic combined with visits at the Private Obstetrician's Clinic. Thus, locally the Private Obstetrician seems to be more in demand, which is contrary to findings of Churchill & Benbow (2000) and Gready et al (1995) where the majority of women attended for their antenatal visits at the General Practitioner.

One of the vital choices women have to make during pregnancy involves who, where and how she chooses to attend for her antenatal visits. The women's choice for antenatal visits is important as this choice would be the focus of how the woman would describe her antenatal experience (Gready et al, 1995). Presently, Maltese women have the choice of attending antenatal visits at the Hospital Antenatal Clinic, the General Practitioner's Clinic, the Private Obstetrician's Clinic and the Primary Health Care Clinic. As was seen from the findings, only five participants used the Hospital Antenatal Clinic as their only setting for antenatal visits. As the other participants chose to attend for

antenatal visits at more than one antenatal clinical setting, this could show a level of uncertainty with regards the care being received. Participants gave affirmative responses when they were asked if their needs were met during their antenatal visits. Such positive responses were seen in all four antenatal clinical settings regardless of which antenatal clinic the participants chose to attend to. Thus it is likely that as the participants were given the freedom to choose for themselves where, who and how to attend for their antenatal visits, they perceived that they received the desired antenatal care.

Most of the women in all the four Antenatal clinical settings reported that the time to talk with the midwife was about right which is similar to the findings of Hundley et al (2000) where women gave similar responses regardless of where antenatal visits were carried out. However, some women that attended the Hospital antenatal clinic, the General Practitioner's Clinic and the Private Obstetrician's Clinic claimed that no midwife was present during their visit. It is vital that the midwife is present during such antenatal visits as it is her area of professional practice and she can provide excellent maternity care. This shows that the women are not aware of the midwives' role, thus there is a need to raise awareness and promote the role of the midwife to the public.

Giving birth is a joint experience, thus it is important that the woman have her husband/partner present. From the 30 participants recruited for this study, 24 had expressed that the midwife was supportive to them throughout labour and birth. Nonetheless, besides the midwife, 28 participants had also their husband/partner present during labour and delivery; out of which, the majority (n=25) stated that their husband/partner was also supportive. Such findings differ from Kabakian-Khasholian et al (2000), where having the husband present was not an option to these women. Being left alone by the midwife can be a cause of concern to the labouring women. Nine from the 30 participants were left alone by the midwife at a stage during labour when it worried them to be left alone. Similarly, Gready et al (1995) highlighted that 17% of the 1195 participants had expressed the same concern. Additionally, Garcia et al (1998) claimed that 24% of the 2406 participants were also worried when left alone during labour.

The majority of women (n=27) were cared for by the same midwife throughout labour and birth and these same participants perceived that this midwife was kind and understanding to them all the time. The other 3 participants that had more than one midwife claimed that the midwives were kind and understanding most of the time. Such results differ widely from the results of Gready et al (1995),

where only 54% of the women were cared for by the same midwife. However the majority of these women claimed that the staff looking after them was kind and understanding all the time. Thus, these encouraging results show that if the mother is cared for by the same midwife, this could possibly enhance the woman's labour and birth experience.

Knowing the midwife beforehand was not an option to these 30 participants, thus it was anticipated that the majority of the women would claim that they had not met or knew any of the midwives that took care of them during the postnatal period. However, Baldacchino (1994) stated that 76% of the 63 participants would have liked to have had the same midwife throughout all the phases of maternity care. Furthermore, Gready et al (1995) found out that positive outcomes are associated with continuity of carer, with women that had met the midwife beforehand feeling more 'confident' and 'relaxed'. Contrastingly Brown et al (2005) stated that continuity of midwifery carer in the postnatal period greatly decreases the likelihood of women giving negative responses regarding their care.

Participants gave various responses when asked if the midwives/nurses were able to spend enough time with them during the postnatal hospital stay. Thirteen of the 30 of the participants expressed that the staff usually had enough time to be with them, and 11 women stating that the staff was either sometimes or always too busy. Infact, only four women responded that the midwives/nurses always had enough time. It is interesting to point out that three out of these 4 women stayed in hospital for more than 48 hours for various reasons, thus as stated by Brown et al (2005); women appreciate mostly the caregivers that have time to spend with them.

Garcia et al (1998) stated that 62% of the 2406 participants had a say in deciding when to go home after having the baby, which was similarly seen in Hundley et al (2000) where 77% of the 1137

participants had a choice about when to go home. However locally the hospital policy is different; if the baby was born through a vaginal delivery, the woman is required to stay in hospital for two nights. Thus the results show that most women abided by this policy. Yet, if the woman wants to leave for home earlier she has to sign a letter that states that she went home against the doctor's order. All four women that left hospital before 24 hours had expressed that they were either not fully satisfied or dissatisfied with the postnatal care. This is similar to Brown et al (2005) in which a low level satisfaction of overall postnatal care was associated with a shorter length of hospital stay.

Help and support provided in the postnatal period was deemed to be enough by the majority of the participants. A good amount of the 30 participants, (n=24) stated that that they had breastfed or were still breastfeeding their baby. Although 15 of these 24 women did receive help and encouragement regarding breastfeeding; a relatively low amount of women (n=6) were provided with privacy. Such results are contrary to Hundley et al (2000) where nearly all breastfeeding mothers (93.6%) were provided with enough privacy to breastfeed their baby.

Satisfaction with care

Twenty four of the 30 participants recruited for this study perceived that they were satisfied with the antenatal care that they received. Such satisfaction could have emerged due to the fact that these women independently chose where to attend for their antenatal visits, thus they would subsequently have rated the antenatal care received highly. Such findings are similar to Hundley et al (2000) where women were satisfied with the antenatal care received.

During labour and delivery nearly all participants but one were fully satisfied with the care received. This high level of satisfaction could be due to the reason that the mother stay for a short period of time at the labour ward and the majority of the participants were cared for by the same midwife. It is interesting to point out that the one participant that was not fully satisfied with the care received, had reported that she had had a primary postpartum hemorrhage. Infact, Churchill & Benbow (2000) and Garcia et al (1998) state that due to unpredictable complications during labour and birth; the women may perceive the experience with a low level of satisfaction.

Satisfaction with care was the lowest when it came to postnatal care; infact eight of the 30 participants showed a low level of satisfaction which was also found in other studies. Yelland et al (1998) found



that one third of the participants left hospital feeling that postnatal care was lacking in support and assistance with both their own personal needs and baby care. Likewise, Garcia et al (1998) reported that less than half of the women were satisfied with the hospital postnatal care. On the other hand, Hundley et al (2000) found that participants were mostly satisfied with the postnatal care. Thus, this suggests the need to review the postnatal midwifery care. Women need more support, help, advice, encouragement and privacy. Additionally, quality time spent with the mother, listening to the mother, treating the mother with kindness and providing her with help in adjusting to motherhood are deemed as basic essential necessities that could aid in establishing a higher level of satisfaction in the postnatal care. However, one must keep in mind the constant problem of overcrowding and understaffing.

The participants were asked if the overall maternity care reached up to their expectations. Twenty five of the 30 participants expressed that the care received was what they had expected to receive from the maternity service. However expectations are subjective and what is perceived as the best for one woman, may be deemed as not so good for another woman. Findings compare well with Garcia et al (1998) and Gready et al (1995) in which the participants rated positively the maternity care received. On the other hand, this is contrary to Kabakian-Khasholian (2000) where women perceived the overall care received with a feeling of passivity.

Information

When the women were asked if they had enough information on various topics during pregnancy, nearly all the participants reported having enough information on smoking and folic acid. However various responses were given about information on other topics, namely foods to eat during pregnancy, alcohol, foods to avoid, diseases harmful in pregnancy, exercises, sex during pregnancy and prescription and over-the-counter drugs. These findings compare well with the findings achieved by Gready et al (1995) in which smoking was the topic that most women stated that they had enough information on. Twenty three of the 30 participants were provided with leaflets that could have helped them during pregnancy. Findings by Soltani & Dickinson (2005) revealed that leaflets were seen as an option in which women preferred the information to be provided to them. Thus it can be stated that a suitable and convenient way of providing information on various topics would be by providing literature in the form of booklets and leaflets to all antenatal women during the booking visits and other subsequent visits. The midwife is

the ideal health professional to provide this essential information to the women. Infact this is supported by findings of Churchill & Benbow (2000) and Gready et al (1995) where the midwife was seen as the primary source of information.

First and foremost, during labour and birth, the women are particularly dependent on the health professionals (Gready et al, 1995). Nearly all participants (n=28) reported that they were provided with information, that the midwife explained what was happening and provided them with information why certain procedures that were being carried out were necessary. Gready et al (1995) reported similar findings from the majority of women. The same 28 respondents claimed that the midwife also took enough notice of their views and wishes. Hence in order to empower the woman to make choices for childbirth; it is essential that the midwife determines and assesses the wishes and feelings of the women in her care (Gibbins & Thomson, 2001).

Fifteen of the 30 participants revealed that they received conflicting advice during the postnatal period; out of which, seven participants stated that this conflicting advice worried and confused them. Most of the conflicting advice was about breastfeeding (n=10), on general baby care (n=4) and on bottle feeding (n=3). One participant received conflicting advice regarding other things but she didn't provide further explanation. Similarly, Garcia et al (1998) and Gready et al (1995) also found out that a great amount of women received conflicting advice which was mainly on breastfeeding. Nonetheless, advice on breastfeeding seemed to be lacking as only 11 out of the 24 women that had breastfed/are still breastfeeding their baby were provided with advice on breastfeeding. This is contrary to Gready et al (1995) where the majority of the breastfeeding women reported receiving enough advice.

Various responses were given concerning help and advice from the health professionals in the postnatal period. Although a good amount of women did receive enough help and advice with regards to feeding the baby, the baby's health and progress and their own health and recovery after the birth; general baby care procedures were not adequately provided. Findings are similar to Yelland et al (1998) where one third of the participants wanted more help on feeding and general baby care. Such findings are contrary to Gready et al (1995), in which the majority of the women had received this essential help and advice.

Involvement in decision making

Changing Childbirth (1993) has clearly highlighted the importance of involving women in decision

making about their care. Usage of birth plans appears to be a relatively new issue in Malta; in fact only two participants had stated that they had written down their wishes for the birth. However 11 of the 30 participants expressed that they had discussed their wishes for the birth. Comparable results were achieved in Kabakian-Khasholian et al (2000); however these women were also expected to accept whatever procedure was being carried out on them. On the other hand, results differ from Hundley et al (2000) as 73% of the participants had written down a formal birth plan and the majority of them felt that this birth plan was taken into account. Thus it seems that the women are dependent and rely on the health professionals as knowing what is best for them and so let them take decisions for them.

During labour and birth, the majority of the 30 participants stated that they were fully involved in all the decisions, which is similar to Gibbins & Thomson (2001) in which all participants expressed that they were involved in decision making. When the women were asked if they wanted to be more or less involved in decision making during labour and delivery; only 17 of the 30 participants reported that they would have liked to be more involved. On the contrary, Brown & Lumley (1998) reported that over 96% of the women had expressed that they wanted to be involved during labour and birth. Nonetheless, the cultural beliefs of the woman and what she understands by the term decision making may have an effect on her response to such question.

Limitations

A patient satisfaction survey could generate a rich source of information for improvements (Lin & Kelly, 1995) yet it should be noted that there are limitations with surveys that study women's views and perceptions. In view of this, the findings of this study are limited because the study relied on a convenience sample of participants that were attending for their postnatal visits at the Gynecology Clinics of the Primary Health Care Centers around Malta. Convenience sampling was applied; which is the weakest form of sampling for quantitative studies (Polit et al, 2001) and is also associated with sampling bias which offers limited generalisability of results (Talbot, 1995). Thus, as not all Maltese postnatal women had the chance of being included in this study, the results cannot be assumed to be representative of all postnatal women in Malta but only of these 30 particular participants.

Although all Primary Health Care Centres around Malta were included in the study, there was no attendance in some of the Centres, thus the data was collected mainly from the south and central areas. In answering the questionnaire, respondents may have modified their responses to accord with what they



perceived the researcher wanted to hear. This could have created bias in the questions identified in the discussion. This is social desirability bias which stems from a person's desire to appear in a favourable light (Polit et al, 2001).

Some women who have had no other type of maternity care (such as private hospitals) or were being provided with maternity care for the first time (such as in primagravidas) had no other type of maternity care to compare to. Nonetheless, women that have used the maternity service before (multigravida) may have developed a sense of dependability to the system; hence this has an effect on how they perceive the maternity care received. Although women do develop expectations of maternity care; the kind of expectations developed and how realistic these expectations are do vary between one person and the other. Nonetheless, women may be satisfied with whatever level of care is being provided and thus will not criticize it.

Conclusion

This study seems to indicate that the maternity care being provided locally compares well with similar studies done in other countries. However, some differences existed which can be attributed to social and cultural differences, to differences in the study groups and also to the maternity care provided. As an outcome of this study, the following recommendations are suggested.

Recommendations for practice

- Leaflets and/or booklets should be distributed to all pregnant women during their antenatal visits regardless of where these take place and should cover various topics rather than just smoking and folic acid. Moreover, the women and their partners should be provided with leaflets and/or booklets that have clear instructions and pictures on how to do certain procedures; such as feeding the baby and general baby care.
- During the parent craft antenatal classes, the women/partners should be allowed to do hands

on experience on general baby care (utilizing a model) besides being demonstrated only on how the procedure should be carried out.

- During the antenatal visits or during the parent craft antenatal classes, the health professionals should take the opportunity to promote the usage of birth plans. Women should be given and allowed the opportunity to choose in what ways they wish their labour to be managed; as this will aid into making them active participants of their care and more involved in decision-making.
- During the postnatal hospital stay, it will be ideal, if a midwife carry out hands on sessions with the women/partners; demonstrates and answers any questions that they might have regarding general baby care and feeding issues. These practical sessions can easily be carried out in the four bedded rooms of the postnatal ward. Such sessions will provide the mother with quality time that will empower her to adapt to her new role and to feel confident when caring for her baby.
- Immediate action should be taken to prevent providing conflicting advice to the women. Health professionals working in the maternity wards should liaise and agree on advice provided to the women. Nonetheless, this advice should be evidence and research based.
- The women should be provided with the necessary privacy during all procedures and especially so during breastfeeding.
- There is a need to enhance the women's knowledge on the midwifery profession and the actual role of the midwife. Such promotion can be carried out by utilizing the media, newspapers, articles, leaflets etc.
- Health professionals working in the maternity wards should make a deliberate effort to understand the women's needs and provide for them, which includes also quality time spent with the woman. Nonetheless, women appreciate the health professionals that listen to them, which as such, will be enhanced if the health professionals had received adequate training in active listening and non directive counselling skills.

Recommendations for research

- It would be interesting to conduct a random sampling study on the women's experiences of maternity care with a much larger sample size using both qualitative and quantitative designs.
- Another recommendation would be that of studying the maternity care experiences of those women that had undergone a caesarean section.
- It is also recommended to replicate the present study on a larger scale in order to obtain reliable and decisive results.

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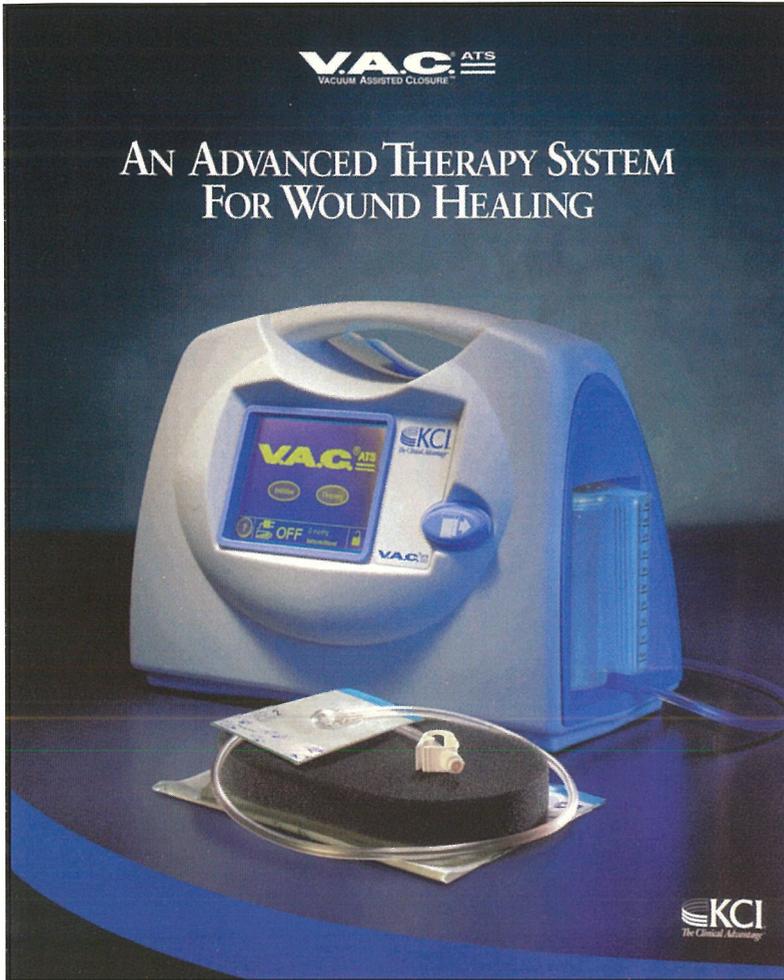
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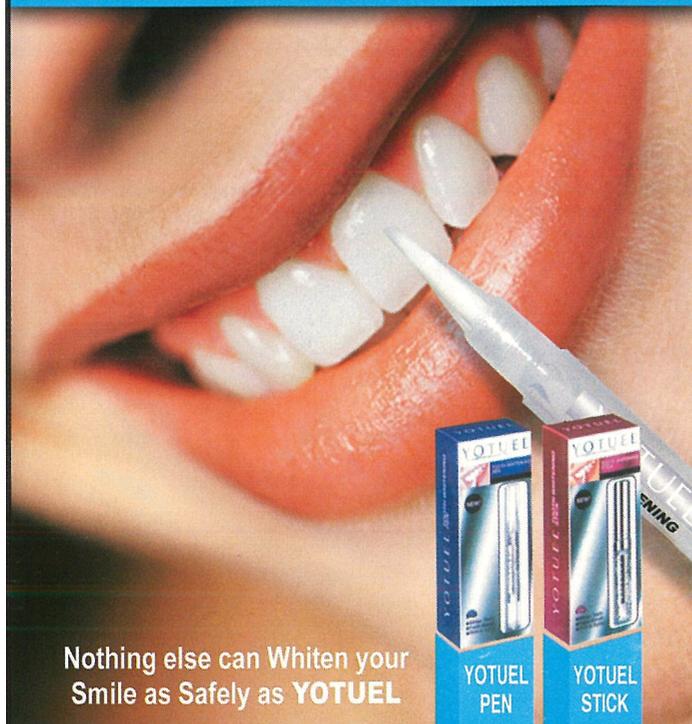
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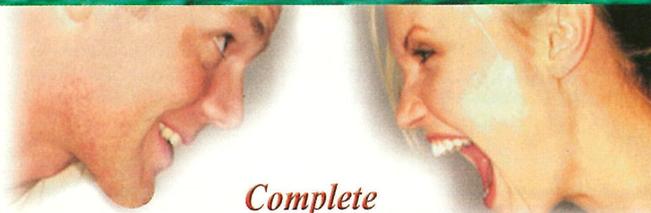
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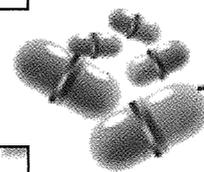
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Nursing home sleeping aid

Patty is visiting Her father Ralph at the nursing home. 'I've been sleeping really well these past few weeks,' Ralph says.
 'Why?' Patty asks. 'Have the nurses been giving you something to help you sleep?'
 'Yes,' Ralph says. 'Every night I'm given an glass of warm milk and viagra.'
 'Why are they giving you viagra?' she asks.
 'I don't know,' Ralph says.
 Patty finds a nurse down the hall and asks to know more about their sleeping aids.
 'The warm milk helps him sleep,' the nurse says.
 'But why the viagra?' Patty asks.
 'Oh,' the nurse says. 'That just keeps him from rolling out of bed.'

What's wrong with me doctor?

An annoyingly self-righteous man went to the doctor for a check-up. He said, "I feel terrible. Please examine me and tell me what's wrong with me."
 "Let's begin with a few questions," said the doctor, "Do you drink much?"
 "Alcohol?" said the man. "I'm a teetotaler. Never touch a drop."
 "How about smoking?" asked the doctor.
 "Never," replied the man. "Tobacco is bad and I have strong principles against it."
 "Well, uh," asked the doctor, "do you have much sex life?"
 "Oh, no," said the man. "Sex is sin. I'm in bed by 10:30 every night. ... always have been."
 The doctor paused, looked at the man hard, and asked, "Well, do you have pains in your head?"
 "Yes," said the man. "I have terrible pains in my head."
 "OK," said the doctor. "That's your trouble. Your halo is on too tight."

The bad and the worse news

A man visits the doctor for a checkup, and after some tests, the doctor comes in with a grave look on His face.
 Doctor: Well, I have some bad news and some really bad news.
 Man: Well, give me the really bad news first.
 Doctor: You have cancer, and only 6 months to live.
 Man: And the bad news?
 Doctor: You have Alzheimer's disease.
 Man: That's great. I was afraid I had cancer!

Twins-5

The Un-Associated Press reported in a news bulletin today that a pregnant woman who has been in a coma for nine months following an automobile accident has given birth to twins, a baby girl and a baby boy. Awakening from Her coma and learning that she had given birth to twins, she asked if names had already been given to them.
 "Yes," Her doctor informed her, "because we didn't know if you would ever come out of the coma, your brother Henry gave them their names."
 "Oh dear God," the woman moaned, "my brother, Henry, is the family idiot. What in the world did he name them?"
 "He named the baby girl Denise," answered the physician.
 "Well, that's not so bad," the woman replied. "What did he name the baby boy?" The physician responded regretfully, "DeNephew."

Cremate me

A businessman on his deathbed called his friend and said, "Bill, I want you to promise me that when I die you will have my remains cremated."
 "And what," his friend asked, "do you want me to do with your ashes?"
 The businessman said, "Just put them in an envelope and mail them to the Internal Revenue Service and write on the envelope, "Now you have everything."

TWO NEW OFFICES

Two doctors opened offices in a small town and put up a sign reading, "Dr. Smith and Dr. Jones, Psychiatry and Proctology."
 The town fathers were not too happy with the sign, and they proposed "Hysteria and Posteriors."
 The doctors didn't find it acceptable, so they suggested "Schizoids and Hemorrhoids."
 The town didn't like that either and countered with "Catatonics and High Colonics."
 Thumbs down again. By now the story was in the papers, and suggestions began rolling in:
 "Manic-depressives and Anal-retentive."
 "Minds and Behinds."
 "Lost Souls and A**holes."
 "Analysis and Anal Cysts."
 "Queers and Rears."
 "Nuts and Butts."
 "Freaks and Cheeks."
 "Loons and Moons."
 None of these satisfied one side or the other, but they finally settled on "Dr. Smith and Dr. Jones, Odds and Ends."

WOMEN, WORK AND BREASTFEEDING

Pauline Fenech

“ The promotion of breastfeeding must not be seen as an excuse to exclude women from the labour force. The burden should no longer fall on women to choose between breastfeeding and work. The burden is on society to facilitate breastfeeding and indeed childcare ”

James Grant,
the late Executive
Director of UNICEF

Women often find themselves pulled in two directions between reproduction (childbearing and breastfeeding) and production (work, paid and non-paid). Both of these are important aspects of women's lives and they should not have to choose between them. (WABA). Women who return to work after childbirth juggle their professional roles with their new family roles. Most put in a double day, fulfilling job requirements while striving to meet the nurturing needs of their child. (Hochschild 2003). Leaving a newborn to return to work can be highly emotional to a mother. Continuing breastfeeding and maternal employment can present many challenges, however, most of these challenges can be addressed.



Women have always combined work and breastfeeding. From the industrial revolution (1830s-1880s) onwards, working women have increased considerably, to the extent that the International Labour Organisation (ILO) now speaks of the 'worldwide feminisation of the labour force and employment'. And more and more women in the work force are mothers of young children. In 1919, the year the ILO was constituted, the first ILO Maternity Protection Convention was adopted (C3). In 1952, a second convention was drawn while the third convention was adapted in 2000 (C103). It recognised that maternity is the social responsibility of society at large and called for protection of individual working women in their role as mothers.

There are several elements to maternity protection as set forth by the ILO. These include maternity leave, maternity benefits, health protection, job protection and non-discrimination, breaks and breastfeeding facilities.

Maternity leave is essential to allow a mother to recover from birth, and breastfeed her infant. Women who receive maternity leave are more likely to remain in the workforce; this has economic benefits for employers, social benefits for women, families and society.

Breastfeeding support in the workplace can be achieved by implementing simple measures. The procedures are practical, safe and easy to implement economically:

- Having flexible work schedule to provide time for expression of milk.
- Provide an accessible location that allows privacy.
- Provide access to a clean water source and a sink for washing hands and rinsing of breastpump equipment.
- Provide access to hygienic storage for the mother's expressed milk (TDH2004).

Employers who support breastfeeding employees can benefit:-

- Less illness among breastfed children of employees.
- Reduced absenteeism to care for ill children.
- Lower healthcare cost.
- Improved employee productivity.
- Higher employee morale and greater loyalty.
- Improved ability to attract and retain valuable employees.

Certainly hospitals and health care centres should provide models for other workplaces, making it possible for a mother employee to return to work and maintain her milk supply. While the

work environment may be less than ideal for the breastfeeding mother obstacles can be overcome.

Tips for the Breastfeeding Working Mums

Timing: Time to take as much maternity leave as you can.

Think it through. Your baby needs you most during his first year, and it's a year that will never come again.

Explore your options.

Consider these alternatives:-

- a) Bring your baby to work. This may not be possible to several women, but there are many workplaces that can accommodate the presence of an infant.
- b) On-site day care.
- c) Nearby daycare providers. Many parents look for childcare near their homes. Sometimes it's more practical to look for a baby-sitter near the workplace, especially if there are long distances.
- d) Visits from your baby. Maybe it's possible for your baby to come and visit during the lunch break or at other times during the day.
- e) Working reduced hours
- f) Opting to flexi-time or shared work

Can you take a leave of absence? Can you go back part-time for a while – either for a couple of full days or 5 half days a week? Can some of the work be done at home?

All countries, including Malta, recognises a mother's right to be with her baby in the early months. The Innocenti Declaration states that "...all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner. ...All governments by the year 1995 should haveenacted imaginative legislation protecting the breastfeeding rights of women and established means for its enforcement. Mothers have a recognized right to breastfeed their infants.

Getting breastfeeding off to a good start

Ensure that breastfeeding works well in the early weeks, this is important to breastfeeding success. When the baby suckles, the breast is stimulated to produce milk. Feeding the baby on cues will get the milk supply in line the baby's needs.

Equipment

Find a method to express milk that best suits the mother. Every method has its pros and cons. Hand expression is free and needs no equipment, but takes a bit of practice. Hand pumps are very portable but may be tiresome. Small electric pumps require an electric outlet but are easy to use without getting tired.

Get to know your breastpump

About two weeks before returning to work, start expressing. Don't panic if only a small amount of milk comes out during the first pumping sessions. The breasts do not respond to the pump the way it responds to the baby's suckle. With practice, milk ejection reflex will become conditioned to the pump.

Storing breastmilk

Expressed breastmilk can be stored in sterile glass or plastic containers designed for the purpose. When using milk bags, these are put in a larger container to protect them from punctures. Label the milk with the date and store toward the back of the freezer for the coldest temperature. In the freezer, breastmilk can stay for 3 months while in the fridge for 3 days. Frozen breastmilk is thawed in the fridge and used within 24 hours, never refreeze milk that has been thawed. Expressed breastmilk should never be overheated as high heat destroys its immune properties. Do not use microwave or put breastmilk on the stove top to thaw or heat. The best method is to heat milk in an open container and shake or stir contents before use. When using stored breastmilk, the oldest milk is used first. At work, most women express their milk on a Monday for Tuesday's feedings, on Tuesday for Wednesday's and so on, refrigerating it or keeping it in a cooler with "blue ice" until taken home.

Pumping at work

Ideally, the place where pumping is carried out, will have an electrical outlet, to make it possible to use an electrical pump, a sink for hand washing and to rinse off the parts of the pump that come in contact with the milk.

A refrigerator is very handy to store expressed milk until time to take the milk home, though it can be substituted with ice pack and a cooler.

Get the baby used to an alternative feeding method

In two weeks time the baby is going to be given milk either by cup or by bottle. Almost all babies will gradually accept a bottle if it's not forced on

them, and if someone other than mum offers it. Do not experiment with bottles early. Bottles are designed to replace breastfeeding, and sometimes they do. If the bottle is introduced too soon, some babies develop nipple confusion, others may not. Some babies switch back and forth from breast to bottle without difficulty. Others quickly learn that it's easier to get milk from a bottle and have difficulty returning to the breast.

Breastfeeding full time whenever not at work

In order to maintain and build-up milk supply, have days when to breastfeed frequently to make up for the times when mother and baby are separated. Try to adopt the policy that baby is given a bottle only while at work or away from baby, but is exclusively breastfed when in mother's care. This will build up a good milk supply and keep the two connected. Do not give bottles when breastfeeding is possible. Pumping does not stimulate the breasts to produce milk as well as a nursing baby does.

Choose a breastfeeding-friendly caregiver

Finally, all mothers should have the opportunity to breastfeed their infants and all infants should have the opportunity to breastfeed. Every woman, regardless of her employment status, will have the opportunity to breastfeed and/or provide breastmilk to her child. It is discriminatory practice to stop a woman from expressing milk or breastfeeding on her breaks or to treat her differently from other employees because she is breastfeeding. (ILO Maternity Protection at Work).

The Breastfeeding Walk-In Clinic at Mater Dei Hospital offers support and help to the breastfeeding dyad (mother and baby). The aim of the clinic is to promote, protect and support breastfeeding. Mothers are empowered to feel confident with their decision to breastfeed by regular monitoring of baby's weight, by providing mother-to-mother support and by using the clinic as a reference point for breastfeeding problems.

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L-ISTORJA TAL-ISPTARIJJIET ĊIVILI U ĠENERALI MALTA

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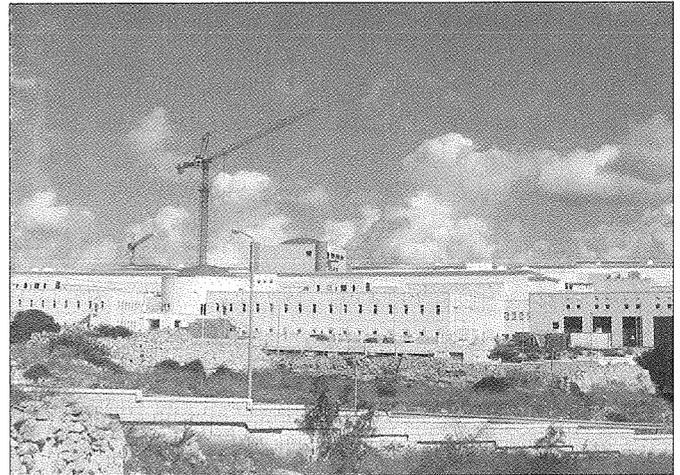
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Dan kien sptar li dejjem kien f'nofs kontroversji ta' kull tip. Però huwa sptar li minħabba li hu proġett ta' dimensjoni enormi u ambizzjuż, għandu żgur jagħmilna kburin, kemm fuq livell nazzjoni u wisq aktar fuq dak tas-saħħa. Il-ftuħ tiegħu ġie inawgurat fl-Imnarja tal-2007.

Referenzi

Alive, Mater Dei, Caring for you in the 21st century, Frar 2007
<http://www.hospitalmanagement.net/projects/mater%5Fdet> 31.5.2007

Meningitis

Dr Trisha Macnair

Meningitis, an inflammation of the membranes that cover the brain and spinal cord, can be caused by infection with a bacterium or virus.

Who's affected?

Although we often think of meningitis as being a particular risk to the very young, children only account for 55 per cent of cases and both viral and bacterial meningitis can occur at any age.

Different micro-organisms tend to cause problems at different ages - bacterial meningitis more often affects children (80 per cent occurs in the under-16 age group and the majority are under five) while viral meningitis more commonly affects older children and young adults.

Viral meningitis

Viral meningitis tends to appear in winter epidemics and is usually less severe. Most people recover fully, often without specific treatment. Initially, vague flu-like symptoms occur with fever and muscle aches.

Bacterial meningitis

Bacterial meningitis tends to be more severe, with a serious risk of complications (one in ten of those affected has long-term problems) and death. Any type of bacteria can cause it, but in the UK the most common types are meningococcal and pneumococcal bacteria.

The bacteria that cause meningitis vary with a person's age, but meningococcal meningitis is the most common. Non-infectious causes of meningitis include cancer and autoimmune diseases.

What are the symptoms?

In bacterial meningitis, symptoms develop rapidly, often within hours, whereas the symptoms of viral meningitis may take a couple of days to develop. In meningococcal meningitis, caused by the bacteria *Neisseria meningitidis*, a rash may develop that starts as purple-red, pin-prick spots and rapidly spreads to become blotchy. An important sign is that the rash doesn't blanch (fade) when pressed.

Symptoms in babies and small children

- Stiff body with jerky movements, or very floppy
- Irritability, or dislike of being handled
- A shrill cry or unusual moaning
- Refusal to feed
- Tense or bulging fontanelle (soft spot on head)
- Pale blotchy skin
- Rapid breathing
- Fever
- Lethargy

Symptoms in adults and older children

- High fever
- Severe headache
- Stiff neck
- Dislike of bright light
- Drowsiness
- Confusion and irritability
- Vomiting
- Muscle pains, stomach cramps and diarrhoea
- Cold and pale hands and feet
- A rash that doesn't fade under pressure (try pressing a glass against the skin)

Complications, especially in bacterial meningitis, include damage to hearing, damage to other nerves in the body, brain abscesses, stroke, and collections of fluid on or in the brain.

Can it be prevented?

Routine vaccination protects against some types of bacterial meningitis, including those caused by one type of meningococcus (MenC), *Haemophilus influenzae* (Hib vaccine) and invasive pneumococcal disease (PCV vaccine).

Vaccination against the mumps virus (for example with the MMR vaccine given routinely to children) protects against viral meningitis caused by mumps.

People who have been in close contact with someone who has bacterial meningitis may need to take antibiotics as a preventive measure.

What's the treatment?

The diagnosis is confirmed using blood tests and a test called a lumbar puncture. A fine needle is inserted, under local anaesthetic, into the person's spine to draw out fluid that can then be examined in a laboratory for infectious organisms.

Treatment depends on the cause of the meningitis, but in most cases intravenous antibiotics will be started immediately and continued if tests confirm the bacterial form.

If other causes are diagnosed they will be treated accordingly. Different medicines may be needed to control symptoms such as seizures.

Delays in treatment increase the risk of long-term damage. If you suspect meningitis, get urgent medical advice. Always consult your own GP if you're in any way concerned about your health.

<http://www.bbc.co.uk/health/conditions/meningitis2.shtml>

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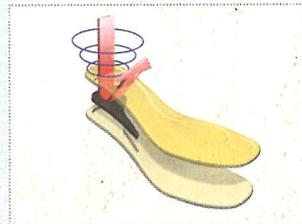
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