Malta Midwives' Journal

Malta Midwives Association

Issue 20

Website: www.maltamidwivesassociation.com
e-mail: info@maltamidwivesassociation.com
Facebook: www.facebook.com/maltamidwivesassociation
Twitter: @MaltaMidwives tel: 77237117
Instagram: @maltamidwivesassociation

URIAGE

EAU THERMALE

NEW

Bariéderm

DERMATOLOGICAL CICA-OIL

STRETCH + SKIN MARKS PREVENTION AND CORRECTION

CLINICALLY PROVEN*

99,9% | natural origin ingredients

*Prevention: In use test performed under dermatological control on pregnant women – 21 days – 21 subjects : self-assessment on stretch marks aspect. Correction: Clinical study performed under dermatological control on women after pregnancy – 6 months – 30 subjects: quotation of stretch marks aspect: results about 2 months – 20 subjects and 4 months - 10 subjects. Clinical study performed under dermatological control – 1 month – 21 subjects : quotation of recent scars.

URIAGE.COM

URIAGE, THE FRENCH ALPS THERMAL WATER

Multi-Mam Intimate Care
Breastfeeding products and more...

After Birth Spray
"Immediate soothing effect
in the external intimate area"

SVEA

Svea Distributors Co. Ltd | 33 Idmejda Str, Balzan | +356 21490162
info@svea.com.mt | www.svea.com.mt

Multi-Gyn®

Natural bio-active products for the relief of
vaginal discomforts

AVAILABLE FROM PHARMACIES

SVEA

Svea Distributors Co. Ltd | 33 Idmejda Str, Balzan | +356 21490162
info@svea.com.mt | www.svea.com.mt Multi-Gyn Malta

Gestarelle G

1 Capsule Everyday

Taken from pre-conception to lactation.

Contains Folic Acid

Iron, Omega-3 and Vitamin D

serolf
trading agency ltd

Contents

62, Office 1, Triq il-Kunċizzjoni, Msida MSD 1839

Editor
Pauline Fenech

Correspondence should be addressed to the editor on MMA e-mail or to the above address.

Cover Photo:
Catriona Grech and baby Jack

Editorial

An important core issue in health care is the concept and the delivery of quality care. Quality in health care can mean different things to different people. The World Health Organisation (WHO, 2016) defines quality of health services as one which is effective, safe whilst at the same time providing care that meets the individual's preferences, needs and desires.

The emphasis on securing quality care in maternity led to the set up of several indicators. Quality indicators serve as 'measurement tools that can be used to monitor, evaluate and improve the quality of patient care, organisational and support services that affect patient's outcome' (WHO, 2016). The results of these indicators are the starting point for achieving accountability and quality improvement in healthcare.

One quality indicator in maternity facilities is the rate of Caesarean section. The WHO acknowledges the increase of Caesarean sections globally as a phenomenon that needs to be monitored. On the other hand it also acknowledges the difficulty that arises in interpreting these rates.

WHO (2017) recommends the use of the Robson classification as a global standard for monitoring, assessing and evaluating Caesarean section rates within healthcare facilitites over time. The Robson classification is a standardised tool which is used to study the birth allocation as well as an enabler to evaluate and implement evidence-based strategies in order to reduce the number of unnecessary Caesarean sections.

Another aspect of quality assurance in the 21st century is the emphasis on patient-centred care. This entails the collection of data on patient's experiences and satisfaction. Through the collection of women's experiences in childbirth, the quality of maternity care can be continuously monitored and improved. Downe et al. (2018) emphasize the need 'to move towards what women actually find is most important to them in maternity care rather than from what professionals tend to think from their perspective that is important to women'.

Furthermore, a qualitative study on integrating women's voices for improving the quality of maternity care indicates that it is not enough to record and collect women's experiences (Cellissen et al., 2022). According to this study, the most essential element is the integration of these experiences as part of the quality improvement system. Furthermore, Cellissen et al. (2022) recommend that care professionals, together with women, who are the service users in maternity, should be involved in the macro-level of health organisations. Women should be given a voice and be part of the process of shaping maternity care policies to improve the quality of health services provided.

References

Cellissen, E., Vogels-Broeke, M., Korstjens, I. & Nieuwenhuijze, M. (2022). Integrating women's voices for quality improvement in maternity care: a qualitatitve study. European Journal of Midwifery. 6:57 https://doi.org/10.18332/ejm/152253

Downe, S., Finlayson, K., Oladapo, O.T., Bonet, M. & Gulmezoglu, A.M. (2018). What matters to women during childbirth: A systematic qualitative review. PloS One. 13(4)e0194906. Doi:10.1371/journal.pone 0194906

Robson Classification: Implementation Manual. World Health Organisation (2017). Accessed September 2022. https://apps.who.int/iris.rest/bitstream/1091705/retrieve

Standards for improving quality in maternal and newborn care in health facilities. World Health Organisation. (2016). Accessed September 2022. https://apps.who.int/iris/rest/bitstream/handle/10665/249155/9789241511216-eng.pdf

MEMBERSHIP FEE

Annual Membership Fee is €20

Kindly settle pending membership fees by visiting maltamidwivesassociation.com

Message from the President

Welcome to the 20th edition of the Midwives' Journal. I hope you all had the opportunity to take a nice break and enjoyed yourselves during the summer period. Having a break from the normal everyday routine is essential for our physical and psychological well-being.

With most of the restrictions of the pandemic lifted, the Association is slowly getting back to the activities that were held before the Covid-19 pandemic. The response for these activities is very encouraging. Pregnant women/couples have the opportunity once again to meet, discuss, interact and socialize with other pregnant women/couples and with health professionals.

Building Better Together

The pandemic has put enormous challenges onto health systems globally. The World Health Organisation (WHO) published a document called 'Building better together: a roadmap to guide the implementation of the Global Strategic Directions for Nursing and Midwifery in the WHO Region.' This document sheds light on the need for health authorities to address policy challenges to ensure that facilities meet the needs of the population. It also highlights the need to identify the important role that midwives have in building health systems' resilience, to maintain the quality of essential health services, and to strengthen health functions for a more progressive and lasting economic and social recovery.

Harmonizing Maternity Care

De Vieres (2012) describes maternity care as one that brings together 'four voices': the voice of midwifery, which sees birth as a healthy physiological process; the voice of obstetrics, which can manage pathology; the voice of fear (or respect), which encourages vigilance; and the voice of trust, which allows a woman to have confidence in herself and her caregivers. The goal for maternity care system is to keep these voices singing in harmony'.

De Vieres (2012) describes the voices of midwifery, obstetrics, fear and trust as an orchestra that plays in harmony, much like Bach's three-part inventions. Each line in Bach's compositions can be played as an independent melody with its own voice, but when the lines are played together, they produce something beautiful, the result of a productive tension between the voices. If one line disappears, or if one line is played too loudly, that beauty is lost.

Similarly, in maternity care, when all four voices are balanced, the result is something beautiful: a healthy baby, a smooth birthing process, a positive experience, a satisfied caregiver, and careful and wise use of health-care resources. But when these voices are out of balance—when fear overwhelms trust, when midwifery overwhelms obstetrics (by being too reluctant to intervene), when obstetrics overwhelms midwifery (with too much unneeded interventions)—that beauty is lost. If fear is not balanced with trust, women are driven to make unwise choices. A safe, healthy, and satisfying birth requires trust on several levels. A woman must trust that her body is designed to give birth, and she must trust her caregivers. Her caregivers must also trust the ability of a woman's body to give birth and, equally important, they must trust each other. Trust can drive out fear. But fear can drive out trust (De Vries, 2012). Maternity care is a (four-part) invention (De Vries, 2012):

- Midwifery teaches us to trust the woman's body and to be watchful and reactive.
- Obstetrics teaches us to respect the birth process, and brings the impressive and helpful tools of medicine to cases of pathological birth.
- Fear keeps us on guard.
- Trust promotes cooperation and drives out unhealthy fear.

The harmonization described by De Vries (2012) in the maternity care system requires that maternity care professionals (midwives and obstetricians) adopt an interprofessional collaborative approach and redefine the boundaries of responsibility in order to meet the needs of women and respect their choices. A culture of interprofessional collaboration and cooperation between midwives and obstetricians is shown to be beneficial to the provision of optimal maternal healthcare, minimize the duplication of tasks, and increases job satisfaction for all.

Finally, I would like to express my sincere gratitude to all the midwives who, on a daily basis strive towards giving a positive experience to women/mothers in their care.

References:

De Vries, R. (2012). Midwives, obstetrics, fear and trust: a four-part invention. Journal of Perinatal Education. 21(1):9-10 DOI: 10.1891/1058-1243.21.1.9

Building better together: a roadmap to guide implemenatation of the Global Strategic Directions for Nursing and Midwifery in the WHO European Region. (2021) https://apps.who.int/iris/handle/10665/350207

Pauline Fenech

Treasurer's Message

I start off this year's contribution by happily announcing that, now that the Covid restrictions have been lifted, use of the MMA premises in Msida is now back on. Slowly but surely the functions being held physically on the premises is picking up.

On the flip side, the negative news regarding the premises is that, although as an NGO, the rent paid to the Housing Authority is heavily subsidised, still the increase of annual rent for both offices, has been increased exponentially. This increase of 25 % on each office over the previous period is bound to have a very negative impact on the Association's bottom line. In fairness, had the rent not been subsidised, the hit to our finances would probably have been unsustainable.

Unfortunately, we're even having problems with our photovoltaic system. A year on, the system is not generating energy. WE have taken this matter up with the supplier, the engineer and even roped in the Commissioner for Voluntary Organisations. Unfortunately we are hitting a brick wall. As a result, the ARMS bills are what they are.

Another negative note is that unfortunately we have had to cancel two social events. The 'Day by the Pool'' and the BBQ which the Association had planned, were cancelled due to lack of take up. These events were not fund-raisers, but were to be sponsored by the Association in recognition of members' contribution throughout the year. We also thought the events would serve as a gathering between friends, after a two-year absence due to the Pandemic. But it seems that Covid has also, unfortunately, effected our way of lives.

Hopefully we will have a good turn-out for the upcoming November event.

Another bit of news is that the personalised sessions, especially those being offered at the parents' home are on the increase. These sessions are beneficial to the parents as they are delivered in the comfort of their home. On the other hand, they represent a manpower challenge – any more midwives that would like to come forward to deliver such sessions, are please asked to do so at once.

Finally, the Association, as usual, continues and will continue to strive for the benefit of midwives and our client base. And in this regard, hats off to all those members who offer a service, whether on the Committee, be delivering lectures or sessions, or in some other material way.

Thanks all. And anyone who is interested in coming forward to give a helping hand, please do so.

Doris Grima

European Midwives Association (EMA) General Meeting

After two years of virtual meetings, this year the European Midwives Association (EMA) held their general meeting in person in Brussels on the 23rd and 24th of September. Pauline and myself attended on behalf of the Malta Midwives Association. We kicked off the first day of the general meeting by debating the importance of being visible by using modern aides to reach out to the public. In order to achieve this goal EMA has in fact updated its social media platform to showcase their work broader and better. A new secretary and treasurer were elected during this meeting. We bid farewell to Joeri Vermeulen and Eva Matintupa and welcomed Reyns Marlene as secretary and Stenbäck Pernilla Catharina as treasurer.

Naturally, we spent the afternoon of the first day

discussing the difficulties, challenges and opportunities that countries such as Slovakia, Romania, Hungary, Poland and the Republic of Moldova are facing because of the influx of migrating women and children from Ukraine. Of course this brought with it a sudden challenge to the receiving country. Midwives coming from the above mentioned countries explained how they worked closely with other large organizations to offer maternity care to the newly migrated women and their families. The challenges faced were similar between all the countries, such as; lack of access to medical records and documents, language barriers, and dealing with post-traumatic stress disorders in women and children who were separated from their families.

A presentation given by midwife Ms Hanan Ben Abdeslam focused on the significance in using cultural sensitive approaches when caring for migrant women. A two year project saw her and various partners conducting three different qualitative studies with vulnerable migrant women to explore their needs and to ultimately design and produce the culturally sensitive kit. The kit includes several illustrations that fully depict pregnancy and childbirth. Materials such as the feotus and pelvic models can be used during discussions as tangible aids for clients to understand better. As can be seen in the below image this kit assists in improving the quality of life and health literacy during pregnancy and after care and improves caregivers knowledge about culture sensitive care.

On the second day the focus shifted towards the situation of maternity care in the host country, Belgium.

We started off by discussing collaboration between professionals in maternity care in Europe. This session was presented by Dr Sophie Alexander, an obstetrician and EBCOG member, who explained how they found the local system of assigning a lead caregiver, a midwife or obstetrician, depending on the woman's health status, worked well in improving outcomes and increasing client satisfaction.

The following speakers presented their struggles in protecting midwifery-led units and home births. They started by uniting the different organizations that are present in Belgium to work towards achieving the same goal. They worked on becoming more visible by attending political negotiations, publishing stories in the media and getting the public to interact with the media. They focused on the importance of building bridges, working in a team and keeping the needs of the clients and their family at the center of it all in order to slowly change and improve the system.

The next EMA general meeting will be held in Istanbul, Turkey on the 22 and 23rd of September 2023.

Marie Borg Barthet
Secretary

Tettiera®'s Raspberry Leaf Herbal Infusion – Nature's gift to Female Reproductive Health

Available in loose leaf format or in unbleached tea sacks.

From the moment we see those lovely double lines on a positive pregnancy test, expecting mothers try their utmost to do everything right!

Whilst childbirth is one of the most amazing opportunities gifted to us women, the fear of difficult labour is enough to have us loose our sleep. Thankfully there a lot of things we can do to prepare ourselves for that special moment.

Tettiera's Raspberry leaf herbal infusion is loaded with nutrients and antioxidants and has been used for centuries to treat various ailments and support labour during pregnancy.

The infusion carries a particularly earthy taste, is bursting with vitamins B and C, as well as minerals that support muscle contractions such as potassium, magnesium, zinc, phosphorous and iron. Red raspberry leaves contain polyphenols like tannins and flavonoids, which act as antioxidants in your body and can help protect cells from damage. According to studies, the leaves also contain small amounts of ellagic acids, which neutralizes carcinogens.

Overall female health

Since this naturally caffeine free infusion is thought to support muscular contractions, research also supports the anecdotal evidence of women saying that the leaves help relieve premenstrual symptoms, such as cramping. The leaves also contain fragarine, which helps tone and tighten muscles in the pelvic area.

How much to take

We recommend asking your mid-wife and gynaecologist before consuming this infusion. Some moms prefer to wait until the third trimester, or even until 34 weeks to start drinking red raspberry leaf tisane, whilst others do so as from the second trimester.

A call to all health-conscious mothers-to-be

We love mummies! You can collect a FREE sample from Tettiera's Facility in Mosta on Monday, Wednesday and Friday between 8.30am to 1.30pm. Please call 99929376 beforehand.

Otherwise, shop for it on tettiera.com and benefit from free delivery on orders of €15 or over or visit Dical House or selected pharmacies.

This information is supplied for personal use only. Always consult your healthcare professional for advice if you are taking other medication or treatments before consuming certain herbs, teas and herbal infusions.

Preconception Care

Introduction

The health of a woman and of a man prior to conception has a direct impact on the pregnancy. As a result, preconception care is the most crucial aspect of prenatal care (Dhavliker, M., & Purohit, P., 2017). The World Health Organisation defines preconception care as the provision of biomedical, behavioural and social health interventions before conception (2012). Furthermore, preconception care seeks to enhance both immediate and long-term maternal, paternal, and child health (WHO, 2017).

According to Delbaere (2021) preconception health is a relative new concept and its content is not always clear for healthcare professionals let alone for the public. If couples are acquainted with sufficient knowledge about the factors that can negatively impact fertility and pregnancy outcomes they would take action and change their lifestyle prior to conception. Such lifestyle adaptations include stop smoking, abstain from drinking even before getting pregnant, maintain a healthy weight, and improve nutrition whilst ensuring that women get enough folic acid (Delbaere, 2021). However, the majority of people are unaware of these crucial precautions, and as a result, they could benefit from preconception care. Preconception care should not be viewed as a one-time appointment with a general practitioner, midwife, or obstetrician; but rather as a continuous encounter with people of reproductive age, regardless of their intent to become pregnant (Coffey & Shorten, 2014). Verbiest (2020) stated that this could be achieved through tailored campaigns on achieving a healthy lifestyle and by providing a supportive climate and actionable strategies with the help of the authorities. The information should be conveyed in a way that empowers people rather than blaming prospective parents or making them feel guilty (Verbiest, 2020).

A healthy and well-balanced diet is an important part of a healthy lifestyle, especially when planning a pregnancy. Within a healthy balanced diet, in order for a woman to maintain her weight, a daily intake of 2,000kcal is required (Denison et al., 2014). Body mass index (BMI) deviations, such as obesity and overnutrition as well as undernutrition and malnutrition, have an impact on both men and women's health during the reproductive years. As the percentage of overweight and obese people is increasing worldwide, obesity is becoming a major global health issue, affecting an individual's fertility and preconception health (Petrocnik, 2021). Unfortunately, there is still a lack of public knowledge of these hazards during the preconception period. It should be recognised that the menstrual cycle is negatively impacted in obese women resulting in dysfunctional uterine bleeding (Souter et al, 2011). On the other hand, Petrocnik (2021) stated that when considering the lower BMI levels, it should be acknowledged that the minimum BMI levels are necessary for a woman to be able to maintain regular menstruation. A shortened luteal phase, anovulatory menstrual periods, and occasionally even amenorrhea are symptoms of functional hypothalamic failure, which is mostly influenced by low BMI levels and intense exercise. Furthermore, deviations in the body mass index also influence pregnancy. The effects of obesity in pregnancy are analysed in an article conducted by Denison et al. (2014), where it is reported that obesity (BMI >30) increases the risk of hypertension in pregnancy and gestational diabetes by almost 11 times, as well as other pregnancy complications, such as spontaneous miscarriage, preterm birth and still birth. Additionally, newborns of obese women are more often macrosomic, putting them at an increased risk for shoulder dystocia which can result in injuries to the cervical plexus, clavicle fracture, foetal hypoxia and even neonatal death (Baxley & Gobbo 2004; Hemond et al. 2016). On the contrary, being underweight (BMI<18.5) increases the risk for miscarriage and doubles the risk of having a growth restricted baby (Imterat et al. 2019; Denison et al., 2014). Correspondingly, fertility of the male population may also be impacted by lifestyle changes and poor eating habits resulting in adverse effects on the semen quality and sperm concentration (Petrocnik, 2021). Therefore, preconception care is crucial to help prospective parents maintain a healthy lifestyle for the health of the mother, father and foetus.

One of the most significant factors affecting fertility is age. It is an incorruptible factor as no one can stop the inevitable process of ageing. Aimala (2021) stated that delayed parenthood has become a fast rising phenomenon in recent decades, both in Europe and globally as a result of economic growth. In Europe, the average age of first-time mothers begins to exceed 30 years. Unfortunately, however, human physiology has not changed to serve the general trend of postponing parenthood (Pedro et al., 2018). According to studies, both women and men underestimate the impact of ageing on fertility. Furthermore, they tend to overestimate their own fertility as well as the ability of fertility therapies to help overcome the fall in fertility that comes with ageing (Fritz & Jindahl, 2018). After the age of 30, and particularly after the age of 35, female fertility starts to decline. In addition to this, the risks of an unfavourable pregnancy outcome increase with a woman's age. These can include a miscarriage, high blood pressure, gestational diabetes, and preterm birth. Moreover, with advanced maternal age come greater risks for the foetus, including low birth weight or chromosomal abnormalities. On the contrary, research is limited on the effects of ageing on male fertility when compared to that of females, and the findings are more contradictory. Aimala (2021) stated that some experts assert that male fertility can already be impaired beyond the age of 30, whilst others are adamant that the fertility age restriction starts at 40. It is crucial to acknowledge that men's ageing will have an impact on the pregnancy and the foetus. Unfortunately, age-related issues can only be overcome by fertility treatments to a limited extent. Pedro et al. (2018) reported that if a natural pregnancy or additional children are anticipated, it is advisable to start to build a family earlier (Table 1). Conclusively,

all men and women have the right to learn all the facts about the effects of ageing on fertility and conception. Thus, the most adequate time for counselling regarding age-related fertility is before a man and a woman plan to start a family. In order to provide effective counselling, it is essential that the expert has up-to-date knowledge on the subject. Hammarberg et al. (2017) and Pedro et al. (2018) suggested that to lower the risk of infertility, education should be provided in schools, in primary care, in contraceptive counselling, and in health promotion.

Prenatal care often begins too late when considering the fact that modifiable risk factors, such as alcohol intake, have a negative impact on both male and female fertility as well as pregnancy outcomes (Hurst & Linton 2015; Goeckenjan 2017; Thompson 2017). Breznik (2021) reported that evidence on the effects of alcohol consumption on the female and male fertility is very limited, however, the available evidence all strongly suggests that when consumed, alcohol negatively impacts fertility. Agarwal et al. (2012) stated that when women consume alcohol they can have disrupted menstrual cycles and require longer to conceive. Furthermore, men can have reduced sperm quality and sperm morphology. In addition to this, numerous studies with substantial evidence suggest that heavy alcohol consumption is correlated with preterm birth, low birth weight, and the occurrence of foetal alcohol disorder syndrome (FASD) (Floyd et al. 2008; Fertig & Watson 2009; May et al. 2016; Carson et al. 2017; Koletzko et al. 2018). May et al. (2016) reported that alcohol is a teratogen, and the foetal system degrades it more slowly than the maternal system. Thus, heavy drinking and binge drinking can have major negative effects on the health of the foetus, including postnatal or prenatal growth restriction, brain damage, facial dysmorphology, and neurodevelopmental abnormalities like mental retardation (Fertig & Watson, 2009). Conclusively, it is crucial to broaden the mind of the population with regards to fertility and to give the population an opportunity to make healthy fertility decisions. Thus, health care providers and educators have a responsibility to spread this information to all people within the reproductive age.

Another factor which negatively impacts the male and female fertility as well as the pregnancy is smoking. Breznik (2021) reported that the female fertility can be seriously inhibited through smoking. This is the case as the menstrual cycle, the physiological function of the ovaries and the hormone levels are impaired by the consumption of cigarettes. Breznik (2021) explained this by stating that when a women smokes at least one pack of cigarettes per day, the length of the menstrual cycle is shortened. Thus, this is a challenge when trying to get

pregnant as the natural menstrual cycle length would be unknown. Furthermore, the uterine flow velocity is effected resulting in ectopic pregnancies and the formation of ovarian follicles (folliculogenesis) (Dechanet et al., 2011). In addition to this, smoking also negatively effects male fertility and their reproduction life plan. Smoking is a modifiable risk factor which weakens the semen quality and contributes to infertility. Furthermore, Anderka et al. (2010) reported that smoking during pregnancy is more likely to result in a small for gestational age foetus, foetal growth restriction, and a higher risk of preterm delivery and early neonatal morbidity. Numerous studies suggest that the number of cigarettes smoked per day and the birth weight of newborns is strongly correlated to the number of cigarettes smoked per day. Additionally, the same negative pregnancy outcomes are seen when pregnant women are exposed to second hand smoke (Anderka et al. 2010; Burstyn, Kapur & Cherry 2010; Dean et al. 2013). During preconception care, health care educators have the responsibility to educate women regarding the negative effects of smoking and encourage them to stop or reduce smoking when planning to have a baby. This is since research indicated that the less smoking the better for fertility.

Preconception care is a crucial component of healthcare that can have a significant impact on the perinatal process. At every health care encounter with people of reproductive age, healthcare professionals should address relevant topics as not a lot of people take initiatives to seek preconception care. As a result, preconception care can be integrated into routine medical care, and more stakeholders can be reached.

References

Aimala, A. M. (2021). Age and fertility. *Preconception Health and Care*.

Anderka, M., Romitti, P. A., Sun, L. & Druschel, C. (2010). Patterns of tobacco exposure before and during pregnancy. *Acta Obstetricia Et Gynecologica Scandinavica*. 89(4), 505–514.

Baxley, E. & Gobbo, R. (2004). Shoulder Dystocia. *American Family Physicians, 69*(7), 1707–1714.

Breznik, M. (2021). Smoking as adverse effects on preconception health and fertility. *Preconception Health and Care*.

Burstyn, I., Kapur, N. & Cherry, N. M. (2010). Substance use of pregnant women and early neonatal morbidity: where to focus intervention? *Canadian Journal of Public Health*. 101(2), 149–153.

Carson, G., Cox, L., Crane, J., Croteau, P., Graves, L., Kluka, S., & Wood, R. (2017). Alcohol Use and Pregnancy Consensus Clinical Guidelines. *Journal of Obstetrics & Gynaecology Canada*. 39(9),

220–254.
Coffey K & Shorten A. (2014). The challenge of preconception counselling: using reproductive life planning in primary care. *Journal of Associated Nurse Practitioner. 26*(5). doi: 10.1002/2327-6924.12054
Dean, S. V., Mason, E., Howson, C. P., Lassi, Z. S., Imam, A. M. & Bhutta, Z. A. (2013). Born too soon: care before and between pregnancy to prevent preterm births: from evidence to action. *Reproductive Health*. 10(1).
Dechanet, C., Anahory, T., Mathieu Daude, J. C., Quantin, X., Reyftmann, S., Hedon, H. B. & Dechaud, H. (2011). Effects of cigarette smoking on reproduction. *Human Reproductive Update*. 17(1), 76–95.
Delbaere, I. (2021). What do we mean by preconception care and why do we need preconception care? *Preconception Health and Care*.
Denison, F. C., Norwood P, & Bhattacharya, S. et al. (2014). Association between maternal body mass index during pregnancy, short-term morbidity, and increased health service costs: a population-based study. *British Journal of Obstetrics and Gynaecology*. 121:72–82. doi: 10.1111/1471-0528.12443
Dhavliker, M., & Purohit, P. (2017). Preconception care: dietary and lifestyle advice. *The Pharmaceutical Journal*. 298(7897). doi:10.1211/PJ.2017.20202157
Fertig, A., & Watson, T. (2009). Minimum drinking age laws and infant health outcomes. *Journal of Health Economics*. 28(3), 737–747.
Floyd, R., Jack, B., Cefalo, R., Herron, A., Husten, C. & Sokol, R. (2008). The clinical content of preconception care: alcohol, tobacco and illicit drug exposures. *American Journal of Obstetrics & Gynaecology*. 199(6), 333–9.
Fritz, R. & Jindal, S. (2018). Reproductive ageing and elective fertility preservation. *Journal of Ovarian Research*. 11(66).
Goeckenjan, M. (2017). Preconeptional risk counselling. In B. Toth (ed.) *Miscarriages, stillbirths, premature births*. Berlin. 53–63.
Hammarberg, K., Zosel, R., Comoy, C., Robertson, S., Holden, C., Deeks, M. & Johnson, L. (2017). Fertility-related knowledge and information- seeking behaviour among people of reproductive age: a qualitative study. *Human*
Fertility. 20(2), 88–95.
Hemond, J., Robbins, R. B. & Young, P. C. (2016). The Effects of maternal obesity on neonates, infants, children, adolescents, and adults. *Clinical Obstetrics and Gynecology. 59*(1), 216–227.
Hurst, H. & Linton, D. (2015). Preconception Care: Planning for the Future. *The Journal for Nurse Practitioners*. 11(3), 335–340.
Imterat, M., Agarwal, A., Esteves, S. C., Meyer, J. & Harlev, A. (2019). Impact of Body Mass Index on female fertility and ART outcomes. *Panminerva Medica*. 61(1), 58-67. doi: 10.23736/S0031-0808.18.03490-0.
Koletzko, B., Cremer, M., Flothkötter, M., Graf, C., Hauner, H., Hellmers, C., & Wöckel, A. (2018). Diet and lifestyle before and during pregnancy – Practical recommendations of the Germany-wide Healthy Start – Young Family Network. *Geburtshilfe und Frauenheilkunde*. 78(12), 1262–1282.
May, P., Marais, A., de Vries, M., Kalberg, W., Buckley, D., Hasken, J., & Hoyme, H. (2016). The continuum of foetal alcohol spectrum disorders in four rural communities in south Africa: Prevalence and characteristics. *Drug and Alcohol Dependence*. 168, 274–286.
Pedro, J., Brandão, T., Schmidt, L., Costa, M. E. & Martins M.V. (2018). What do people know about fertility? A systematic review on fertility awareness and its associated factors. *Upsala Journal of Medical Sciences. 123*(2), 71– 81.
Petrocnick, P. (2021). Why is body mass index important in preconception period. *Preconception Health and Care*.
Thompson, E., Vàzquez-Otero, C., Vamos, C., Marhefka, S., Kline, N., & Daley, E. (2017). Rethinking preconception care: a critical womens's health perspective. *Maternal and Child Health Journal*. 21(5), 1147–1155.
Verbiest, S. (2020). Preconception health: an overview. In J. Shawe, E. A. P. Steegers, & S. Verbiest (eds.) Preconception Health and Care: A Life Course Approach. Switzerland: Springer.
World Health Organization Meeting, Geneva, (2012). Preconception care to reduce maternal and childhood mortality and morbidity. Retrieved from: http://www.who.int/maternal_child_adolescent/documents/concensus_preconception_care/en/
World Health Organization. Meeting to develop a global consensus on preconception care to reduce maternal and childhood mortality and morbidity. Retrieved from: http://apps.who.int/iris/bitstream/10665/78067/1/9789241505000_eng.pdf

Chiara Scerri
B.Sc (Hons) Midwifery

NUK Nature Sense

As close to nature as never before

The best NUK Baby Bottle that has ever been developed!

Recent tests* show that **midwives and paediatricians** are in favour of this baby bottle

92% of the babies accept this teat because of its sense of nature

99% of the mothers would recommend this bottle to others

98% of the interviewed **midwives & paediatricians** confirm that the softness & feel is very similar to a mother's breast

RECOMMENDED

BY MIDWIVES, PAEDIATRICIANS & ORTHODONTISTS

*Independent Market Research in Germany 2016

@NukMalta

NUK

The Dialectical Tensions Involved In First-Time Parenthood

Parenthood is a complex experience and concept in modern society. While many ideologies of new parenthood circulate in our culture, they are not equally accepted. Life transitions have been widely explored especially those relating to parenthood. However, unlike many other important life events, parenthood generally begins without much preparation or professional training. The first experience of parenthood is thought to be the most challenging especially when compared to subsequent parenting (Lorensen, Wilson and White, 2004). Throughout the years, many new parents have reported a lack of preparation for the actualities new parenthood brings with it (Mercer, 1981; Cowan and Cowan, 1992; Berger and Loveland Cook, 1996; Nolan, 1997; Cronin and McCarthy, 2003; Deave, Johnson and Ingram, 2008; Borg Xuereb, Abela and Spiteri, 2012; Spiteri and Borg Xuereb, 2012; Spiteri, 2019). This lack of preparation has shown to increase parental stress and distress in pregnancy but substantially after the birth of the first-born child (Simpson et al., 2003). Therefore, preparing parents for new parenthood is an essential role for midwives and this role needs to be firmly integrated into maternity services spanning from the preconception period well into the postpartum.

Research with first-time expectant and new parents has revealed many dialectical tensions which need to be understood in an attempt to better support new parents (Spiteri, 2019). Relational dialectics theory is founded on the idea that relationship experiences, such as new parenthood, are understood through competing cultural norms and expectations or discourses (Baxter, 2011). Baxter (2011) explained how dialectical theory was about the unity and the differences within relationships. According to Wood (1997), there are inherent tensions between opposing impulses or dialectics; these tensions and our reactions towards them are what we can use to understand how relationships function, and how they develop through time. Lusk (2008) claimed that by studying dialectics, one could acknowledge these facts and try to find solutions for the conflicts that exist.

Relational dialectics is an expansion of Mikhail Bakhtin's idea that life is an open monologue and humans experience collisions between opposing wishes and needs within relational communications (Baxter, 2004). Baxter and Erbert, (1999) described the dialectical theory as a family of theories rather than a single, unitary theory since dialectical theorists share some fundamental rules but vary in some details. Shared assumptions include a belief in the centrality of contradiction to relationships and the role of contradiction in change processes (Cornforth, 1968).

Three supra-dialectics exist which are: (1) the dialectic of Integration – Separation; (2) the dialectic of Stability – Change and (3) the dialectic of Expression – Privacy (Baxter, 1993). Baxter and Erbert (1999) described how each dialectic could be exhibited either internally or externally. Understanding these dialectics has the potential to better support new parents in their transition to first-time parenthood.

Figure 1.1 displays the three main supra-dialectics together with their internal manifestation within dyadic relationships and external manifestations of the dyad with the broader social order as explained by Baxter (1993).

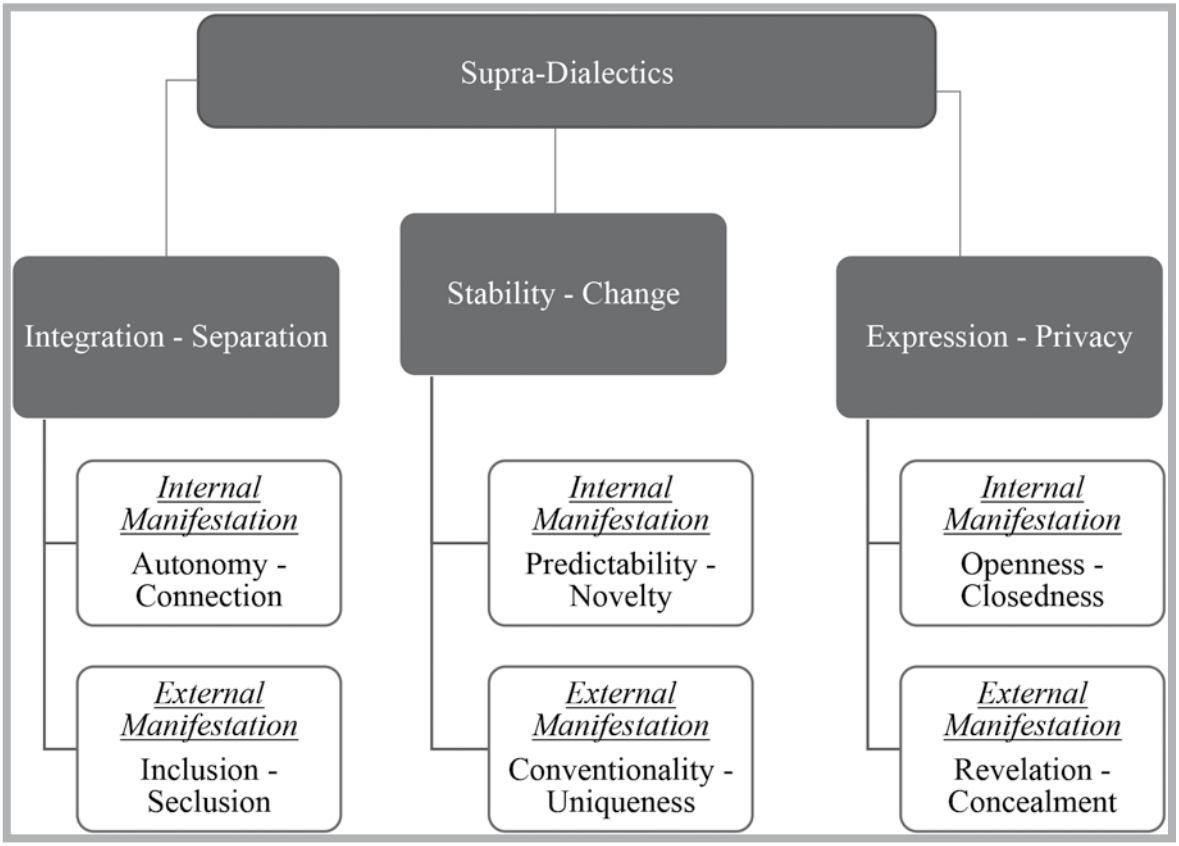


Figure 1.1 – Supra-dialectics (Baxter, 1993)

The first supra-dialectic, Integration – Separation refers to the basic contradictory tensions between social solidarity or unity, and social division or separation (Baxter and Erbert, 1999). Within a dyadic relationship such as a couple about to become parents, this dialectic refers to the tension between the autonomy or independence of the individuals and their interdependent connection. Baxter (1993) refers to this internal manifestation as the Autonomy – Connection dialectic. Healthy relationships need both autonomy and connection of the partners, yet these two necessities are generally viewed as oppositional: naturally, partner autonomy confines connectedness just as connectedness limits partner autonomy.

At the interface of the dyad with the broader social order, dyadic members face the dialectic of Inclusion – Seclusion, that is, the pressure between the pair's connection as a couple with others versus the pair's isolation from others. Healthy relationships need alone time to develop a unique culture of two; but simultaneously, relationships need to be embedded with others so that they can be acknowledged. However, having alone time as a couple restricts the time available for the couple to engage socially with others, and vice versa (Baxter and Erbert, 1999).

Stability – Change, the second supra-dialectic refers to the central opposition between stability and instability (Baxter, 1993). Within the couple's relationship, this dialectic appears as the Predictability – Novelty paradox. Here, individuals are faced with concurrent yet antagonistic needs for uncertainty and novelty versus certainty and predictability (Baxter and Erbert, 1999). Relationships need predictability and certainty of various types while at the same time absolute certainty and predictability can give rise to emotional deadening, boredom and inadequate stimulation for partners, requiring spontaneity, novelty and other kinds of uncertainty. Within the social order, this supra-dialectic is exhibited in the Conventionality – Uniqueness contradiction (Baxter and Erbert, 1999). While relational identity is built on a perception of uniqueness for the pair; the dyad also relies on the support of basic social norms in conducting the ordinary task of relating (Baxter and Erbert, 1999).

The third and last supra-dialectic, Expression – Privacy, refers to information openness versus informational discretion (Baxter and Erbert, 1999). This dialectic turns into the Openness - Closedness conflict within with dyadic relationship as partners struggle with concurrent needs to be both open and closed with one another. Partner trust and intimacy are built on the foundation of disclosive openness yet at the same time, honesty can hurt and the partners and their relationship thereby destabilising their trust and intimacy (Baxter and Erbert, 1999).

The Revelation – Concealment tension captures the external expression of the third supra-dialectic, as dyadic partners wrestle with the different needs to both reveal and conceal information about the relationship from others in their social network (Baxter and Erbert, 1999). On one side we are presented with a society that needs information about the couple to acknowledge its existence while on the other side the relationship itself needs a boundary of privacy for themselves.

Local interpretative phenomenological research with expectant and new parents revealed how participants' experiences of preparation for first-time parenthood was dynamic, sometimes conflicting, changing with time and also with the context these individuals found themselves in (Spiteri, 2019).

The findings of this study presented the range and polarity of some of the experiences which could be viewed as dialectical positions. Baxter's (1993) three main supra-dialectics described above were exhibited during the in-depth interviews conducted with a purposive sample of 24 individuals and 12 couples (Spiteri, 2019). The findings of this study revealed how partners in a relationship face an ongoing challenge of negotiating the oppositions of integration and separation (Braithwaite and Baxter, 2006). From the moment of conception, the male and female participants engaged in this dialectic.

For the men, as their sperm separated from their bodies and integrated with the female egg to create new life, most appeared to extend this separation to many of their preparatory experiences as now they were separate from their partners and their unborn child. This separation meant that many men required epoch moments to help internalise the changes that were occurring, prompting them to integrate better with the experience. The dialectic of integration and separation was also apparent as the postnatal couples described their need for couples' time in an attempt to sustain their romantic relationship. At the same time, however, relationship wellbeing appeared to be dependent upon others' legitimisation of the couple as a social unit, or in this case, a family unit and this was in fact exhibited by the participants who stated that they would be interested in attending postnatal groups together with their infants.

The dialectic of expression-privacy was also revealed during the qualitative interviews. In its internal manifestation, this dialectic captured the dilemma of openness and closedness, as the participating men and women communicated with their respective partners. Relationships are built on the foundations of open and honest disclosure (Braithwaite and Baxter, 2006). Simultaneously, relationships involve respect for each person's right to privacy and the obligation to protect one's partner from the hurt that can often result from excessive honesty (Rawlins, 1983).

This dialectic was particularly pronounced amongst the men as they chose to keep their fears and worries from their partners throughout the pregnancy phase. Dindia (1998) in fact, framed the expression-privacy dialectic around issues of protection, in which the decision to disclose or not revolved around a concern to protect oneself from hurt or embarrassment versus a concern to protect the other from hurt.

Hence, men's decision not to express their true feelings during pregnancy may be viewed using this same example, they could have kept their feelings to themselves in an attempt to protect their wives, or they might have withheld their true emotions not to embarrass themselves or threaten their virility. A third dialectic, stability-change was also expressed by the participants of this study. Baxter and Montgomery (1996) described how relationships required both stability and change to establish and sustain their wellbeing. The connection

between stability and change may be especially crucial to relationship parties during times of significant transition like the one explored here. The postnatal experience in itself created a dialectic in that while it was a joyous time for most parents it also presented many of the participants with hardship. Participants struggled with establishing routines that would work for their new realities because they needed to be flexible in their approaches.

In summary, acknowledging these dialectical tensions has the potential for future work with first-time parents especially with regards to the design and implementation of interventions aimed at supporting individuals through their transition to parenthood. Addressing the apparent contradictions that are related to the first-time experience of parenthood is paramount in achieving optimum transitions with positive outcomes for both the parents and their children.

References

Baxter, L. A. (1993) 'The social side of personal relationships: A dialectical analysis'. In S. Duck (Ed.), Social context and relationships, pp. 139-165. Newbury Park, CA: Sage.

Baxter, L. A. (2004) 'A tale of two voices: Relational Dialectics Theory', Journal of Family Communication, 4(3-4), PP. 181-192.

Baxter, L. A. (2011) 'Voicing relationships: A dialogic perspective', Los Angeles, CA: Sage.

Baxter, L. A. and Braithwaite, D. O. (2006) 'Social dialectics: The contradictions of relating', in Whaley, B. and Samter, W. (eds.) Contemporary communication theories and exemplars. Mahwah, NJ: Erlbaum, pp. 275-292.

Baxter, L. A. and Erbert, L. A. (1999) 'Perceptions of dialectical contradiction in turning points of development in heterosexual romantic relationships', Journal of Social and Personal Relationships, 16(5), pp. 547-569.

Baxter, L. A. and Montgomery, B. M. (1996). Relating: Dialogues and dialectics. New York: Guilford.

Berger, D. and Loveland Cook, C. A. (1996) 'Maternal postpartum learning needs', International Journal of Childbirth Education, 11(1), pp.22-26.

Borg Xuereb, R., Abela, A., & Spiteri, G. (2012) 'Early parenting – Portraits from the lives of first-time parents', Journal of Reproductive and Infant Psychology, 30, pp. 468–482.

Cowan, C. P. and Cowan, P. A. (1992) When partners become parents: The big life change for couples. New York: Harper Collins.

Cronin, C. and McCarthy, G. (2003) 'First-time mothers – identifying their needs, perceptions and experiences', Journal of Clinical Nursing, 12(2), pp. 260-267.

Deave, T., Johnson, D., and Ingram, J. (2008) 'Transition to parenthood: the needs of parents in pregnancy and early parenthood', BMC Pregnancy and Childbirth, 8(30), pp. 1-11.

Dindia, K. (1998) 'Going into and coming out of the closet: The dialectics of stigma disclosure', in Montgomery, B. M. and Baxter, L. A. (eds.) Dialectical approaches to studying personal relationships. Mahwah, NJ: Lawrence Erlbaum, pp. 83-108.

Lorensen, M., Wilson, M. E. and White, M. A. (2004) 'Norwegian families: transition to parenthood', Health Care Women International, 25(4), pp. 334-348.

Lusk. H. M. (2008) A study of dialectical theory and its relation to interpersonal relationships. Honours Thesis Projects. University of Tennessee.

Mercer, R. T. (1981) 'A theoretical framework for studying factors that impact on the maternal role', Nursing Research, 30(2), pp. 73-77.

Nolan, M. (1997) 'Antenatal education – where next?' Journal of Advanced Nursing, 25(6), pp. 1198-1204.

Rawlins, W. K. (1983) 'Negotiating close friendship: The dialectic of conjunctive freedoms', Human Communication Research, 9(3), pp. 255-266.

Simpson, J. A., Rholes, W. S., Campbell, L., Tran, S. and Wilson, C. L. (2003) 'Adult attachment, the transition to parenthood and depressive symptoms', Journal of personality and social psychology, 84(6), pp. 1172-1187.

Spiteri, G. (2019) 'An exploration of preparation for parenthood amongst first-time biological parents', Newcastle Upon Tyne: Newcastle University.

Spiteri, G. and Borg Xuereb, R. (2012) 'Going back to work after childbirth: women's lived experiences', Journal of Reproductive and Infant Psychology, 30(2), pp. 201-216.

Wood, J. T. (1997) 'Clarifying the issues', Personal Relationships, 4, pp. 221-228.

Georgette Spiteri
RM, B.Sc. (Hons.), M.Sc. Midwifery (Melit.), PhD (Ncle)

Alone, we Can do so Little; Together we Can do so Much (Helen Keller)

Communication is the basis of all we do at home or at work. Communication is about the exchange of information between individuals. That information is then used to make decisions that will affect the present and the future of the people involved in communicating those ideas (Boon, 2005).

Communication for us as midwives plays an integral part in our profession. The ability to communicate enables people to form and maintain personal relationships. And the quality of such relationships depends on the calibre of communication between the parties (Brennan & Williams, 1974).

We communicate with our colleagues; we communicate with members of other professions and most importantly we communicate with the mothers and their partners. At its most basic level, communication is about the exchange of information between individuals (Choren, 2015). Good communication comes as the result of knowing and understanding who you are talking to (Newnam & Goode, 2019).

Communication is not only verbal, but body language also plays a big part in our job. With communication one can integrate respect. When we communicate, we are trying to create a shared reality (Echterhoff & Schmalbach, 2018). The way we communicate demonstrates the respect we are imparting to our colleagues and the empathy and support we are endowing to the mothers and their partners.

The definition for communication between co-workers needs to address the necessity for functional relationships communication between team members in the workplace can be defined as developing and maintaining functional relationships through an exchange of feelings and ideas (Kim et al., 2022). Often egocentrism plays a huge role, in a lack of understanding during the communication process. Egocentrism is basically "an inability to take on other people's perspective" (Bottom et al., 2004). Collaboration and communication go hand in hand. If employees are unable to communicate effectively, it is very likely for collaboration not to be effective. Collaboration in the workplace brings many benefits from promoting self-analysis and resulting in efficient problem solving. The effects of poor communication in the workplace set every collaborative project for failure, and almost everything in the 21st century workplace is a collaboration (Khan, 2021).

Another viewpoint focuses upon "toxic personalities" defined as "anyone who demonstrates a pattern of counterproductive work behaviours that debilitate individuals, teams, and even organizations over the long term" (Kusy & Holloway, 2009). Because of this, messages are too often muddled, not easily understood, and generally, can create scenarios where colleagues are not able to understand each other. This leads to breakdowns in communication, and at times animosity within the workplace. It seems reasonable to conclude that one of the most inhibiting forces to organisational effectiveness is a lack of effective communication (Lutgen-Sandvik & Beverly Davenport Sypher, 2009).

The effects of poor communication may cause tensions to rise, resulting in a potential conflict between team members. Failure to communicate may cause co-workers to make the wrong assumptions, such as leaving other co-workers to pick up their work, when this task was not previously discussed between a team (Khan, 2021). Frequent causes of conflict include poor communication, personality differences and conflicts of interest (Umiker, 1998). Behaviour that results in conflict could include bullying, limited communication or not sharing important information, and verbal violence (Runde et al., 2010).

Unfortunately, sometimes one tends to harm one another through a blaming system instead of moving forward together as a team. Daniel Goleman uses the term 'social intelligence' to refer to our ability to 'act wisely in human relationships' (Goleman, 2006). He divides social intelligence into two capabilities:

- Social awareness – refers to skills in empathy, attuning to a person, understanding another's thoughts, feelings, and intentions, and knowing how the social world works.
- Social facility – refers to interacting smoothly at the nonverbal level, self-presentation, influence, and concern.

Both range from basic, low-level capabilities to more complex skills. Interpersonal skills enter the picture when you consider situations where there are:

- different priorities and expectations that generate conflict, misunderstandings, disagreements
- uncooperative behaviours such as withholding information, not meeting commitments, power games
- diverse people together (different cultures, ages, genders, working styles).

Communicating competently is an art and must be skilfully adapted for better output and successful attainment of goals of any workplace. Every person's communication skills affect both personal and organisational effectiveness (Narasimhan, 2007).

Although conflict sometimes cannot be averted as it can be work stress related, it can be managed. Since conflict will always be present in an individual, it is important to develop the abilities to fittingly manage a difficult conversation or interaction. Experts agree that the crucial skills can be acquired; they believe that conflict competence can be defined and learned.

One definition of conflict competence is "the ability to develop and use cognitive, emotional, and behavioural skills that enhance productive outcomes of conflict while reducing the likelihood of escalation or harm" (Runde et al., 2010). Compromise and collaboration are both

a balance of assertiveness and cooperativeness. The difference between the two is that compromise is often a compromise between two parties with comparable power, whereas collaboration is focused on finding a clarification where all parties involved have their needs met. Compromise is centred on fixing a problem with a set number of resources and collaboration grants a broader view on problem solving.

A combination of compromise and collaboration has also been characterised as a problem-solving response (Greer et al., 2012). Although there is not a correct solution, responses characterized by open-mindedness to the ideas and perspectives of others promote positive outcomes (Quinn & Al, 2011). The level of intensity of a misunderstanding must be taken in consideration to determine how best to approach the issue. One can divide the level of intensity of a conflict in five tiers.

Level 1 is differences. Those are facets in which two or more people have different viewpoints on the situation; they understand the other person's viewpoint and are complacent with the difference. This level of conflict can be a boon for a team because it allows individuals to collate or analyse without an emotional overlay.

Level 2 are misunderstandings in which two people perceive the situation differently. Misunderstandings are frequent and can be minor but can also escalate. If there are negative ramifications such as missed events or obligations people tend to find fault and accuse one another which adds adverse emotions to the situation. If the misunderstandings are recurrent, it may indicate problems with communication.

Level 3 is disagreements; these are instances when individuals have different perspectives of the situation, and despite understanding the other's position they are uncomfortable with the difference. This level can also easily intensify if ignored.

Level 4 is discord. In those instances, conflict results in relationship issues between the people involved even after a specific conflict is resolved. There is often constant tension between those persons.

Level 5 is polarization, which describes situations with extreme negative feelings and conduct in which there is little to no hope of resolution. For those conflicts, the mandatory first step is the agreement to communicate.

An element of preparation is to acknowledge one's emotional response and how it might affect one's view of the situation. Addressing a difficult crisis when one is angry or frustrated is more likely to be fruitless than when one is calm. Several famous quotes illustrate the point.

"Speak when you are angry, and you will make the best speech you will ever regret." *(Ambrose Bierce)*

Effective communication involves knowing how to listen meticulously. It's the ability to offer empathy, tolerance, and helpful feedback based on what one hears. Also, a friendly attitude, confidence, and effective nonverbal communication will also help to develop good relationships with the members of your team and others. Good communication skills generate trust with others. Of all the tell-tale signs that communication could be better, listening flies under the radar. That's because most of us are bad listeners, yet we don't recognise the fact. Not paying attention while someone's talking to you, already planning your response, or interfering, are all indications that you're not using your listening skills. When someone's talking to you, give your full attention. Wait for them to finish, and then ask questions to validate their points. Practicing empathetic listening can have the knock-on effect of encouraging your co-workers to improve their own listening, as well

The ability to listen and not just hear helps build up trust. The ability to listen attentively and embrace diverse points of view aides' others to have confidence in one's decisions. When one communicates effectively, this improves the relationship within the team and with those outside the team. One should listen carefully to others thus this will create and nurture mutual respect. Finding ways to interact on a more personal level opens the door for meaningful communication. Thus, devote some time to getting to know your co-workers. Simple team-building activities can help, and they don't have to be rigorously programmed. Sharing photos and dedicating a channel for casual conversation among other simple ques enhance comradeship within the team and others. This allows co-workers to share personal experiences and build professional relationships enhanced by trust and bilateral esteem.

"Once a human being has arrived on this earth, communication is the largest single factor determining what kinds of relationships he makes with others and what happens to him in the world about him." *(Virginia Satir)*

References:

Boon, S.D. (2005), Review of Applied Social Psychology: Understanding and Addressing Social and Practical Problems. *Canadian Psychology/Psychologie Canadienne, 46*(4),251-252. https://doi.org/10.1037/h0087032

Brennan, J., & Williams, N. (1974). *The conscious communicator: making communication work in the workplace.* Addison-Wesley.

Choren, A. (2015). The importance of Communication in the Workplace. *IEEE Potentials, 34*(3), 10-11. https://doi.org/10.1109/mpot.2014.2331793

Echterhoff, G., & Schmalbach, B. (2018). How shared reality is created in interpersonal communication. *Current opinion in psychology*, *23*, 57-61. https://doi.org/10.1016/j.copsyc.217.12.005

Gilovich, T., Griffin, D., & Kahneman, D. (Eds.). (2002). *Heuristics and biases:* The psychology of intuitive judgment. *The Academy of*

Management Review, 29(4),695. https://doi.org/10.2307/20159081
Goleman, D. (2006). *Social intelligence: the new science of human relationships.* Bantam Books.
Greer, L.L., O., Aaldering, H., & Dreu, C.K.W. (2012), Conflict in medical teams: opportunity or danger? *Medical Education, 46*(10), 935-942. https://doi.org/10.1111/j.1365-2923.2012.04321.x
Khan, H. (2021) *The Causes & Effects of Poor Communication in the Workplace.* https://WWW.SIMPLR.COM/BLOG/2021/causes-effects-poor-communication-workplace
Kim, K.Y., Eisenberger, R., Takeuchi, R., & Baik, K. (2022). Organizational-level perceived Support enhances organizational profitability. *Journal of Applied Psychology.* https://doi.org/10.1037/apl0000567
Kusy, M., & Holloway, E. (2009). *Toxic workplace!: managing toxic personalities and their systems of power.* Jossey-Bass.
Lutgen-Sandvik, P., & Beverly Davenport Sypher. (2009). *Destructive organizational communication: processes, consequences, and constructive ways of organizing.* Routledge.
Narasimhan, K. (2007). Quality Management: Creating and Sustaining Organizational Effectiveness. *Managing Service Quality: An International Journal, 17*(5),594-595. https://doi.org/10.1108/msq.2007.17.5.594.7
Newnam, S., & Goode, N. (2019). Communication in the workplace: Defining the conversations of supervisors. *Journal of safety research*, *70*, 19-23. https://doi.org/10.16/j.jsr.2019.04.09
Quinn, R.E., & Al, E. (2011). *Becoming a master manager: a competing values approach.* Wiley.
Runde, C.E., Flanagan, T.A., & Centre For Creative Leadership. (2010). *Developing your conflict competence: a hands-on guide for leaders, managers, facilitators and teams.* Jossey-Bass; Centre for Creative Leadership.
Umiker, W.O. (1998). *Management skills for the new health care supervisor.* Aspen Publishers.

Doris Spagnol Abela, SRN, SCM,
PGDip Psychology,
MA Bioethics (Melit),

Oxytocin- a High-Alert Drug: How Can We Optimise Its Use During Labour?

Introduction

The nature of this high-alert drug presents several concerns pertaining to its use in obstetrics. To address a suspected local overuse of this uterotonic drug during labour, I conducted a three-month cohort prospective observational study in 2021 at the Department of Obstetrics and Gynaecology at Mater Dei Hospital (MDH). This research project aimed to investigate the local use of oxytocin (OT), audit its use against local protocols and compare this to international guidelines. Maternal and neonatal outcomes were assessed. Collated data was statistically analysed using IBM SPSS Version 27 tests namely One-Way ANOVA, Pearson Correlation and Chi-Squared to test for any correlations between several factors and the use of OT.

OT as a high-alert drug

Tachysystole following OT administration is one of the leading causes of obstetric liability. The possibility of negative outcomes of OT is heightened by the inclusion of OT in the Institute for Safe Medication Practices list of high-alert medications (Simpson and Knox, 2009), as this drug is considered to be the most common cause of avoidable adverse perinatal outcomes.

The use of such medications, which have a high propensity for harm require special precautions and monitoring measures both before and during their administration to protect the patient's well-being-; in this case both mother and foetus (Krening et al., 2012).

Study Design and Data Collection

The study was performed at the two Obstetric postnatal wards at the Department i.e. Obstetrics wards 1& 3. A copy of the local OT protocol followed was obtained prior to data extraction. It was also learnt that locally, non-cephalic presentations are delivered by Elective Low Segment Caesarean Section (EL/LSCS).

The inclusion criteria encompassed singleton births with cephalic presentations between July 2019 and September 2019, while EL/LSCS cases which included breech and multifoetal pregnancies were excluded from the study as in such cases the mother would not have gone into labour in a natural way, which fell beyond the scope of the study.

Data was collected from pertinent patient files from respective wards on alternate days during the study period, since the minimum duration of stay following normal deliveries at that time was 48 hours. A pre-designed checklist (Figure 1), which was validated by three experienced obstetricians from the Department of Obstetrics and Gynaecology, MDH was used for data extraction. This checklist included date of data collection, maternal age, parity, mode of delivery of any previous

Factors	Data		
Date of data collection			
Age of the mother			
Nulliparous or multiparous			
If multiparous, were previous births delivered normally or by C-section			
After how many weeks into pregnancy did the mother come to MDH Obstetrics and Gynaecology unit			
Was Oxytocin used			
If Oxytocin was used; for how many hours			
Was Oxytocin used for induction or augmentation of labour			
Amount of OT units administered			
Duration of Labour 1st stage,2nd stage, 1st+2nd			
Was delivery following Oxytocin use normal, aided with forceps or C-section			
Apgar score- at 1 minute and at 5 minutes			

Figure 1: Checklist used during data extraction

pregnancies, gestational age, OT use and indication, amount of OT units used, mode of delivery following OT use and Apgar scores (AS) at 1 and 5 minutes.

Data Analysis

A Null Hypothesis and an alternate hypothesis were set for each of the correlations, which were accepted or rejected according to the p-value obtained from the statistical test carried out, which was in turn determined by the set of factors being analysed.

The 95% confidence Interval was used throughout the whole study. Following data extraction, calculations were worked out to determine the amount of OT units administered, the duration of OT infusion, the duration of labour and the Bishop score (BS). OT used beyond delivery was not considered in this study i.e. only OT used during the first and second stage of labour was considered. Mothers who ended up going for Emergency Low Segment Caesarean Section (EM/LSCS) were grouped and analysed separately than the remaining cases, as the reason for carrying out such a procedure could have been one or more out of various such as no progress and/or foetal distress, not essentially due to OT administration. Variables that were tested for any correlations with OT use include parity, BS, gestational age, prostaglandin gel use, AS and mode of delivery. The amount of OT units used and OT indication were also correlated.

Results

Out of the 392 cases reviewed, 316 met the inclusion criteria. 143 mothers used OT; 113 did not use OT; 33 mothers ended up going for emergency C-section and 16 cases had to be omitted due to missing data, leaving a total of 305 cases for evaluation. (Figure 2) 59 % of the mothers were Maltese and 41 % were of foreign origin.

The AS at 5 minutes was not found to be significantly less with OT use, however other studies documented a significant correlation of a 5 minute AS less than 7 with OT use (Oscarsson et al., 2006).

The mean duration of the first stage of labour has been shown to be significantly longer with more OT units used. This positive correlation could be explained by the notion that if the mother is administered more OT, the contractions have not yet reached the expected level of intensity and/or frequency, leading to a longer first duration of labour. This finding however is not consistent with the findings of other authors including Zhang et al. (2011) and Hidalgo-Lopezosa et al. (2016) who reported a significantly shorter first stage of labour when higher doses of OT were used (initial infusion rate of 4mU/min and increasing by 4mU/min).

In the current study the mode of delivery following OT use did not vary significantly with the mode of delivery of the control group. This finding differs from the results of other studies including Tesemma et al. (2020). There was a statistical significance of a longer second stage of labour with a higher incidence of ventouse delivery. The duration of labour was shown to be significantly shorter for women with more parity. This finding is supported by Selman and Johnston (2013) who deduced that the first stage of labour for nulliparous women lasts between eight and eighteen hours on average, while for multiparous mothers, the first stage lasts from five to twelve hours. The second stage of labour is reported to be about 3 hours for nullipara and 2

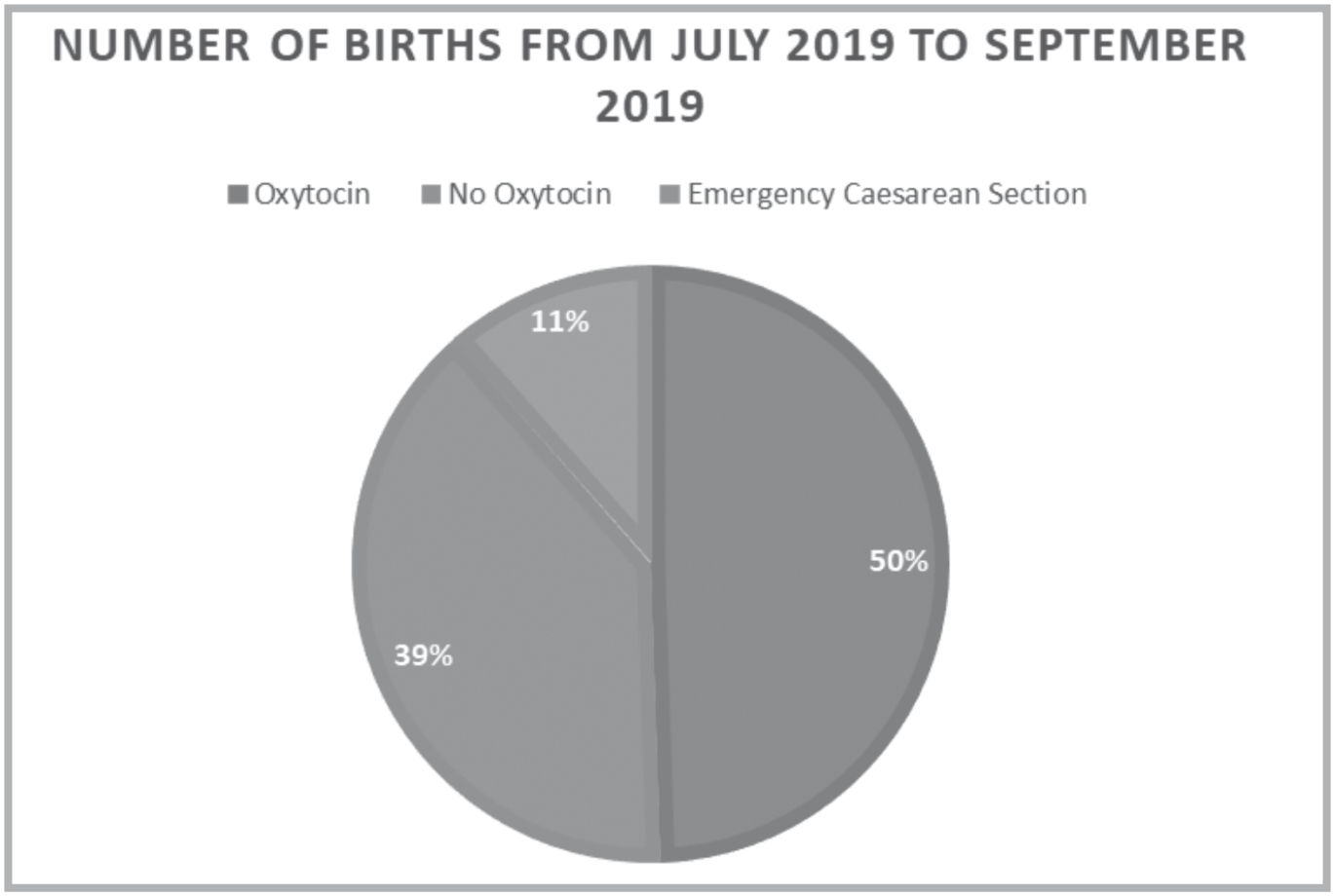


Figure 2: Total Number of Births (N=305)

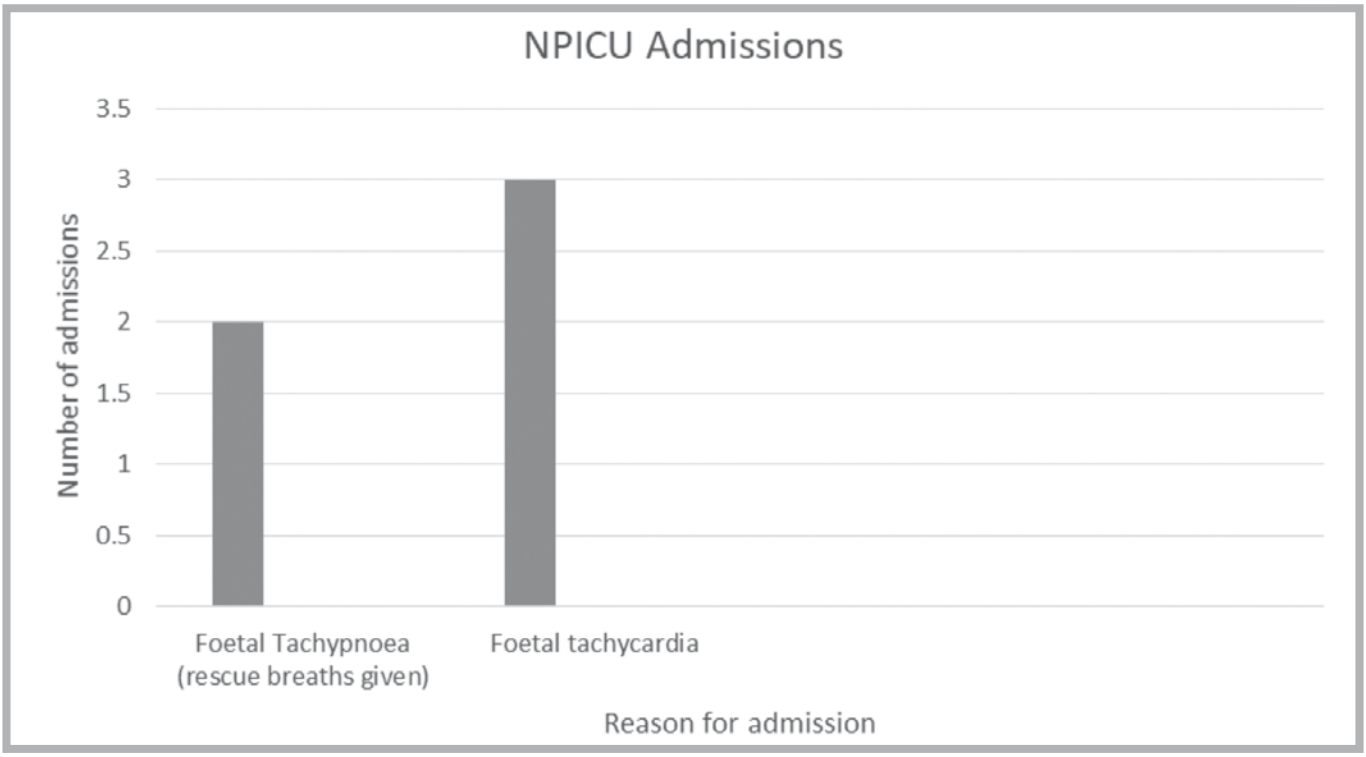


Figure 3: NPICU admissions (N=5)

hours for multipara (Selman and Johnston, 2013).

Although all NPICU admissions (Figure 3) in this study occurred following OT use, it cannot be concluded that this was a direct consequence of OT administration, keeping in view the presence of other confounding factors. However, it emphasises the need to adopt a standardised approach towards OT use and to investigate further the influence of OT on neonates.

The same applies for the occurrence of Em/LSCS. The rationale behind Em/LSCS being performed following OT use is not necessarily precipitated by OT use, but literature does show a significant positive correlation (Krening et al., 2012).

Disparities from the local protocol pertaining to sooner than recommended rate doubling and higher than recommended initial infusion rates were observed in 7.7% of the OT group. Although there appears to be no specific clinical justification for such deviations, one would need to analyse the individual cases in greater depth and look at the respective patients' notes for possible explanations.

There was a 4.3 % deviation across the sample population wherein the amount of OT units used in these reviewed cases was higher than the maximum recommended amount defined in the local protocol i.e. 10 IU in 500 mL. Such higher than recommended usage could be justified by specific clinical reasons, the identification of which fell beyond the scope of this study. The 4.3% deviation from the local protocol may be regarded as a relatively low figure. However, when one considers deviation from the respective Summary of Product Characteristics (SPC), the situation is such that the protocol itself recommends an off-licence dose since the SPC of the locally used OT recommends that 5 IU are mixed with 500 mL of electrolyte solution and that 10 IU per 500 mL are only advised in cases of in-utero foetal death and labour induction earlier in pregnancy. The average gestational age in the investigated group in this study was 39.35 weeks. Consequently, the SPC indication regarding labour induction in earlier pregnancy is not applicable. It must be highlighted that such off-licence recommendation is evident in other reviewed international guidelines. This indicates the need for further clinical studies and evaluation in order to update respective protocols and/or product market authorisation in order to standardise the use of OT.

In cases of tachysystole and change in FHR patterns, the infusion rate of OT was observed to be adjusted to lower rates or stopped altogether. The one breech case encountered in this study, was delivered by Em/LSCS, rather than by EI/LSCS. In spite of the limited number of opportunities to come across such occurrences, this still emphasises the importance of reviewing current local protocols pertaining to breech presentations, as highlighted by Fenech and Grech (2020).

Recommendations

An updated, possibly more detailed version of the local OT protocol could be issued and made more accessible to all respective HCPs. A number of patient files had missing data. This might have been a result of such data being documented elsewhere in the patient file or not being documented at all. This point reminds us of the importance of systematic documentation and filing, about which more awareness should be made. This would not only facilitate necessary documentation by HCPs on the ward, but also avoids the occurrence of any potential associated errors. Perhaps a more appropriate way forward would be through the use of drug order sets, specific to the use of OT (ISMP, 2020).

Findings of this study support the growing belief that OT should not be used routinely during labour, but reserved specifically to situations where OT is indicated to protect maternal and foetal well-being. This logic pertains not only to the relatively short-term effects observed during labour,

but also to potential effects that might come up later in life. There seems to be no universal agreement in scientific literature on the most suitable OT dosing regimen that best safeguards maternal and foetal well-being. More studies are required to better evaluate the use of OT and its effects, addressing also the concept of OT discontinuation once established labour is reached, which is supported by the study conducted by Daniel-Spiegel et al. (2004), with no labour prolongation.

Since evaluations for the study did not make use of partograms, occurrences of uterine hyperstimulation could not be investigated. This could be an aspect for future studies for deeper understanding of the actions of OT. Evaluating CTG enables the identification of uterine tachysystole and FHR patterns during OT administration.

Taking cord blood samples to evaluate for acidaemia is another aspect one could correlate with OT use together with the mother's fluid intake during OT administration to investigate the water intoxication adverse effect of OT. The use of OT in specific patient populations including diabetic and hypertensive mothers could also be a possible subject for future research. High dose and low-dose OT regimen protocols should be investigated further with the aim of finding the best evidence-based OT regimen. These elements could lead to a deeper understanding of the actions of OT within an actual clinical environment.

Conclusion

The benefits of OT during parturition cannot be underestimated. However, this high-alert drug must be used with great caution to prevent any adverse outcomes on mother and neonate, which outcomes can occur during labour itself or later in life. Respective HCPs must be updated on any emerging evidence on OT to be better equipped to educate the parturient about OT and the associated risks, both immediate and delayed. This will facilitate both HCPs and respective mothers to make informed decisions on OT administration for best possible outcome (Khajehei, 2017).

Optimising OT use during labour should be the common goal of all HCP stakeholders aiming at maintaining maternal and foetal well-being and making the birth experience a positive one for all those involved.

A risk-benefit assessment should be carried out before deciding to initiate OT administration and strategies must be in place to reduce the associated maternal and foetal risks as much as possible. This study gives a snapshot of local obstetric practice pertaining to OT use at MDH. Further studies are suggested to investigate the actions of OT with the aim of reaching the implementation of the standardised use of this high-alert drug. One such study would be the evaluation of the clinical studies pertaining to the market authorisation of OT and equivalent products and to analyse why several protocols including the local one, differ from the respective SPCs.

This study shows that there is no general consensus on the optimum dose of OT for induction or augmentation of labour, both at the national and international level. It was also observed that there are substantial differences between the various protocols evaluated, in particular with respect to the maximum recommended dose of OT and dosage regimen. Such lack of consensus may be attributed to intra and inter clinical disagreement between HCPs, namely obstetricians and midwives. An approach aimed at addressing such practice variation is to have active involvement of the Pharmacist who would be in an ideal position to coordinate the use of appropriate checklists. Such checklists may take the form of pre and in-use checklists which would facilitate collaborative clinical decision-making prioritising patient safety (Clark et al., 2017). Furthermore, the use of drug order sets would facilitate a standardised treatment approach thereby minimising potential prescribing and drug administration errors (ISMP, 2020). In such situations it would be of value that Pharmacy co-ordinates an interdisciplinary group of the requisite stakeholders in the drafting, implementation, monitoring and continuous updating of relevant clinical practice guidelines, ensuring effective adherence to evidence-based practice.

References

Altman M, Sandström A, Petersson G, Frisell T, Cnattingius S, Stephansson O. Prolonged second stage of labour is associated with low Apgar score. European journalof epidemiology. 2015 Nov; 30 (11):1209-15.

Clark S, Belfort M, Saade G, Hankins G, Miller D, Frye D, Meyers J. Implementation of a conservative checklist-based protocol for oxytocin administration: maternal and newborn outcomes. American journal of obstetrics and gynecology. 2007 Nov 1; 197(5):480-e1.

Daniel-Spiegel E, Weiner Z, Ben-Shlomo I, Shalev E. For how long should oxytocin be continued during induction of labour?. BJOG: An International Journal of Obstetrics & Gynaecology. 2004 Apr; 111(4):331-4.

Falzon RM. Optimisation of oxytocin use during labour (Master's thesis, University of Malta).

Fenech P, Grech LM. Malta Midwives Journal: issue 15: March 2020.

Hidalgo-Lopezosa P, Hidalgo-Maestre M, Rodríguez-Borrego MA. Labour stimulation with oxytocin: effects on obstetrical and neonatal outcomes. Revista latino-americana de enfermagem. 2016 Jul 25; 24.

Institute for Safe Medication Practices (ISMP). ISMP List of High-Alert Medications in Acute Care Settings. ISMP; 2018.

Institute for Safe Medication Practices. Errors Associated with Oxytocin Use: A Multi-Organization Analysis by ISMP and ISMP Canada [Internet]. Canada: ISMP; February 2020 [cited 31 August 2021]. Available from: https://www.ismp.org/resources/errors-associated-oxytocin-use-multi-organization-analysis-ismp-and-ismp-canada.

Khajehei, M. Labour and beyond: The roles of synthetic and endogenous oxytocin in transition to motherhood. British Journal of Midwifery. 25. 230-238. 10.12968/bjom.2017.25.4.230.

Krening CF, Rehling-Anthony K, Garko C. Oxytocin administration: the transition to a safer model of care. The Journal of perinatal & neonatal nursing. 2012 Jan 1; 26(1):15-24.

Oscarsson ME, Amer-Wåhlin I, Rydhstroem H, Källén K. Outcome in obstetric care related to oxytocin use. A population-based study. Acta obstetricia et gynecologica Scandinavica. 2006 Sep; 85(9):1094-8.

Selman T, Johnston T. Mechanisms and management of normal labour. Obstetrics, Gynaecology & Reproductive Medicine. 2013 Jul 1; 23(7):208-13.

Simpson KR, Knox GE. Oxytocin as a high-alert medication: implications for perinatal patient safety. MCN: The American Journal of Maternal/Child Nursing. 2009 Jan 1; 34(1):8-15.

Tesemma MG, Sori DA, Gemeda DH. High dose and low dose oxytocin regimens as determinants of successful labour induction: a multicenter comparative study. BMC pregnancy and childbirth. 2020 Dec; 20(1):1-8.

Zhang J, Branch DW, Ramirez MM, Laughon SK, Reddy U, Hoffman M, Bailit J, Kominiarek M, Chen Z, Hibbard JU. Oxytocin regimen for labour augmentation, labour progression, perinatal outcomes. Obstetrics and gynecology. 2011 Aug; 118(2 0 1):249.

Rebecca Marie Falzon
B. Sc (Hons) Pharm.
Sc. (Melit.) M Pharm. (Melit.), M. ACP (Melit.)

Incontinence and Pregnancy with Particular Reference to the Role of Urodynamic Investigations

An introduction to urinary incontinence

The term urinary incontinence is defined by the International Continence Society (ICS) as 'an involuntary loss of urine which is objectively demonstrable, and a social or hygienic problem' (D'Ancona CD, et al, 2019)[1]. Urinary incontinence causes a significant impairment in quality of life (QOL) in terms of distress, embarrassment, and economic costs, to both the individual and society. It is an extremely common worldwide complaint in women of all ages particularly in pregnancy. Pregnancy and childbirth both contribute to the development of urinary incontinence and pelvic organ prolapse.

Continence depends upon both intact micturition physiology (including lower urinary tract, pelvic, and neurologic components, intact pelvic floor muscle and connective tissue support), as well as functional ability to toilet oneself. The main types of urinary incontinence are **stress, urgency, and overflow incontinence.** Many women have features of more than one type; **mixed urinary incontinence**. Therapy is guided by the type of incontinence.

Standardization of terminology by ICS gives the following definitions for urinary incontinence;

Stress Urinary Incontinence (SUI) - Complaint of involuntary loss of urine on effort or physical exertion, including sporting activities, or on sneezing or coughing[1]. It is the most common type in younger women, with the highest incidence in women aged 45 to 49 years

Urgency Urinary Incontinence (UUI) - Complaint of involuntary loss of urine associated with urgency[1]. It is more common in older women and may be associated with comorbid conditions that occur with age. It is believed to result from detrusor over activity, leading to uninhibited (involuntary) detrusor muscle contractions during bladder filling. This may be secondary to neurologic disorders (e.g., spinal cord injury), bladder abnormalities, increased or altered bladder microbiome, or may be idiopathic.

Mixed Urinary Incontinence (MUI) - Complaints of both stress and urgency urinary incontinence, i.e. involuntary loss of urine associated with urgency and also with effort or physical exertion including sporting activities or on sneezing or coughing[1].

Enuresis - Complaint of intermittent incontinence that occurs during periods of sleep. If it occurs during the main sleep period, then it could be qualified by the adjective "nocturnal". The patient has to be asleep when enuresis happens and is usually unaware of it[1].

Overflow Urinary Incontinence - Complaint of continuous involuntary loss of urine in the setting of incomplete bladder emptying. Associated symptoms can include weak or intermittent urinary stream, hesitancy, frequency, and nocturia. When the bladder is very full, stress urinary leakage can occur or low-amplitude bladder contractions can be triggered resulting in symptoms similar to stress and/or urgency urinary incontinence. Overflow urinary incontinence is caused by detrusor underactivity or bladder outlet obstruction.

Effect of pregnancy and childbirth on urinary incontinence and pelvic organ prolapse

Pelvic floor disorders (PFDs) include pelvic organ prolapse (POP), urinary incontinence, and faecal incontinence. An area of intense investigation is the effect of pregnancy and childbirth on a woman's risk of developing PFDs and whether this risk can be reduced by modifications to obstetric care.

The biologic mechanisms of injury to the pelvic floor during pregnancy and childbirth have not been fully determined. Data suggest that pregnancy and delivery contribute to pelvic floor injury due to compression, stretching, or tearing of nerve, muscle, and connective tissue. Intact neuromuscular function and pelvic organ support are both critical to normal function of pelvic viscera.

The main risk factors for PFDs include;

Parity is comprised of several components (pregnancy, labour, delivery), each of which may contribute to the development of pelvic floor disorders (PFDs). PFDs are more prevalent among women who have delivered at least one child [2-15]. Furthermore, the rate of PFDs increases with increasing parity. Among parous women, it has been estimated that 50 percent of incontinence and 75 percent of prolapse can be attributed to pregnancy and childbirth (Patel DA et al, 2006)[16].

- **Pregnancy** — Urinary incontinence is more common during pregnancy than before pregnancy. Many women experience their first symptoms of incontinence during pregnancy. The prevalence and severity of incontinence increase during the course of pregnancy [17-20]. The highest incidence of incontinence is noted in the second trimester[17] and, based upon the cumulative rate of new incontinence symptoms, prevalence peaks in the third trimester[17-20]. Urinary incontinence symptoms resolve in many women after delivery or the postpartum period, but many will have persistent symptoms.
- **Labour** — Most of the available evidence suggests that labour, in the absence of vaginal delivery, has a negligible effect on the development of PFDs later in life. However, some studies have yielded inconsistent results [21-28].
- **Mode of delivery** - **Vaginal versus Caesarean delivery** — Vaginal delivery appears to be an important risk factor for the development of PFDs, particularly SUI (Jansson MH et al 2021)[15].
- A meta-analysis of 15 studies (both observational and trial data) reported an increased risk of SUI following vaginal delivery compared with caesarean delivery (adjusted odds ratio [OR] 1.85, 95% CI 1.56-2.19, risk difference 8.2 percent) (Tähtinen

RM et al, 2016)[29].

Operative vaginal delivery — Operative vaginal delivery with forceps appears to increase the risk of developing POP and SUI [30-32]. Instrumented delivery also increases the risk of anal sphincter laceration, which increases the risk of faecal incontinence.

Vacuum-assisted vaginal delivery does not appear to have the same impact on risk of prolapse or urinary incontinence[31-32].

- **Maternal age** — increasing maternal age is associated with an increased risk of PFDs (Gyhagen M, et al, 2013)[33, 34].
- **Birth weight** — increasing infant birth weight appears to be associated with an increased risk of POP, but the relationship to urinary incontinence is unclear (Gyhagen M, et al, 2013)[33, 34].

Obstetric care interventions to reduce the long-term risk of pelvic floor disorders (PFDs)

- **Prophylactic pelvic floor muscle exercises** — Pelvic floor muscle exercises (PFE) performed during pregnancy help to decrease the short-term risk of urinary incontinence in women without prior incontinence, but a long-term benefit has not been established.

  In terms of postpartum PFE, there is increasing evidence that some women sustain injury to the levator ani muscle complex at childbirth[35, 36]. PFE should therefore be initiated as early as is physically possible for the new mother and increased gradually in the postpartum period.
- **Caesarean delivery** — while caesarean delivery has been associated with a lower risk of PFDs compared with vaginal delivery, caesarean delivery does not eliminate the risk of a future PFD. Thus, pregnant women who request caesarean delivery should be advised that there is no evidence that elective caesarean delivery prevents persistent urinary incontinence in women with incontinence symptoms before or during pregnancy. Antepartum maternal characteristics are poor predictors of PFDs. At this point, there are no maternal characteristics that can be used to reliably guide specific women to the option of planned caesarean delivery. Clinicians should explore patient concerns about vaginal delivery and educate patients about the risks associated with repeat caesarean delivery (ACOG Committee Opinion No. 761:2019)[37].
- **Vaginal delivery management** - Avoidance of protracted active labour or second stage of labour, coached versus uncoached maternal pushing, and selective use of episiotomy have not been proven to decrease the risk of PFDs[38-40].

Incontinence management and the role of Urodynamic studies

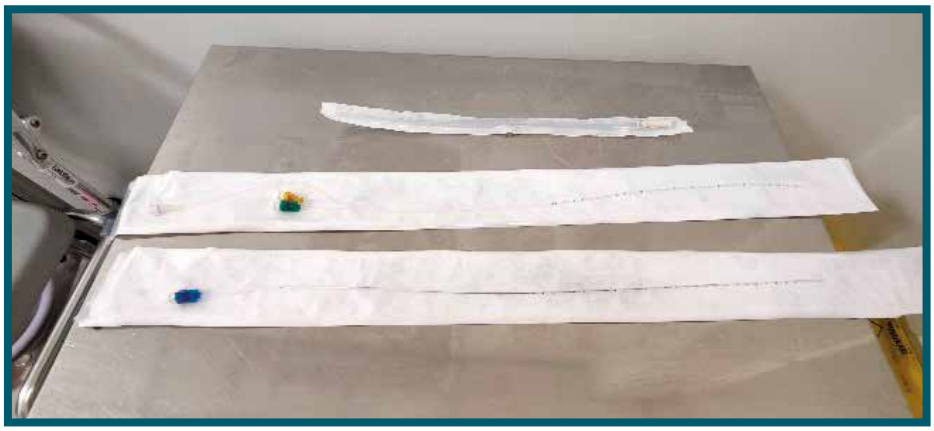
Initial treatments for most types of incontinence (stress, urgency, or mixed) include lifestyle modifications, weight loss and PFME, along with bladder training in women with urgency incontinence and in some women with stress incontinence (Abrams P et al, 2010)[41]. Conservative therapies are typically used for six months.

Urodynamic testing is recommended when a patient fails to improve with conservative treatment, and when surgical treatment is planned. It is also indicated when the diagnosis of lower urinary tract dysfunction is unclear, and when objective findings do not correlate with subjective symptoms.

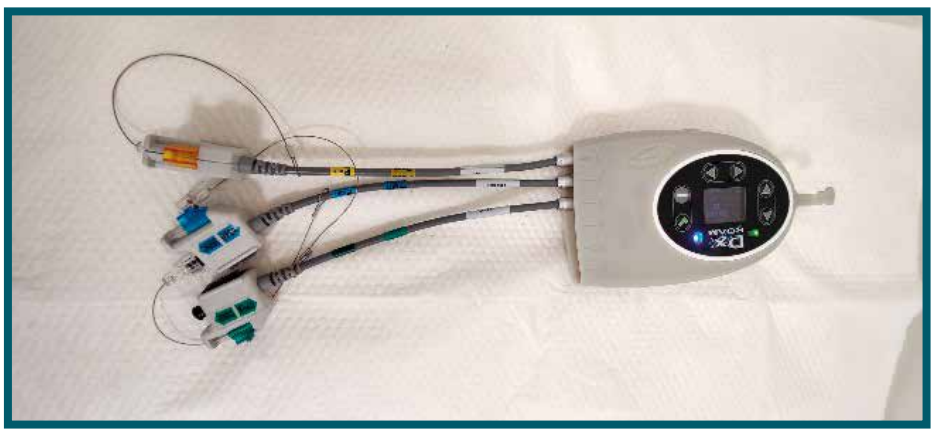
The main components of urodynamic testing are **cystometry** (measuring bladder pressure during filling of the bladder), **uroflowmetry** (measuring urine flow over time), **pressure-flow study** (determining whether poor flow is due to obstruction or detrusor weakness), and **urethral pressure profile or leak point pressure** (for diagnosis of intrinsic sphincter deficiency).

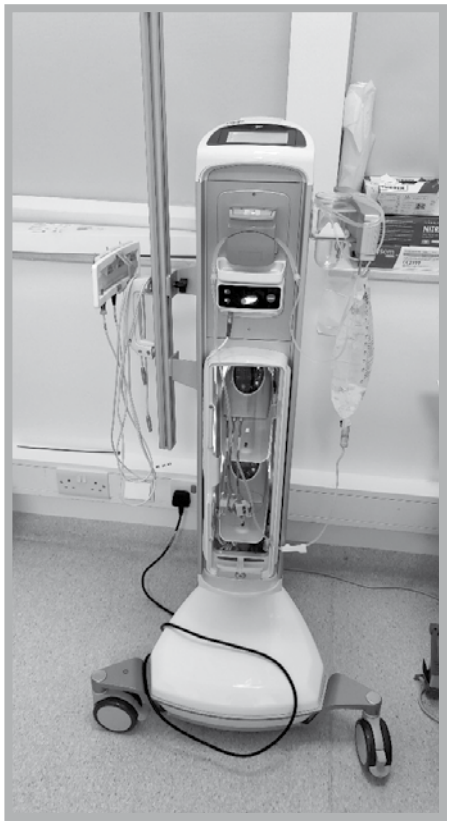
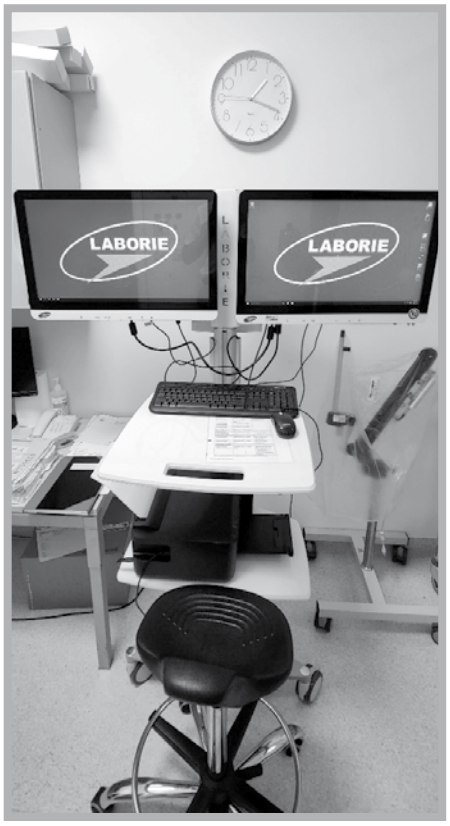
Cystometry

- Filling cystometry is the method by which the pressure/volume relationship of the bladder is measured during bladder filling. It is used to distinguish detrusor over activity (involuntary contractions of the bladder) from stress incontinence (leakage due to an increase in abdominal pressure).



(Top) Urodynamic catheters and (below) wireless transducer



Laborie Urodynamic machine and monitors

The test can also identify patients with abnormalities of bladder sensation, capacity, compliance and mixed incontinence.

- At Mater Dei Hospital, air-charged multichannel testing is employed, where one channel (vesical catheter) measures bladder pressure continuously. An additional channel simultaneously measures abdominal pressure continuously through the rectum (rectal catheter). The urodynamic machine subtracts intra-abdominal pressure from bladder pressure, which gives a continuous reading of true detrusor pressure (the pressure created by the detrusor muscle alone).

Uroflowmetry

- measures urine volume voided over time.

In women, uroflowmetry can be useful in clinical situations, such as:

- Frequency, urgency, and urgency incontinence as some of these patients have outlet obstruction.
- Voiding difficulty, hesitancy, or difficulty maintaining the urine stream, which can also be due to outlet obstruction (from previous pelvic surgery or urethral kinking with anterior vaginal wall prolapse) or weak detrusor (as in neurologic diseases).
- Planned pelvic surgery as poor uroflow may be a predictor of postoperative voiding difficulty after incontinence surgery or radical pelvic surgery. This information allows for preoperative counselling or training in self-catheterization.

Benefits and efficacy of urodynamic studies

Clinical evaluation with urodynamic studies leads to a more accurate diagnosis of incontinence type. There is still debate as to whether urodynamic observations are routinely required prior to surgery for pure SUI. The VALUE study was a randomised trial in which women, whose predominant symptom was SUI, were randomised to undergo urodynamic observations or clinical assessment alone prior to undergoing mid-urethral tape surgery. Other than differentiating between mixed and pure SUI, the investigators found no difference in surgical outcomes between those who underwent urodynamic observations and those who did not (Nager et al.2012)[42]. However, this study has been criticised over whether the findings are appropriate for other types of stress incontinence procedures and applicable to daily clinical practice.

Thus, urodynamic studies provide clinicians with an objective diagnosis of SUI prior to surgery. Potentially, urodynamic observations may mean that some women avoid unnecessary surgical intervention. Techniques can be adjusted intraoperatively and patients can be given appropriate preoperative counselling to manage their expectations (Bing MH et al, 2015)[43]. Moreover, results must be interpreted with caution in the context of a patient's entire clinical picture.

Patient Referral for urodynamic studies

Before referring patients for urodynamic studies a complete patient evaluation should be performed. Patients presenting with any type of incontinence, a history of recurrent UTI, and /or pelvic organ prolapse should be referred to Gynaecology Outpatients for initial assessment. After proper evaluation by the gynaecologist, patients may be referred for Urodynamic assessment through the appropriate MDH form.

Incontinence Prevention during Pregnancy and Postpartum

Pelvic floor exercises help strengthen the muscles that support the bladder, uterus and bowels. These exercises should be encouraged during pregnancy to develop the ability to relax and control the perineal muscles in preparation for labour and birth.

In the postpartum period, PFEs are highly recommended to promote the healing of perineal tissues, increase the strength of the pelvic floor muscles and help these muscles return to a healthy state, including better urinary control. PFEs are thus the mainstay of incontinence prevention both in the puerperium and long-term.

References

1. D'Ancona CD, Haylen BT, Oelke M, Herschorn S, Abranches-Monteiro L, Arnold EP, Goldman HB, Hamid R, Homma Y, Marcelissen T, Rademakers K, Schizas A, Singla A, Soto I, Tse V, de Wachter S. An International Continence Society (ICS) Report on

the Terminology for Adult Male Lower Urinary Tract and Pelvic Floor Symptoms and Dysfunction. Neurourol Urodyn. 2019 DOI: 10.1002/nau.23897
2. O'Boyle AL, Woodman PJ, O'Boyle JD, et al. Pelvic organ support in nulliparous pregnant and nonpregnant women: a case control study. Am J Obstet Gynecol 2002; 187:99.
3. Hendrix SL, Clark A, Nygaard I, et al. Pelvic organ prolapse in the Women's Health Initiative: gravity and gravidity. Am J Obstet Gynecol 2002; 186:1160.
4. Handa VL, Garrett E, Hendrix S, et al. Progression and remission of pelvic organ prolapse: a longitudinal study of menopausal women. Am J Obstet Gynecol 2004; 190:27.
5. Rortveit G, Hannestad YS, Daltveit AK, Hunskaar S. Age- and type-dependent effects of parity on urinary incontinence: the Norwegian EPINCONT study. Obstet Gynecol 2001; 98:1004.
6. Abramov Y, Sand PK, Botros SM, et al. Risk factors for female anal incontinence: new insight through the Evanston-Northwestern twin sisters study. Obstet Gynecol 2005; 106:726.
7. Goldberg RP, Abramov Y, Botros S, et al. Delivery mode is a major environmental determinant of stress urinary incontinence: results of the Evanston-Northwestern Twin Sisters Study. Am J Obstet Gynecol 2005; 193:2149.
8. Subak LL, Waetjen LE, van den Eeden S, et al. Cost of pelvic organ prolapse surgery in the United States. Obstet Gynecol 2001; 98:646.
9. Carley ME, Turner RJ, Scott DE, Alexander JM. Obstetric history in women with surgically corrected adult urinary incontinence or pelvic organ prolapse. J Am Assoc Gynecol Laparosc 1999; 6:85.
10. Moalli PA, Jones Ivy S, Meyn LA, Zyczynski HM. Risk factors associated with pelvic floor disorders in women undergoing surgical repair. Obstet Gynecol 2003; 101:869.
11. Chiaffarino F, Chatenoud L, Dindelli M, et al. Reproductive factors, family history, occupation and risk of urogenital prolapse. Eur J Obstet Gynecol Reprod Biol 1999; 82:63.
12. Rinne KM, Kirkinen PP. What predisposes young women to genital prolapse? Eur J Obstet Gynecol Reprod Biol 1999; 84:23.
13. MacLennan AH, Taylor AW, Wilson DH, Wilson D. The prevalence of pelvic floor disorders and their relationship to gender, age, parity and mode of delivery. BJOG 2000; 107:1460.
14. Samuelsson EC, Victor FT, Tibblin G, Svärdsudd KF. Signs of genital prolapse in a Swedish population of women 20 to 59 years of age and possible related factors. Am J Obstet Gynecol 1999; 180:299.
15. Jansson MH, Franzén K, Tegerstedt G, et al. Stress and urgency urinary incontinence one year after a first birth-prevalence and risk factors. A prospective cohort study. Acta Obstet Gynecol Scand 2021; 100:2193.
16. Patel DA, Xu X, Thomason AD, et al. Childbirth and pelvic floor dysfunction: an epidemiologic approach to the assessment of prevention opportunities at delivery. Am J Obstet Gynecol 2006; 195:23.
17. Solans-Domènech M, Sánchez E, Espuña-Pons M, Pelvic Floor Research Group (Grup de Recerca del Sòl Pelvià; GRESP). Urinary and anal incontinence during pregnancy and postpartum: incidence, severity, and risk factors. Obstet Gynecol 2010; 115:618.
18. Viktrup L, Lose G. The risk of stress incontinence 5 years after first delivery. Am J Obstet Gynecol 2001; 185:82.
19. Thorp JM Jr, Norton PA, Wall LL, et al. Urinary incontinence in pregnancy and the puerperium: a prospective study. Am J Obstet Gynecol 1999; 181:266.
20. van Brummen HJ, Bruinse HW, van der Bom JG, et al. How do the prevalences of urogenital symptoms change during pregnancy? Neurourol Urodyn 2006; 25:135.
21. Lukacz ES, Lawrence JM, Contreras R, et al. Parity, mode of delivery, and pelvic floor disorders. Obstet Gynecol 2006; 107:1253.
22. Handa VL, Blomquist JL, Knoepp LR, et al. Pelvic floor disorders 5-10 years after vaginal or cesarean childbirth. Obstet Gynecol 2011; 118:777.
23. Handa VL, Blomquist JL, Knoepp LR, et al. Pelvic floor disorders 5-10 years after vaginal or cesarean childbirth. Obstet Gynecol 2011; 118:777.
24. Sze EH, Sherard GB 3rd, Dolezal JM. Pregnancy, labor, delivery, and pelvic organ prolapse. Obstet Gynecol 2002; 100:981.
25. Brown SJ, Gartland D, Donath S, MacArthur C. Effects of prolonged second stage, method of birth, timing of caesarean section and other obstetric risk factors on postnatal urinary incontinence: an Australian nulliparous cohort study. BJOG 2011; 118:991.
26. Gartland D, Donath S, MacArthur C, Brown SJ. The onset, recurrence and associated obstetric risk factors for urinary incontinence in the first 18 months after a first birth: an Australian nulliparous cohort study. BJOG 2012; 119:1361.
27. Groutz A, Rimon E, Peled S, et al. Cesarean section: does it really prevent the development of postpartum stress urinary incontinence? A prospective study of 363 women one year after their first delivery. Neurourol Urodyn 2004; 23:2.
28. Chin HY, Chen MC, Liu YH, Wang KH. Postpartum urinary incontinence: a comparison of vaginal delivery, elective, and emergent cesarean section. Int Urogynecol J Pelvic Floor Dysfunct 2006; 17:631.
29. Tähtinen RM, Cartwright R, Tsui JF, et al. Long-term Impact of Mode of Delivery on Stress Urinary Incontinence and Urgency Urinary Incontinence: A Systematic Review and Meta-analysis. Eur Urol 2016; 70:148.
30. Blomquist JL, Muñoz A, Carroll M, Handa VL. Association of Delivery Mode With Pelvic Floor Disorders After Childbirth. JAMA 2018; 320:2438.
31. Volløyhaug I, Mørkved S, Salvesen Ø, Salvesen KÅ. Forceps delivery is associated with increased risk of pelvic organ prolapse and muscle trauma: a cross-sectional study 16-24 years after first delivery. Ultrasound Obstet Gynecol 2015; 46:487.
32. Tähtinen RM, Cartwright R, Vernooij RWM, et al. Long-term risks of stress and urgency urinary incontinence after different vaginal delivery modes. Am J Obstet Gynecol 2019; 220:181.e1.
33. Gyhagen M, Bullarbo M, Nielsen TF, Milsom I. Prevalence and risk factors for pelvic organ prolapse 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. BJOG 2013; 120:152.
34. Gyhagen M, Bullarbo M, Nielsen TF, Milsom I. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. BJOG 2013; 120:144.
35. Schwertner-Tiepelmann N, Thakar R, Sultan AH, Tunn R. Obstetric levator ani muscle injuries: current status. Ultrasound Obstet Gynecol 2012; 39:372.
36. Li X, Kruger JA, Nash MP, Nielsen PM. Anisotropic effects of the levator ani muscle during childbirth. Biomech Model Mechanobiol 2011; 10:485.
37. ACOG Committee Opinion No. 761: Cesarean Delivery on Maternal Request. Obstet Gynecol 2019; 133:e73.
38. Schaffer JI, Bloom SL, Casey BM, et al. A randomized trial of the effects of coached vs uncoached maternal pushing during the second stage of labor on postpartum pelvic floor structure and function. Am J Obstet Gynecol 2005; 192:1692.
39. Fitzpatrick M, Harkin R, McQuillan K, et al. A randomised clinical trial comparing the effects of delayed versus immediate pushing with epidural analgesia on mode of delivery and faecal continence. BJOG 2002; 109:1359.
40. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. Cochrane Database Syst Rev 2017; 2:CD000081.
41. Abrams P, Andersson KE, Birder L, et al. Fourth International Consultation on Incontinence Recommendations of the International Scientific Committee: Evaluation and treatment of urinary incontinence, pelvic organ prolapse, and fecal incontinence. Neurourol Urodyn 2010; 29:213.
42. Nager C, Brubaker L, Litman H, Zyczynski H, Edward Varner R, Amundsen C, et al. A randomized trial of urodynamic testing before stress-incontinence surgery. N Engl J Med 2012; 366:1987–97.
43. Bing MH, Gimbel H, Greisen S, Paulsen LB, Soerensen HC, Lose G. Clinical risk factors and urodynamic predictors prior to surgical treatment for stress urinary incontinence: a narrative review. Int Urogynecol J 2015;26: 175–85.

Daliso Chetcuti
MD EFOG – EBCOG

Joanna Ghigo
MD MBA FRCOG FECSM CCT (UK)

Colief®

Infant Colic Drops

Lactase Enzyme Drops

To be used with **breast milk** or **formula**

Prevents & Treats Colic

4 drops with every feed

Safe from birth

Natural

Effective

Breathe Easy Patch

Soothing patch for easy breathing

Breathe Easy Roll-on Vapour Rub

Soothing rub for easy breathing

Available from pharmacies
or online **www.shop.prohealth.com.mt**

Prohealth

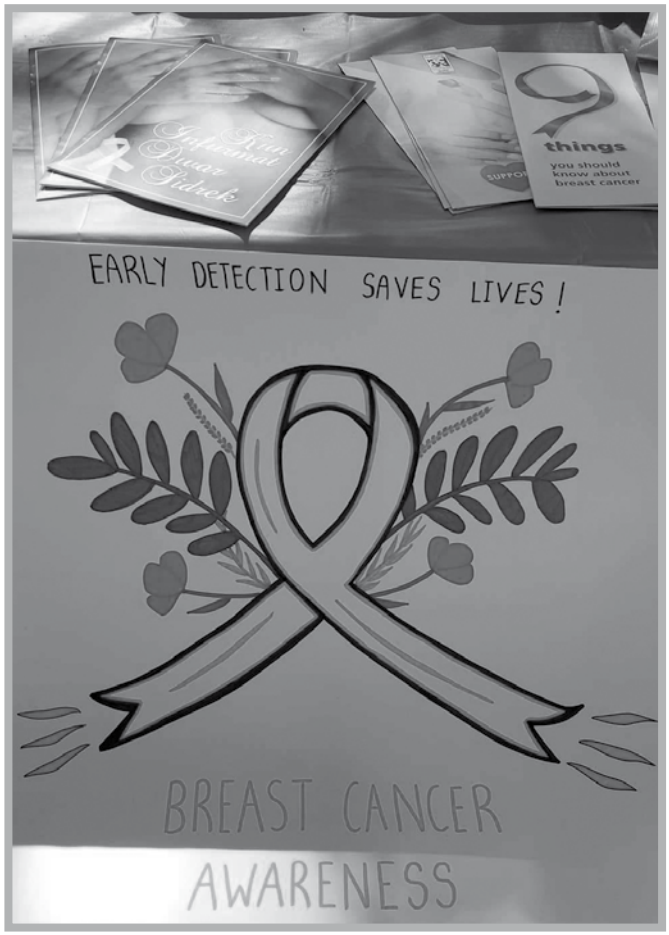
Organizzazzjoni Studenti Qwiebel

It is officially that time of the year! Pink October!

This year, as always, Pink October aims to raise awareness about breast cancer. We've all heard of breast cancer but are often unsure what to look for. A dimple, lump or abnormal skin textures can be a sign of breast cancer but without routine self check-ups one cannot always notice these abnormalities.

In Organizzazzjoni Studenti Qwiebel's (OSQ) activity today at Quadrangle our aim was to raise awareness amongst university students, lecturers and staff about breast cancer. Setting ourselves up in the entry of Quad we offered free pens, pink ribbon pins as well as information pamphlets. Additionally, we also managed to acquire a lifelike breast mannequin from the Midwifery Department, on which we demonstrated to passer-by's how to perform a breast check up on themselves. Due to the mannequin purposefully having lumps and skin abnormalities, the students had the chance to look for and feel the abnormal breast, making them all the more aware. All throughout this process a member of the OSQ committee was walking them through the process, educating them and informing them of what they are doing.

When October rolls round, many people find themselves examining themselves. This is great, after all this is the aim of pink October, however, examining oneself once a year is not enough. This should be done once a month. Ideally a self-check is done three to five days after their period in menstruating women and in menopausal women the same day every month. Checking yourself once a month ensures that you are familiar with your body as well as distinguish anything that is not your normal. This makes sure that if there are any abnormalities they are caught quickly and efficiently. If you notice any unusual dimples, lumps or skin abnormalities make sure to contact your doctor.



Cupcakes were made by Nina Zahra, student midwife, and sold for 2 Euros each. All proceeds went to Action For Breast Cancer Foundation Malta

From left to right: Amy-Jo Mifsud, Nina Zahra, and Abigail Grima.

Self check-ups may seem daunting at first, we at OSQ understand. We are often asked by people if they are doing it right so we have prepared a step-by-step guide to self-checks.

Before following the steps find a cosy private space just for you and if you want put on your favourite relaxing song. Anything that gets you in the zone.

Step 1: Strike a power pose and look at your skin in front of the mirror. With your hands resting on your hips visually asses your breasts.

Step 2: Gently move around. Asses and compare both breasts visually, make sure to lean forward, backwards as well as side to side

Step 3: Lift one arm and check for soreness. Use your other hand to gently asses the breast for soreness.

Step 4: Using three fingertips rub gently in circular messaging motion, doing so move up and down the breast.

Step 5: Then go from the centre of the breast towards the collar bone and arm pit.

Step 6: Message in a circular motion. From the armpit towards the nipple in a circle like fashion.

Step 7: Place thumb and forefinger around the nipple squeezing gently to see if discharge is seen

Step 8: Repeat steps 3 to 7 laying down

We hope that we have inspired you to maintain your self check ups monthly not just yearly. If you have any questions or would like to know more follow our OSQ Facebook and Instagram accounts.

We hope to see you all soon at another one of our events.

Emma Micallef
1st Year Midwifery Student


suavinex group
40 YEARS as baby experts
A BABY BOTTLE INSPIRED IN YOU.
The first weeks together are unique. It's time to meet you, to find those little tricks that only work with your baby. That is why we have created the Zero.Zero baby bottle, designed and inspired by the mother's breast to help avoid colic and confusion between breast and nipple. So, you can enjoy the cuddles.
Zero.Zero™
Anti-colic bottle
0.0 colic. confusion.
*The World Health Organisation (WHO) recommends breastfeeding exclusively for the first 6 months of life.
ANTI-COLIC BAG
PATENT
THE BUBBLES DISAPPEAR
NEW SILICONE TEAT
BASED ON SCIENTIFIC STUDIES
MINIMIZES CONFUSION BETWEEN TEAT AND NIPPLE
EU MADE IN EUROPE
Tests approved by the Spanish Society of Paediatric Dentistry & recommended by the Italian Association of Specialists in Orthodontics
suavinex
FOR A MORE LOVELY WORLD

Group B Streptococcal Infection in Pregnancy and Newborn Babies

Amidst the global pandemic in these last years, babies continue to be born and debate continues around the best way to manage group B streptococcal infection (GBSI) during and after pregnancy. Although GBS are a group of benign bacteria commonly found in the vagina or rectum of healthy individuals (NHS, 2021; CDC, 2022), colonisation in pregnancy can sometimes leave serious implications in a neonate, if left untreated with high morbidity and mortality rates (NHS, 2021; RCOG, 2017).

GBSI could pass from the GBS positive mother to the fetus during labour (CDC, 2022). The Centers for Disease Control and Prevention (2022) affirms that a pregnant woman who tests positive for GBS and receives intravenous antibiotics during labour has a 1 in 4,000 chance of delivering a baby who will develop GBSI. If the woman does not receive antibiotics during labour, chances are significantly increased (1 in 200).

According to the Royal College of Obstetricians and Gynaecologists (2017) certain factors predispose the baby to a higher risk of developing GBSI. These include:

- Preterm labour – the earlier, the greater the risk
- Previous baby with GBSI
- Pyrexia or other signs of infection during labour
- GBS positive mother
- Prolonged rupture of membranes

Prevention is better than cure. However, locally the testing for maternal GBS status is still not routinely offered to all pregnant women. In view of this, in the antenatal period, families need to be routinely informed about GBSI and most importantly screening. This is one powerful way to prevent GBSI in neonates (CDC, 2022) and is important as GBSI is symptomless (NHS, 2021;CDC, 2022;RCOG, 2017). Women are to be provided with clear and up to date evidence based information to enable an informed decision. Screening should be offered between 36 and 37 weeks (CDC, 2022).

GBS disease may either be early onset (occurring in the first week of life) or late onset (up to 3 months of life) (CDC, 2022).

Signs and symptoms may include:

- Respiratory distress
- Sleepy/floppy/lethargic neonate
- Poor feeding/vomiting
- Hyper/Hypothermia
- Skin changes/Mottling
- Tachycardia/Bradycardia
- Hypotension
- Hypoglycaemia

(RCOG, 2017)

Most frequently, GBSI transmission happens soon after babies are born (NHS, 2021). At this time, the vast majority of women are still in-patients thus midwives in the postnatal wards have a crucial role in early detection and timely referral. Most babies with GBSI make a full recovery with appropriate timely treatment (RCOG, 2017). On the other hand, unfortunately, some babies may develop serious problems like sepsis, pneumonia or meningitis which could be fatal or leave lifelong implications (NHS, 2021; CDC, 2022;RCOG, 2017).

If a newborn develops signs of GBS infection, evidence strongly suggests that such an immuno-compromised cohort should be treated with immediate intravenous antibiotics (RCOG, 2017). Locally, babies are transferred to NPICU for intensive monitoring and escalation of treatment. Conversely, babies in the obstetric wards who appear to be generally well need to be monitored closely as most babies born to women who tested positive for GBS bacteria do not need treatment if their mother received antibiotics during labor (CDC, 2022). Women must also be informed that it is completely safe and paramount to breastfeed (RCOG, 2017). If the mother is unable to breastfeed for one reason or another, the mother should be supported to express breast milk if she wishes to do so (NICE, 2021).

Finally, although late onset sepsis is less prevalent, it should not be forgotten. Parents must be made well aware of signs and symptoms of infection in a neonate and where to seek help postnatally after being discharged home.

In conclusion, GBSI in pregnancy and the postnatal period must not be overlooked. Further awareness is solicited amongst all healthcare professionals involved in the care of pregnant women. It would be ideal if midwives take on a more active role in prevention, treatment, and monitoring of GBSI.

Reference list

Centers for Disease Control and Prevention. (2022). *Preventing Group B Strep Disease in Newborns.* https://www.cdc.gov/groupbstrep/about/prevention.html.

Hughes, RG, Brocklehurst P, Steer PJ, Heath P, Stenson BM on behalf of the Royal College of Obstetricians and Gynaecologists. (2017) Prevention of early-onset neonatal group B streptococcal disease. Green-top Guideline No.36. BJOG 2017;124:e280-e305

NHS. (2021). *Group B strep.* https://www.nhs.uk/conditions/groupb-strep/.

NICE. (2021). *Neonatal infection: antibiotics for prevention and treatment.* https://www.nice.org.uk/guidance/ng195.

Annabelle Cachia
B. Sc Midwifery

M.Sc Dissertation Abstracts

Pregnancy Nutrition Knowledge in Malta: An evaluation of current maternal and antenatal care providers' attitudes and knowledge, and development of a protocol for a trial of pregnancy nutrition education and support.

Background: Pregnancy is a determining period of future health for both the mother and her children and maternal nutritional status is a critical modifiable factor for maternal and foetal health. Poor maternal nutrition can lead to both immediate and long-term consequences in the offspring, while also affecting maternal health during pregnancy and postpartum

Aim: To investigate mothers' and antenatal care providers' (ACP) pregnancy nutrition knowledge in Malta and their attitudes towards it in terms of its provision and support. Results will also help to inform a protocol for a trial of pregnancy nutrition education and support.

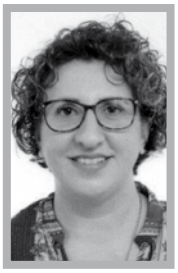
Methods: Mothers (n=100) in Mater Dei Hospital (MDH) Postnatal wards and ACPs (n=64) working in MDH completed a one-time questionnaire. Questionnaires were designed to assess maternal and ACPs' attitudes towards and knowledge of nutrition during pregnancy. Questionnaires included a combination of closed- and open-ended questions and were analysed using quantitative (t-tests; ANOVA) and qualitative (thematic analysis) methods.

Results: Despite ACPs recognising the importance of nutrition during pregnancy, knowledge scores of both mothers and ACPs were not adequate (mean scores of 41% and 54% respectively). Although ACPs obtained higher nutrition scores compared to women, nutrition knowledge gaps were still highlighted. Food safety was the most frequently discussed topic during pregnancy and both mothers and ACPs achieved the highest knowledge scores in questions relating to food safety. Mothers showed interest in pregnancy nutrition and actively searched for this information when they found out they were pregnant, however they reported receiving limited pregnancy nutrition advice, which reflects on clinicians reporting that they provided limited nutrition advice, which was described as 'general' and focused on food safety. Mothers also reported that receiving more pregnancy nutrition knowledge would positively influence their food choices. Clinicians reported having low confidence in providing pregnancy nutrition information, which was associated with significantly lower knowledge scores when compared to those with high confidence (64% and 52% respectively) (p=0.025 independent samples T-Test). This and other barriers such as lack of knowledge, time constraints and priority given to other topics were identified as limiting the ability for ACP to provide adequate pregnancy nutrition knowledge.

Conclusion: This study provides important insights into pregnancy nutrition knowledge and attitudes of mothers and ACPs in Malta. It demonstrates the need for targeted nutrition education programs for women to improve pregnancy nutrition knowledge and behaviours, which may lead to healthier maternal diets and improved maternal and infant outcomes.

Alison Boffa
B. Sc (Hons) Midwifery
M.Sc Nutritional Medicine

Newly Qualified Midwives' Lived Experiences of Caring for Women During Labour and Birth



Once student midwives successfully complete their midwifery training, they become newly qualified midwives [NQMs] and their professional midwifery career commences. One of the maternity settings where they provide midwifery care, is the birthing unit and this study focuses on the lived experiences of NQMs while working at this particular setting.

The aim was to elicit and understand the meaning of NQMs' lived experiences of caring for women during labour and birth. The objectives of this study revolved around capturing NQMs' experiences of caring for women during labour and birth, uncovering the meaning of these experiences and elicit any supportive measures which NQMs identify as helpful when caring for women during labour and birth in such initial phase of their career.

A Heideggerian hermeneutic phenomenological research approach was adopted and a purposive sampling technique was used to recruit ten participants. One-time, one-to-one, semi-structured, in-depth interviews were conducted with each of the ten participants in this study. These included NQMs employed at the main local hospital who had worked at the Central Delivery Suite [CDS] as part of their rotation period in the last two years post qualification. The research process and analysis of the data were guided by van Manen's (1990) six-step approach. Hermeneutic philosophical notions and the William Bridges transition theory (1991) guided the study and the interpretation of the findings.

Two themes and their corresponding subthemes emerged from the data. The theme Baptism of Fire captures all the challenges, hurdles and impediments that NQMs faced once they started their placement at the CDS. In the theme Containing the Fire, findings revealed that after some time, things started to fall into place and NQMs started to better cope with challenges and address obstacles they faced. The main outcome of this study reveals that NQMs'experiences at the CDS were impacted by the outcome of their placement at the birthing unit when they were still student midwives, as well as the support and guidance they found from their colleagues once they started their rotation period and became part of the team as qualified midwives. Many of the findings were congruent with the current literature, however there were a number of unique findings that emerged from this study. These include that working at the CDS and assisting a woman in labour and birth, gives NQMs a sense of fulfilment. Moreover, they viewed their experience at the CDS as the essence of midwifery and a steppingstone in the growth of their career, as they felt that they were now true midwives.

Several recommendations emerged from the study focusing on better assisting NQMs as they embark on their journey of caring for women during labour and birth. The main recommendation, based on the participants' narratives, is for NQMs to be assigned to a senior midwife when on the birthing unit, so they have someone to refer to for guidance and support.

Jeanette Gauci
B.Sc. (Hons) (Melit), M.Sc. (Melit.), RM, Dip, RN

Restoring Dignity to New Mothers Seeking Asylum

This study presents the ethical and human challenges arising in the journey of asylum seekers who are pregnant and how our healthcare system can be better prepared to tackle them.

The first chapter offers a critical analysis of the experiences new mothers face while crossing over to a new country by means of sea and how this affects the mother's dignity and her health. It also exhibits traumatization leading from the abuse (possibly even sexual abuse), and lack of privacy that these women endure and its effect on pregnant women's health.

The following chapter detail the health effects of the sudden, social, cultural changes and linguistic challenges on both mother and newborn, and how can the health care systems aid this transition. As both legal rights and opportunities may vary between citizens and those who are fleeing across borders illegally. The competences and training needed by the healthcare professionals to work with such cases are also to be explored in this chapter.

The third chapter then considers the emotional impact on the asylum-seeking mother in the postnatal period, the responsible authorities, and the healthcare workers responsibilities and duties in such situations. The standard of living situations that these mothers will experience after giving birth and the preparedness as a community in aiding their settlement.

While the fourth chapter considers the ethical issues and challenges which emerge through out these mothers' lived experiences of giving birth in a foreign place and their transitional period into a new society. Exploring what could be done from both healthcare sectors and society in general in order to facilitate this cultural and linguistic change, while conserving their well-being.

Conclusion: The study gave attention to how leaving one's country in search of a better life affects new mothers seeking asylum. These difficult situations influence people's health greatly and can even lead to the loss of life. The dissertation finally concludes with recommendations for policy makers, education, and training for healthcare professionals.

Ann Marie Meilak
B.Sc. (Hons) Midwifery
M.A. Bioethics

Women's Expectations, Experience and Satisfaction with Antenatal Care in Malta

Background: Women's expectations, experiences and satisfaction with antenatal care (ANC) are known to have a long-lasting effect on the women, newborn and the family as a whole. International research has demonstrated that women expect high quality care based on the principles of continuity of care and carer, respect, and individualised care. There is international agreement, including within the World Health Organization (WHO) that midwifery-led continuity of carer (MCOCr) models of care should be the mode of care offered to all low-risk pregnant women since this is safe, is more likely to meet the women's expectations, promotes positive experiences and increases satisfaction with care. However, despite the evidence and the WHO's recommendations, ANC in Malta is led by obstetricians within the fragmented national healthcare system (NHS) and the private sector against out-of-pocket payments.

Research Aim: This study aimed to explore women's expectations and satisfaction with Antenatal Care in Malta as well as gain an insight into local women's views on continuity of carer (COCr) and midwifery-led continuity of carer (MCOCr) models of care.

Methods: A cross-sectional study involving 284 local women who had received ANC in Malta and had given birth between December 2019 and December 2021, were recruited via convenience sampling. Data from consenting participants was collected in Maltese or English through a self-administered online questionnaire using a combination of closed-ended and open-ended questions. An adapted version of the Patient Expectations and Satisfaction with Prenatal Care Tool (PESPC Tool) was used to assess women's expectations and satisfaction with ANC through the Likert scale. Participation was on a voluntary basis and anonymity was strictly maintained. Data was analysed using descriptive and inferential statistics using SPSS. Answers from open-ended questions were thematically analysed to identify common themes about women's views and perceptions of COCr and MCOCr. Permissions to conduct this study were sought and granted by the Hannover Medical School and the University of Malta's Faculty of Health Sciences Research Ethics Committees.

Findings: Women expect to receive continuity of carer, preferably within midwifery-led models of care. They also expect to receive clear information and good communication which also focuses on psychological care. Participants who did not receive COCr and received most of their care within the NHS expected improved care and services (4.6%). Women who received COCr were 13.8% more satisfied with the care they received, compared to women who did not receive COCr. However, when adjusting for possible cofounding factors only a relationship was found between the presence/absence of COCr and satisfaction with care, due to the imbalance within the population of the two groups. Despite some women lacking the general knowledge about the 'true', 'wider' role of the midwife, possibly since the role of the midwife in ANC is limited in Malta, 83.5% of participants expressed interest in MCOCr models of care, with some claiming that they have a right to be able to access this model of care, and for it to be offered to all women within the NHS.

Conclusion: Women greatly value ANC and are overall satisfied with the care they received however they do expect improvements, particularly when it comes to care offered within the NHS. They expect COCr, preferably within midwifery-led models of care and expect the midwife to play a larger role in the provision of ANC.

Jolene Camilleri Chircop
B.Sc. (Hons) Midwifery, MSc. Midwifery

A Mother's Experience

Catheterization in Elective Caesarean Section Pre-Spinal Or Post-Spinal?

The first time I experienced trauma from catheterization insertion was during a gynaecological surgery that was done under emergency conditions for vaginal bleeding. This left me with a urinary tract infection and incontinence for a number of days post-op. This time, for my planned C-section, I asked the midwife in charge whether it would be possible to have the catheter inserted after anaesthesia, to prevent me from another traumatic experience. Despite my explanation to the midwife, I was told that the current practice is to have it inserted before entering the operating theatre.

I already knew about the discomfort that I had to pass through but there was little time to process all that was happening. I was told that we were running late for the C-section. This situation was very stressful for me.

On trying to insert the catheter, I found it hard to cooperate due to my past psychological and physical trauma. The procedure was also painful. Time was ticking and the midwife started to become impatient that we would be late for the operation. This made me even more anxious and even less cooperative.

Finally, after two attempts, the catheter went in. But unfortunately, after a couple of seconds it went out again, and the procedure had to be repeated. More time was being lost and a second midwife was summoned to help. She calmly took charge of the situation and told me that if unsuccessful they can insert it in theatre. In fact, the catheter had to be inserted post-spinal anaesthesia on the operating table. The process this time was smooth and it was done in a matter of seconds. For me, the insertion of the urinary catheter post- spinal injection was totally painless.

The question that arises from this experience is: why do C-section patients have to pass through a negative traumatic catheterization experience pre-anaesthesia when the same procedure could potentially be done post- spinal injection without any pain.

For example, across a number of hospitals in the United Kingdom, it is routine practice to have the catheter inserted post-anaesthesia[1]. Furthermore, as argued by Prof Weiss (2021)[2] childbirth and postpartum educator *'The bladder catheter would ideally not be placed until after the spinal/epidural is working well. This will prevent you from feeling the insertion. While putting in a catheter isn't terribly painful, it is uncomfortable, particularly when you're also having contractions. If someone asks to do the catheter before you get an epidural, ask them if there is a reason that it can't wait until after the epidural is in and working. This is usually not a problem'.*

So is there a local justified medical reson for which catheters are inserted before the spinal anaesthesia is given? Why is catheterization not done post-spinal injection? Is this just a matter of a routine procedure, or a hospital protocol? Or is it for time or logistic reasons?

Over the past years a number of medical researchers, amongst them Lang, et al (2001)[3] have gone a step further and argue that 'The use of an indwelling urinary catheter is an unnecessary part of Caesarean delivery and patients undergoing caesarean sections (elective/ repeat, urgent, or emergent) can safely avoid the use of an indwelling urinary catheter' following a research study that they carried out.

Is it thus time to re-evaluate C-section procedures at Mater Dei Hospital?

References

[1] What happens – Caesarean section, NHS. Retrieved from https://www.nhs.uk/conditions/caesarean-section/what-happens/

[2] Weiss, R.E. (2021). Urinary catheter use in labor and delivery. Retrieved from https:/www.verywellfamily.com/urinary-catheter – 2759013

[3] Lang, J.F. et al. (2001). Use of indwelling urinary catheter at Caesarean delivery. Obstetrics & Gynaecology, Volume 97. Issue 4, Supplement 1 April 2001, p.S66. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0029784401013035

Mother

Pampers.
premium protection™

Our best and softest protection for baby's sensitive skin.

vjsm.com.mt | VJ Salomone Marketing | 8007 2387

Pioneered to benefit the mother and baby's unique breastfeeding bond

Swing

comfortable. silent. efficient.

Express milk quietly and discreetly – The Swing electric Breastpump combines a multi-awardwinning design with the latest technology. The electric breastpump is very quiet and therefore represents the ideal solution for regular and discreet breast pumping.

Medela breastpumps can help to prolong breastfeeding. With the integrated 2-Phase Expression they mimic the baby's natural sucking rhythm to express more milk in less time. Short, stimulating patterns are followed by longer, more intensive ones, providing optimal milk flow. As a leader in breastfeeding solutions, we are delighted to be able to support you – also with advice and practical help to suit your changing needs. **www.medela.com**

medela

Baby Protective Facial Cream

ideal for pH 5.5 healthy skin
sebamed®

The moisturizing complex in SebaMed's **Baby Protective Facial Cream** prevents dryness, enhancing the barrier function against noxious substances and soothing baby's tender skin.

Contains panthenol and lipid compound which protect against irritation around the mouth from saliva. The presence of Vitamin E safeguards against harmful environmental influences.

Available from all leading pharmacies

europharma

Sole Distributors
Europharma Ltd
Catalunya Buildings, Psaila Street, Birkirkara Tel: 2385900
www.europharma.com.mt info@europharma.com.mt

Sona®

RECOMMENDED FROM BIRTH

Baby Biotic

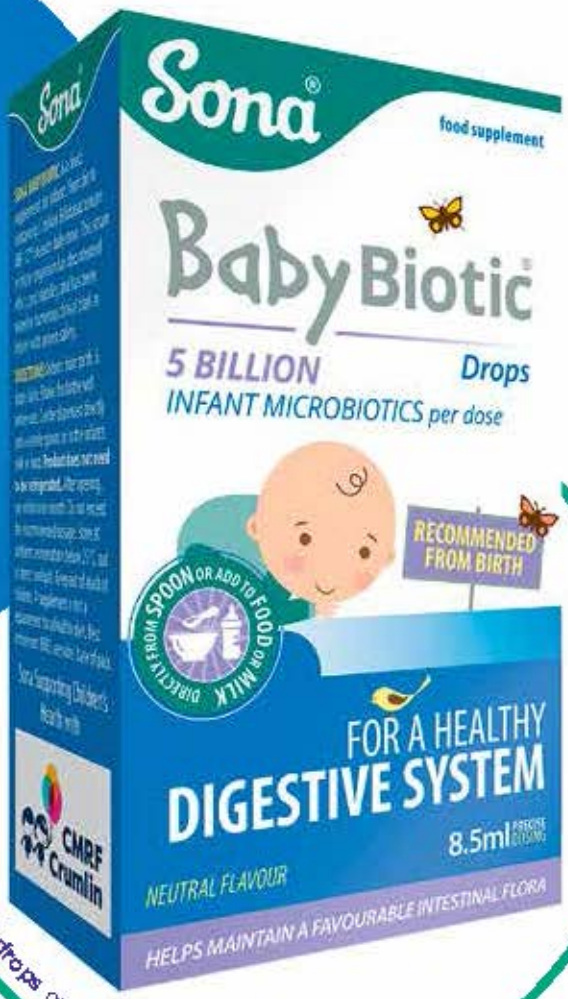
INFANT PROBIOTIC DROPS

Combats Diarrhoea

Boosts Immunity

Strengthens Intestinal Flora

Reduces Colic & Irritability



DIRECTLY FROM SPOON OR ADD TO FOOD OR MILK

6 DROPS

Administer 6 drops onto a spoon or into milk/food

Sona®
Feel good

@SmithsPamaPharmacy

Mustela®

New organic ingredients

Still the same fragrance

Skin care for every skin type!

DRY SKIN | NORMAL SKIN | VERY SENSITIVE SKIN | ECZEMA-PRONE SKIN

@mustelamalta

@mustelamalta