

12/5/17
contents



Midwives Journal

**VANCOUVER
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TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

From: *Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services, A joint WHO/UNICEF Statement, Published by the World Health Organization, 1211 Geneva 27, Switzerland, 1989.*

FRONT COVER:

The five delegates from the Midwives Association Malta. *From left:* Mrs. R. Farrugia, Ms. M. Abela, Ms. M. Vella Bondin, Mrs. M. A. Formosa, Ms. J. Borg Micallef.

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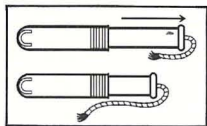
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FETAL HEART RATE MONITORING IN LABOUR

M. C. Spiteri R.G.N., R.M., A.D.M., P.G.C.E.A.

Introduction

It has been known for the last 160 years that the fetal heart rate patterns vary during uterine contractions when the mother is in labour (Inch, 1982, p. 86). While in the majority of labours the fetal heart rate variabilities are a normal response of the fetus to labour or delivery stress, in some cases such changes may be a warning sign that there is a deviation from normal. These facts form the basis of frequent checking of the fetal heart rate pattern.

Methods vary from the use of a fetal stethoscope (auscultation) to listen to the unborn baby's heartbeat and feeling the mother's abdomen to assess the frequency and strength of her contractions, to the use of the electronic apparatus (Maternity Services Advisory Committee, 1984, p. 9). The Pinard fetal stethoscope has long been accepted as a valuable tool of the midwife to confirm the presence of the baby's heartbeat and to reassure the mother that her baby's heart is still beating.

It was not until the 1950's that continuous monitoring of the fetus during labour by electronic means was proposed as a way to prevent poor fetal outcome (Klapholz, 1986, p. 93). By the late sixties, intrapartum fetal monitoring by continuous cardiotocography had become accepted as a tool in the management of labour in British hospitals.

The fetal heart activity may be recorded externally with an abdominally placed transducer which picks up blood flow in the great vessels of the fetus and analyses fetal heart pulse intervals (Morton, 1986, p. 32). It may also be recorded internally via an electrode attached to the baby's scalp and it transmits fetal cardiac electrical activity.

The uterine contractions are picked up and recorded by the uterine tocodynametre positioned on the curvature of the uterine fundus. Contractions can also be recorded internally via the uterine catheter, introduced through the cervix into the amniotic cavity after rupture of membranes. The recordings of the fetal heart rate and uterine activity

are traced on a graph paper running at a speed of one or three centimeters per minute.

Interpretation of the Fetal Heart Rate Pattern

In recent years the electronic system of recording the fetal heart rate pattern has been used in preference as it has been considered more reliable than the fetal stethoscope. The normal cardiotocograph demonstrates a baseline heart rate of 120 to 140 beats per minute, with the acceleration rate coinciding with fetal movement and uterine contractions. The Pinard can pick up the baseline heart rate, but it is unable to detect the brief changes in the fetal heart rate or baseline variability.

Fetal bradycardia of less than 120 beats per minute or fetal tachycardia of greater than 160 beats per minute and loss of baseline variability with or without contractions, indicate fetal compromise and are easily detected on the monitor.

The use of the fetal stethoscope does not so easily provide such warning signs of fetal hypoxia. Whilst such recordings of the fetal heart rate variabilities are continuously visualised on the screen of the monitor throughout labour, the intermittent auscultation with a fetal stethoscope may constitute less than 2% of the time a mother spends in labour.

The relationship of the fetal heart rate in early or late decelerations to the uterine contractions are easily visualised and traced on the graph paper. The Pinard is very limited in giving such information. During a uterine contraction, the fetal heart cannot easily be heard by auscultation and the procedure itself may cause discomfort to the mother.

The monitor however can restrict the mother's movements; she cannot walk about freely unless a telemetry or a handheld transducer is used. She cannot relax in a bath with any of these sophisticated methods. The mother can also find the concept of an electrode physically attached to

her unborn child's head unacceptable and painful for the baby.

The fetal stethoscope provides good information antenatally from 24 to 28 weeks gestation onwards when the fetal heartbeat can be heard clearly abdominally with the Pinard. It is also useful when the mother is in labour. The midwife needs to check the fetal heartbeat between the uterine contractions.

Through practice one can find that the Pinard is a useful tool to pick up the baby's heartbeat at the best place before applying the ultrasound transducer. It saves the apprehensive mother much anxiety and fear that all is not well with her baby until the sensor (ultrasound transducer) is adjusted properly and the fetal heart is clearly identified by the mother and the midwife. Furthermore, gel is applied to the sensor for better transmission and it can be very messy on the mother's abdomen. However an abdominal palpation, followed by auscultation of the fetal heart rate before applying the transducer avoids such unnecessary and insensitive practice.

Selection of mothers for monitoring with Electronic Fetal Monitor

The Dublin trial, MacDonald et al (1985), revealed one advantage of electronic fetal heart rate monitoring (EFM) over intermittent auscultation. When EFM is used in conjunction with fetal scalp blood sampling and appropriate clinical action (eg nurse the mother on one side, stopping the oxytocin infusion if in progress, detecting any hypertension, decision for intervention by caesarean section or forceps delivery), the rate of early neonatal seizures was significantly reduced.

Other randomized trials of electronic fetal monitoring by Renow et al (1976) showed a major decrease in fetal neurological damage in monitored mothers. In their study high risk mothers were randomized to monitored or auscultated group. There was one stillbirth thought secondary to asphyxia in the auscultated group.

Thirteen babies in the auscultated group had neurological abnormalities compared to two in the monitored group. Four of the auscultated infants showed evidence of brain damage in long term follow-up. Studying such researches one would be inclined to monitor all mothers in labour (re EFM and Fetal Blood Sampling), irrespective of their classification as high or low risk. However, this suggestion can be a controversial issue as to what

a "normal" fetal scalp pH should be and what endpoint a particular pH should predict (Beard, 1971, p. 874).

Severe acidosis can occur with normal fetal heart rate patterns (Painter, 1978, p. 271). When electronic fetal monitoring and fetal blood sample pH are used in combination, they have a 7% false negative rate in predicting a five minutes Apgar score of less than 7 (Wood et al, 1981, p. 527). The predictive value of electronic fetal monitoring or fetal blood sampling is poor, because the incidence of fetal asphyxia and its consequences is low in a low risk population (Klapholz, 1986, p. 102).

Scientific evidence has not solved the problem of which mothers should be monitored continuously with the electronic fetal monitor – the high and the low risk or the high risk only!

Antenatal screening does not always have a part to play in deciding who should be monitored continuously in labour. Unexpected events such as meconium staining of the amniotic fluid can indicate the presence of additional risk to the fetus, who needs continuous fetal heart rate monitoring.

Regular intermittent fetal heart rate monitoring in normal and healthy mothers in the first stage of labour can also indicate who should need continuous fetal heart rate recording.

Suspicious fetal heart rate recordings are best backed up by a fetal scalp blood sampling, to estimate the fetal pH. Normal values are 7.30 to 7.35 (Sweet, 1988, p. 496). Series of fetal blood pH should be carried out, if possible to have a comparison of results. It is a known fact that a well grown fetus can maintain a normal pH for up to ninety minutes even in the presence of marked hypoxia, thereby providing the obstetrician with false reassurance (Fleischer, 1982, p. 55).

Psychological aspects of fetal monitoring: Maternal Reaction...

The use of electronic fetal heart rate monitoring during labour has changed the labour suite atmosphere from a birthing room to an intensive care unit. A mother seeking a "natural childbirth" may not wish intrapartum monitoring whilst another mother who has experienced fetal losses may consent to monitoring very willingly.

Starkman's Studies (1976) shows the positive and negative reactions to intrapartum fetal monitoring. The monitoring was viewed as a protector during the absence of the staff from the room, especially to women who had experienced fetal losses. The fetal monitoring was utilized by the mothers as a way to relieve anxiety. It provided the midwives with more accurate information about the mother's contractions that the mother could no longer describe because of the administration of regional anaesthesia.

The monitoring affected interactions with the women's husbands in participation and sharing of the husbands in the experience of labour.

The monitor served as a means of distraction to pass time, an aid of mastery of contractions and for monitoring Lamaze phases. The women felt that they could tolerate pain better, knowing that the worst of each contraction had already been experienced.

Starkman's report revealed very few totally negative reactions against fetal heart rate monitoring. Several mothers resent monitoring because attention was diverted from them to the monitor, in times when they really needed attention themselves. Others were irritated because the monitor as "A Mechanical Monster" in being a source of physical discomfort, by insertion of internal electrode and of wires dangling between their legs, by fearing that they might injure their baby if they moved. They felt unable to change position and be active. Uterine contractions were then intolerable and they needed more sedation.

The majority of mothers accept fetal heart rate monitoring but still monitoring can also be a source of anxiety. Inconsistent information regarding the use of the machine may be the cause of anxiety in the mothers. They may interpret monitors as being only used in problems in labour and not in normal labours. They become apprehensive and suspicious when the midwife decides to use an available monitor to obtain the basic measurements of the fetal heart rate and uterine activity.

Another source of anxiety may be created when circumstances, as when meconium stained amniotic fluid may alert the mother of a potential problem. Prior to the introduction of the fetal monitors the midwife might note the condition and used to be more watchful to the possible complications of fetal hypoxia. Since fetal monitors are now used, the mother is told about the possible fetal hypoxia which

may necessitate intervention if the machine indicates irregularities in the fetal heart rate.

Other anxieties come from fears and fantasies, related to monitors being a potential danger to the unborn child, eg. fetal electrode being the source of pain for the baby or the ultrasound monitor may transmit energy to the baby and may provide harm later on in life. These anxieties are related to complete and conflicting information on such technology.

Another anxiety may be due to the unavoidable continuous noises the monitor emits, showing the changes in the fetal heart rate. The mother needs reassurance and clear explanation of the tracings.

Anxiety may be expressed as dissatisfaction. A mother who may have a prior experience of "natural childbirth" and a healthy infant, may express total resentment at the interference of the monitor if she were to need the machine in subsequent labours. She may feel 'out of control' and she may miss her previous fulfilling experiences of "natural childbirth".

How can the mother and her partner be familiarized with the fetal monitors?

The young couple may obtain knowledge about fetal monitors from relatives or friends who have already gone through the system of fetal heart rate monitoring. They may obtain further information through reading literature and through the media. The best source of information about fetal monitors may be available in the childbirth classes, where the midwife discusses with the group of parents, the pros and cons of the use of fetal monitors. Group discussions on the subject give the couples an opportunity to learn others' views on the equipment. A tour in the maternity unit where the mother is to have her baby, is very helpful as she can observe for herself such technology being used.

During labour, the midwife explains further why the monitor is needed to be used, either for short or long periods. The midwife may encourage the mother to express her feelings about the monitor during the course of labour. The mother may also offer suggestions concerning the use of fetal monitors.

The Midwife

Through their studies Garcia et al (1985) found that the method of fetal heart rate monitoring (eg. intermittent auscultation or continuous

electronic fetal heart rate monitoring) was less important to the mother in labour than the support and reassurance she received from the midwife. The need to receive human comfort and to have someone with whom the mother can discuss her anxieties can in no way be met by the monitor.

The midwife is unique in providing sufficient reassurance and helping the mother feel more or less in control. Personal care can be further valued when the midwife is competent enough to interpret the tracings and explains and discusses such tracings to the parents.

Many midwives take great pride in their ability to read and interpret the fetal heart rate recordings. The use of such recordings may be more intellectually stimulating than listening to the fetal heart with a fetal stethoscope.

There may be a tendency for the midwife to lose her skills once she depends entirely on the machine. She may lose her sensitivity and awareness of a caring professional in failing to realise who is the right candidate for continuous fetal heart rate monitoring. Furthermore she may fail to realise that unnecessary intervention may affect the mother's progress in labour.

The role of the midwife as an expert in normal childbirth becomes increasingly important in the face of new and complex technology. As an advocate for parents' choices her responsibilities increase as the use of obstetrical technology proliferates (Van Wagner 1987, p. 29).

It is important that the midwife shares information and experience of clinical practice with other midwives because such education is a continuum throughout the midwife's professional life.

Ethics

As the practice of midwifery becomes more and more complex through scientific advances, the midwife must be aware of the impact of the ethical implications. Should every mother in labour be put on a fetal monitor? Is the scalp electrode always necessary with the rupture of fetal membranes? The midwife must be certain that the mother does not suffer unduly through her clinical practices and she works towards her ultimate goal to have a safe delivery for the mother and baby. It has been said that the brain of the midwife must take counsel from the heart!!

The Risk of Electronic Fetal Monitoring

With every technological advance the risks and benefits must be weighed. Concern has been expressed with regard to the safety of the ultrasound monitors since energy at the 1-10 mW/cm² level at the transmitting crystal surface is employed. However no data yet suggests that the level of energy is harmful to the fetus (Klapholz et al, 1986, p. 112).

There are specific risks from electronic fetal monitoring via the scalp and fetal blood sampling, due to the incidence of infection and significant haemorrhage from scalp lacerations (Overturf et al, 1975, p. 244).

Maternal risks include increased infection rate and discomfort of monitoring itself. Another risk is the needless intervention in normal, low risk labours due to the obstetrician's reaction to a false positive test (Klapholz et al, 1986, p. 112). Most studies indicate that the majority of the increase in caesarean section rates is due to a change in the management of cephalopelvic disproportion, breech presentation and pre-term infants, rather than the intervention because of fetal distress (Hall et al, 1976, p. 496).

Haverkamp et al (1976) showed an increase in caesarean section rate for fetal distress – 16.5% versus 6.8% in the auscultated group. However, they further showed that fetal blood sampling was able to decrease the caesarean section rate for fetal distress to 3%.

Cost

The cost of a caesarean section delivery is much more than a vaginal delivery. If a number of monitored women are incorrectly diagnosed, a substantial additional amount of money is needed, increasing the financial burden on the Health Service. There is a considerable number of fetal monitors in every maternity unit and the life-span of each machine is guaranteed for five years. Where the rate of birth is large enough to necessitate the need of the monitors in use for 24 hours daily, it is of the utmost importance to have technical staff available for 24 hours machine maintenance. Papers and other supplies add to the expenses, and the cost of fetal monitoring would be even higher were all mothers in labour monitored continuously 24 hours daily.

However, the cost of fetal life, happy childhood, healthy adulthood, happy families, and a healthy nation are priceless in monetary cost. The diagnosis of early hypoxia with the aid of the electronic fetal heart rate monitors, followed by effective clinical management prevents the undesired outcome of a brain damage infant. It is much more costly, physically, emotionally and financially, to treat a sick newborn in an intensive care unit and to support him and his family for life. Healthy children reflect a healthy nation.

Conclusion

Electronic fetal heart rate monitoring is a major scientific and clinical advance in obstetrical and midwifery care. Its measurement of uterine contractions and fetal heart rate during labour, supported by fetal blood sampling provide the opportunity of early identification of fetal hypoxia and intervention before irreversible fetal cerebral damage or fetal death occurs. The fetal monitor's use has obviously surpassed that of the Pinard's fetal stethoscope, yet the Pinard's traditional significance remains always respected.

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DRUG USAGE IN MALTESE PREGNANT WOMEN

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During pregnancy drugs are used primarily to treat maternal disease, but the fetus also becomes a drug recipient. Consequently medication prescribed during pregnancy may result in unexpected and occasional tragic effects in the developing fetus for whom the drug was not intended. Drug usage in pregnancy and lactation has been the subject of many reports. It is generally believed that drug intake in pregnancy is high, and variable in different countries. This study attempted to identify drug usage during pregnancy in Maltese women.

MATERIAL AND METHODS

This study formed part of an international multicentre study on Drug Usage in Pregnancy organized by the WHO-Euro. A 100 pregnant women delivering during the period 8-16th October 1987 were questioned before discharge from the hospital, while their hospital files were reviewed so that the standard survey forms could be completed. This population accounted for 1.8% of the deliveries registered in the Maltese Islands during the year of the survey. This study population included two sets of twins, one stillbirth, 5 cases of preterm births (under 36 weeks gestation) and six infants with congenital malformations.

RESULTS

The majority of women (99%) received some form of medication sometime during their pregnancy, so that only one patient received no therapy at any time during the pregnancy. A large proportion (96.97%) of women received drugs antenatally, while 75.76% and 62.63% received drugs during the intrapartum and postpartum

periods. More medications were prescribed however during the latter two periods of pregnancy than during the antenatal period (Table 1). The pattern of drug prescription in Malta compared favourably with that reported from other countries (Savona-Ventura and Grech, 1990/91).

ANTENATAL USE OF DRUGS

Ninety-six women out of a hundred took some form of medication antenatally with a total number of 177 prescriptions. The majority of prescriptions (96.05%) were commenced after conception and only 4 women received 7 prescriptions pre-conceptionally for medical disorders pre-dating the pregnancy. This therapy was continued during the pregnancy. The majority (62%) of pregnancies were planned, while only 15% of women were using some form of contraception (natural methods) when pregnancy occurred. None were using hormonal contraception or had an IUCD in situ at the time of conception. Before pregnancy 6% of women were on oral contraceptives, but stopped the medication with a view of getting pregnant. Thirty-four women were cigarette smokers and only two of these (6%) stopped prior to a planned pregnancy. Eighteen (53%) continued to smoke until pregnancy was confirmed, while 14 (41%) continued to smoke throughout their pregnancy. Alcohol was taken on social occasions by 65 women pre-conceptionally, but only 23 women took alcohol at any time during their pregnancy. Coffee, tea and cola intake varied little during pregnancy when compared to pre-conceptual habits (Table 2).

The seven prescriptions given to four women pre-conceptionally included therapeutic measures for treating hypertension, psychiatric states and

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Advisory Board: P. K. Lunde (IUPHAR), M. N. G. Dukes, I. Linde, M. Wagner (WHO-EURO).
Malta coordinator: C. Savona-Ventura.

TABLE 1: *Drug therapy during pregnancy and lactation.*

DRUG THERAPY	WOMEN		PRESCRIPTIONS		mean no. drugs per woman
	no.	%	no.	%	
No prescriptions	1	1.0	-	-	-
ANTENATAL PERIOD					
Preconception	4	4.0	7	1.3	1.75
Antenatally	95	95.0	170	30.9	1.79
INTRAPARTUM PERIOD					
	75	75.0	238	43.2	3.17
POSTPARTUM PERIOD (Breastfeeding women)					
	62	62.0	136	24.7	2.19
TOTAL	100	-	551	-	5.56

TABLE 2: *Self administered habitual "drugs".*

		preconception no.	postconception no.
CONTRACEPTIVES	(hormonal)	6	-
	(other)	40	15
SMOKING	part of pregnancy	34	32
	all of pregnancy		18
ALCOHOL		65	23
COFFEE:	seldom	24	24
	<3 cups/day	38	34
	>3 cups/day	19	13
TEA/COLAS:	seldom	17	16
	<3 cups/day	45	47
	>3 cups/day	27	26
TOTAL		100	100

bronchial asthma. These prescriptions were continued throughout the pregnancy. The drugs included Neuroleptics (Maloferidol, Benzhexol); Antihypertensives (Methyldopa), Diuretic (Fursemide), Mineral/electrolyte (Potassium chloride), Sympathomimetic (Pseudoephedrine), and Corticosteroid (Bechomethasone).

Altogether 95 women had 170 prescriptions ordered during the antenatal course of their

pregnancy. The majority of these took haematological (91.6%) and metabolic/nutritional drugs (29.5%), these accounting for the majority of prescriptions (56.2% and 18.8% respectively). Only 41 women (43.2%) received other drugs during their pregnancy with 42 (24.7%) prescriptions. The majority of these were anti-infectives prescribed systemically or topically. The remainder were prescribed for a number of medical disorders which appeared during the pregnancy to

alleviate minor symptomatology and to manage specific obstetric problems such as habitual abortion and preterm labour (Table 3).

INTRAPARTUM PRESCRIPTION were given to 75 women each of whom received a mean of 3.17 prescriptions. A number of these prescriptions (62/26.1%) were indicated for the induction and maintenance of general anaesthesia which was administered to 12 women undergoing Caesarean section (4 elective and 8 emergency). The drugs used included the general anaesthetics nitrous oxide, halothane, etomidate, and thiopentone; the narcotic analgesic fentanyl; the parasympatholytic atropine; and the muscle relaxant pancuronium and suxamethonium. A further number of prescriptions (98/41.2%) were administered for analgesia during labour, these including the narcotic pethidine; the neuroleptic promazine; the general anaesthetic trichloroethylene; and the local anaesthetic lignocaine.

A further number of intrapartum prescriptions (63/26.5%) were made to augment or delay the process of labour with the administration of oxytocin, dinoprostone, and salbutamol. The remaining prescriptions (15/6.3%) were administered to the women for a variety of indications and included anti-infectives, anti-

hypertensives, anti-emetics/antacids, tranquilizers, and corticosteroids – the latter drug being used to augment fetal lung maturity in two cases of preterm labour (Table 4).

POSTPARTUM PRESCRIPTIONS were given to 62 women who received a mean number of 2.19 prescriptions. The postpartum period was considered to commence right after the end of the second stage of labour. Sixty-five women in the study group (65%) were breastfeeding or were planning to breastfeed. None of the patients who were artificially feeding their infants received drugs to suppress lactation during their stay in hospital. The majority of women received drugs for the third stage of labour to prevent postpartum haemorrhage in the form of syntometrin accounting for 43.4% of postpartum prescriptions. A further 36.8% of postpartum prescriptions were given as local analgesia in the form of lignocaine. The remaining 27 prescriptions were administered for a variety of other purposes (Table 5).

DISCUSSION

The thalidomide story in the late 1950's which produced the well-defined fetal abnormalities served to illustrate that drugs administered during the first trimester of pregnancy may be potentially harmful

TABLE 3: *Antenatal Prescriptions.*

DRUG CLASS	no. of women		no. of prescriptions	
	no.	%	no.	%
HAEMATOLOGICAL	87	91.6	97	56.5
METABOLIC/NUTRITIONAL	27	28.4	32	18.8
ANTI-INFECTIVES	19	20.0	20	11.8
B-SYMPATHOMIMETIC	4	4.2	4	2.4
ANTIHISTAMINE	1	1.1	1	0.6
ANTIHYPERTENSIVE	1	1.1	1	0.6
DIURETIC	1	1.1	1	0.6
ANTIEMETIC	4	4.2	4	2.4
ANTIDIARRHOEAL	1	1.1	1	0.6
LAXATIVE	1	1.1	1	0.6
EXPECTORANT	2	2.1	2	1.2
SEX HORMONE	1	1.1	1	0.6
ANALGESIC/ANTIPYRETIC	3	3.2	3	1.8
ERGOT DERIVATIVE	1	1.1	1	0.6
MISCELLANEOUS	2	2.1	2	1.2
TOTAL	95		170	

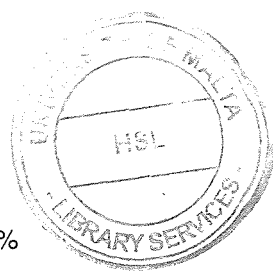


TABLE 4: *Intrapartum Prescriptions.*

DRUG CLASS	no. of prescription	
	no.	%
GENERAL ANAESTHETICS	30	12.6
NARCOTIC ANALGESIC	56	23.5
NEUROLEPTIC	50	21.0
PARASYMPATHOLYTIC	4	1.7
MUSCLE RELAXANT	21	8.8
LOCAL ANALGESIC	1	0.4
PITUITARY HORMONE	49	20.6
PROSTAGLANDIN	13	5.5
B-SYMPATHOMIMETIC	1	0.4
ANTI-INFECTIVE	2	0.8
ANTI-EMETIC	2	0.8
ANTACID	1	0.4
ANTI-HYPERTENSIVE	5	2.1
DIURETIC	1	0.4
CORTICOSTEROID	2	0.8
TOTAL	238	

TABLE 5: *Postpartum prescription in Breastfeeding women*

DRUG CLASS	no. of prescription	
	no.	%
PITUITARY HORMONE + ERGOT	59	43.4
ERGOT DERIVATIVE	1	0.7
LOCAL ANALGESIC	50	36.8
ANTI-INFECTIVE	4	2.9
ANTI-EMETIC	2	1.5
NARCOTIC ANALGESIC	3	2.2
ANTI-HYPERTENSIVE	3	2.2
IMMUNOGLOBULIN (Anti-D)	3	2.2
CORTICOSTEROID	2	1.5
PARASYMPATHOLYTICS	5	3.7
PARASYMPATHOMETICS	2	1.5
NEUROLEPTIC	2	1.5
TOTAL	136	

to the fetus by causing teratogenesis. This resulted in the routine testing of drugs in experimental animals before release for use during pregnancy. However, some of the drugs known to be teratogenic in laboratory animals are apparently not teratogenic in humans and vice-versa. Furthermore the detrimental effects of diethylstilboestrol on the offspring long after delivery served to stimulate a

more cautious approach towards drug usage in pregnancy. Drugs taken later in pregnancy may also put the infant at risk by interfering with metabolic processes.

During pregnancy drugs are prescribed primarily to treat or prevent maternal disease. While as a general rule drugs should only be prescribed to

pregnant women when absolutely indicated, this study shows that the major proportion (97.0%) of women received some form of medication antenatally with a mean number of drugs per women approximating 1.8. The majority of these prescriptions (73.5%) were however haematological or nutritional supplements in an attempt to prevent deficiency anaemia during pregnancy. It remains doubtful whether well nourished women require Iron and vitamin supplementation during pregnancy since the average diet contains adequate amounts of these substances and the physiological readjustments of pregnancy enhance absorption and utilization when required (Landon, 1975; Lind, 1983). However even in developed countries faulty nutrition in contrast to under nutrition may be difficult to identify and may predispose to nutritional deficiencies, particularly in women who may have suffered from menorrhagia before becoming pregnant. Folate supplementation is particularly important in conditions that increase folate requirements such as multiple pregnancy, high alcohol intake, chronic haemolytic anaemias and anticonvulsant therapy. Calcium supplementation, prescribed to 11 patients in this study, has been shown to be unnecessary since in the overwhelming majority of pregnant populations there is sufficient positive calcium balance without depleting maternal bone reserves (Pearson, 1984). It has been shown that in the Maltese set up there has been little change in the frequency and causes of pregnancy anaemias over a period of twenty years, in spite of the more frequent use of prophylactic haematological agents. It has been suggested that these agents should not be prescribed indiscriminately, but should be used only when indicated by a low haemoglobin and MCH levels (Zammit and Savona-Ventura, 1992). Iron supplementation is associated with a number of side effects ranging from allergy to gastrointestinal disorders. High haemoglobin levels and increased iron stores have been associated in various studies as "risk factors" for myocardial infarction, cancer, and rheumatoid disease.

The other main indication for drug usage (11.8% antenatal prescriptions) appears to be anti-infective agents, mainly antimicrobials administered systemically or topically. There is no evidence that any of the antimicrobial drugs approved for general use, with the possible exception of the tetracyclines and rifampicin, are teratogenic in man. On the other hand however a number of antimicrobials have been identified to be teratogenic in animals

(Batagol, 1983). In later pregnancy antimicrobial drugs may compete with fetal metabolic pathways causing significant problems in the neonatal period especially in the premature infant (Lewis, 1978). The general principle that only well established drugs are administered to pregnant women applies significantly to antimicrobial prescriptions.

The other antenatal prescriptions in this series were prescribed pre-conceptionally or during the antenatal period for a variety of medical conditions. Women appeared to be overall aware of the possible adverse effects of drugs on their fetus, but were reassured when these were prescribed by their medical practitioners. This awareness that chemical substances may adversely affect their unborn child extended to tobacco and alcohol, since the majority of women decreased significantly their smoking and alcohol habits during their pregnancy. The smoking behaviour in pregnant Maltese females has been previously reviewed (Bonnici et al, 1989) to show that 37.5% of females stopped smoking on discovering they were pregnant, while a much higher percentage (63.4%) attempted to stop.

The more active intervention policy during the intrapartum period to prevent maternal and fetal morbidity and mortality has resulted in more frequent administration of drugs during labour and delivery. Thus 75.6% of women received some form of medication during labour with a mean number of drugs per woman of 3.17. The majority of these drugs were used for induction/augmentation of labour, intra-partum analgesia and intra-operative anaesthesia. The use of intra-partum analgesia and intra-operative anaesthesia in Maltese women has been previously reviewed (Savona-Ventura, 1984). The use of systemic analgesia and anaesthesia was shown to be associated with depressed Apgar scores of the infants, though this may not have been the result of a direct association with drug usage. The pharmacokinetics of pethidine during labour suggests that there is a trend towards "trapping" of the drug in the fetal circulation with a delay in excretion after delivery (Savona-Ventura et al, 1991).

A few intrapartum prescriptions were administered for maternal conditions pre-existing during pregnancy or occurring in the intrapartum period. Only dexamethazone and salbutamol were administered for fetal indications to delay labour and stimulate lung surfactant production in cases

Continued on page 19.

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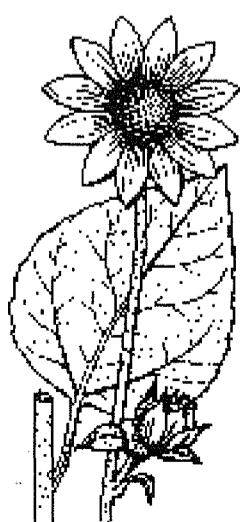


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YOUR LETTERS

Midwives Journal, Midwives Association (Malta),
167, Marina Street, Pietà, Malta.

Flat 1, 17 The Grange,
Wimbledon,
London SW19 4PS,
27th March 1993.

To The Editor,
Midwives Journal,
Midwives Association (Malta),
167, Marina Street,
Pietà, Malta.

Dear Editor,

I wish to send my warmest congratulations to the Midwives' Association (Malta) on the publication of their own Midwives Journal, which I read with great interest.

I remember with affection my days in Malta, and proud that your President was one of my first student midwives!

I would also like to pay tribute to my one-time colleague Miss Mary Vella-Bondin, who was determined to get the Association started, and has done so much for the midwives in Malta.

I wish your Association and magazine every success and send my very best wishes to all the midwives in Malta.

Yours sincerely,
Elizabeth Thomson

15.4.93

Dear Editor,

Following the publication of the first issue of the Midwives Journal, I feel I should congratulate the Editorial Panel for their achievement.

This has been a milestone for the Midwifery Profession in Malta and it has also filled a much needed gap.

I would like to encourage the Editorial Panel to continue issuing the magazine on a regular basis, as this will bring Midwives closer together since its success depends to a greater extent on the Midwives' contributions.

I am convinced that all will have a lot to contribute.

Yours Sincerely,
Rita Borg Xuereb, Midwife.

Dear Editor,

I wish to congratulate the President and the Organising Committee of the Midwives Association (Malta) for the excellent programme on the International Day of the Midwife 1993. It was a very good idea to have this year's celebration in Gozo. (There was nothing to be wanting from the beginning of the day.) Everything ran as scheduled and was of a very high standard.

The attendance was very encouraging – around a hundred in all. This reflects the midwives' interest in their profession. Besides, the success of this activity will certainly encourage the organisers not to hesitate planning other similar activities for the future.

Mary Vella-Bondin

Drug Usage in Maltese Pregnant Women – continued from page 14.

of preterm labour. The concept of treating the fetus in utero is relatively new. Although the fetus has long been recognized as a separate biological entity, it has remained out of reach of direct therapy until recently. Pharmacological measures have been found useful in the management of some fetal problems (Queenan, 1983). The administration of dextrose solutions to provide energy and as a diluent for oxytocic infusions during labour may also adversely affect the neonate.

The postpartum administration of drugs to women who plan to breastfeed their young carries two potential problems, firstly lactation may be suppressed and secondly the drug may appear in the milk in sufficient concentration to harm the infant. Drugs were administered during the postpartum period to 62.6% of women with a mean number of drugs per woman of 2.19. All women receiving drugs planned to breastfeed their young. The majority of drugs were administered during the third stage of labour or within the first twenty-four hours after birth. Lactation does not start until about 36 hours after delivery and some drugs may interfere with the establishment of lactation by diminishing the levels of prolactin (Wenner, 1979). The majority of Maltese women (48.6%) discontinue breastfeeding because of insufficient milk in the first three months postpartum. A number of women (3%) do not breastfeed because of failure to initiate breastfeeding (Savona-Ventura and Grech, 1990).

While very few drugs prescribed during pregnancy or lactation are known to damage the baby, it remains useful to remember Sir Thomas Browne's comment in 'Religio Medici' (1642) "*Every man is some months elder than he bethinks him: for we live, move, have a being and are subject to the actions of the elements and the malice of disease, in that other World, the truest Microcosm, the Womb of our Mother.*" If Moses on Mount Sinai had the opportunity to review and re-edit his commandments he would surely make the following addendum. "*All yea who administer drugs to the unborn child shalt obey the following commandments. Whoever shall fail to observe these and damage the child irreparably, shalt suffer brimstone and hellfire for eternity.*

I. *Thou shalt not prescribe drugs to pregnant or lactating women unless absolutely indicated.*

II. *Thou shalt have only one thought in mind, that is to do the maximum good to the mother with the least harm to the child.*

III. *Thou shalt then prescribe drugs for as short a time and in the lowest dose possible.*

IV. *Thou shalt wherever possible prescribe drugs orally or topically in preference to systemic injection.*

V. *Thou shalt prescribe well established preparations rather than new drugs.*

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CHILDREN AT RISK

Margaret Abela

R.G.N., R.M., B.A. Religious Studies, B. Sc. Hons. in Nursing Studies

When used legally the term "child" refers to any person who has not reached the 18th birthday, while in every day speech it refers to the person whose adolescence has not yet begun. According to Sperling et al (1977, p. 129) "Childhood is the period between infancy and adolescence. It therefore begins at about the third birthday and ends about the eleventh." Here the period from birth to 16 years is going to be considered. In Malta this is the age when the child can take certain responsibilities, although he/she is still considered a minor until 18 years. The age of 16 is the age when it is no longer compulsory to attend school. The child is issued with an individual identity card and he/she can start to work. This is also the age when civil and church marriages are allowed. Childhood is a period of rapid physical and psychological development and if anything goes wrong at any stage, it will effect the individual all his life. This is also the time when the child is being socially integrated and he has to learn to adapt to be able to cope with his environment. The child is continually bombarded by risk factors being it in his own family and home, the school, in society, at large.

The child is at risk of being abused physically, emotionally and sexually. There is also the risk of abuse through neglect and child labour. In the past there has been an increase in child abuse as is evidenced by public debate, daily press reports and literature. One cannot first say that primitive societies did not have child abuse; it was there and was accepted as a way of life. The abuse of civilised societies is creating more psychological and long lasting problems. Child abuse is today being discovered as a social problem.

Maternal Deprivation

The risks for the child start from before birth. The outcome of an unwanted pregnancy is an unwanted child. The same happens when the mother is told the sex of the baby during pregnancy and it is not what she had expected. The child becomes the victim of hate of the parents and

although kept by the parents, knows that he is rejected. There is poor attachment and deprivation when the child is nursed in SCBU especially if it is for a prolonged time. The same happens when the mother leaves home for any reason whatsoever. The child needs "love" and "esteem" to grow physically and emotionally. "Giving him food and body contact becomes a sign of love. Praising his deeds becomes a sign of esteem" (Sperling et al 1977, p. 121). The child becomes socialised through love and esteem which help him to endure frustration, build self confidence and feel secure. The unloved child fails to thrive and feels rejected by family and peers. He sees the environment as hostile and himself as inadequate. These children are ashamed of failure and go at great lengths to conceal their fears. There is the great risk that these individuals become adult psychopaths as a result of the great deprivation and rejection suffered in childhood. These individuals are characterised by selfish and demanding behaviour and a very low tolerance for frustration. Lack of discipline and difficulty in adjusting to authority turns them into delinquents while difficulty in tolerating monotony and routine together with impoliteness makes it very difficult for them to retain a job and to be accepted by work mates (Sperling 1971).

Physical Abuse and Emotional Abuse

In 1962 Kempe published an article on the clinical radiological and psychiatric manifestations of serious injuries in children inflicted by parents and other custodians. He called this the "battered baby syndrome" (Galea Salamone 1989). The child had no rights and was considered as the property of the parents and could be treated as they saw fit. In Malta there are no official statistics related to child rearing methods. Physical punishment is used to discipline children but this can lead to child and it is difficult to draw a line. The child may not be hurt physically but what about the resulting psychological trauma. Corporal punishment should not be used; it trains the child to use physical aggression and it militates against a positive

harming environment. Any chastisement used should always be educational. Emotional abuse harms adults and one has to imagine the great harm it does to the developing child. The child is usually abused by the most significant other or others in his life. These are usually the parents, guardians or close relatives. The child who is continuously scolded and criticised will get the feeling that he is good for nothing. Comparing to other children, being it in the family or outside the family is just as harmful. Some adults tend to punish children by not speaking to them for hours on end which does great psychological harm.

The Physically Handicapped Child

The child here is already at a disadvantage because he may be unable to engage in many normal children's activities because of physical restrictions. The child is stressed because he feels cut off from the rest of his friends and this is aggravated by the distress of his parents. Chronic physical illness leads to high rates of emotional and behavioural problems. Restrictions may affect the way that the child looks at himself and his self-image is affected. This will have an impact on his behaviour; the child seeing himself as a person of little worth whose actions do not matter. Here the attitudes of the parents are very important and they have to be careful not to exaggerate and become unreceptive to the child or on the contrary become too overprotective. Such children need a lot of support by family and friends but they have to be taught and allowed to be independent like other children. Early integration is very important. The child will attend an ordinary school if the handicap is not very severe and this helps to "teach the child to see himself though 'different' as not necessarily inferior" (Kershaw 1973). The parents of such children need a lot of help to overcome their distress which can interfere with the development of their child. Reynell (1973) quotes Goldie (1966) as saying that the parents "are attempting to accept, love and live with their handicapped child while at the same time they are mourning the normal child who they had hoped for and of whom the handicapped child is a perpetual living reminder."

The Accident Prone Child

Accidents are common in all children. Childhood is the time when one sustains most injuries probably due to "neural, motor and intellectual immaturity"

(Burton 1973). The toddler is all the time bumping his head but most of the time nothing happens, unless the child falls from some height. According to Burton (1973) the injury prone child is identified "not by the type of injury he sustains, nor the circumstances in which he sustains it, rather it is the persistence with which he is able to hurt himself bodily even when placed in a well controlled environment." These children will have more accidents when put in a hazardous environment where the child can fall down the stairs because there is no proper guard or take an overdose of drugs because the medicine is not kept locked up and out of reach. Usually there is some stress underlying the proneness to injury. Most of the time there are problems at home eg. an ill mother or sister who is getting all the attention and the accident prone child is feeling unloved. By getting injured the child will get some attention and at the same time temporarily escape some pending problem. Accident prone children should be assessed by a psychologist who will also talk to the parents so that together they will be able to devise a plan to help the child in the best possible way and thus enable him to overcome his problems. Timely and proper action is essential to avoid possible fatal injuries.

Neglected Children

As already mentioned children could be abused by being neglected. The young child is fully dependent on the adult to care for him/her and this includes all aspects of care. In today's society which claims, to have equality amongst its members and which claims that the citizen's rights are respected it seems that children have very little rights. The children that are neglected most, are those coming from broken families, one parent families, drug abusers, alcoholics and very young mothers. The baby could be underfed because of ignorance or because the mother does not have enough money to buy the baby milk and diluted feeds are given. Sometimes the mother continues to give milk alone because it is the easiest way out and no other food is introduced which eventually results in malnutrition. The child is most vulnerable to damage when there is rapid growth and development (Dohbeng J., 1968 in Rutter 1975). The brain of the malnourished child is mostly effected during the first 2 years of life and any damage sustained is difficult to repair. There is the ever present risk of a lower level of intelligence and mental retardation (Rutter 1975) which will

contribute to keep the individual in the poverty culture.

We are all the time exposed to the risks of the natural environment and children have to be protected from such risks. The neglected child, left in the sun on a hot summer day will suffer from sunburns which could be fatal. On the other hand excessive cold can produce cold injury which can also kill the child. The parents of children who are at risk should be well supervised by the social worker who counsels them in the best possible care of their offspring. Neglected children usually live in very poor home conditions which are also inhygenic. Children are allowed to get and remain filthy. They are rarely given a bath and many times become infested with lice. The child who goes to school will have the increased stress of coping with being avoided by the other school children because of the dirt, infestation and bad smell. Such children tend to become very self-conscious, concentrate less and do bad at school. Consequently they fall behind. Here the school must together with the social worker and head-teacher will talk to the parents and try to help the defenceless child to gain his self-esteem by correcting the neglect.

Some parents directly neglect the health of their children by failing to follow the compulsory immunisation programme. In Malta those who fail to turn up are visited by the area Health Inspector or the Community midwife and not the social worker. The mother is asked to take her child for the immunisation and is told that if she fails to do so within the stipulated time legal action will be taken. In spite of this, some still fail to immunise their children. As is the case in most countries the largest number of defaulters come from the most depressed area in Malta (Cottonera), and this means that these people need more personalised attention and help, they need the help of a good social worker who befriends them and helps them to take interest in their children and help themselves.

Developmental Screening

Before birth the same sequential development occurs in each individual but after birth development varies. In spite of this variation certain developmental milestones have to be achieved at specific intervals. Developmental screening should be done by a well trained person at the indicated intervals each child should be assessed regularly.

Special attention is given to the children at risk to detect any delay in development promptly which could be due to general retardation, pathological factors such as diagnosis in neurological impairment. At times there is a familiar pattern of slow development in one or more areas (Weiss et al, 1988). Children at most risk are those who had a difficult birth; those whose apgar score was low at birth, the premature and those who had developed some problems during the neonatal period. Here again the children of drug abusers, alcoholics and teenage single mothers are also at great risk of developing problems. The child is examined regularly until he enters school and is then followed up by the school medical service. While examining the child the nurse will note any signs of physical abuse eg. burns, bites, bruises, etc. If there is any doubt the case should be followed up and action taken before it is too late. Any problems with developmental milestones should be further examined and treated so that optimum improvement can be achieved if not completely overcome.

Child Labour

In Malta children have compulsory education until 16 years of age. Most children finish the secondary school education and start work, but there are quite a large number who start work earlier. These are the children who are all the time absent from school and the sad thing is that their G.P. produces medical certificates to make them do so. There are also parents who ask for a special permission to discontinue their children's education so that they can send them to work. Recently the education department has taken the matter seriously and is now very strict about school attendance. After counselling a number of children returned to school and said that they are now happy and that they had left because their friends made them do so. A number of children themselves wanted to work because they said it was better to earn money than to waste time at school while others needed the money because they were drug abusers. These children used to get illegal employment. The child who is pushed into the world of work early while he is dealing with the stress of puberty will have the superimposed stress of work as well. This may lead to physical and mental illness. The child who has neglected his education will eventually fall far behind his peers and this fact can make him jealous of them. Some of these children develop anti-social behaviour because

when they get older they will start to think that it was society's fault that they had left school and started work.

Sexual Abuse of Children

Sexual abuse is perhaps the most recently recognised form of abuse in children. In looking at statistics about child abuse Vousden (1984) notes that "In all areas there was an increase, but the greatest upward trend was seen in cases of sexual abuse, a frightening increase of 126.5% as the number of cases went up from 98 to 222 in a year", ie in 1985. But is it a real increase or is it because more people are finding the courage to report? Children might be afraid to report because the offender may have threatened the child or told him that there will be a family crisis if the father goes to prison. Perhaps today people are more open about problems in the family; the wife speaks up about violence in the family and other problems will surface. Sexual abuse often occurs because

parents refuse to acknowledge its existence. It is girls that are mostly sexually abused. The child is mostly abused by members of the family or by adults known to the victim. Incest knows no class, in the higher social classes it occurs between father and daughter and it is rarely revealed because of the disgrace to the family. In the lower social classes, where there is poverty and overcrowding, boys and girls sleep together and here incest occurs mostly between brother and sister.

In Malta the criminal code sections 198, 200 and 201 deal with carnal knowledge with violence while section 203 and 207 deal with defilement of minors and violent indecent assault. But although the child is still considered a minor until 18 years the law indicates that action will be taken if the child is 12 years and under. In my opinion the child in Malta has very little protection. Children under 14 years get pregnant and have babies and nothing happens. During 1983-1986 there were:

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9 girls under 14 years who had a baby }
Total 0.90%

24 girls under 15 years who had a baby
42 girls under 16 years who had a baby
104 girls under 17 years who had a baby
(Savona-Venture, Grech E. S., 1987)

There are girls who have their second baby before they are 17 years and in fact 13 of the girls mentioned had their second baby.

The victim of incest suffers many and long term consequences and it is difficult to predict the intensity of such consequences. McAre (1987) says that "it has been observed that victims have a tendency to develop a variety of traits. These range from a tendency to develop a poor self-image, to promiscuity, delinquency, aggressiveness, jealousy, abnormal sexual behaviour and even murder." They can also become child abuser themselves when they grow up.

Conclusion


According to Bowely (1965), for the infant and young child to have normal mental health it is essential that he "should experience a warm intimate and continuous relationship with his mother

(or permanent mother substitute, one person who steadily 'mothers' him) in which both find satisfaction and enjoyment." This complex rich and rewarding relationship together with relation with father and others is the basis of character development and mental health. Any deprivation or separation, as happens when the child is hospitalised, will harm the child; it will take much longer for the child to get better. The harm sustained varies with the individual child and studies have shown that development will be retarded physically, intellectually and socially and signs of physical and mental illness may appear. The child who is neglected or abused will also suffer great harm which will affect his personality and make it difficult for him to establish and maintain deep and meaningful intrapersonal relationships. Over indulgence, also does a lot of harm and although many parents believe it is love, it is infect another kind of abuse. Sexual abuse and incest is perhaps the worst kind of abuse. Society should make its best to identify early the children at risk and to offer them adequate protection in time.

In Malta it was only very recently that the problem of child abuse came to the open. In June 1990 the society for the Protection of Abused Women organised the first seminar on child abuse.

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THE FAMILY – A NECESSARY SOCIAL UNIT?

Mary Vella-Bondin R.G.N., R.M., M.T.D.

It has been said that the family is the 'nucleus' of society and that the 'workshop' of society is the family group. It is a widely accepted concept of social science that the family is, and has always been, the most important of all human groups because of its functions. With a few exceptions of negligence importance, it can be said to be universal, existing in all human societies.

In modern Euro-American societies it is accepted for the ideal family to consist of a married couple, the male being the head, and their legitimate or adopted children. The family unit provides fulfilment for the latent and manifest needs of each member. The children, who require a long period of care by a limited number of individuals, experience, in the family circle, relations of intimacy, develop their social code and learn about natural consequences by parental control of the environment. Here children grow up as normal human beings capable of playing the adult role. In addition, the family also cares for the dependent aged and, indeed, for any of its members who may become temporarily or permanently dependent owing to various vicissitudes.

The functions of the family as a social unit are manifold and it is best to look at each member of this group individually and try to assess the value of the family environment for his physical and emotional needs.

First we have the infant and certainly, the mother's milk, mother's love, mother's time, and loving hands, loving voice, are but a few of the first experiences. In this first year the bulwark of confidence and sense of security is built. The place where these can best be provided is undeniably a happy family.

During the preschool years, the child, who has spent a great deal of his time in the care of a wise and loving mother, is well ahead in his mental and

emotional development, provided, no misdirected over-possessive love prevents the growth of his independence. Brothers and sisters in a home own identity, companionship and competition. An only child is lonely and the institutionalised child lacks identity and background. Also, brothers and sisters are a ready made 'playgroup'. It is a miniature society, which provides every experience of the grown-up world; sharing, caring, choosing leaders, recognising strengths and weaknesses in the individual, enjoying to the full family festivities – birthdays, holidays, weddings. A full and generous life, which no other social unit, no matter how foresighted and missionary, can ever hope to imitate. Mental development is faster when there are older children to copy.

The young adult is at the most difficult stage of his or her life, on the threshold of independence, yet still insecure. Full of a growing need to establish an independent personality, yet, not sure how to do this. The outside world is where he will practise and postulate his courage, also where he voices his rebellions. But, whether he knows it or not, he uses his family as a safety-valve and if the parents are wise enough, they can guide many a youngster through this thorny period. To the world he will go to hunt and forage, but, to the warmth of the home he will return to lick his wounds.

The wife – love and motherhood are unmistakably the woman's basic instincts. Where can she find fulfilment for the age old needs? At work, or handing her baby to a nursery or child-minder, or to some other child care organisation? Of course not, the average woman needs and is ready to admit, that above all, she would like a home and a family.

In every modern society man is required to be socially productive in some form. This means programming and disciplining his life. For many hours he must be at work. At the end of the day

he is tired and the ensuing experience after work can make all the difference to his continuing state, of a healthy well adjusted adult. First, a warm welcome; second, a seat in his own favourite chair; third, a meal prepared and laid before him, then to relax in the bosom of his family or to pursue his hobby. Does a flat or lodging, bingo or pub provide these small day to day joys? No, it is rather a cold, comfortless existence compared to the more human fulfilment a man achieves in his own home.

The problem of the age has always been with us. In some societies, say in the former days of China, ancestor worship made the veneration of the aged parents a necessary obligation. Here, we have no religious cult as such, so it is for the individual to concern himself with the old. To be identified with one's own family in the next and succeeding generations is one of the greatest joys left to the old people. At national and family festivities, where would they like to be? Certainly, with their children and grand children. At times of illness, from whom can they most reasonably seek comfort, love and care if not from their children? This aspect of the home, either constituting a sanctuary for the older members, or, of being the centre from which help, protection and council will

come at all times, is another very important aspect of the function of the family in our society.

There is much evidence to show that the family is a very important recognised social group and, for this reason, it is strictly supervised and regulated by central agencies of authority – the State, the Law and Religion. A classical example is found in the Russian family. Following the revolution of 1917, a period of civil war, was enhanced by family disruption. Children fought against their parents and parents against their children. Divorce was easy to obtain, contraception was free to all and promiscuity was universally accepted. But the Russians soon realised, at their own expense, that family disorganisation was only one facet of social disorganisation and by 1936, the Government's policy had changed completely. Efforts were made to support and strengthen the family. Today, in Russia, family as an institution, is accepted, revered and glorified.

Is the family a necessary social unit? Looking around us and considering all that has been said, one cannot but conclude that the family was, and still is, the nucleus of Society. It will be beneficial for the nation to give due reverence to the family unit.

PRAYER

I put my little Babe under your protection Mary my Mother.

Make its tiny mind grow up to love the truth of faith.

Consecrate its will to the service of God.

Fill its heart with love for its Creator.

Fashion its little body in all perfection.

Let its organs be sound, its senses acute, all its members strong and healthy.

You can obtain this favour for me and my child most powerful Mother.

I put my trust in you.

AMEN.

Padre Pio of Pietrelcina—Italy
30th March 1983

LAWS AND REGULATIONS GOVERNING MIDWIFERY

Catherine Attard
Diploma Student Midwife

Today, the midwife who is responsible for the delivery of midwifery care to women in all levels of society, is regarded as a well-educated person, practising as a member of a profession which is respected both nationally and internationally. Her practice is controlled by legislation and she has a responsibility to maintain professional competence and to accept responsibility for her own actions and for the image of the profession.

Skill in midwifery can be compared to the skill of driving a car. Good car drivers who dare to drive make it their business to keep up to date with road traffic legislation. Similarly, a good midwife must be conversant and up to date with statutory structure, legislation and codes of professional conduct and practice which form the basis of statutory control of the practice of midwives, the Midwives' Rules enshrined in Nurses, Midwives and Health Visitors Act 1979.

Primary midwifery legislation, Section 15, taken from Midwives Act 1951 and Midwives Act 1970, requires midwives to attend refresher courses whilst secondary midwifery legislation stress compliance with midwives' practice rules as the responsibility of any midwife practising in the United Kingdom whether employed within or out the National Health Service or self-employed. Failure to do so is likely to result in an allegation of professional misconduct. In order to maintain professional competence, the midwife should make every effort to keep up her expertise in the full range of midwifery practice and if necessary should approach her supervisor of midwives for assistance. If, for any reason, she has lacked opportunity to maintain one particular skill, she has an obligation to declare herself incompetent in that area and to seek remedial training before undertaking the procedure in question.

Periodic educational refreshment is invaluable here and according to the Midwives' Rules, Rule 37:

"All midwives are required to attend refresher courses at regular intervals, as long as they continue in practice."

These courses should be arranged to meet the professional needs of individual midwives. Information about clinical practice, research, education, assessment, management, communication and counselling. According to Roch (1986):

"The courses should be a time for expansion, exploration and stretching, enabling midwives to look forward to the next five years with new strength and inspiration and they should be placing midwifery into the hands of determined midwives, truly refreshed with rekindled enthusiasm."

Parker (1987) states that:

"The quality and content of the course is the responsibility not only of the course organisers, but of the participating midwives, who should participate fully, constructively and positively."

National Boards approve suitable courses or may consider alternative evidence of appropriate professional education submitted by the midwife. Post-basic courses became necessary with developments in the midwife's role. Examples include administration of inhalational analgesia, parent education, family planning, special and intensive care of the newborn, elementary principles of teaching for midwives in the clinical situation in training schools, research appreciation and counselling.

Other forms of education beyond basic midwifery training include the Advanced Diploma of Midwifery; Preparation for Midwife Teachers, ENB Course 997; Teaching in Clinical Practice for Midwives, ENB Course 405; Special and Intensive Nursing Care of the Newborn, ENB Course 904; Short Course on Special and Intensive Nursing Care of the Newborn, ENB Course 901; Course in Family Planning and others. Although these courses are stressful and require a great deal of commitment, there is a need to stimulate midwives to further their knowledge and the course can be regarded as an investment for the present and the future, one which pays dividends. According to Grant (1987):

"The midwife can give a better standard of care to mothers and babies."

as participants are able to apply knowledge, analyse, synthesise, evaluate, appraise constantly their skills and knowledge so that care is evaluated critically. Continuing education is essential in order to keep abreast of the many changes that affect her practice and these also include major scientific and technological advances, changes in society, in the roles of men and women, in the family, community, changes in employment, education, attitudes, beliefs and values.

For those midwives who return to practice after an absence of five years or more or who have not practised for more than twelve weeks in the previous five years, they are required to undertake a theoretical and practical midwifery course of at least four weeks.

Education in preparation for parenthood courses also help midwives to improve their skills in this sphere. The control of the practice of midwives, whilst being the responsibility of the UKCC, National Boards and LSA's by virtue of primary and secondary legislation, is also influenced by practising midwives themselves. Some midwives, unfortunately, despite training and certification, regress to bad old ways. However, midwives should be accountable for their own actions and Harding (1988) states that:

"Every conscientious midwife should strive to practise the best management for each woman in her care."

Thus in order to maintain responsibility for the image of the profession, a midwife should strive to preserve standards, improve care, initiate change and try experiments in order to move forward. For example, randomised controlled trials are the only way to test accurately the effect of an intervention, which, according to Bryce (1987) may include:

"Components of antenatal care, positions in labour, electric fetal monitoring, various ways of caring for the perineum, advice on breast-feeding."

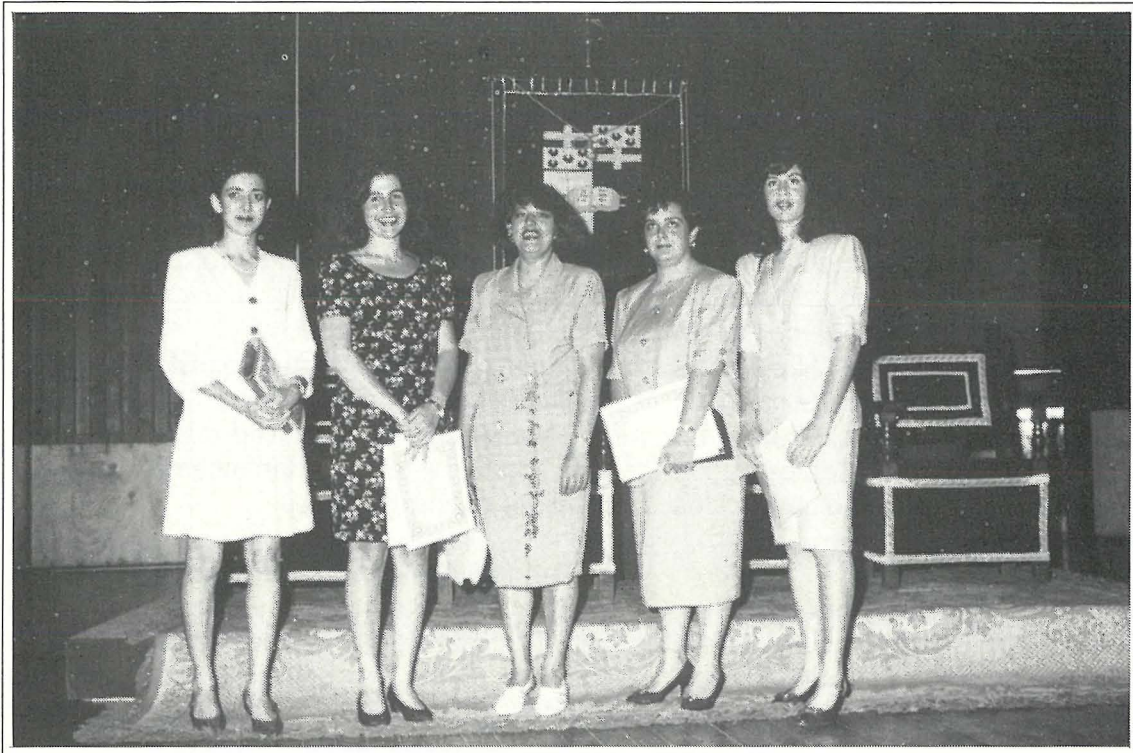
All of these vital components of the care which midwives give have an effect on the health and wellbeing of mothers and babies. New knowledge established by research helps the midwife to develop a questioning attitude towards her own practice. It is imperative that all midwives keep up

to date with any proposals for change. This includes being aware of the activities of professional organisations and statutory bodies, reading the current journals and discussion documents which are circulated for comment and consultation. She can be a member of professional organisations, participate in elections and can draw midwifery issues to the attention of the public.

Daring to practise, lays upon the midwife great responsibility. Midwives, however, have the opportunity to advance education in midwifery, to spread knowledge of the art and science of midwifery and to improve the standards of care provided to mothers, babies and families throughout the countries of the world.

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Congratulations to the newly qualified Midwives.

From left: Miss Stephanie Micallef, Miss Carmen Cachia, Mrs. Marthese Spiteri, Miss Stephanie Mary Caruana, Mrs. Marthese Spiteri.

A public discussion entitled 'Ergajna Itqajna' was held on Radio Malta I on the Midwives' role in Malta over the years. A number of Midwives participated including one who spoke of her experience during the war dating 50 years back. A number of listeners aired their views.

Front row from left: Miss Josephine Borg Micallef, Mrs Generosa Bonnici, Miss Mary Attard, Mrs M'Angela Formosa.

Back row: Mrs Rita Borg Xuereb, Mr Joe Vella (Programme Producer), Mrs. Josephine Portelli.



MALTESE MIDWIVES AT INTERNATIONAL CONGRESS

Five members of the Midwives Association Malta attended a congress organised by the International Confederation of Midwives in Vancouver, Canada.

The congress, hosted by the Midwives Association of British Columbia, was attended by 2,500 midwives from 52 countries. The official delegates Miss M. Abela, Mrs M. A. Formosa and Miss J Borg Micallef as an observer left Malta a week before to participate in the International Confederation of Midwives' Council Meeting which decides about future policies.

The theme of the congress was *Midwives: Hear the Heartbeat of the Future*. Great emphasis was made on the Safe Motherhood Initiative, which aims to reduce the 500,000 maternal deaths occurring each year by half by the year 2000. The topics tackled during the sessions focused on the types and quality of midwifery care given in developed and developing countries.

It was stressed that, since the role of the midwife includes that of a practitioner of normal midwifery, she should move out of the hospital and into the community. It was also stated that women, who are the principal consumers of midwifery care, should have a greater say in their care.

During her address, the Minister of Health of British Columbia announced that midwifery practice was being legalised in the province. This was a historical announcement and the highlight of the congress.

The Maltese contingent promoted Malta in various ways but this was most evident when two of its members wore the traditional national costume during the official opening and the Canada night. This was received with great applause and enthusiasm by all the participants.



The two official delegates, Ms M. Abela, President, and Mrs M. A. Formosa, vice-President, during one of the council meetings.



The Maltese flag being carried up to the stage during the roll call.



All the Maltese delegation together with Ms Ruth Bird ex-midwifery teacher in Malta and accompanying persons.

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