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Malta Midwives' Journal



Malta Midwives Association

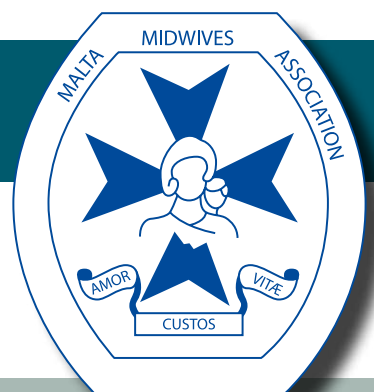
Issue 13 March 2019

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Editorial

Dear Member,

This publication marks the first issue for 2019. Please note that as from now, our biannual publications shall be issued every March and September unlike previous years. In line with past issues, this issue brings you a vast array of articles which will surely spark everyone's interest; from educational papers to articles about local midwives' experiences abroad.

It has been an eventful year for the Malta Midwives' Association; most notably, the initiation of Postnatal Support Group meetings held weekly at our premises. The response and attendance by mothers and their babies has had positive outcomes; thanks to all midwives who are offering their time and support to help in this initiative. Also, whilst we thankfully bid farewell to three midwives, we welcome our new midwife members on the committee after an Annual General Meeting was held last month. Additionally, the MMA would like to congratulate all newly-qualified midwives and wish them a fulfilling career. In this issue, we proudly present to you their undergraduate dissertation abstracts; which all revolve around innovative midwifery themes.

This is my first editorial as co-editor; taking on the role after fellow midwife, Rebecca Mizzi. We would like to thank her for her contribution to the association and her assistance to produce the best possible publications of this journal. We always look forward to identify novel topics for upcoming issues. Whilst we are truly grateful to all who contribute to our publications, more midwives and professionals are always welcome to share their knowledge and experiences with our readers.

Lauren Marie Grech
Co-Editor

MEMBERSHIP FEE

Annual Membership Fee is €20.

You can settle your pending fees by contacting one the Committee Members.



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

Editorial Board
Pauline Fenech & Lauren Marie Grech

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

The views expressed in the Journal are those of individual contributors and are not necessarily those of the Midwives' Association.

Front cover:
Committee Members and their babies
Rebecca Mizzi & Emilia - Francesca Cachia Galvagno & Luigi Carmel.

Upcoming Conferences

"Enhancing Well-Being in the Journey to Parenthood"

8 April 2019 Department of Midwifery, Faculty of Health Sciences

**2nd world congress
on maternal fetal neonatal medicine**
4-6 April 2019. London, UK

**14th International Normal Labour and Birth
Research Conference**
17-19 June, Grange Over Sands, Cumbria, UK
Uclan.ac.uk/conferences

Midwifery Today Conference
30 October-3 November 2019.
"Creating a Better Future for Birth"
midwiferytoday.com/conference/belgium-conference-2019



Message from the President

Dear Members,

I would like to start off this message by expressing my congratulations to Dr Josephine Attard on her new appointment as Head of the Department of Midwifery at the Faculty of Health Sciences at the University of Malta. I am sure that under her leadership and guidance, midwifery education will continue to strive to greater achievements. On behalf of the Association, I wish Dr Attard every success in her mission.

By now you are all aware of activities carried out by the MMA. Our aim for this year is that these activities will continue and we plan to increase the educational activities for midwives and for parents.

On the 22nd February, we held the Annual General Meeting. Three members from last year's committee could not continue: Ms Rebecca Mizzi, Ms Antoinette Formosa and Ms Isabelle Aquilina. On behalf of the Association I would like to thank them for their service. In view of this, in January, nomination forms were sent to all members to fill the vacant committee posts. The three nominations received were of: Ms Pauline Borg, Ms Laura Calleja, Ms Gabriella Grixti. Election was not required as the three nominated midwives took office from the previous resigned members.

The European Midwives Association (EMA) held its Annual General Meeting in Athens on 5th & 6th October 2018 where Ms Marie Soler and myself attended the meeting. WHO representative, Ms Fran McConville, who is the technical advisor for midwifery, stressed on the need for all European countries to update their intrapartum care practices to the recent WHO guidelines. These guidelines are the result of rigorous and robust systematic reviews from many countries. I urge every midwife to be familiar with this document which can be accessed on: www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

The agenda of the EMA Annual General Meeting also discussed the study entitled 'European Standards of Care for Newborn Health' which was supported by a baby milk company, however, this was not endorsed by EMA delegates, Malta included. Delegates stated that the rates of breastfeeding in many European countries are declining and called for midwives to strongly advocate for breastfeeding the newborn infant. It was highlighted that the International Code of Marketing of Breastmilk Substitute is still relevant.

The second day of the EMA meeting was focused on the Operational Refugee And Migrant Maternal Approach (ORAMMA) project. This is a 2 year project, funded through the European Union's Health Programme to develop an approach to maternal healthcare for migrant and refugee women. Greece, Netherlands and the United Kingdom are piloting this project which is into its second year. Part of this project is to train midwives and other health professionals to engage with pregnant migrant women in developing cultural competence as well as for migrant women to receive the care they need. It is critical that healthcare professionals recognise the way their own views are influenced by their culture, be open and receptive to those of other cultures, and have

the skills they need to have effective and respectful communication with migrant women.

Moving on, the International Day of the Midwife's theme for this year is 'Midwives: defender's of women's rights'. This theme is highly congruent with Kate Gilmore's address at the ICM Triennial Congress in Toronto, 2017. Ms Gilmore, who is the Deputy High Commissioner for Human Rights at the United Nations, emphasised the 'significance of midwives as generators of female empowerment in health and in human rights contexts and that midwives can make a difference through supporting women's and girls' rights.' She affirmed to:

'Stand up for rights!

- Be midwives who provide dignified access to care, regardless of a patient's identity or social status;
- Be scientists who pursue knowledge without fear or favour, but deploy its fruits for the betterment of a planet under strain; a climate undergoing hurtling change and a people undergoing inconceivable suffering;
- Be authors who love the truth; who prize evidence, protect fact and diversify voice.
- Be innovators and creators – so that more rapidly and comprehensively we replace unfairness and exclusion with something more equal, inclusive and more sustainable.
- Be dissidents who speak truth to power, and not for our own elevation but rather for the elevation of that in which we believe, that which we know to be true.' (Kate Gilmore, 2017).

Another interesting report is that of the Euro-Peristat project, which monitors and evaluates perinatal health in Europe. Euro-peristat has released its latest report with data and indicators for 2015: Core indicators of the health and care of pregnant women and babies in Europe in 2015. The previous European Perinatal Health Report was last published in 2013 with data for 2010. The following are examples of 2 indicators, however the full report can be accessed from www.europeristat.com.

Maternal age at delivery. In Malta the percentage of mothers younger than 20 years of age was 3% in 2015, compared to 6.5% in 2010. This indicates that less women under the age of 20 are having children in this high risk age group. The percentage of mothers over 35 years was 19.1% in 2015, compared to 15.5% in 2010, thus showing an increase in women having children at an older age.

Mode of delivery. Total Caesarean rates varied widely in European countries, from 16.1% of total births in Iceland to 56.9% in Cyprus with a median rate of 27.0% in all countries. In Malta 68% of births were normal vaginal deliveries and 32% were caesarean in 2015. This showed some improvement from the 66.9% normal vaginal delivery rate and 33.1% caesarean rate reported in 2010.

My earnest hope is that the above data and information serve as stimulus to reflect and evaluate our practices.

Lastly, I would like to encourage more midwives to come forward and join in the Association's activities. Simultaneously, I cannot but not thank all those midwives who regularly offer their support, their time and energy to the Association. Their contribution is greatly appreciated.

Pauline Fenech



Treasurer's Message

Dear Colleagues

Over the past year both offices were upgraded. Both were given a thorough white wash, new blinds installed and a new A/C for the second floor was also commissioned.

Last year the services on offer increased considerably and new services were introduced, amongst them a post-natal group which meets every Wednesday from 10 till noon. A complete list is found on the MMA website. We appeal to members to promote the services.

One of the greatest challenges of the past twelve months was the five-fold increase in rent. Even though, to be fair, the rent is discounted since the MMA is a voluntary organisation, the increase has obviously impacted, and will continue to impact the bottom line.

The service on offer can be promoted by word of mouth. An interesting way of doing this is to encourage family and friends to donate a voucher by way of gifts. These vouchers are a unique opportunity to give a gift which is quite specific and useful at the same time. Vouchers are available for, amongst others, baby massage, mother massage, pilates and parental skills.

The Committee is thankful to all those who support the MMA in some way or other. Obviously one way of contributing is by paying the annual membership fee. In this regard, whilst thanking those who have already paid up, we send out a gentle reminder to those who have not yet paid up.

Doris Grima
Treasurer

Committee Members

Pauline Fenech	President
Mary Buttigieg Said	Vice President
Marie Soler	Secretary
Doris Grima	Treasurer
Josephine Xuereb	Member
Francesca Cachia Galvagno	Member
Pauline Borg	Member
Laura Calleja	Member
Gabrielle Grixti.....	Member

L-ewwel Maltija li segwiet kors fl-Università ta' Malta

L-Arkivji Nazzjonali ta' Malta

Lucia Levanzin kienet l-ewwel mara Maltija li segwiet kors fl-Università ta' Malta. Dan intqal f'wieħed minn sensiela ta' posts mill-Arkivji Nazzjonali ta' Malta.

Levanzin kienet imwiġda fil-familja Ingliżi fl-1874 f'Haż-Żabbar. Hi segwiet il-kors tal-qwiebel li kien mifruq fuq sentejn. L-iskola tal-Qwiebel kienet twaqqfet f'Malta fl-1869 u fl-1915 għaddiet taħt l-Università. Intant, 100 sena ilu, propju f'Ottubru tal-1919, l-ewwel żewġ studenti nisa bdew jistudjaw l-Università: Teddie Camilleri fil-kors għall-Baċcellerat fl-Arti u Blanche Huber fil-kors tal-medicina.





Letter

Dear colleagues,

One of my visions as the newly appointed Head of the Midwifery Department at the Faculty of Health Sciences, is to integrate interpersonal values of respect, collegiality, professionalism, and caring to build an organisational climate that fosters the development of students in both academia and clinical practice setting.

This involves trying to get the best from each individual member of the team, respecting their different skills so that the impact of the whole is greater than the sum of its parts. Accordingly, the main aim of the midwifery education programme is to prepare the graduate to achieve the competencies needed to be able to fulfil the requirements of a midwife as laid down in the definition of the midwife, International Confederation of Midwives (ICM 2017) and comply with European Union, Midwives Directive 80/154/EEC Article 4, Directive 2005/36/EC Article 42, amended by Directive 2013/55/EU, and with the Health Care Professions Act [cap.464, p4, art IV, 23(5)]

Subsequently, the midwifery undergraduate education programme is divided into 50% academic and 50% clinical component. While the importance of classroom teaching is acknowledged, good quality clinical placements nurturing a good clinical learning environment constitutes the most significant influence on the learning process and is therefore necessary in order that students' achieve effective learning outcomes.

Clinical learning environment is defined as one that provides an interactive network of forces within the clinical setting which influences the students' clinical learning outcomes; it consists of all that surrounds the student, including setting, equipment, clinical staff, patients and educators; the learning environment is therefore



an important element in the whole learning process (Papp et al, 2003). Consequently, present day midwifery educators place a high value on students' clinical learning as it provides *Practice by doing* which retains high levels of recall retention of learning as illustrated through the learning pyramid (Figure 1)

The first four levels (lecture, reading, audio visual and demonstration) are passive learning methods. In contrast, the bottom three levels (discussion group, practice by doing and teach others) are participatory (active) learning methods. The Learning Pyramid clearly illustrates that active participation in the learning process results in a higher recall of learning (5%: Lecture 10%: Reading 20%: Audio-Visual 30%: Demonstration 50%: Discussion 75%: Practice Doing 90%: Teaching Others).

Based on the research, the least effective method would be a lecture. Long term retention rates of a typical lecture, where an individual merely stands in front of people and talks is considered to be around 5%. However, if people get actively involved and collaborate with others his or her retention rate dramatically increases.

The difference in retention between passive and active (participatory) methods may be due to the extent of reflection and deep cognitive processing.

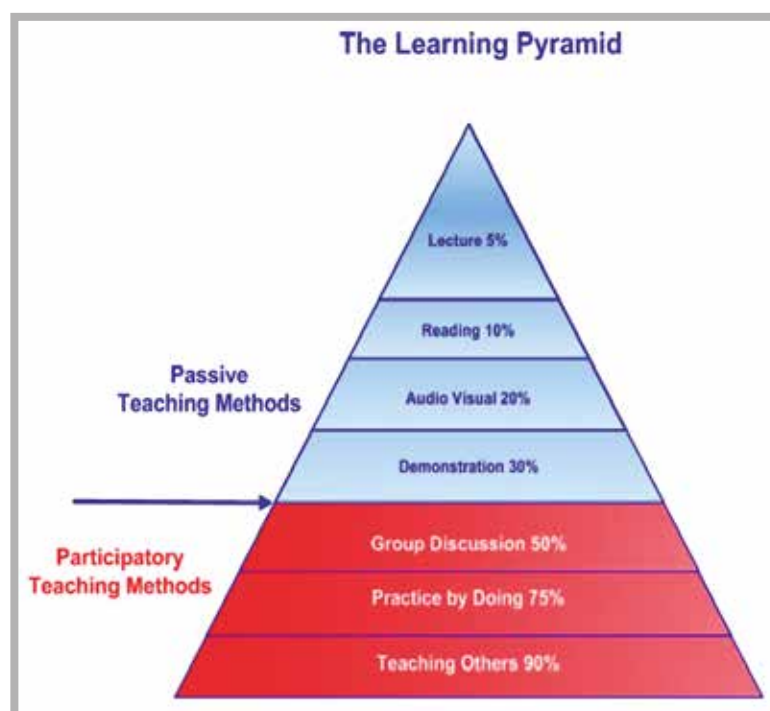
Acknowledging the extreme value of *Practice by doing*, the Nursing and Midwifery Council UK (NMC, 2008) asserts that clinical practice experience should provide learning opportunities which enable the achievement of proficient clinical midwifery skills and stated learning outcomes.

However, discrepancy may exist between theory and practice because academics and practitioners work from different perspectives, one from the academia and the other from practice. In order to meet the clinical learning needs of students, collaboration between midwifery academic educators and clinical midwifery staff is essential. This presents on-going challenges for providers of midwifery education, and is therefore, an area that requires continuous discourse, deep thought and collaboration in order to provide the best learning environment and support for midwifery students in the clinical placement areas.

I sincerely look forward to work with you, nurture our collegiality, friendship and collaboration in maintaining high standards in the education of the future midwifery workforce. This will enable the midwives of the future sustain high levels of quality midwifery care for mothers babies and families from all walks of life.

Best Wishes

Dr Josephine Attard
Head of Midwifery Department
Faculty of Health Sciences



Source: The National training Laboratories in Betel, Maine, (2012)

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Midwives and Nurses making an impact: Health 2020 and the Sustainable Development Goals (SDGs) WHO Regional Office for Europe Meeting Athens 2018

Midwives and nurses have a fundamental role in promoting health and wellbeing, preventing illnesses, most notably non-communicable diseases (NCDs) while substantially contributing to primary health care. Both these professions hold core values which are essential to improve health outcomes of patients and their families. These include equity, social justice and universal health access to care¹.



The World Health Organisation (WHO) Regional Office for Europe supports Member States by conducting health research and disseminating data, sustaining national health policies as well as preparing for future health challenges². One of the priorities of the regional office is to strengthen midwifery, nursing and their health system strategies^{2,3}. The important role of midwives and nurses is highlighted in *Health 2020* - a European policy framework for health and wellbeing, discussing Sustainable Development Goals (SDGs). One strategy of the framework is to support governments by improving the health and well-being of populations, reducing health inequalities and ensuring delivery and access to people-centred care^{1,3}.

The WHO Europe Human Resources for Health programme held its biennial meeting of government Chief Nursing Officers, WHO Collaborating Centres and the European Forum of National Nursing and Midwifery Associations (EFNNMA) last October, in Athens, Greece. In 2015, after consulting with EFNNMA and further relevant stakeholders, the WHO Regional Office has developed and published the *European strategic directions for strengthening nursing and midwifery towards Health 2020 goals*³. This framework aims to enhance the contribution of nurses and midwives of Member States towards achieving the goals highlighted in the *Health 2020* policy. Hence, the overall purpose of this WHO regional meeting was to review the progress done using this framework and discuss enablers towards achieving the *Health 2020* policy objectives.

The meeting was organised around three main themes; Include, Innovate and Invest. These themes were highlighted through a series of panel discussions on improving access to care, using innovations to meet people's needs and better investing in health systems.

Lauren Marie Grech was invited to participate in this meeting through the newly designated WHO Collaborating Centre for Health Professionals, Education and Research, Department of Clinical Pharmacology & Therapeutics, Faculty of Medicine and Surgery, University of Malta⁴. As a soon-to-be newly graduate, Ms Grech's contribution on the panel chaired by Dr Billie Hunter under the 'Include' theme, was to provide insight on the role of newly graduated midwives in improving and facilitating universal access to people-centred and midwifery care.

She discussed how today, midwives around Europe are facing a number of challenges such as staff shortages

and highly-medicalised care, resulting in less midwifery autonomy and negative outcomes of care. Enhancing and promoting midwifery care in the community, in primary health services and through multidisciplinary teams are potential strategies to overcome these challenges. Such interventions will lead to positive outcomes on the population's health, leading to improved patient satisfaction and enhanced wellbeing, as well as an improved health system, decreasing the burden on tertiary health care.

New graduates, in collaboration with experienced practice midwives, can utilise their newly-acquired knowledge to practise according to latest evidence-based research whilst still addressing people's needs. This is an asset to the midwifery profession; which contributes to enhanced people-centred care. Undertaking postgraduate research, specifically interdisciplinary projects can be further advantageous to the profession as it leads to a strengthened research base and a broadened base of knowledge in distinctive areas related to midwifery. The WHO Collaborating Centre for Health Professionals, Education and Research works to improve safe and effective medication use and health literacy of health care professionals. Ms Grech proudly contributes to the centre by conducting research about medication safety in relation to midwifery practices.

Evidently, graduate midwives have a lot of potential whereby they can contribute to better practice and care. Whilst acknowledging that they are just entering the workforce they can make an impact on optimal people-centred care.

Ms Lauren Marie Grech
B.Sc. (Hons) (Melit.) Midwifery

Prof Maria Cordina
B.Pharm (Hons) (Melit.), Ph.D. (QUB)
Head, WHO Collaborating Centre For Health Professionals Education and Research
Department of Clinical Pharmacology and Therapeutics

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- ² The World Health Organisation in the European Region. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0006/318489/WHO-Europe-brochure-EN.pdf?ua=1.
- ³ European strategic directions for strengthening nursing and midwifery towards Health 2020 goals. Copenhagen: WHO Regional Office for Europe, 2015. http://www.euro.who.int/__data/assets/pdf_file/0004/274306/European-strategic-directions-strengthening-nursing-midwifery-Health2020_en-REV1.pdf.
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Meeting Place:
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JOIN MALTA MIDWIVES ASSOCIATION

Midwives Day

SUNDAY BUFFET LUNCH
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Venue: Zenzero restaurant at 13:00hrs

(Located next to Life Sciences Park)

Price: Free for Association members & Children under 10 years;
Non-Association members 22€

Holy mass will be celebrated beforehand at 12:00hrs at Mater Dei Chapel

Reserve at
maltamidwivesassociation1974@gmail.com
or
Call on 77237117

All the Family is invited!





“To Err is Human, to Cover Up is Unforgivable, and to Fail to Learn is Inexcusable.”

Sir Liam Donaldson

(Chair, W.H.O., World Alliance for Patient Safety)

Patient safety is defined as the prevention of errors and adverse events to patients associated with health care (WHO, 2018). It is estimated that around the world, more people die from medical errors in hospitals, than they die from motor vehicle accidents, breast cancer or aids. It is also estimated that in the U.S., the death toll from medical errors is as high as 100,000 per year. Patient safety problems, of any kind can occur during the course of providing health care (Kohn, 2000). The events, range from the harmless, like misplacing patient records, to the harmful, like administering the wrong drug, wrong site surgery, transfusion error or mistaken identity.

In 2001 the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, describes the immense divide between what we know to be good health care and the health care people actually receive. Human error is a determining factor in 70% of errors and adverse events experienced in healthcare. In fact, it is a commonly held belief that in some healthcare settings human error represents the root cause of many adverse events. No matter what the degree of harm, most adverse events are symptoms not of bad character or incompetence on the part of the individual care provider, but of a faulty system.

According to the Institute Of Medicine (I.O.M., 2000), health care must be fundamentally redesigned to make safety a design function rather than the individual health care provider's responsibility (I.O.M., 2000). Emphasis is placed on the system of care delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) is built on a culture of safety that involves health care professionals, organizations, and patients. Creating a culture of blame and retribution will lead to problems being driven underground and poor quality being uncorrected because health professionals will be afraid of admitting to errors and failure.

Gosbee and Gosbee (2010) in their book, "Using Human Factors Engineering to Improve Patient Safety", recommend that health care leadership should adopt the human factor philosophy to the issue of patient safety -A shift that is needed by healthcare organizations to overcome the blame and shame attitude. Rather than look at individuals who are involved in an adverse event, it looks at system failures, behind the event to develop a long lasting resolution. Human characteristics, capabilities and limitations with regards to patient safety, include concerns such as sleep deprivation, fatigue, stress, memory, perception and environmental factors.

Within obstetric departments, patient safety is also a problem (R.C.O.G., 2017; Say et. al., 2014). Obstetrics involves a high risk for both maternal and fetal morbidity and mortality (Gupta, Guleria & Arora, 2016; Hamdan, 2013). The obstetric patient is unique in that the majority of patients are young and healthy. Conversely, when

an adverse event occurs, either for mother or child, it can have a catastrophic effect (Gellar, Cox, Callaghan & Cynthia 2004; Sabol & Caughey, 2017). A neo-natal insult can result in significant long term consequences including the trauma and cost of lifelong care (Pettker et al., 2009), and maternal morbidity, which to a large extent can be prevented (Gellar et al., 2004).

Recently it has been reported that in the UK, within a two year period more than two-hundred thousand maternity care errors occurred (B.B.C., 2017). Of these sixty-three thousand resulted in harm to mother and baby and also in two-hundred eighty maternal deaths. Safe and competent care of the highest standards entails more than trained staff and appropriate resources. The work environment, adverse conditions at work, supervisory support, employee communication, levels of organisational commitment and the team all play a role in moving mother and child along the continuum of morbidity and mortality (Vincent, 2010; Gellar et al., 2004; Waterson, 2014). Today, virtually all healthcare organizations have goals around improving the safety and quality of care (Dzau, 2016). Many have implemented systems that identify patient safety incidents and track implementation of recommendations to reduce hazards. A system of learning from patient safety events is present at Mater Dei Hospital (M.D.H), on the initiative of the Patient Safety and Quality Improvement Team (PaSQIT).

PaSQIT is a team of a core group of leaders and innovators from different professional backgrounds which was formed in 2013. These professionals work with the management of Mater Dei Hospital and with all employees and stakeholders working with the national health system to help the achievement of improvements aimed at attaining the mission statement of the Hospital that is **“To consistently provide holistic acute quality patient care in a safe effective and dignified environment”**.

The overall aim of PaSQIT is to educate, motivate, empower and work with healthcare professionals and workers to bring about changes in practices and methods of care that will result in a safer patient environment leading to a higher quality of care, and a better patient experience.

PaSQIT aims to contribute for the development of a culture of change amongst all the healthcare professionals and workers. The aim is to encourage stakeholders to embrace the change culture and take up ownership and responsibility for the continuous improvement of their work environment and work processes. Improvements are aimed at making hospital work more enjoyable, less stressful and more patient-centered.

In 2015, on the initiative of PaSQIT, a new system was launched at MDH. The safety alert for learning (SA Learn) is on a confidentiality bases where one can disclose events or near misses and still remain



anonymous. The form can be downloaded from Kura or from the Patient Safety icon from any Mater Dei desktop. Filled forms can be posted in the letter box situated near the PaSQIT office (Brown Foyer, 1st floor), or sent by e mail to saslearn@gov.mt or pasqit.mdh@gov.mt. Safety events are categorized according to severity of event and investigated. Subsequently recommendations for care are given where necessary and lessons learned from these events are disseminated on the patient safety web site and yearly seminars.

Systems for learning are the foundation of efforts to identify gaps and to create safer systems. However their success depends on the organizational culture that facilitates and encourages this system as well as mechanisms that transform these incidents into recommendations for safer care. Flemons and Mc Rae (2012), argue that organizations need to emphasize the 'business case' for safety into one of disclosure of incidents for learning and quality improvement. When disclosure of adverse events and close calls are submitted, the expectation is that speaking of an event will lead to lessons learned; an analysis of the event will shed light on contributing factors, and interventions to reduce the likelihood of recurrence of the event. The fundamental principle is that learning occurs. An increase in the number of reports would positively reflect a shift in attitude and culture.

Systems that provide healthcare workers with the opportunity to give information on hazards, hazardous situations, errors, close calls and adverse events make it possible for an organization that receives such reports to use these opportunities to learn (Kohn, 2000). If well supported by healthcare employees and hospital administration, these systems of patient safety are an important component to foster an organizational culture of safety all aimed to improve systems in which they practice creating safer caring environments. To fundamentally change the system, we need a new kind of environment, one where noticing and learning from mistakes is not only acceptable but expected. A culture of safety is the foundation on which successful safety efforts are built. Punishment does not improve safety; creating better systems does.

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Erasmus: Maltese Students' Experiences

Nottingham

From the first day, the lecturers and the whole team made sure we were settled in well and welcomed us with a whole set of activities. We were given the opportunity to attend lectures at the University of Nottingham, where we improved our knowledge and skills with the use of their labs full of equipment. On 4th of May, we were invited to attend a student conference for International Midwives' Day. It was a great pleasure, as we heard guest speakers from the International Confederation of Midwives and Royal College of Midwives talking about the future of midwifery whilst we later spoke to them about midwifery in Malta.

During our Erasmus programme, we had 8 weeks of clinical placements. We worked for 3 weeks on the antenatal and postnatal wards, one week in the community where both antenatal and postnatal care are provided and 4 weeks on Labour Suite. At every placement, a mentor was allocated to each one of us. Having a mentor means that you get to work with the same midwife as much as possible, and so the aims and objectives of each placement were more easily achieved.

There are a number of similarities between the Maltese and British models of midwifery care, although there are various differences observed. Midwifery autonomy is more predominant in the UK. The opportunity of observing different practices such as waterbirths, exposed us to new experiences and enhanced our midwifery skills, practices and knowledge. From this enriching experience, we have been greatly empowered to provide family centered care focused on informed choice and control, aiming towards midwifery led care based on continuity of care in Malta.

This experience has broadened our knowledge on what the profession of midwifery means in other countries and also gave us the opportunity to work in a midwifery-led setting, which is quite different from what we are used to here in Malta. We would definitely recommend other students to apply for an Erasmus programme at the University of Nottingham, as apart from having the opportunity to work in a different country where things are practiced differently than what we are used to, you also get to work with all the wonderful midwives, doctors and other healthcare professionals in partnership, making childbirth a whole new world for parents and their families.

Janice Bajada, Daniela Buttigieg & Luana Gauci

Newcastle

On our Erasmus experience, we had the privilege to study at Northumbria University in Newcastle. In our first week we met the link tutor, who had given us an overview of how things are done at the university. They were very welcoming and helpful and checked up on us regularly to see how we were doing throughout the whole 9 weeks. We were placed at the delivery suite of the Sunderland Royal Hospital, where we learnt different techniques and skills regarding midwifery care. We also had the opportunity to work with the

community midwives, who provided care for mothers, both antenatally and postnatally. During our 4 week placement at the delivery suite, we noticed that most of the care was very similar to Malta, but less medicalized to some extent. However, when it came to the use of pain relief, Malta was seen to focus more on natural pain relief when compared to the UK, where the epidural was found to be more popular. We also experienced home births and water births, something which we had never experienced in Malta. Both of these environments made women more at ease during labor, something which we think would be beneficial to Maltese mothers, if such practices were introduced in Malta. With that being said we also noticed that the Maltese practice focuses more on infection control and mothers are provided with more advice and support when it comes to breastfeeding. With regards to community care, although the care is similar in Malta and the UK postnatally, it was nice to see that in the UK low risk mothers were cared for by the midwife antenatally. Also, when it came to the booking visit, it was done in the comfort of the mother's home. Given that the midwife had the opportunity to care for the mother both antenatally and postnatally, it provided continuity of care throughout the mother's entire maternity experience. We really enjoyed our time in Newcastle as it was a very positive learning experience and whilst we appreciate the opportunity given to us by our faculty, we encourage other students to take on their own Erasmus experience.

Hannah Debono & Karin Duff

Cardiff

My 8-week midwifery placement at the University Hospital of Wales (UHW) in Cardiff was sincerely one of the greatest experiences of my life. Working within the NHS Midwifery system in the UK has shown me the true meaning of working with women and their families through midwifery-led care both in the hospital and the community settings. Midwives in Cardiff have the chance of offering antenatal and postnatal care through caseload midwifery, offering mothers continuity of care. It was such a great opportunity to see strong, trustworthy relationships form between mothers and midwives. I also experienced working in the midwifery-led unit with low-risk cases where the birth environment was simply beautiful; offering mothers the chance of a normal physiological birth including waterbirth. I equally enjoyed my time working on the delivery suite and experienced the management of some rare high-risk cases. Additionally, I got the chance to work with specialist consultant midwives such as those taking care of various social issues, and was present for child-protection conferences. However, this is only a small part of what I experienced and learnt on Erasmus. I would recommend, without a doubt, that other students go on Erasmus and experience another perspective to midwifery as it has not only been beneficial to me as a student but also as a person.

Kristina Galea



Is your baby starting to wriggle and to crawl away during diaper change? Do you sometimes find taped diapers hard to apply? Then say goodbye to fussy changing times with Easy-On Pampers Pants. Just one pull to put on and provide your baby up to 12 hours of dryness.

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Car Safety in Pregnancy

The major cause of death in women of childbearing age, and the major proportion of maternal deaths is motor vehicle crashes^{1,5}. It is also the main cause of traumatic foetal mortality. While statistics on these circumstances are somewhat limited, and until recently, not well documented², there is enough evidence to propose suggestions for the prevention of injury during motor vehicle accidents during pregnancy. Approximately half of fetal losses in motor vehicle crashes could be prevented if all pregnant women wore seat belts properly⁴. Another study estimates that proper use of the seatbelt could save 200 fetuses per year.¹¹

During the earlier trimester of pregnancy, foetal survival depends on maternal circulation for nutrients and oxygen, which can easily be impaired in maternal traumatic injuries. While in the later trimester, there is a risk of early labour, placental abruption, and amniotic rupture when exposed even to minor trauma incidents, with placental abruption being the leading cause of foetal death in maternal trauma¹.

Recent studies and technology have brought the use of pregnant crash test dummies to better understand the mechanisms in motor vehicle crashes so as to determine causes of maternal and foetal injuries. This included the measurement of the effects of restraining devices on abdominal trauma, abdominal force, foetal head injury and foetal head acceleration. According to one such study, it was concluded that energy from the crash was transmitted to the foetus within the head & thorax, with lap-belt-only arrangements giving a three-to-fourfold increase.¹⁴

Improved survival, as well as, improved maternal and foetal outcome was shown with the use of seatbelts. In fact, it appears that having a 3-point seatbelt and airbag deployment are the most effective protection for both woman and foetus^{1,14}. However, another study also shows that the impact created by the lap belt on the pelvic bone may still result in foetal head compression⁶. Nevertheless, due to improved maternal outcomes among restrained drivers, foetal morbidity and demise is still diminished and therefore correct use of a 3-point belt and the use of airbags is recommended¹.

Research on the use of airbags is limited and with mixed results, however if used together with a seatbelt it does not seem to have an adverse effect on maternal or foetal outcome⁷. Women should wear a 3-point seatbelt properly, as lap or shoulder restraints alone are not enough. There is a significant decrease in injury when properly restrained. The 3-point seatbelt should be worn with the LAP BELT PLACED BELOW THE ABDOMEN AND THE SHOULDER BELT PLACED DIAGONALLY ABOVE THE ABDOMEN (see image attached).

While research shows that the majority of women DO actually wear a seatbelt, the number of pregnant women that actually wear the seat belt properly is even less than half, with a number of women having misconceptions about the effects of seat belt use. Research suggests that proper education on the placement of seatbelts and their importance should be provided to all pregnant

women^{1,8}. It has in fact been documented that there was an increase in the use of seat belts after prenatal education classes that focused on seat belt use during pregnancy³.



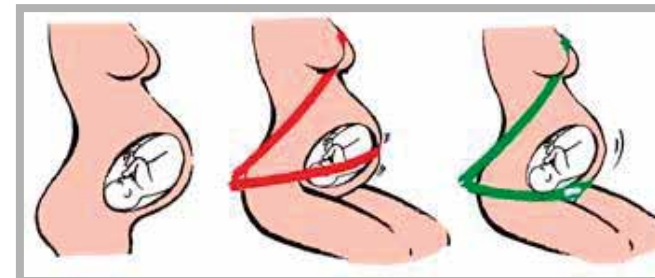
Car Safety How-To's:

- Secure the lap belt under the belly, over the pelvis and on the hipbones, with the belt flat on the thighs. NEVER wear the belt across or above the belly.
- Remove outer clothing that makes the seat belt slide up on your belly.
- ALWAYS use the shoulder belt too. It should fit between the breasts and off to the side of your belly. Do NOT place the shoulder belt under the arm or behind the back.
- Air bags do not replace the need for a seat belt. They can be dangerous if it opens and you're not buckled up.
- Adjust the front seat so it's as far away as possible from the steering wheel and dashboard while still allowing you to reach the pedals comfortably. If your steering wheel is adjustable, aim it up and away from your stomach. That way, the air bag will deploy toward your chest, not your belly.
- It's safest to sit at the back of a vehicle with a 3-point safety belt.
- If you're in a car accident, no matter how minor, speak up straight away and see your healthcare provider as soon as possible. Although feeling just fine, it's important that a doctor ensures both you and your baby are unharmed.⁹

According to international law, ALL pregnant women must wear seatbelts when travelling in motor vehicles, as the pregnancy in itself does not exempt one from the



law. Pregnant women are only advised NOT to wear 'lap-only-belts' since it may cause grievous injuries to the baby in utero. The lap belt only may do more harm than good,¹¹ however, together with the diagonal strap these injuries are minimised if the lap belts worn properly as the collision forces are absorbed by the entire body frame.¹³



While there are items on the market to change the position of the seatbelt for added comfort, most are not officially crash tested. Any products adjusting the diagonal strap will interfere with the seatbelt's function and are unnecessary as the diagonal strap does not actually pose a risk to the foetus. On the other hand, the use of products on the lap belt may in fact relieve pressure from the abdomen; however these products are yet to be tested by official sources and only recommended by parent communities. Therefore their use cannot be professionally recommended, as it is the parent's judgement call. As professionals, we should embrace the concept that knowledge saves lives and provide women with prenatal or antenatal seat belt counselling and educational material on the proper placement of belts as it has been shown to decrease morbidity in motor vehicle accidents.¹

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Katrina Farrugia
Senior Midwife NPICU

Postnatal Group

It is a known fact that becoming a parent is not easy (it is what everyone warns you about during pregnancy). However no one realises how hard it truly is before going through it themselves. What's more is the fact that our lifestyles have changed with families becoming less extended and more nuclear, meaning less support available. On the other hand society has also become more demanding and judgemental. Having the necessary support helps to make the transition to parenthood easier. What parents experience is lots of attention during pregnancy and the immediate postnatal period. However, at some point the midwife's visits stop, while parenting challenges are ongoing. During this time some parents feel alone, lost and desperate with no one to turn to. Following requests from parents themselves MMA felt the need to start a postnatal support group where parents

can avail themselves of midwifery services ranging from clinical (parameter charting, help with breastfeeding, baby weighing) to practical (weaning, sleeping tips) to psychological (debriefing of the birth experience and discussing any other challenges). Meetings are held every Wednesday from 10.00 to 12.00 at MMA premises. No booking is needed. The group aims to provide mums with a safe place where they are not judged and feel supported both by midwives and also by other mothers attending these sessions. Through chatting over a cup of tea they share their experiences and what worked best for them. I would like to thank all midwives that offered their time; otherwise this service would not be possible.

Francesca Cachia Galvagno



The Role of Oxytocin in Physiological Childbirth

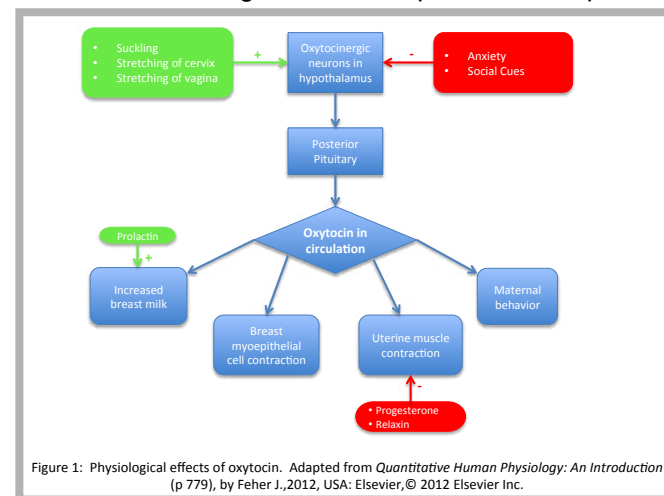
Oxytocin, many times referred to as the *love hormone*, is a vital component of a comprehensive neurochemical system that empowers the body to adjust to exceedingly emotional circumstances (Carter & Porges, 2013).

The Physiology of Oxytocin

Oxytocin is a neuroendocrine oligopeptide produced by the magnocellular neurons situated in the supraoptic and paraventricular nuclei of the hypothalamus. Endogenous oxytocin is released in the peripheral circulation from the posterior pituitary and nerve terminals as a reaction to diverse stimuli (Vranchnis et al. 2011). It is also secreted by the corpus luteum, placenta, amnion and decidua. The central and peripheral actions of endogenous oxytocin are executed by its receptors. Apart from the myometrium and mammary gland, expression of oxytocin receptors is also noted in the endometrium, decidua, ovary, testis, epididymis, vas deferens, thymus, heart, kidney and brain. The expression profile shows a tissue-specific as well as a stage-specific pattern (Kimura et al. 2003; Danalache et al. 2010). Since there are a number of variants of the oxytocin receptor, this hormone can have various clinical effects.

Oxytocin is implicated in several physiological and pathological mechanisms and plays a pivotal role in childbirth and lactation (Kim et al. 2017). It is responsible for the initiation, enhancement and frequency of uterine contraction through its effect on uterine smooth muscle (Arrowsmith & Wray, 2014). In labour, oxytocin is released by the fetal posterior pituitary. Conjoint with vasopressin, it is associated with the process of spontaneous labour. It has also been shown to play a crucial role in social bonding. A recent line of evidence has shown that mothers with fluctuant patterns of attachment have lower peripheral oxytocin levels (Samuel et al., 2015). (Figure 1)

A literature review on the role of oxytocin in ameliorating well-being outlined that apart from endocrine and physiological changes, oxytocin is also responsible for the cause and benefits of an overall sense of wellbeing facilitating a synergy of social interactions, serenity, harmony and decreased fear resulting in higher levels of trust. Maintaining a low blood pressure and positive



emotional engagement were amid the long-term benefits of oxytocin. On the other hand, lack of oxytocin is linked with an unhealthy state and low quality of life. Social phobias, autism and schizophrenia have all been linked to lack of oxytocin (IsHak, Kahloon & Fakhry, 2011).

Oxytocin and Physiological Birth

It has been hypothesised that physiological labour and birth bring into play a healthy form of stress (eustress) on the unborn child. In turn, this creates an epigenomic effect on specific genes especially those responsible for immune responses, weight regulation, and a number of tumour-suppressor genes (Dahlen et al. 2013). Epigenetics refers to the study of heritable changes in gene function that takes place without a change in the DNA sequence. In most cases, these modifications turn genes on or off, permitting or stopping the gene from protein synthesis.

Diminished or increased levels of a number of hormones namely; oxytocin, cortisol and adrenaline generated in labour are likely to result in fetal epigenomic remodelling anomalies which induce effect on abnormal gene expression translational effect (not necessary the gene but the protein) (Dahlen et al. 2013). Non-communicative diseases and bio-behavioural difficulties in the neonatal period and adulthood can be exhibited as a result of this epigenetic remodelling. It has been suggested that the association between the intrauterine environment and the child's health can be epigenetically modulated. This could take place through DNA methylation in the newborn, and implies that physiology of labour and birth may be subject to epigenetic remodelling, especially in the transition from intrauterine to extrauterine life (Monk et al., 2012; Lutz and Turecki, 2014).

Skin to skin following birth

Maternal oxytocin is thought to be released during skin to skin contact following birth. Tactile, olfactory stimulation and exposure to body temperature were all variables implicated in this process (Winberg 2005). Bystrova and colleagues (2009) studied whether different delivery and maternity ward routines effected the mother-infant interaction one year postpartum, delving particularly conditions including skin to skin contact and the newborn being swaddled or dressed in ordinary clothes, in conjunction with or without early suckling. These variables were compared with separation in the delivery ward and during the maternity stay (rooming-in versus nursery care in the maternity ward) to establish their effects on mother-infant interaction one year postpartum using the Parent Child Early Relational Assessment (PCERA). Findings from this study revealed that contact between the mother and the infant in the initial two hours following delivery appeared to be noteworthy for maternal sensitivity, for infant's self-regulation and irritability and for mutuality in the dyad at the time when the infant was 1 year old as measured by PCERA. The effect seems to be consequential to the skin-to-skin contact between



mother and infant in the initial 2 hours (early sensitive period). However, early suckling seemed to make up for the absence of skin-to-skin contact.

On a similar note, a systematic review on early skin to skin contact for mothers and their healthy newborn infants, revealed, that babies that were put skin to skin made more physical contact with their mothers and cried less. This also had a positive effect on maternal attachment and babies breastfed for a longer period of time (Moore, Anderson & Bergman, 2007).

Effects of synthetic oxytocin

Synthetic oxytocin (Pitocin®, Syntocinon®) is routinely used for induction or augmentation of labour (Wood et al. 2014; Reinl et al. 2017). It also plays a crucial role in preventing postpartum haemorrhage (WHO, 2012). It has been documented that although Syntocinon was developed to mimic the effects of endogenous oxytocin, it appears to interrupt the emotional relationship between the mother and the child, bond and lactation and to influence the development of the child (Feldman et al., 2010). Synthetic oxytocin is known to have a wide therapeutic window and its effectiveness differs amid women (Reinl et al. 2017). Risk factors found to be associated with higher oxytocin requirement in labouring women encompassed mother with diabetes, intrapartum fever and fetal macrosomia (Frey et al. 2015). In line with this, Reinl et al. (2017) also identified high body mass index, maternal diabetes and labour induction as risk factors requiring high doses of oxytocin for delivery. Due to unanticipated individual's sensitivity to synthetic oxytocin and prolonged exposure, mothers are more likely to deliver by a caesarean section. Besides, mothers may be at risk of uterine rupture, haemorrhage, hyponatremia, tachysystole, fetal hypoxia, acidemia and abnormal cardiotocography (Simpson and Knox, 2009).

Conclusion

In conclusion, there is evidence that oxytocin plays an important role in the long term effects on the mother and the infant in connection with physiological childbirth. Effects of oxytocin could encompass changes in both the production and its release as well as its receptor function. These effects may be mediated via the epigenetic changes in the oxytocin system or another mechanisms which have yet to be elucidated.

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Hirschsprung Disease, Stoma Care and Rectal Washouts

Hirschsprung disease is a birth defect that affects 1 in 5,000 individuals (Frykman and Short, 2012). It involves missing intestinal ganglion cells, most commonly in the rectosigmoid part of the colon (short-segment Hirschsprung disease) but it can also affect the entire colon (long-segment Hirschsprung disease) and rarely the small intestine. The lack of ganglion cells prevent the affected parts from relaxing, causing narrowing and functional colonic obstruction. Dysmotility of the colon leads to stasis of the stools and subsequently bacterial overgrowth, diarrhoea and dehydration (Kessman, J 2006).

Diagnosis usually occurs in infancy. Symptoms include: lack of bowel movement in the first 48 hours of life, poor feeding, poor weight gain, vomiting and progressive abdominal distension. There are two tests usually used to diagnose Hirschsprung disease, a contrast enema and a rectal biopsy. In Hirschsprung disease, x-ray results of the contrast enema will show a wide area in the intestines followed by a constriction where the intestines are affected. The wide area is the healthy bowel filled with stools.

In a rectal biopsy, samples are taken from the large intestine using a small suction device through the anus. The absence of ganglion cells in the samples confirm Hirschsprung disease. Additional samples may have to be taken under anaesthesia in theatre if the first samples are inadequate or inconclusive. Early diagnoses is important to prevent complications such as enterocolitis

or colonic rupture. Surgery in newborn babies with Hirschsprung disease is usually in two stages. The first operation involves bringing out normal intestine through the abdominal wall as a temporary stoma thus bypassing the affected part. The second surgery is a pull-through procedure in which there is removal of the intestine without ganglion cells and reattachment of the healthy portion of the colon to the rectum.

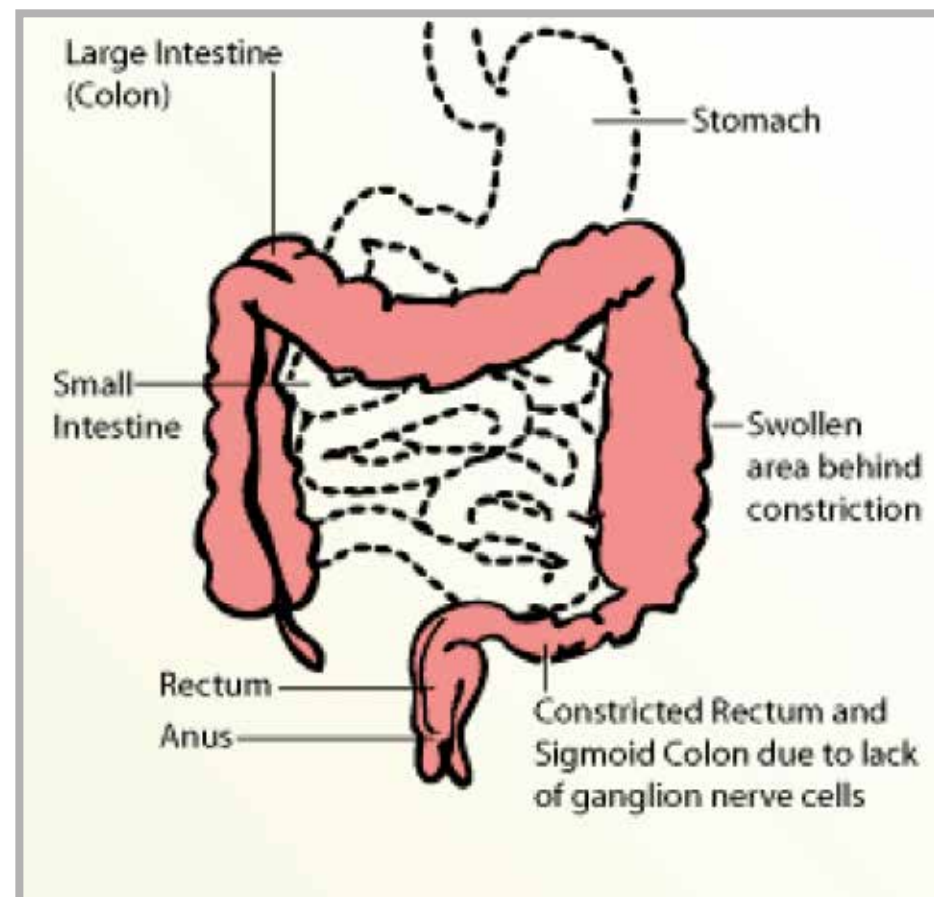
There are two main types of stomas:

- Ileostomy: a portion of ileum is brought out through the abdominal wall and is normally sited in the right iliac fossa, effluent is usually less solid
- Colostomy: a portion of the colon is brought through the abdominal wall and is normally sited in the left iliac fossa (the transverse, descending or sigmoid colon may be used).

Post operatively, the stoma is observed closely for colour (should be deep red/pink), position (should be slightly raised) and wound appearance. When the stoma is active a stoma bag should be fitted. Document all stoma actions on the fluid chart- including a description of the colour, consistency and indicate amount of effluent. Drain the stoma bag regularly, when it is up to 1/3 full to prevent leakage. Change the bag every 3 days if it does not leak. Aperture should be cut to the shape and size of stoma to ensure peristomal skin protection from effluent of stoma. A wide aperture may cause skin irritation from stoma effluent whilst a too tight aperture may damage the stoma.

Seek medical advice if the stoma bleeds excessively (some bleeding is normal on cleaning), if it prolapses out or retracts in to the abdomen, if the stoma becomes dark or bluish in colour and if losses become increasingly watery.

Patients with Hirschsprung disease may suffer from enterocolitis either before or after corrective surgery (Cincinnati, 2016). Enterocolitis is an inflammation of the intestine; early symptoms include abdominal swelling, vomiting, foul smelling stools, diarrhoea, lethargy and fever. This disorder can be serious and can be even fatal if left untreated (Nunez, R., Torres, A., Agulla, E., Moreno, C., Marin, D. and Santamaria, J., 2007). Due to immature immune system young infants are believed to be at a higher risk of enterocolitis (Frykman, P. and Short, S., 2012).



Caring for a baby investigated for Hirschsprung disease

Monitor for bowel obstruction by assessing and recording:

- Frequency, colour and amount of vomiting
- Colour and amount of nasogastric aspirate (NGT/ OGT size 10Fr for open drainage) Green vomit/ nasogastric aspirate indicates the presence of bile, making bowel obstruction more likely.
- Abdominal distension (tight, shiny, soft, visible bowel loops and visible veins). Routine measurement of abdominal girth is not an accurate method of determining abdominal distension.
- Frequency, amount, consistency, colour, +/- blood of bowel movements

Rectal washouts significantly decrease the incidence and severity of enterocolitis by preventing faecal stasis and bacterial overgrowth. They are performed to decompress the lower intestine and deflate the abdomen by removing gas and stool using small amounts of 0.9% Sodium Chloride. A rectal washout involves passing a size 10Fr tube or larger into a baby's anus and up into their bowel. The bowel is then washed out with warm saline solution to help remove any faeces. Instructions for rectal washout should include frequency of washouts, size of tube, insertion length and amount (mL) Sodium Chloride 0.9% solution to be used (usually 20mL/Kg)



Procedure for rectal washout

Prepare all the necessary equipment:

- Warm saline (body temperature)
- Lubricating gel
- Bowl and a jug
- Rectal tube/ Nelathon catheter/ NGT size 10Fr or larger
- 50ml bladder syringe
- Gloves and apron
- Inco sheet

Following preparation of equipment:

- 1) Wash hands and put on apron and gloves.
- 2) Undress the baby but leave the vest on and cover with chest with a blanket to keep baby warm. Ensure area is free from draught.
- 3) Look and gently feel the baby's abdomen. Any swelling should go down after performing the washout, if the baby's abdomen remains swollen, inform the doctor.

- 4) Remove plunger from syringe.
- 5) Lay the baby either, on their back with their legs raised or on their left side, as this will aid the flow of saline into the rectum.
- 6) Put lubricating jelly on the tube each time it is inserted to prevent soreness.
- 7) Gently insert an empty tube about 5cms unless ordered differently by the surgeon (GOSH, 2015, The Royal Children's Hospital Melbourne, 2016) into the rectum to release flatus before the washout.
- 8) If the tube cannot go in, do not use force to push the tube but rotate it gently whilst inserting. Changing the baby's position may also help.
- 9) Pull out the catheter slowly. Attach a 50ml syringe to the tube. Kink the end of the tubing below the syringe and pour a small amount of saline into the syringe, slowly releasing the kink to allow the saline to flow to the end of the tubing. This prevents excess air going into the rectum and allows a quicker start to the flow.
- 10) Gently reinsert the tube into the rectum. You can vary the position of the tube in or out slightly in order to get the best results. **Never force the tube** as it could cause damage to the lining of the bowel.
- 11) Holding the tube in place with one hand, fill the syringe barrel with 20mls of saline. This can be difficult at first if doing this on your own. If there are two people, one can hold the syringe and comfort baby as necessary.
- 12) Holding the syringe up allows the saline to flow into the bowel. Abdominal massage at this point is helpful to move the stool, if tolerated. When the saline has flowed into the rectum, lower the syringe below the level of the baby's bottom and allow the fluid to drain back in a bowl.
- 13) If the saline does not flow into the bowel, hold the tubing up higher and gently use the plunger to start the flow. Use smaller amounts of fluid (10ml) to release wind.
- 14) Check that the fluid draining out is equal to the volume that went in. If the solution does not drain back, the tube may be blocked. Gently rotating the tube whilst withdrawing it from the baby's bottom and changing the position of the baby (side to back, or side to tummy) can help. Unblock the tube by taking it out of the baby's anus and flushing with saline in a bowl.
- 15) Refill the syringe with another 20ml and hold up to begin the washout procedure again. If possible, ensure the tube stays in the rectum during the procedure, to minimise discomfort and protect the baby's anus from soreness.
- 16) Repeat procedure until the prescribed amount of saline is used or the backflow is running clear. Stop before if the baby is unduly distressed, cold or seems unwell.
- 17) Gently and slowly, withdraw the catheter from the baby's rectum, with the syringe upside down over a bowl. Gently massaging the tummy as you withdraw the catheter.



- 18) Observe the colour, consistency and smell of the stool. Inform the doctor if there are signs of infection; these can include unusual stool colour, foul smelling stools, diarrhoea and blood in stool.
- 19) When the procedure is complete, clean, dry and dress the baby appropriately to keep warm.
- 20) Fluid should be disposed of in the sluice. Clean all equipment.
- 21) Some babies will continue to have small bowel actions on their own – this does not mean they do not need a washout.
- 22) Notify the surgical team if two successive washouts fail to achieve abdominal decompression.

Rectal washout complications include emotional distress and pain on insertion of tube. These complications may be reduced by holding the baby during the procedure and using appropriate lubrication. The most severe complication of rectal irrigation is bowel perforation; however, this appears to be rare in children. In 2016 Christensen, Krogh, Perrouin-Verbe, Leder, Bazzochi, Peterson Jakobsen and Emmanuel concluded the occurrence to be 1 in 1 million procedures (0.0001%). If undertaken with care, rectal washout is a safe procedure to implement.

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Teaching Respect for Hands-On Care

One of the greatest challenges before US midwives is teaching the value of hands-on care to birthing women, the midwives who come after us, the medical profession, the nursing profession and the overall culture. Our culture's love affair with machines, contraptions and gadgets has, unfortunately, blinded literally hundreds of millions of people to the importance of human contact, feeling, experience and judgment in maternity care. Part of what makes our task a challenge is that hands-on care can be difficult to describe, to record in a few short words, to evaluate—even to recognize, especially to people who have never been present continuously through a labour and birth. We midwives have to learn how to excel at this kind of description, and we need to re-legitimize the art and importance of storytelling if our profession is to thrive once again.

If we don't tell our stories, how are we to teach women that cervical dilatation can reverse itself simply because they go to a hospital or because the wrong person enters the room? How can women re-learn confidence in their bodies unless they hear how well women's bodies work, given the right atmosphere? How else can we give the woman who has always had pain medication while giving birth the confidence to labour without medication?

When midwifery was "on a roll" during the 1970s and 1980s, many in our movement thought insurance companies and health maintenance organizations (HMOs) would recognize the savings that would follow adoption of the high-touch, low-tech version of midwifery care we wanted for ourselves and those close to us. That was because few understood the intricacies of how services are billed in hospitals, the extent to which

women's health insurance plans would limit their choices of care provider, the medical-legal requirements of hospitals, the close links between insurance companies and hospital corporations or the ease with which judges and juries could be convinced that a yard-long electronic foetal monitor (EFM) strip is equivalent to or better than the notations made by a midwife or nurse providing intermittent auscultation (along with kind words, comfort measures, encouraging stories and loving touch). EFM strips have incredible illusory power; to the uninitiated they make it look as if someone is in the room with the labouring mother and give the impression that knowing the foetal heart rate during contractions is more important than it actually is. (No one has been able to count the unnecessary Caesarean sections that have been performed because of low foetal heart rates recorded during contractions simply because of EFM).

It seems to me the only reason the assessment of cervical dilatation is still done by hand in hospitals is that no one has yet invented a set of indwelling calipers that can be installed to do the job mechanically—although some inventors in the early 20th century did try. We may be able to land a spaceship on Mars, but human flesh still doesn't lend itself to easy measurement as it changes form, consistency and position during the process of labour.

Excerpted from

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Ina May Gaskin



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Newborn Screening

Newborn screening has a long history which now spans more than 50 years. This is considered as the single most effective public health measure, since it provides us with the means of detecting a wide range of inborn conditions and initiate treatment at an early stage. Screening may avoid the development of severe neurocognitive abnormalities, some of which can be life threatening.

Dr Robert Guthrie is considered as the father of newborn screening, so much so, that it is still common nowadays to use the term Guthrie test/card when referring to newborn screening. Dr Guthrie graduated in medicine, however, he was never interested in practicing medicine but was more interested in microbiology. His second newborn had developmental abnormalities and suffered from mental retardation. This chapter in his life led him to the development of a simple test to monitor patients suffering from phenylketonuria (PKU), a condition known to cause severe mental retardation. This was known as the bacterial inhibition assay or Guthrie test. In 1961 he learned that his niece was diagnosed with PKU at the age of 15 months. Unfortunately, the diagnosis came too late for her, since her mental development was already affected. Dr Guthrie decided to focus exclusively on developing a system where all babies could be screened at an early stage, in order to allow for a better prognosis for those affected from this disease. He found that he could perform the Guthrie test, which he had developed, by using a dried blood spot sample collected from a heel puncture. More than 50 years have now passed and newborn screening has seen a lot of developments, but this sample collection method is still being used today.

Newborn screening in Malta started in 1989 with congenital hypothyroidism (CHT) and haemoglobinopathy screening. The first attempt was to introduce a screening programme based on a dried blood spot sample, however this proved to be problematic and so an alternative sample type had to be used. This is why our newborn screening programme for the past 30 years was based on a cord blood sample. The use of a cord blood sample has some advantages such as it is easy to collect, adequate volume of sample is collected, considered to be non-invasive and ensures compliance since it is collected right after birth. However, it has also a number of limitations such as a slightly higher false positive rate in CHT screening and most importantly it

limits the expansion of the screening programme to include other conditions such as PKU. This is why a decision was taken to shift our screening programme from one based on a cord blood sample to a dried blood spot approach.

The effectiveness of a screening programme is dependent on the interaction between a multidisciplinary team including midwives, clinicians and medical laboratory scientists. Each member of this team has an important role to play to ensure effective screening.

The aim of any screening programme is to be able to identify those subjects who are most likely to have a disease and make sure not to miss any true positive cases. Two important factors which will help us achieve this aim are to ensure that every baby is screened and also that the quality of sample provided does not affect the measurement of the analyte of interest. This is the important role of the midwife. The midwife collects the screening sample and provides information about screening to the parents. Timely, accurate and concise information provided to the parents is essential in newborn screening programmes. It is important to provide this information using both verbal means and printed material.

The information needs to be provided at a time which is not too early during the pregnancy but at the same time not just before or after delivery. Mothers' main interest during their hospital stay after delivery is the health of their child and other information they are provided will have little to no relevance to them. Ideally, information is provided around the third trimester of pregnancy and parentcraft sessions may provide the adequate setting for this information. During this period parents are able to ask questions and understand the importance of newborn screening.

The effectiveness of the screening programme depends on the collection of good quality blood spot samples. Failure to provide a good sample for analysis leads to delayed screening which can lead to increased risk to the newborn, unnecessary repeat sampling with associated stress to newborn and parents and also to false positive or even worse false negative results.

Currently, the blood spot cards in use by the clinical chemistry laboratory allow the collection of up to 5 separate blood spots. A minimum of 3 good quality blood spots are required. Ideally a good quality blood spot would be one which completely fills the dotted circle on the blood spot



1. Confirm the identity of the baby and completely fill the demographic details on the blood spot card.
2. Position the leg of the infant in such a way to increase blood flow towards the heel.
3. Warm the heel to increase blood circulation in the heel.
4. Clean the heel using a sterile alcohol pad. Allow the alcohol to evaporate and wipe dry with sterile gauze to ensure that the heel is completely dry. Contamination with alcohol can cause haemolysis rendering the sample unsuitable.
5. Hold the heel in a dorsoflexed position and place the paediatric lancet device next to the lateral aspect of the heel. It is important to avoid the central part of the heel since this can harm the calcaneum bone.
6. Wipe off the first drop of blood because this will most probably contain tissue fluid which can contaminate or dilute the blood sample.
7. Allow a large second drop of blood to form and lightly touch the filter paper to this large drop of blood. Allow the drop of blood to soak through the filter paper and completely fill the printed circle on the card.
8. The heel can be gently massaged to aid blood flow. However milking must be avoided since this will contaminate the blood with tissue fluid.
9. Repeat this process from step 7 until you fill all the circles.
10. If blood flow stops repeat the process from step 4 using sterile equipment.
11. Allow the blood spot to dry in air and send to lab for analysis.
12. Cards can be sent to lab either in the foam racks provided for transport of these cards or if these are not available, cards can be placed individually in paper envelopes. Plastic bags should not be used.

Table 1: Procedure for collection of dry blood sample

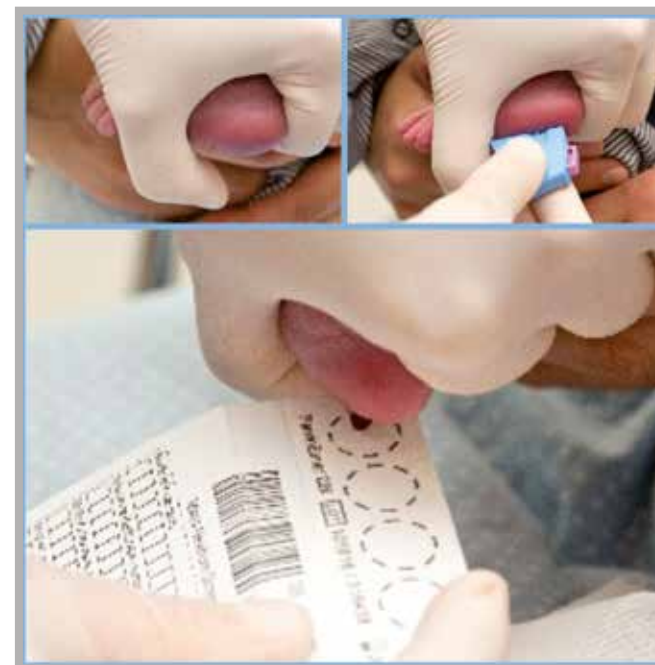
card. It is produced from a single drop of blood which completely soaks through to the other side of the filter paper. All of these requirements are necessary since each one of them could have an impact on the outcome of the screening test. It is important to understand that all of the analysis performed at the clinical chemistry lab are standardised on an assumed quantity of blood contained in a 3.2mm disc punched out of a blood spot sample which completely fills the dotted circle. This means that the size of the drop collected can influence the measurement of the analyte in that punched disc. Studies have shown that the concentration of analyte measured can vary with the size of drop collected. Some analytes have shown a falsely elevated level while others have shown a falsely

of the analyte being present in the punched filter paper disc. Another factor which can affect the screening result is sample contamination. Contamination can be caused either from bacterial growth or other contaminants which can be present on the baby's skin or the environment where the sample is being collected. This is why it is very important not to handle the blood spot card from the filter paper side whilst cleaning of the heel should be done carefully to remove any creams or faecal contamination which could contaminate the blood spot sample. The dry blood spot card should be delivered to the lab without delay since changes in analyte levels can occur with time. It is sometimes very difficult for the lab to identify these factors and so analysis would still be carried out. This can lead to either false positive or false negative screening results.

Over the past 50 years there have been several developments in newborn screening. The technology has evolved in such a way that now we can screen for up to 40 different inherited diseases from the same blood spot. Other conditions are being added to this list, year after year. Malta will also experience this expansion in the newborn screening tests carried out on our newborn population and next year we will be adding PKU screening. I am sure that in the coming years we will also see further expansion to the current screening programme. A good understanding of the processes being performed by each member of this multidisciplinary team, effective communication and close collaboration are essential elements in the success of the screening programme.

Ian Brincat

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decreased level. Layering of multiple drops of blood on the same spot can also lead to a higher concentration

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The UNICEF UK Baby Friendly Initiative Annual Conference 2018

On the 15th and 16th November 2018, I had the opportunity to be among the 900 delegates who attended this conference in Liverpool, UK. The conference aimed at putting emphasis on education and research with the target to improve knowledge and understanding of infant feeding and relationship building. This two-day conference was packed with very interesting oral and poster presentations which looked into infant feeding research from various perspectives. In this report, I have chosen to discuss only a few of these presentations which I feel are particularly pertinent to our local maternity care practices.

Dr Karin Cadwell presented very important research findings on the effects of using synthetic oxytocin during labour on breastfeeding. The negative effects related to breastfeeding have been particularly highlighted and included: decreased maternal endogenous oxytocin, increased risk of negative neonatal outcomes, decreased neonatal rest during the first hour with the potential of decreasing the consolidation of memory, decreased neonatal pre-feeding cues, decreased neonatal reflexes associated with breastfeeding, maternal depression, somatic symptoms and anxiety disorders. Surely so many negative effects of synthetic oxytocin on breastfeeding should be food for thought in today's maternity care and it is timely that the increasingly common use of synthetic oxytocin during labour should be reconsidered.

Another interesting presentation was that by Professor Renee Flacking, who presented her research findings pertaining to the neonatal environment and the long-term impact of neonatal care. Flacking emphasised that neonatal care is not only about survival of the infant but should aim to protect infants' and parents' physical and mental health, whilst ensuring that a positive parent-infant relationship develops. Becoming a parent of a preterm baby requiring neonatal care, constitutes an extraordinary life situation in which parenting begins and evolves in a medical and unfamiliar setting. In view of this, the importance and impact of physical and emotional

closeness between parent and infant in neonatal units need to be acknowledged. Findings on the long-term impact of different neonatal environmental care settings and culture, on infants and parents were highlighted. The construction and design of space and place was strongly influential on the developing parent-infant relationship and for experiencing a sense of connectedness and a shared awareness with the baby during feeding. Flacking recommended that considering such findings is vital when developing or reconfiguring NICUs so that account is taken of the influences of spatiality upon parents' experiences. She added that even without redesign there are measures that may be taken to make a positive difference for parents and their babies.

Janet Calvert presented her research on the development and evaluation of an advertising campaign in Northern Ireland which was aimed at encouraging positive attitudes and challenge negative attitudes towards breastfeeding in public, increase support for breastfeeding in public and increase awareness of the benefits of breastfeeding. The 'Not Sorry Mums' campaign was advertised on TV, radio, outdoor, print and digital. Evaluation showed an increase in positive attitudes towards breastfeeding and increased awareness of the importance of breastfeeding to health. Findings revealed that the campaign encouraged and empowered new mums to breastfeed in public and to reframe public breastfeeding as a deeply protective act that deserves support from the entire community. To view the NotSorryMums TV advert visit <https://www.youtube.com/watch?v=fis2D3WfurM>. Such a campaign has shown to be an effective mechanism for getting important messages about breastfeeding to the wider public and so it is worth considering the local promotion of breastfeeding using such advertising measures.

How Baby Friendly Standards impact on the local cultures of a maternity unit, was explored in the research presentation by Anna Coonan-Byrom. How the standards influenced the beliefs, practices, views and tacit assumptions of staff working in maternity units that engage or have engaged with Baby Friendly were examined, together with the perceptions and experiences of parents using those maternity services. Findings revealed that Baby Friendly enhances staff and service-user Sense of Coherence (SOC), helping them to become informed and informing, responsive and standardised, and to have the belief and motivation needed to optimise infant feeding care practices. Coonan-Byrom argued that Baby Friendly enables 'emotional', 'practical' and 'informational' support for both staff and service-users, when combined with effective leadership. Coonan-Byrom emphasised that it is crucial that ongoing policy, practice and research recognise embodied experiences, situated knowledge and internal/external resources to



enable the development of infant feeding care that addresses individual and organisational SOC through comprehensibility, manageability and meaningfulness. Clearly such positive findings should enhance the local stimulus needed to work wholeheartedly towards achieving Baby Friendly accreditation in our local maternity care units.

Dr Kajsa Brimdyr has been observing many babies and mothers during skin-to-skin care in various countries. Research findings reveal that holding a baby in skin-to-skin immediately after birth, and continuing, uninterrupted for at least one hour, is vital to the health of both the baby and the mother and is a key part of the Baby Friendly Standards. More

specifically, Brimdyr discussed how babies who are held skin-to-skin, and go through Wildstrom's 9 stages (birth cry, relaxation, awakening, activity, rest, crawling, familiarization, suckling, sleeping), are more likely to leave the hospital exclusively breastfeeding. In addition, these babies are warmer, they have better blood glucose levels, better respirations and so ultimately they are healthier babies. Such babies were also reported to cry less and so save valuable energy and they are primed (by their hormones) to fall in love. Mothers, with the hormones of labour, are also primed to fall in love and so mother-and-baby together can form the most important bond of their lives, with their hormones acting like extra-special glue to ensure the connection. These findings should be encouraging to local skin-to-skin practices so that more and more mothers and babies are provided with the opportunity of skin-to-skin care during the first hour after birth.

Dr Wendy Jones presented the evidence on the relationship between breastfeeding and perinatal mental health. The dichotomy of "breastfeeding problems caused my mental health issue" and "breastfeeding was the only positive thing in my life" were discussed. The controversies about the safety of drugs in breastmilk were also presented. Dr Jones highlighted that there are many difficulties around mothers not being able, or not choosing, to access support either for their breastfeeding problems or their mental health. There appears to be much advice but often little support and listening. Her recommendations focus on the need for healthcare professionals to be trained on breastfeeding, the safety of drugs in breastmilk and on being sensitive to the needs of mothers around infant feeding. Dr Jones urges healthcare professionals to "Be Kind, value their



(mothers') breastfeeding if that is what they wish. Accept that they want to stop if that is what they wish. Support them, you don't have to have the answers but don't undervalue the importance that you listened to them". Surely such evidence and recommendations are valuable to the care provided locally to mothers and can help to improve the services already given in various local maternity care settings.

In conclusion, this conference has seen an inspiring programme of presentations on a whole range of issues affecting the care of babies, their mums and families. Presentations have demonstrated that the BFI standards have been implemented not only in maternity services but also in neonatal units and

universities. If there is a commitment to always improve on the quality of care provided in our local settings, then we have a lot to learn from such evidence. I encourage midwives to attend such an interesting yearly conference on regular basis, to keep updated with the latest evidence in such important aspects of maternity care. It is also helpful to follow the website <https://www.unicef.org.uk/babyfriendly/> for many useful resources. The 2019 BFI Annual Conference will take place in Glasgow on 28-29 November. Booking will open in Spring 2019.

Suggested reading

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Top left to right: Garbielle Grixti, Prof Rita Borg Xuereb, Jackie-Mariella Sultana, Larissa Dimech, Francesca Chetcuti, Channele Muscat, Danika Bilocca, Louanne Caruana, Sofia Lundquist, Ms Christie Hili, Dr Rita Pace Parascandolo, Ms Nicole Borg Cunen, Dr Josephine Attard
Bottom left to right: Kylie Scerri, Lauren Marie Grech, Kirsten Camilleri, Laura Calleja



University of Malta B.Sc. (Hons.) Midwifery Dissertation Abstracts 2018

Midwives' Perceptions of Work-Related Stress in Midwifery

Work-related stress (WRS) is a major issue in healthcare, with the midwifery profession ranked as one of the most stressful occupations amongst other human service professions. In view of this, the aim of this study was to explore midwives' perceptions of WRS in midwifery practice in Malta. The objectives were to identify factors which contribute to stress in midwifery, to explore and assess the impact of WRS on midwifery practice and to determine the implications of WRS on midwives' physical, emotional and psychological wellbeing. A quantitative research design was employed using a self-administered questionnaire, designed by the researcher. The questionnaire was distributed to a sample of 50 midwives working at obstetric wards, the delivery suite and the neonatal unit at the local state hospital. Participants were recruited by convenience sampling. Descriptive statistics were used to analyse closed-ended questions while answers from open-ended questions were analysed using content analysis. Results were presented in charts and tables.

The study yielded a response rate of 76% (n = 38). Lack of staff and resources, high patient load and daily rates of

medical inductions of labour and caesarean sections were found to be the factors which contributed mostly to WRS amongst participants. Obstetric and neonatal complications which were perceived most stressful were related to neonatal death, abnormalities and resuscitation as well as dealing with foetal and neonatal death. Overall it resulted that WRS has a negative impact on the midwife's delivery of care, interaction with colleagues and on the midwife's physical, emotional and psychological wellbeing. While stress-contributing factors results are similar to other studies examining WRS in midwives; findings about impact on midwifery care are amongst the first in literature. Educational seminars to address WRS, improvement in staffing and clinical strategies to control workload to reduce WRS; in order to preserve the midwife's wellbeing and enhance optimal care should be implemented. Future longitudinal quantitative research using larger samples is recommended, as well as qualitative studies exploring the impact of stress on midwives and on provision of midwifery care.

Lauren Marie Grech

Parents' Views on Neonatal Care Provided in an Intensive Care Unit with an Open Ward Setting

The aim of this study was to identify parents' views on having an infant being cared for in an open ward setting of a neonatal unit. The objectives were to assess parents' perceptions of the advantages and drawbacks of having an open ward setting in a neonatal intensive care unit and to identify parents' views on the communication received from midwives and nurses in such a setting. The study was also interested in investigating parents' experiences of relating to their infant in an open ward setting of a neonatal unit and in identifying parents' views on the level of comfort and privacy offered in this setting.

A quantitative approach was adopted and data was gathered through the use of a structured, self-report questionnaire designed specifically for the study. The response rate achieved was that of 84%, representing a convenience sample of 42 parents, mothers and fathers. Data was analysed manually using descriptive statistics and through content analysis. Findings indicated that parents often felt overwhelmed and scared when initially entering the open ward setting of the neonatal unit, but the setting also gave them a sense of safety. Communication between nurses/midwives and parents in this setting was

generally felt to be satisfactory, although weaknesses were identified in terms of parental ability to ask questions, and to receive detailed responses. Although overall parents felt that they were able to build a close bond with their infant while at the neonatal and paediatrics intensive care unit, they identified challenges associated with this, including the visiting hours, which were viewed as restrictive at times. Comfort and privacy were also considered to be somewhat compromised in the open ward setting, particularly during breastfeeding, given the close proximity to other families. However, being able to easily meet others who were in a similar situation to their own was considered an advantage of the open ward setting, together with the availability of numerous nurses/midwives. Recommendations for practice, education and further research were proposed, including measures such as the introduction of privacy screens whilst breastfeeding and the use of private rooms for discussions about infant condition, so as to enhance parents' comfort and privacy whilst visiting their baby within the open ward setting of the neonatal unit.

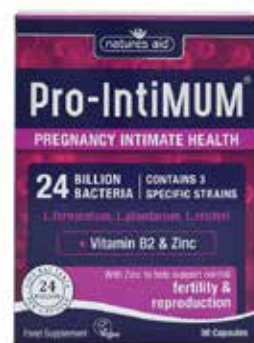
Kylie Scerri

Midwives' Views of Caring for Women with Physical Disabilities During the Antenatal, Delivery and the Postnatal Period

Approximately 12% of women of childbearing age report a disability with a considerable amount report having a limitation in their mobility. The aim of this study is to explore the midwives' views when caring for women with physical disabilities during the antenatal, intranatal and the postnatal period. The objectives of the study were to explore midwives' competence and educational preparedness in providing care for physically disabled women during the perinatal period, and to identify available resources in hospital that can assist these women and their midwife in care. A qualitative study was carried out, using semi-structured, face-to-face interviews, with a convenience sample of nine midwives working in the obstetric wards and delivery suite in the local

general hospital. Braun and Clarke (2006) content thematic framework was used for the purpose of analysing data gathered. The findings of this study indicate that midwives do not have the necessary knowledge and practical experience to provide care to physically disabled women. While the majority of midwives showed positive attitudes towards physically disabled women, only few expressed negative feelings while caring for this group of women. Moreover, midwives are aware of the barriers that hinder the provision of quality care for physically impaired women. Recommendations for midwifery practice, education, and further research are proposed.

Francesca Chetcuti



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Noise Exposure on Preterm Infants in the Neonatal Unit: Neonatal Staff Awareness

Infants born prior to term gestation are often admitted to the Neonatal Intensive Care Unit [NICU] in view of their increased risk of morbidity and mortality. The presence of technological resources and on-going staff activity, often characterise such unit with loud ambient noise. Evidence-based research has verified several implications of noise exposure on the well-being of preterm infants. Thus, the implementation of noise-reducing measures has proven to be a vital aspect in reducing stress on hospitalised neonates. The aim of this study was to explore local neonatal staff awareness of noise exposure on preterm infants in the neonatal unit. The objectives of this research project were to: assess the recognition of midwives and nurses on Sound Pressure Levels [SPLs] in the neonatal unit, investigate the perceived factors contributing to noise levels in the Neonatal Paediatric Intensive Care Unit [NPICU], identify the knowledge of midwives and nurses of the effects of noise exposure on preterm infants and explore the attitudes and practices of midwives and nurses in relation to noise-reducing measures. A quantitative approach utilising a self-administered questionnaire, was adopted. A sample of fifty midwives and nurses working in the NPICU at the state hospital were selected through

convenience sampling, generating a response rate of 86% (n = 43). Collected data was analysed manually and presented in the form of calculated percentages, diagrammatic representations and tables. Findings revealed that although local neonatal staff were not familiar with the recommended sound limit in the neonatal unit, perceived noise levels were comparable to those mentioned in similar studies overseas. While various elements in the NPICU were believed to elevate SPLs at different degrees, the perceived highest and lowest noise-contributing factors were further identified. Although midwives and nurses were knowledgeable of several effects of noise exposure on preterm infants, staff awareness was lacking when certain aspects of physiological response and long-term neurodevelopment were addressed. Moreover, participants' attitudes towards the efficacy and implementation of noise-reducing measures did not correlate with local practices in the NPICU. For this reason, various recommendations for clinical practice, education and further research were proposed in accordance to the conclusions of this study. The importance of increasing neonatal staff awareness through training and education was highlighted together with the need for establishment of a written noise control protocol.

Chanelle Muscat

Midwives' Views of Caesarean Section at Maternal Request

The aim of this study was to explore midwives' views about caesarean section done at maternal request, without clinical indication. The objectives were to explore midwives' insight into reasons underlying maternal request for caesarean section where there is no clinical indication, to explore midwives' perceptions of maternal entitlement to choose to undergo a caesarean section and to explore midwives' perceptions regarding appropriate management in cases of maternal request for caesarean section. A qualitative approach was used to conduct the study and a semi-structured interview schedule was used to generate data.

Participants were recruited through convenience sampling from a local, general hospital. Audio-recorded, face-to-face interviews were held with eight qualified midwives with experience caring for women who deliver their baby through caesarean section. The study had a 100% response rate.

Thematic analysis, described by Braun and Clarke (2006), was used to analyse data.

According to the participants, various factors influenced women to opt for a CS, with fear being the most prevalent element. Midwives had mixed feelings about women's entitlement to opt for a CS, disagreeing with it in principle but feeling that respecting maternal autonomy was an important consideration. Circumstances where it was considered more acceptable, such as in the case of prior traumatic birth, were identified. Midwives' highlighted the importance of providing individualised antenatal support to women considering a non-clinically indicated CS. Recommendations for further research, practice and education were suggested, such as introducing midwifery-led care in the antenatal period in an attempt to minimise maternal fear of natural birth, which may lead to requests for CS.

Laura Calleja

Midwives' Awareness of Domestic Abuse in Pregnancy

The aim of this small-scale quantitative study was to explore midwives' awareness of domestic abuse [DA] among pregnant mothers by seeking to identify midwives' knowledge of DA in pregnancy and to evaluate their views on routine enquiry for DA during pregnancy. In order to fulfil these objectives, a sample of midwives (n = 40) was recruited by convenience, non-probability sampling technique from all maternity sections of the local general hospital. Participants were invited to answer a self-administered, semi-structured questionnaire consisting of both closed and open-ended questions. All distributed questionnaires were answered which yielded a 100% response rate. Data obtained by closed-ended questions was analysed through simple percentages, mean, median and mode by Microsoft Excel 2013 and presented in bar graphs and pie charts. On the other hand, the data gathered in the open-ended questions was analysed by means of content analysis. Permissions to carry out the study were obtained from the respective authorities. The findings revealed that locally midwives are knowledgeable about the signs and the common forms of DA during pregnancy. However, knowledge on the effects of DA amongst pregnant

women and the local services available should any referral be needed was found to be lacking. Congruent with the findings of other studies, local midwives appreciated the beneficial effects of routine enquiry for DA in pregnancy and have also identified a number of barriers that limit them from enquiring for DA. On the basis of the results, it is highly recommended that midwives are offered further courses and training concerning DA in pregnancy in order to facilitate identification of pregnant women experiencing DA and hence offer adequate care and support to women. Furthermore, the need to introduce routine screening for DA during the pre-conception, antenatal period and in the postpartum period is critical to safeguard the lives of both the woman and her child. Moreover, further research should be conducted to assess the effectiveness of screening for DA on the rate of abuse disclosure. Nevertheless, it was suggested to provide written guidelines and policies at the wards containing information regarding signs of DA during pregnancy, how to document safely and effectively, and the sources midwives can refer to in case of suspecting DA.

Kirsten Camilleri



Compassion in Midwifery: Midwives' Perspectives

Compassion is widely known as the "art of being professional and human", and it is considered to be a desirable quality in midwifery care. Although midwives do practice compassionate care in their clinical encounters with women, yet the concept of compassion is poorly defined and understood by midwives. Midwives are aware of workplace stresses but few relate this to compassion fatigue, missing out on recognising symptoms of compassion fatigue and identifying prevention strategies to overcome it. Hence, the aim of this study is to delve into midwives' perspectives on the concept of compassion, with the objective to analyse the concept and identify the elements comprising compassion. At the same time, the causes, indicators and preventative strategies of compassion fatigue as perceived by local midwives are explored.

A qualitative approach was chosen for this study using a self-

designed face to face interview. Eight Maltese midwives, were recruited by convenience sampling from the maternity wards at the local state hospital; achieving a 100% response rate. Data was analysed through content thematic analysis using the Braun & Clarke (2006) framework.

The study findings revealed that midwives perceived compassion as being a broad term that encompasses several attributes, and rightly defined the concept of compassion. Although, compassion fatigue was not clearly understood by participants, these midwives were aware of the ill effects of this problem proposing preventative strategies as identified in the literature.

Recommendations for clinical practice, education and research are proposed to enhance the importance and significance of compassion in the midwifery profession.

Gabrielle Gixti

Midwives' Experiences of Breaking Bad News to Mothers at the Birth of an Infant with Congenital Anomalies

The role of the midwife in breaking bad news (BBN) to mothers at the birth of an infant with a congenital anomaly is anticipated as being stressful for both the midwife and the parents, as it is a unique moment in life where an assemblage of happiness from giving birth and great sadness from the unexpected news is experienced. The aim of this study is to explore the midwives' experiences of BBN at birth, when the infant has a congenital defect. The objectives of this study are to explore the midwives' competence (knowledge, skills and attitudes) of BBN to mothers at the birth of an infant with a congenital anomaly; to identify procedures carried out by the midwife when BBN; and to explore the midwives' own emotional impact when coping with such situations.

In order to fulfil the aim of this research study, a qualitative approach was adopted using self - designed, face - to - face semi - structured interviews. A target population of ten midwives, working at the delivery suite in the local general hospital were chosen by convenience sampling. A response rate of 100% was achieved. The interview recordings were transcribed via verbatim transcription and data was analysed by thematic content analysis, as described by the framework by Braun and Clarke (2006).

The findings of this study demonstrate that the midwives' competence in BBN is varied. The main challenges faced by midwives included being unprepared for such unexpected situations and their lack of knowledge on congenital anomalies. The participants' confidence in BBN is mostly dependent on the type of the congenital anomaly. From data analysis, it was demonstrated that while midwives possess effective non - verbal communication skills to assist mothers with their emotions, they lack the required verbal communication skills to answer maternal concerns. Midwives identified several mandatory procedures to ease the facilitation of BBN for both themselves and the mothers. All midwives expressed a feeling of unhappiness, shock and trauma upon the realisation of the baby's anomaly, with most midwives claiming of becoming emotionally involved. The results exhibited several recommendations for practice, education and further research. These include the need for improving the midwives' knowledge on congenital anomalies, improving the midwives' communication skills, investing a special designated area in the postnatal maternity wards for such families and the need for a large - scale study to identify the phenomena being studied in greater depth.

Danika Bilocca

Motivating Pregnant Women on Healthy Nutrition during Pregnancy: Midwives' Views

Healthy nutrition in pregnancy is a significant determinant of health for both the mother and her child (Marangoni et al., 2016). The aim of this study was to analyse the midwives' views on motivating pregnant women on healthy nutrition during pregnancy. The objectives of this study were to assess the midwives' awareness on healthy nutrition during pregnancy, to assess how the midwives motivate pregnant women on healthy nutrition and to identify what barriers limit midwives from doing so. To fulfil the overall purpose of the study, a quantitative study was carried out, using a self-designed questionnaire consisting of open and closed ended questions. A sample of 30 Maltese midwives was selected by convenience sampling technique from different maternity settings at the local public hospital. The response rate was 100% (n = 30). Data was analysed using descriptive statistics and content analysis. The findings of this study revealed that midwives are knowledgeable about nutrition in pregnancy, despite the lack of formal education on the subject. Overall, midwives are confident in motivating women in

this regard; however, they acknowledged a lack of confidence when motivating women with specific dietary requirements. The midwives were aware of the barriers that hindered them from effectively motivating their clients such as heavy workload, shortage of staff and cultural issues. In line with previous research findings, participants identified the need for more education and training and to increase awareness on nutrition during the pre-conception period amongst women of childbearing age to further motivate them to adopt healthier nutrition and lifestyle changes. For this reason, the researcher proposed recommendations for further research, education, practice and management, such as repeating the study using a qualitative approach to generate more in-depth findings, ensuring that all midwives have access to evidence-based information through CPD programmes and possibly extending the antenatal care services in the community for more continuity of care and more opportunities to promote healthy nutrition during pregnancy.

Larissa Dimech



Mothers' Views on Positions during the Second Stage of Labour

There are many known physical benefits on women's use of upright positions during the second stage of labour. The aim of this study was to explore mothers' views on different positions during the second stage of labour. The objectives were to explore mothers' experiences of different positions, mothers' preferred positions and explore mothers' decision making regarding their choice of positions during this stage of labour.

A qualitative approach using semi-structured interviews was chosen to gather data from participants. Eight newly delivered mothers were recruited by convenience sampling from the obstetric wards in the state maternity hospital. The data was analysed using Braun & Clarke (2006) framework of content thematic analysis. The findings revealed that participants were

knowledgeable of the different upright birthing positions namely the on all fours, sitting and standing but lacked knowledge of the benefits these positions had during the second stage of labour and birth such as shortened birth duration, reduced incidence of operative delivery and better management of pain. Despite this, participants were keen to try these positions but were hindered by their midwife who had a major role in the decision making. Consequently, most participants gave birth in the supine position (i.e. on their back). Recommendations for education, clinical practice and research are being proposed advocating the upright positions favoured by the gravitational pull.

Louanne Caruana

Caring for Women Going Through a Miscarriage: Midwives' Experiences

This small-scale qualitative study sought to explore the midwives' experiences of caring for a mother who is going through a miscarriage. In order to meet the aim of the study, the following objectives were set: to explore how midwives care for women going through a miscarriage and to identify how midwives help women cope with their miscarriage. A sample of six midwives working at Obstetrics Ward 2 in the Local General Hospital were recruited through purposive sampling and participated in a face-to-face semi-structured interview. A 100% response rate was achieved. The data collected was transcribed verbatim and analysed using Braun and Clarke's (2006) thematic analysis.

The findings of the study demonstrated that midwives use a combination of different care practices when caring for women experiencing a miscarriage as there was no one correct way to provide care. However, the provision of physical, psychological care and support and preparing mothers for their loss were seen as being the most important care practices. Midwives were seen to have conflicting views on how they can help women to grieve and come to terms with their miscarriage. Moreover, they claimed that the care provided is based on women's individual

needs and according to the gestation at which the miscarriage occurred.

Midwives themselves were emotionally affected by the experience of miscarriages and found the provision of care rather challenging. Nevertheless, midwives felt satisfied by the parents' appreciation of their care, this being seen as a driving force to improve the care provided.

Whilst the findings of this research mainly corresponded with those of other studies, a number of differences were observed which were mainly due to each hospital having their own protocol of care and services available for women. Based on the study's findings, a number of recommendations for practice, education, research and management were suggested such as the need for mothers of early miscarriages to be given a token to symbolise their loss such as a keepsake box, which will help them remember their loss. Other recommendations include dividing Obstetrics Ward 2 into two wards one of which catering solely for perinatal loss, and for there to be further promotion of the support services available to staff members caring for miscarrying mothers.

Sofia Lundquist

Women's Experiences of Aquanatal Exercises

Regular physical activity during pregnancy is associated with substantial health benefits (RCOG, 2017). In fact, pregnant women are advised to adhere to 150 minutes of moderate physical activity per week. An aquatic environment has been found to provide women with an alternative to on-land based exercises as they are an effective and safe form of physical activity (Smith & Michel, 2006). The aim of the study was to explore women's experiences of aquanatal exercises to identify the perceived benefits and drawbacks of attending aquanatal exercises, whilst looking into women's motivation behind their participation in these form of exercises. Women's overall satisfaction with participating in aquanatal exercises was also explored. A qualitative study using face-to-face, semi-structured interviews was conducted with seven mothers who participated in aquanatal exercises which were recruited by purposive sampling technique. The collected data was transcribed verbatim and analysed using thematic analyses (Braun & Clarke, 2006).

Four themes were identified; 'The Overall Satisfaction of Attending Aquanatal Exercises', 'The Midwife Instructress', 'Mother's Motivation and Drawbacks' and 'The Impact of Aquanatal Exercises on the Birthing Experience'. Findings demonstrated that all mothers were satisfied with their experience of participating in aquanatal exercises, which was

attributed to the positive outcomes in their overall wellbeing. Findings also showed that mothers deemed the presence of the midwife as the instructress as supportive and vital. Factors which motivated participants to attend aquanatal classes were mainly the motivation to experience a healthy pregnancy and promotion through social media. The session fee was considered to be a drawback to attending these exercises. The impact of aquanatal exercises on increased self-efficacy during childbirth and positive birthing outcomes were also highlighted. On the basis of the results obtained, recommendations for practice, education and future research were proposed such as to increase awareness amongst midwives on the benefits of aquanatal exercises, promotion of these classes during booking visit and throughout parentcraft sessions, to increase women's use of non-pharmacological interventions to treat anxiety and pregnancy related discomforts. In addition, midwives should be encouraged to engage in courses that allow them to gain more knowledge about the vast options of physical activity during pregnancy such as aquanatal exercises. Moreover, a comparative study exploring women's experiences of aquanatal exercises and 'on-land' exercises would be beneficial in identifying possible influences on outcomes of labour.

Jackie-Mariella Sultana

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