

The Stork

440

YEARS

1974 - 2014



Celebrating the Official Inauguration of the Association - September 1975

Malta Midwives Association

Issue 4 July 2014



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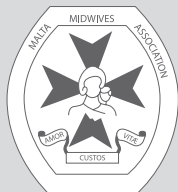
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Contents

Editorial.....	3
Executive Committee.....	3
President's Message Midwives - Improving Women's Health Globally	4
1 st Midwives Association Executive Council 1974-1975.....	4
Secretary's Message	5
Treasurer's Message.....	5
ICM 30th Triennial Council Meeting 27th – 30th May and Congress 1st- 5th June 2014.....	6
Tista' 'tredda' abbord I-Air Malta.....	6
Promotion for Midwives' Day 2014.....	8
Looking Back, Moving Forward.....	9
The Freedom To Move During Labour.....	12
An Overview of Metformin Use in Fertility Management, Pregnancy and Lactation.....	17
Reducing the risk of SIDS and other sleep-related causes of infant death.....	21
Grieving Parents: What am I to do?	23
MSc Abstracts	
What are the factors that promote and/or hinder low risk pregnant women from having a natural normal childbirth?	25
Does Job Rotation Aid For The Development And Performance Of Midwives Within The Maternity Department – 'Mater Dei Hospital', Malta?.....	25
Going Back To Work After Childbirth: Women's Lived Experiences	26



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Editorial Board

Pauline Fenech

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and should be addressed to the
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Editorial

Dear Member,

We now welcome the summer season. I sincerely hope you will enjoy the summer period and perhaps you can take the opportunity to slow down and find some time for yourself.

This year the Malta Midwives Association (MMA) is celebrating its 40th anniversary: 1974 – 2014. The Association was founded by the late Ms Mary Vella Bondin who was the first president. Unfortunately, I could not find any photos related to the first executive committee. Therefore, I would like to take this opportunity to ask all members whether they can share pictures of MMA's activities and photos of midwives during the period of 1974 to 2014 with the Association. We are planning to hold a photo exhibition to commemorate the 40th anniversary later this year.

MMA is very please to hear of Dr Rita Borg Xuereb's new appointment with the International Confederation of Midwives (ICM). Dr Borg Xuereb was elected to represent midwives from the Southern European Region on the ICM Board. This is a huge opportunity for her personally and for the Maltese midwifery profession.

In this issue Dr Hall gives an overview of the Bristol project. She talks about the subtle changes in midwifery practices that are required over time on a personal level and organisational level. The focus is on exploration of possibilities, a need for creativity, intuition and a willingness to consider new options by challenging the status quo.

MMA feels that the Bristol project has been very successful and hopes that it will serve as a springboard for other projects.

Dr J. Craus gives an informative overview of Metformin, its properties, indications for use and what are the benefits. Ms R. M. Xuereb and Ms S. Castillo write on how to prevent SIDS and how to help grieving parents respectively. It is always very difficult and challenging when health professionals are required to support and look after the parents who have just lost a foetus, IUD or sibling. I encourage you to read the article of SIDS to help to minimize/eliminate this unpredictable event and be informed and understand on how to support grieving parents when this situation occurs.

Finally, the council is doing some incredible work and it is important that we hear from you. I would like you to participate by sending me your feedback about what you like or do not like about this publication, what topics you would like to see more of, ideas you wish to share, suggestions and so on. It will be very encouraging if you could put in the effort and make your voice heard by selecting the topics and subjects you think should be raised in these publications. You can send me an email addressed to the editor on:

info@maltamidwivesassociation.com

I look forward to hearing from you.

Pauline Fenech

Executive Committee

Buttigieg Said Mary	– President, Projects Manager & Representative of the Malta Movement of the Unborn Child.
Fenech Pauline	– Vice President & Representative of the MEUSAC.
Gilson Rebecca	– Secretary & Representative of the Malta Health Network.
Spiteri Clara	– Assistant Secretary & Representative of the National Council of Women.
Grima Doris	– Treasurer & Antenatal Education Programme Co-Ordinator.
Xuereb Ruth Marie	– Public Relations, IT Co-Ordinator & Representative of the Malta Health Network.
Analise Gingel	– Committee Member for Social and Educational Events & Representative of the National Council of Women.
Marie Soler	– Committee Member for Social and Educational Events & Representative of the Malta Movement of the Unborn Child.
Stephanie Cutajar	– Committee Member for Social and Educational Events & Representative of the MEUSAC.



President's Message

Midwives - Improving Women's Health Globally

The ICM 30th Triennial Congress united nearly four thousand Midwives from around the world, all aiming to learn, share their knowledge to improve maternal and infant health services at national level.

Human rights in childbirth are core issues which were given high priority. Human rights improve health care, dignity and autonomy and they are to be fully respected. It is the right of every expectant woman to actively participate in her care based on informed consent and choice. Care that meets the holistic needs of every mother individually, care that maximizes the maternal and foetal wellbeing.

On the other hand it is the right and duty of every midwife to provide optimal care to each mother and family. Midwives it is the time to stand and be counted, to make our voice heard. We need justice for women and midwives.

Midwife - be with women, be the women's advocate, be the agent of change. It is no longer acceptable to provide care in a one size fits all system. Our system is imposing detrimental effects on the health of the mother, the baby, the midwives, the organisation, and the nation.

Care needs to be women centred, based on scientific evidence and properly regulated. Women need to have a range of options that cater and respect their holistic needs including one's long term emotional impact.

Enhanced birth outcomes demand individualized care:- saving hospital technology and interventions for the women who really need it.

Dr Ricardo Herbert Jones, Obstetrician, emphasises that *'the humanization of childbirth does not represent a romantic return to the past, nor a devaluation of technology rather it offers an ecological and sustainable pathway to the future'*.

We can change the world, improve maternity care, give women best possible care, and be their guardians. Low risk women should have the option to be cared for and give birth in a Midwifery Led Unit. Evidence shows major benefits in giving birth in Midwifery Led Unit.

It is the time that we unite to give low risk women in Malta a safe choice based on scientific evidence.

**Mary Buttigieg Said
President**

1st Midwives Association Executive Council 1974-1975

President	Mary Vella Bondin
Vice President	May Pecorella
Treasurer	Rose Caruana
Secretary	Mary Anne Baldacchino
Member	Josephine Calleja
Member	Sr Letizia Coreschi
Member	Sera Delia
Member	Mary Dimech
Member	Frances Schembri

A general meeting for the approval of the statute was held at the 'Anglo Maltese Club' hall at 221, Merchants Str, Valletta on Thursday 7th November 1974 at 5.30pm. For this First General Meeting 31 midwives attended and the Association's Statute was approved.

Dr Paul Cassar in his book, *The Maltese Midwife in History* (1978, pg 10) states:

"the new feeling of identity of the Maltese midwife found expression in November 1974 in the formation of The Midwives' Association of Malta with the aim of:

- *Holding post-graduate lectures and demonstrations*
- *Publishing literature on midwifery and related matters*
- *Promoting and maintaining the unity of the members of the profession"*



Mary Vella Bondin,
1st President of the Association



Secretary's Message

Dear Colleagues

The ICM's 2014 new subtheme for the International day of the midwife was "Midwives changing the world one family at a time" This subtheme accompanied the International Day of the Midwife's main theme for the past years: "The World Needs Midwives Now More Than Ever" The two themes together send a strong signal that midwives provide care that changes families, communities and the world by saving the lives of mothers and babies. This year, being the MMA'S 40th year anniversary the MMA went the extra mile to celebrate the International Day of the Midwife. An open day, which was a new venture for MMA was a success with couples enjoying sessions on normal birth as well as midwifery skills free of charge provided at the premises. This truly was a highlight of the week of activities! Midwives were not forgotten in the celebrations with a free buffet dinner for all members on the 5th May.

Midwifery also features strongly in this years' blood

donor day with the title being: "Safe blood for saving mothers". We strongly encourage all midwives to donate blood.

The MMA is also having an increasing role in the media, with a press release regarding breastfeeding on Air Malta flights as a reply to the article 'Tista' tredda' fuq l-Air Malta sakemm ma dejjaqx lill-ohrajn' published in Newsbook. Following this publication a meeting was held with Airmalta head of cabin crew were MMA gave suggestions for policy on breastfeeding on board. MMA has also achieved a greater presence on social media with the facebook page – Malta Midwives Association Parents' corner. The committee hopes to further expand MMA's appearance in the media to further promote the well being of mothers and their families and the role of the midwife.

**Rebecca Gilson
Secretary**

Treasurer's Message

Dear colleagues

As is now customary, I am penning this article to provide you with an update.

Currently the association is providing the following courses:

- Parental Skills from 0 to 6
- Baby massage
- Mother massage
- Immunization and minor ailments
- Dealing with child emergencies *
- Pilates (two groups)
- Ante natal educational classes *¹

Additionally, the MMA also provides courses for midwives and the general public. Midwives now had the opportunity of undergoing a Complimentary Therapy course, Seminar on Normalizing childbirth and programmes in public speaking.

A major initiative is the Bristol experience. Having tapped EU funding, the MMA facilitates week-long visits to Bristol, in the UK. A number of colleagues have undergone this experience. I am sure that most of you have had the occasion to speak to those midwives who have been to Bristol and who speak of this experience in a very positive way. This venture was a breakthrough for the MMA and there is a lot of hard work being inputted by the President and others monitoring these visits.

May 5 was Midwives Day. The Association carried out a number of activities to mark this event. These included a Reunion for those couples who, during the previous year, had attended one of our antenatal educational sessions. Also an Open Day for the general public. A

buffet Dinner was held on the day and it is heartening to note that those who attended enjoyed the evening. Unfortunately, the foul weather over the weekend ruined the plans for an open air picnic.

It is encouraging to note that the on-going appeal for membership is not falling on deaf ears. Only very few midwives have not yet enrolled in the MMA. Once again we appeal to those who have not yet decided to join to do so right away.

I would be failing my duty were I not to thank all those who are giving up much of their free (or should I say family) time to share in the workload of the Association. If more offer some of their time, the load will continue to spread. So any volunteers out there please enrol NOW.

The Committee invests much energy in all activities it organises and which are well attended. So do please take note of activities and courses. Spread the word around and encourage people to call on 77237117 to book one of our courses. Alternatively bookings can be made via email on info@midwivesassociation.com address.

I look forward to the AGM whereat I will be in a position to provide colleagues with the usual financial report. Hopefully, the AGM will be well attended and suggestions tabled for better improvement of the services offered by the MMA.

Reference

¹ courses marked with an asterisk are provided in both Maltese and English

**Doris Grima
Treasurer**



ICM 30th Triennial Council Meeting 27th – 30th May and Congress 1st- 5th June 2014

The International Confederation of Midwives (ICM) is the sole global representative of midwives. It is made up of more than 116 associations with more than 300,000 midwives from all over the world. ICM is also responsible for the development of midwifery as a profession and to ensure that all individuals who use the title of midwife are appropriately qualified. ICM works with other international organisations to achieve its main objectives:

1. To promote and strengthen the Midwifery profession
2. To promote the aims of the Confederation internationally
3. To work to improve women's health globally

The midwives associations have the responsibility to ensure that midwives within their country achieve all the competencies required to practise their profession. The Midwives association also has a duty to ensure that the right laws are in place to regulate the profession and that clinical practice is based on research evidence and is cultural sensitive.

One hundred and sixty-eight delegates from all over the world were present during the 30th Triennial Council meeting. We had 3 full packed days with meetings, discussions and taking decisions about where we want to take our profession in the future.

As the ICM is a confederation, by law the Council is the actual governing body of ICM, and they meet every three years to evaluate what they had achieved in the previous triennium and to plan and agree on a strategy for the subsequent three years. The council is

also responsible for the financial administration of the confederation. It was a pleasant surprise to hear that financially the confederation is doing well. This was a far cry from my last Council meeting in 2005, Brisbane, Australia, where ICM was financially very unstable. It shows that ICM has worked very hard to reach financial stability it is enjoying now, 9 years later.

At the end of the Council meeting, all the delegates vote for the Board that they wish to represent them in the next Triennium. The Board is made up of the President, Vice President and Chief Executive Officer, and representatives from each region around the world, 3 midwives from Asia Pacific, 2 midwives from Africa, 2 midwives from the Americas and 3 midwives from Europe.

I was elected to represent the Southern European region. It was a joyous occasion for our Association and our country as for the first time Malta is on the Board of the ICM, responsible for the Midwifery profession across the world and a voice that supports and promotes maternal and child health across the world. This achievement is also testimonial of how our profession has evolved in Malta during the past decade. We are now in a position of helping and supporting other countries in working towards excellence in Midwifery care for women, children and their families. The new Board took office on 5th of June 2014 and we had our first meeting on the 6th June.

Dr Rita Borg Xuereb
Head Department of Midwifery
University of Malta

Congratulations to Dr R Borg Xuereb for her new appointment of ICM Board

Tista' tredda' abbord I-Air Malta

Wara li deher l-artiklu fuq newsbook website 'Tista tredda' fuq I-Air Malta sakemm ma ddejjaxx lill-oħrajn' fil-11 ta' April, 2014, l-Assoċjazzjoni tal-Qwiebel Maltin (MMA) ħasset il-bżonn li tikkummenta fuq dan l-artiklu biex tkun vuċi għal gid tat-trabi u l-familji u wkoll għall-professjoni tal-qwiebel Maltin.

Stqarrija tal-Assoċjazzjoni tal-Qwiebel Maltin (MMA)

Dan l-añhar, kelliem għall-Air Malta gie rraportat minn Newsbook li stqarr li "omm b'tarbija tista' tredda' abbord l-ajruplan, sakemm ma ddejjaxx lill-passiġġieri oħra".

Añna nifhmu li din il-pożizzjoni hija simili għal dik ta' linji tal-ajru oħrajn. Linji ta' ċertu preġju bħal jinkludu l-Air Canada, il-Luffthansa, l-Air France u l-British Airways li wkoll ma għandhomx regoli uffiċjali dwar dan. Linji tal-

ajru oħra li m'għandhomx regoli uffiċjali dwar it-treddiegħ abbord.

Madanakollu fuq quddiem nett jidher li hemm linji bħall-Alaska Airlines, il-Jet Blue Airlines u l-WestJet li għandhom regoli ċari favur l-ommijiet bit-trabi. Saħansitra l-membri tal-ekwipaġġ jiġu mħarrġa dwar kif għandhom jgħinu lill-ommijiet li jkunu qed ireddegħu. U f'każ li omm li tkun tredda' ddejjaxx lil xi passiġġier ieħor, huwa l-passiġġier u mhux l-omm li jittiehed f'parti oħra tal-ajruplan. Il-linji li huma avanzati ħafna f'dan il-qasam saħansitra ma jippermettux li xi membru tal-ekwipaġġ iġieghel lill-omm titgħattha b'kuttra.

L-Assoċjazzjoni tal-Qwiebel Maltin (I-MMA) tiringrazzja lis-Sjr Charmaine Attard ta' din

Why do babies cry?

Babies actually cry a lot! On average a newborn baby cries 5 hours per day, and this reduces to 3 hours by 3 months of age. Now that's a lot of crying!

Babies usually cry cause they are hungry, tired, uncomfortable or in need of a nappy change. If you have dealt with these, but still your baby cries inconsolably, think of colic!

Reduce the hours of crying

CRYING BABIES - THINK COLIC!

What is Colic?

Babies with colic are distressed, tend to draw their knees up, clench their fists, and just cry inconsolably no matter what. This is very distressing for parents, who just cannot console their baby in any way.

A baby's immature digestive system cannot digest lactose, a very important sugar which is found in breast and formula milk. This causes bloating, gas collection and is very distressing for the baby.

Thankfully, it's a temporary condition, until the baby is 4-6 months, and their digestive system has now matured and able to produce lactase, the enzyme responsible for breaking-down lactose, making milk more easily digested.

Choose



Colief is a natural product containing the enzyme lactase, and the only colic solution clinically proven to reduce colic.

It is added to breast milk or formula milk, prior to feeding, and it breaks-down lactose, making it more easily digested by babies; resulting in happier babies, with much less crying. Colief also helps mothers continue breastfeeding, without the need to switch to low-lactose formula feeds.

So whilst other colic-related products help to alleviate the symptoms of colic, Colief prevents colic!



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FORMULA**



4 DROPS
TO EXPRESSED MILK

**INFANT
FORMULA**



4 DROPS
SHAKE OCCASIONALLY

**INFANT
FORMULA
IN ADVANCE**



2 DROPS
USE WITHIN 12 HOURS



www.colief.com

 babymalta.com



• minn paġna 6

I-informazzjoni. L-MMA trodd ħajr ukoll lill-linja nazzjonali li almenu mhix tagħmel bħalma għamlet il-linja tal-ajru, id-Delta Airlines, li kif kitbet l-istess Sjr Attard, l-ewwel reazzjoni għal mistoqsija ta' omm jekk tistax tredda' waqt il-vjaġġ, ċaħdet din it-talba, biex aktar tard, wara li l-mara pprotestat, il-kumpanija skużat ruħha.

L-MMA, filwaqt li trodd ħajr lil l-Air Malta għall-impenn tagħha, tneġġeg lill-management biex attivament jikkunsidra li jagħmel pass ieħor 'il quddiem. L-MMA tara illi l-Air Malta tista' u għandha tagħti rigal lill-ommijiet li ikunu jixtiequ jreddgħu fuq l-ajruplani tal-Air Malta hekk kif il-linja qiegħda tiċċelebra l-40 anniversarju. Jgħidu li "life begins at 40" u allura ejja nirrikonoxxu li t-treddiġh ta' tarbija huwa sinjal qawwi ta' ħajja. Li tarbija tixrob mis-sider tal-omm huwa dritt naturali tat-tarbija u ħadd ma għandu dritt iċaħħadha milli tixrob il-ħalib l-iktar addattat għaliha.

L-MMA pubblikament tappella lill-Air Malta biex tagħmel qabza oħra fil-kwalità ta' servizz. L-MMA lesta li tikko-opera mal-Linja Nazzjonali sabiex tiffassal politika u prassi favur it-treddiġh abbord. Jekk ikun hemm regoli ċari wieħed ikun jista' wkoll jilqa' għal dawk is-sitwazzjoni fejn passiġġiera oħra jistgħu jiddejjqu minn din is-sitwazzjoni u għalhekk politika miktuba tkun għal benefiċċju ta' kulħadd, l-omm, il-passiġġiera l-oħra u l-membri tal-ekwipaġġ. L-MMA għandha rakkomandazzjoni konkreti

f'dan ir-rigward. Għalhekk l-Assoċjazzjoni tal-Qwiebel Maltin pubblikament tistqarr li lesta tgħin fit-fassil ta' din il-policy fuq it-treddiġh abbord l-ajruplan. Ejja nimmarkaw l-anniversarju tal-Air Malta b'xi ħaġa li tidher li tolgot f'tit mill-klijenti imma li żgur għandha sinifikat qawwi ħafna.

* * * * *

Wara li ħarġet din il-pess release, MMA giet mistiedna għal-laqqha mal-kap tal-'cabin crew' is-Sjr Charlene Bebiano Oliveira biex tiddiskuti kif il-linja nazzjonali Air Malta tista' tiffacilita lill-omm li tixtieq tredda' fuq it-titjiriet tagħha. Għal din il-laqqha kienu wkoll preżenti żewġ membri tal-'cabin crew'. MMA kienet rappreżentata minn Sjr Rebecca Gilson u Sjr Pauline Fenech.

Il-laqqha kienet posittiva ħafna. Ir-rappreżentanti tal-Air Malta huma konxji fuq il-bżonn li tarbija teħtieġ li tiġi mreddgħa waqt it-titjira. L-ekwipaġġ jaf sew dwar l-importanza li tarbija għandha bżonn tixrob waqt l-inżul u t-tluġh sabiex jiġi evitat uġiġh fil-widnejn. Is-Sjr Bebiano Oliveira sostniet dwar l-importanza li l-omm li tkun tixtieq tredda' waqt it-titjira, tinforma l-ekwipaġġ meta din titla' fuq l-ajruplan. Min-naħa tiegħu l-ekwipaġġ ikun jista' jgħin lill-omm billi: jgħinuha ssib post komdu, joffruha aktar ilma u xi mħadda żghira biex tpoġġiha taħt it-tarbija (l-imħadda skont esiġenza tat-titjira).

Din l-informazzjoni nbagħtet lill-membri tal-cabin crew tal-Air Malta.



**Promotion for
Midwives' Day
2014**



Looking Back, Moving Forward

It was in December 2010 that I first noted a message on a Midwifery research list from Mary Said Buttigieg relating to the aim to promote normal birth in Malta. At the time my response was to try to link Mary with a local birth centre to facilitate visits, but I also shared with her information about a course we ran at the time for qualified midwives around promoting normality. From that point on discussions began around developing a project where we could provide learning around normal birth for midwives and obstetricians.

For those who have not participated the final programme involved groups of midwives coming to the University of the West of England in Bristol, UK for four and a half days teaching and with an observation visit at a birth centre. Sadly no obstetricians were able to attend, though in total 69 midwives participated. We are fortunate around our locality to have a number of birth centres in different towns where midwives are leaders of the care for women with straightforward pregnancies. Recent research around the place of birth in the UK demonstrates that midwife-led care in such units for women is safe and effective for promoting normal birth (<https://www.npeu.ox.ac.uk/birthplace/results>). Following the study days the participants were all provided with a work pack with the plan to continue the reflection on practice and discussion together in order to make changes to care and promote normal birth in Malta. Having summarised the project the purpose of this article is to look back on the experience of the midwives on the programme and to look forward to how it will be developed further. The article is based on a talk that was given on the final study day undertaken in Malta in May 2014. (Where I write Malta here the island of Gozo is included throughout!)

Looking Back

Prior to attending the course I asked each participant to take some time to reflect on their own story of being a midwife; why they chose to be a midwife and what had brought them on the programme. The theory behind this is that for things to change, we need to start by changing ourselves: we need to recognise where we have come from so that we can move on from that point. In the first session we then asked the midwives to tell us what they wanted to change. For all the groups, apart from some small variations, the same issues were raised (Box 1).

Box 1 What did you want to change?

- Women to be enabled to be more assertive and understand the midwives role
- Doctors to have less involvement in normal birth
- Midwives to have more autonomy
- More involvement in antenatal and postnatal care
- To return to team midwifery

This gave a touch point from where the groups could move forward and demonstrates what actually midwives are wanting in Malta. I was clear with each of the groups,

and this was apparent as the weeks went on, that the evidence for normal birth and knowledge of midwifery practice that could facilitate normality was well known amongst the midwives. What was however required was the motivation and support to help you make the changes yourselves.

For us who were the group of teachers involved in the project there were many positives. Prior to the final study day I asked my colleagues for some views on their experience of the project. They all enjoyed teaching the groups and having the opportunity to share in your learning. The comments included recognition of enthusiasm within the groups:

Each group was enthusiastic, enquiring and friendly. It was really rewarding to be able to share developments in UK midwifery practice and hear about the hopes and challenges from the system in Malta

Enjoyed working with the Maltese midwives. I found them very open and engaging and willing to participate. At time difficult to keep focussed as they were very chatty!

It was clear to us that you as midwives wanted to change and were benefitting from being away from the usual practice area having opportunity to discuss and debate. The comment about being 'chatty' is therefore a positive one as it reflects how the ideas were bouncing around among you.

I also asked if the teachers felt there was anything else we could have offered you. The comments included: *Perhaps antenatal preparation -e.g. 'Birthing from within'*. (this is a form of antenatal education we use in teaching our own students based on the work of Pam England (with Horowitz 1998)

*Greater involvement from the doctors
Developing policy*

We recognised that there is an element of fragmentation currently in the services in Malta and midwives need more input across the whole pregnancy continuum. We also felt that there needed to be some opportunity and involvement of midwives in the development of policies that were relevant to midwifery practises. The need for involvement of Obstetricians in the 'normality' agenda was also viewed as important as well as being recognised as a significant barrier to change. The issues around a multidisciplinary approach with the centrality of the women in their care had been discussed in each of the groups.

I also questioned the teachers about whether they had any further advice. Suggestions are as follows:

A change in the way childbirth is perceived probably has to be initiated by the women of Malta themselves, as it was in Britain in the 1980s. The changes take a long time, and I can only suggest that the midwives keep taking the small steps that they can and are doing, and hopefully change will be accepted a little at a time.

• continued on page 10



• continued from page 9

Maybe if they could get into the schools and talk to young people? Or put natural childbirth on public agendas and in the media?

Small steps at a time, make little significant changes to 1 room and demonstrate the benefits, keep up the enthusiasm.

Work together, believe you can make a difference and make change happen

The mention here of small steps I will return to, but the idea of starting in one room, turning one into a 'normal birth' room with appropriate equipment and furnishing has been a tried-and-tested method for encouraging women and midwives. Changing the physical environment to make it more homely is known to have an impact on normal birth rates (Hodnett et al 2012).

Moving Forward

The success of the project now relies on the midwifery team moving forward in Malta in order to consolidate the group learning. At the completion of each week an evaluation form was completed and these demonstrated for the majority that self-development had taken place. The midwives talked about being 'motivated', 'empowered' and 'encouraged'. For example:

'I was empowered to believe that I can do it'

'Everything informative and empowering to act for change'

'Knowledge was not new but there was reinforcement of knowledge which was motivational'

There was also evidence that they had learnt practical tips to help in the care of women:

'I learnt that simple things can make the mothers' experience of labour more relaxing and pleasant'

'It was an amazing experience in a beautiful place. Hoping that it will help us reflect on our practice and change it to a more natural way. In order to help mothers, babies and their families have a safe positive experience in childbirth'

Further there was evidence that some of the midwives had regained a lost passion for their role:

'Relit the fire in me to become a better midwife and help women have an amazing natural experience'

'This experience has given me the time to reflect on my job as a midwife and my responsibility as a change agent'

The concept of a midwife as a 'change agent' is one of a 'force for good' or could be the opposite. Midwives therefore have the choice to how they use their power. In relation to our role as public health champions and health educators midwives have responsibility to utilise evidence to promote the wellbeing of mothers and their families. Within Malta, where limitations have been placed on midwives, the fact that so many have now received the programme means that there is a force of moving forward together with a common goal- the 'why' (though there will not always be agreement about how, what, and when!). These large numbers also mean that information and learning can also be cascaded more quickly to other colleagues and a snowball effect should begin to take effect.

The final messages we wanted to leave with you as a

• continued on page 15



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- wipe with a disposable tissue,
- repeat the operation in the other nostril,
- remove the nozzle from the bottle and clean with soapy water, rinse and wipe.



The Freedom To Move During Labour

Picture a woman in labour and what do you see? For most of us, the vision is instant: a bed, and a woman on her back. In fact, a recent survey showed that this vision represents reality: around 85% of UK women give birth on a bed. What's more, over half of women are delivering babies lying on their backs and over half of this group have their feet in stirrups too (Maternity Service Survey 2013)

The majority of women residing in countries where the western birth culture dominates give birth to their babies in semi-recumbent positions (sitting in bed). Since the 1970s, research has acknowledged the fact that upright birthing position (including on all fours, squatting, using birthing ball, chairs and stool) and mobility during labour enables the uterus to contract more efficiently, reduces perception of pain and shortens the second stage. As a result, women have a better urge to push, they require less interventions including the use of oxytocin for augmentation of labour, and therefore improved neonatal outcomes (Liu, 1974; Sleep et al., 1989).

Even though evidence shows that there are many advantages in the use of different positions that can be used during labour, still the bed remains the central piece of furniture in many of the birth rooms around the world. A bed is for getting into and it implies certain kinds of postures. In the majority of hospitals around the world, bed bound is perceived as normal, and sometimes even inevitable. Any change or variation to this type of setting where the bed is the centre of attraction, is perceived as innovative and daring (Jong et al., 1997). In fact, the idea of giving birth on a bed is so ingrained in our culture, that some of us just can not imagine doing so without one.

It is obvious that the birth environment has an impact; on how the women will progress throughout labour and on how the midwives will act and conduct the delivery (Shermer and Raines, 1997). A room that has the bed as the main focus with little supportive equipment and birth aids will not encourage a mother to change from the traditional use of the bed to mobilising and adopting different birthing positions (Chamberlain and Stewart, 1987).

NICE Guidelines (2007) recommend "women should be discouraged from lying supine or semi-supine in the second stage of labour and should be encouraged to adopt any other position that they find most comfortable"

Moreover, WHO (1996) advises against recumbent or supine position for longer periods during labour and birth and states that care givers should encourage and support the woman to take the position in which she feels most comfortable. Furthermore, it supports the fact that upright positions may improve childbirth outcomes and decrease the risk for instrumental deliveries.

Recently our general state hospital has been provided with a birthing stool (picture 1) which

has managed to transform many births into the most amazing experiences both for the midwives who chose to use it and for those mothers who believed that this non-traditional way will help them cope and feel empowered to deliver on the stool.

Sitting and squatting is the most natural position for the woman. This birthing stool is specifically designed for use during childbirth in that it bears up a substantial amount of

weight and pressure. Since it is low to the ground, the labouring woman can either relax her legs or plant them firmly to the ground. It allows a mother to sit or squat while giving birth, whilst at the same time she is able to lean back on her birthing partner for support. Most importantly, the birthing stool is designed like a horse shoe with a hole in the middle thus enabling the midwife to monitor the progress of labour whilst at the same time maintaining a hands off technique, and allowing a space for the baby to slide through.

Moreover, a labouring woman does not remain on the birthing stool for the duration of her labour, but she is encouraged to change position and move around. In the mean time the midwife, or the accompanying person, can perform some forms of complimentary therapy such as massage, aromatherapy, or even apply compresses to help ease the labour pain. These are done in conjunction with the breathing exercises. This combination will eventually result in less need for interventions and analgesia.

The concept of the



Picture 1: the birthing stool available at the Central Delivery Suite at the General State Hospital with the chair behind for the accompanying person to support the woman in labour.

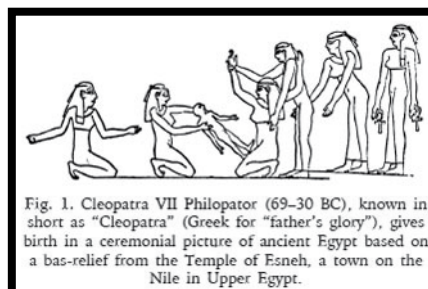


Fig. 1. Cleopatra VII Philopator (69–30 BC), known in short as "Cleopatra" (Greek for "father's glory"), gives birth in a ceremonial picture of ancient Egypt based on a bas-relief from the Temple of Esneh, a town on the Nile in Upper Egypt.

Picture 2 : Cleopatra giving birth kneeling



Picture 3: French midwife Louise Bourgeois delivering a woman on the chair



birthing stool is ancient and has been widely practiced in many cultures. In fact, the birthing stool/ chair dates back to Babylonian times (2000 BC) and a famous drawing from Egypt depicts Cleopatra (69-30 BC) kneeling to give birth (picture 2). More recently, a French midwife, Louise Bourgeois (1563-1626) challenged the prevailing practice by shifting women from delivering on the bed to delivering on the chair (picture 3).

In 2007, a randomised controlled trial in Sweden, found that the birthing stool reduces the number of instrumental vaginal deliveries, fewer reports of severe labour pain, fewer fetal heart rate abnormalities than supine posture, giving birth on the stool had no adverse consequences for perineal outcomes (ie, perineal lacerations, tearing or perineal oedema), and it was considered that it may even protect against episiotomies, however, more second degree tears were reported.

The study, concluded that there was a higher incidence of blood loss, but only 500-1000ml which is considered physiological in a healthy population. The researchers however, noted that blood loss was increased regardless of birth position if women had been exposed to synthetic oxytocin augmentation during the first stage of labour. (Waldenström & Gottvall, 2007)

Women who gave birth on the stool reported a higher degree of satisfaction that they had made the decision themselves about their birthing positions and felt that they had been given the opportunity to take their preferred position. Women also reported that they felt more empowered, protected and self-confident, leading to greater childbirth satisfaction (Waldenström & Gottvall 2007). In 1991 a study conducted by the same authors (Waldenström & Gottvall, 1991) found that women who used the birthing stool seemed to have experienced less pain and expressed more satisfaction during their labour and delivery process

So, what began as a change in birth positions for the convenience of those assisting the mother in labour, has been shown scientifically to be an inconvenience for women and babies. Hence, providing women with the possibility of delivering on a birthing stool rather than instructing them to adopt the traditional position of going onto the bed, will give the birthing woman choice. The birthing stool offers an alternative mode to the traditional birth position. Women have the right to choose and to feel comfortable in whatever position they would like to deliver their baby.

Women experiences who delivered on the birthing stool since it was introduced few months ago at the General State Hospital

Mother 1:

22 year old woman who became mother for the first time using the birthing stool accompanied by her partner

"My experience of giving birth on the birthing stool is definitely a positive one. Prior to going into labour, I was carrying out my breathing exercises during the

contractions and using the birthing ball at the Obstetric ward. Once my contractions intensified, I was transferred to the labour ward where I crawled up to the bed begging for an epidural.

There was a change in shift and the midwife who was taking care of me introduced me to the birthing stool. The midwife showed me how to use the birthing stool and I was able to cope better with the pain and felt more in control of my body.

The stool also enabled my partner to stay behind me and massage my back to further ease the pain. The room had dimmed lights and music was playing in the background which also helped to make the atmosphere more peaceful and relaxing. In the meantime the midwife helped me to focus on my breathing exercises.

I gave birth to a healthy 3.19kg female and my perineum was intact. I encourage other fellow pregnant women to give this method a try. The fact that my partner was behind me massaging and supporting me, with the midwife alongside, guiding me through the process, made the whole experience easier and fulfilling for both of us.

My partner and I went into labour with an open mind and open to suggestions from the midwives since they have the necessary knowledge and experience. We are glad we gave the birthing stool a try and without a doubt, if I'll be expecting another child the first thing I'll ask for when I'm in labour will be the stool."

Mother 2:

32 year old mother gave birth to her second baby on the birthing stool following a previous ventouse delivery

"In my first labour, I had quite a difficult time as my labour was induced and since it went on for what seemed like forever, I took all types of analgesia available. Due to the fact that I had an epidural, I was confined to bed and after an exhausting 2hrs of pushing, I had a ventouse delivery. This time round however, I was determined it was going to be different, and thank God my midwife encouraged me to remain mobile throughout all of the labour.

She also introduced me to the birthing stool especially when it came to the second stage. The delivery was marvellous and both my partner and myself were overwhelmed by the experience. I delivered a 3Kg baby with a mere laceration to my perineum, and I needed no pain relief or medical intervention throughout. I have shared my wonderful and positive childbirth experience with all my friends"

Kylie Bezzina and Carmen Wareing: their experiences as midwives using the birthing stool:

Kylie Bezzina:- I always tried to aim to allow women to be mobile as much as they can during their labour and birth. Before the birthing stool was introduced into our practice I used to encourage women to deliver on all fours, squatting, standing or even kneeling. However, the birthing stool was something new and innovative and so I immediately started doing my research and reading about its' risks and benefits.

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team from the UK are as follows:

- Have belief in yourselves to make changes: have courage as there are so many of you, but also begin with you. Think of what you would like to do to improve the service you give women and make changes in how you do things. Sometimes keeping a journal or notes of what you have done allows you to look back and see that changes in practice work! Talk to each other about what you have done and reflect on what could have been done better- not just on 'negative' cases but sharing 'good' practice.
- Working together for good of women and babies: the common goal I mention above is this, what is best for this individual woman? Midwives, obstetricians, anaesthetists, paediatricians should all be pulling together for this reason, not for any false professional pride. Women and babies should be central to the service, not the service existing for the professionals.
- Aiming for personal professional fulfilment: there is nothing wrong with wanting to enjoy your role! It is very frustrating for midwives if they are working in an environment where they do not feel valued or enabled to fulfil their role effectively. Making changes that are positive for midwives too is a good thing as they will also give more to women.
- Seeking and utilising evidence to create midwife-led policy: Midwives as professionals should be involved in creating policies that enable midwives to act as professionals. Within the UK midwives are responsible for policies within a multiprofessional team and again there is team-working to ensure the policies place women as central to care.
- Developing appropriate education: If you are going to have midwives in the future who are going to be able to facilitate normal birth then students need to be learning about the 'normal' role of the midwife both in the classroom and in the clinical areas. Theory and practice should be linking together; clinicians and educators both have responsibility



for the future.

- Market midwifery care: in order to educate women in Malta about the role of the midwife then midwives need to tell them what they do. In the UK some units provide education for women via web sites so that women know what is available to them. For example: <http://www.nbt.nhs.uk/maternity-services/maternity-services>. Other suggestions involve utilising the media, setting up open days and events that tell women midwives provide care that is appropriate for normal birth.

Total change will take time and there are many barriers to cross before there will be major progress. But there is a momentum now in Malta, thanks to the leadership and vision of many of your colleagues and there is a choice now for midwives to follow that lead. As was indicated above there need to be 'Small steps' and I know already some who were on the programme have started making changes in their practice. Over time the 'small steps' will become larger. Practises that were once 'unusual' will become 'usual' and those that are currently not 'evidence-based' will become rarer.

It has been a privilege working with you and I look forward to hearing how progress is made in increasing straightforward birth in Malta.

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The birthing stool is another aid to help us promote mobility during labour and avoid the supine position. Since at the moment, only one birthing stool is available in our hospital, midwives should not forget that our beds can be turned into a "chair" like and women can still adopt the sitting position.

When we attended to the study programme in Bristol a lot of information was given to us regarding the different positions that can be used during labour and birth including the birthing stool. This filled me with so much excitement and motivation since it made me realise more than ever the importance of mobility during labour and how this can facilitate the process of birth while easing the pain.

The advantages mobility has on the mother and her baby is so vast and evidenced based that we cannot oppose to those women who wish to stay mobile and use other positions rather than the supine one for their birth. With the support of my senior midwives I managed to help a woman deliver her baby on the birthing stool. It was such a wonderful experience, especially for the mother and her partner.

For me the birthing stool gave birth and midwifery another whole dimension. Moreover, it continued to give me the drive to do further research so that I, together with my colleagues will be able to provide women with unforgettable experiences.

Carmen Wareing:- As a midwife with 22 years of experience, I have to admit that I was rather set in my ways and I have at times practiced midwifery following a certain routine. The birthing stool was introduced to my area of work just before I embarked on a normalising childbirth project to Bristol. This experience clearly motivated me to change certain aspects of my practice and the introduction of the birthing stool was the push I needed.

To my amazement, I watched a newly graduate midwife conduct a stool delivery, and I was so impressed by the beauty of the whole experience, that I was determined to implement it as well. As a result, I have noticed that mothers cope much better in the 1st stage and they progress much better in the 2nd stage of labour.

A hands off technique is also maintained, and with some dimming of the lights, and some relaxing music in the background, a beautiful birth setting is established. The birthing stool has proved to be a vital aid in midwifery practice since all parties are rewarded with better delivery outcomes and higher rates of satisfaction.

In conclusion we can state, that it is our role as midwives, to provide women with the necessary information on how they can mobilise and use different positions during labour. This should start from the antenatal period so that mothers who come to the labour ward would not have this imprinted image that they are going to deliver their baby on the bed like others do.

Moreover, the use of the different positions and the birthing stool during labour should be supported by all the midwives working at the Obstetric wards and welcomed by the midwives working at the Delivery Suite. In this way we are creating a circle where women are constantly being made aware of the different aids being offered.

This change involves many challenging factors however our mission should be aimed at providing women and their families with better opportunities and choices which will ultimately lead to better outcomes and higher satisfaction rates for all parties involved

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**Kylie Bezzina Bsc. (Hons) in Midwifery
Carmen Wareing SRN, SRM**

An Overview of Metformin Use in Fertility Management, Pregnancy and Lactation

Introduction

Polycystic ovarian syndrome, type 2 diabetes [T2DM] and gestational diabetes [GDM] are closely related conditions characterised by both insulin resistance and an altered glucose homeostasis. Metformin is a biguanide compound that exerts its desired clinical effect by decreasing hepatic glucose production, as well as by decreasing intestinal absorption of glucose and increasing peripheral uptake and utilization of glucose. The latter two effects account for the increased insulin sensitivity on metformin. The net result is a decrease in glucose levels without a concomitant increased risk of either hypoglycaemia or weight gain as is often seen in women using insulin to control their diabetic condition. These effects make this drug very attractive to use particularly in pregnancy. However this drug is known to cross the placental barrier and its use has been limited by concerns regarding potential adverse effects on the mother and the developing fetus [1-3].

Historically metformin use in pregnancy has been reported as early as in the late 1970 in South Africa. It was already noted that pregnant women with T2DM and GDM treated with metformin had a lower perinatal mortality than those untreated. The reduction in perinatal mortality though it remained higher than the background rate, it was reduced comparable to those women treated with insulin[4].

A higher level of evidence came for the Metformin in Gestational Diabetes [MiG] trial, the largest study so far reported of metformin use in women with GDM. This trial enrolled 750 GDM pregnant mothers to either metformin or insulin therapy. There was no statistical significant difference in the composite fetal outcomes between the two groups although preterm birth was found to be increased in the metformin group. Women in the metformin group had less weight gain than in the other arm. The results provide further data about the safety of metformin use in pregnancy [5-10].

Metformin use in PCOS and GDM

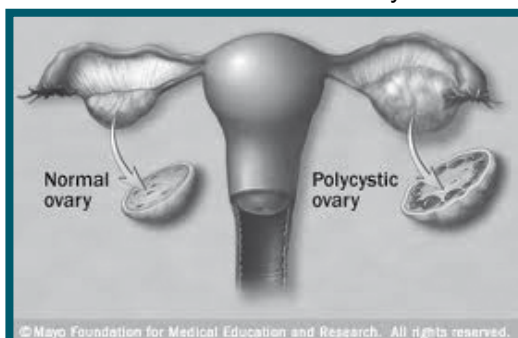
Polycystic ovary syndrome (PCOS) is the most common endocrine disorder in women of reproductive age, producing symptoms in approximately 5 to 10% of women of reproductive age. It is thought to be one of the leading causes of the female subfertility. In PCOS there is a hormonal imbalance secondary to anovulation leading

to elevation of testosterone, dehydroepiandrosterone sulphate [DHEASO₄], androstenedione, prolactin, and luteinizing hormone [LH] along with a normal, high or low oestrogen

levels. According to the Rotterdam criteria, a diagnosis of PCOS can be made in a woman if she has 2 of the following 3 manifestations:

1. Irregular or absent ovulation,
2. elevated levels of androgenic hormones, and/or
3. enlarged ovaries containing at least 12 or more follicles measuring 2 to 9 mm in diameter and/or have an increased volume of 10 mL or greater.

Only one ovary meeting these criteria is necessary to meet the definition of polycystic ovaries.[11] Approximately 30% to 40% of women with PCOS have impaired glucose tolerance, and as many as 10% will develop diabetes by the fourth decade. Women with PCOS are also more insulin resistant than similar age- and weight-matched controls. The role of metformin in ovulation induction is well established, and several studies have demonstrated that women with PCOS are more likely to ovulate with metformin than with placebo alone. Therefore, women with PCOS often conceive while on metformin, and exposure during organogenesis is common. At present, metformin is classified as Class B in pregnancy, with no evidence of animal or fetal toxicity or teratogenicity. Reproduction studies in rats and rabbits show no teratogenicity with dosages up to 600 mg/kg per day, approximately twice the recommended human dosage. Additionally, there are numerous reports using metformin for the treatment of gestational diabetes mellitus (GDM), without evidence of fetal harm. Although metformin does cross the placenta, a partial placental barrier likely exists, as maternal and fetal concentrations are different. Several studies have reported an increased risk of spontaneous abortion in women with PCOS, perhaps 20% to 40% higher than in the general obstetric population. This increased risk may be due to hyperinsulinemia, which adversely affects endometrial function and the intra uterine environment by causing a low grade inflammatory response [12-21]. The real role of metformin is not as a stand alone ovulation induction agent but as an adjuvant to clomiphene. The addition of metformin to clomiphene is beneficial even in clomiphene resistant individuals due to their synergistic properties [22].



Metformin in breastfeeding mothers In the literature there is a paucity of information on the effect of PCOS on breastfeeding. There is evidence though from case control or epidemiological studies that PCOS can be linked with low breast milk production. The root of the problem in poor breast milk production in PCOS is unknown and

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• continued from page 17

hence both herbal remedies and prescription drugs have often produced variable and unimpressive results [23]. Galactagogues are substances that promote lactation in humans and other animals. They can be endogenous, herbal or synthetic [24]. Metformin may be the best solution to consider for those women with PCOS that wish to breastfeed their newborn infant. Several women treated with metformin after delivery gained full milk supplies after initial milk supply problems. Recent studies have shown that metformin levels are relatively insignificant in the breastmilk. There are some data on two herbal galactagogues: herbal goat's rue and fenugreek. These two herbs are reputed to increase milk supply and possibly even stimulate breast growth. They can also have potential hypoglycemic properties thought they are not used for this purpose. The doses of these herbs is not well known especially to stimulate breast growth in women with PCOS [25-29]. Domperidone (Motilium®) and metoclopramide (Maxolon®) are medications used for gastrointestinal distress that, as a byproduct, act as galactagogues by stimulating prolactin production. Both have been used successfully to help mothers with previous full supplies to regain them, but not as successfully with primary failure. Domperidone may be a better choice since women with PCOS may be more vulnerable to depression, and metoclopramide can induce depression in some postpartum women [3-30]. Conclusion Metformin appears to be a safe drug to use preconceptionally and may help women to conceive. As it appears safe it would be advisable that those women that conceived whilst taking metformin should continue taking this medication and seek medical advice. There is data on the effect of metformin on the developing fetus that appears to be reassuring. It may help the developing fetus by giving protection

from a high glucose intrauterine environment ultimately leading to macrosomia. This will help to break the vicious cycle where it is known that macrosomic babies are more prone to develop insulin resistance and the metabolic syndrome [three out of five of the following medical conditions: abdominal (central) obesity, elevated blood pressure, elevated fasting plasma glucose, high serum triglycerides, and low high-density cholesterol (HDL) levels] and ultimately having big babies themselves. The data on breastfeeding appears to be reassuring too, however more work is needed on the effect metformin has on breast milk production.

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Reducing the risk of SIDS and other sleep-related causes of infant death

Sudden unexpected infant death syndrome (SUIDS) has been identified since ancient times: “and the woman’s child died in the night” (Old Testament: 1 Kings 3:19). SUID describes the sudden and unexpected death of an infant under the age of one year whose death can be explained (SUID) or remains a mystery after a thorough case investigation (SIDS), (including a scene investigation, an autopsy and a review of the clinical history). Suffocation, asphyxia, entrapment, infection, ingestions metabolic diseases or trauma may be the cause of SUID.

Despite the continuous SIDS prevention program each year in the United States about 4,000 infants die suddenly and unexpectedly. In Malta since the year 1998 – 2013 five infants died of SIDS. In 2011, the American Academy of Pediatrics (AAP) developed 18 recommendations to continue reduce the risk of SIDS and sleep-related suffocation, asphyxia and entrapment amongst infants in the general population.

To start with, women should receive **regular prenatal care**. Evidence shows that babies of mothers who receive regular prenatal care are at a lower risk for SIDS. Women should be encouraged to quit **smoking**, consume zero **alcohol** or use **recreational drugs** during pregnancy and after the baby is born. Babies of mothers who smoke during pregnancy are up to 3-4 times more likely to die of SIDS. Thus, smoking exposure during pregnancy and after birth should be avoided, and families should be encouraged to keep their homes and cars free from tobacco.

Once the baby is born, parents should be advised to create a safe sleeping environment. This means putting the baby to sleep on his/her back. The **back-to-sleep** position does not increase the risk of choking or aspiration. This is even more so in infants with gastroesophageal reflux. Once the infant rolls from supine to prone and from prone to supine, the infant can be allowed to remain in the sleeping position that he/she assumes.

To maintain a safe sleeping environment, the AAP recommends using a **firm sleeping surface** (mattress) covered with a fitted sheet. Once the mattress is covered it should maintain its shape. Meaning no gap is formed between the mattress and the side of the infant’s bed. Pillows or cushions should not be used to reduce the incidence of occipital plagiocephaly. Instead parents should be thought how to practice **supervised tummy-time** as this prevents positional plagiocephaly and helps promote neck and shoulder muscle development. **Soft materials or objects such as pillows, quilts, comforters or sheep skin quilts** should not be placed under the infant or in the crib as these may potentially increase the risk of SIDS, suffocation, entrapment and strangulation. If a mattress cover to protect against wetness is used, this should also be fitted tightly to the mattress. While sitting devices such as car seats, strollers, swings and carry cots are useful; one should not routinely put the infant to sleep here, particularly infants younger than 4 months of age. This is because the infant might assume a position that can create risks for suffocation or airway obstruction.

Room-sharing can reduce half the risk of SIDS. Epidemiologic studies have not demonstrated any bed-sharing situations that are protective against SIDS or suffocation. Hence, any bed-sharing situation is unsafe. If on the other hand a breastfeeding mother wishes to breastfeed and bed share with her baby, it is important that she understands the proper way to bed share. That is, the baby is sleeping on a clean, firm, non-quilted surface. No other children, pets or stuffed animals are allowed in the bed, and at the end of the feed the baby is placed again on his back to sleep (McKenna, 2009). Findings obtained from surveying home videos filming 10 breast fed infants and 10 formula fed infants for 3 nights eight hours each night found that formula feeding mothers were more likely to sleep on their backs or with their backs to the baby (Ball, 2006). On the contrary, breastfeeding mothers tended to adopt a curved sleeping position with their knees bent (thus, preventing the baby from sliding down under the covers) and with their arms raised above the infants’ head (thus, preventing the baby from moving up into or under the pillow). From this study also revealed that the curved sleeping position helps prevent mothers or anyone bed-sharing from rolling onto the baby (Ball, 2006).

SIDS risk increases when the infant is younger than 3 months, parent/s are smokers or the mother smoked during pregnancy, bed-sharing with someone who is excessively tired or is using medications. Infants should not share a bed with siblings or anyone who is not their parent. The AAP stresses out that device promoted to make bed-sharing ‘safe’ are not safe, and if an infant is brought into the adult bed for feeding or comforting, the infant should then be returned to his/her own bed, in an area free of hazards, such as window-covering cords or electric wires, because they might present the risk of strangulation. Moreover, **products or devices** marketed to reduce the risk SUID or **cardiorespiratory monitors** to reduce the risk of SIDS should not be used. This is because no products have been yet tested for safety and effectiveness.

Overheating the infant during nap or night time might cause the infant to go into deep sleep. This could lead to difficulty in waking up which could lead to SIDS. The definition of overheating varies with every infant (therefore it is difficult to provide a specific room temperature). However, the infant should be appropriately dressed with no more than 1 layer of clothing than an adult would wear and not excessively wrapped. Prior discharge from hospital, healthcare professionals should make certain that parents know how to evaluate signs of overheating such as hot or sweaty to touch, have damp hair, have flushed or red cheeks, have a heat rash or breathing rapidly. If a blanket is used to cover the baby, the baby should be placed on his/her back with the feet at the end of the crib (**feet-to-foot**). The blanket should not reach higher than the baby’s chest and tucked firmly under the crib mattress.

Healthcare professionals should encourage and support mothers to breastfeed their babies for the first 6 months.

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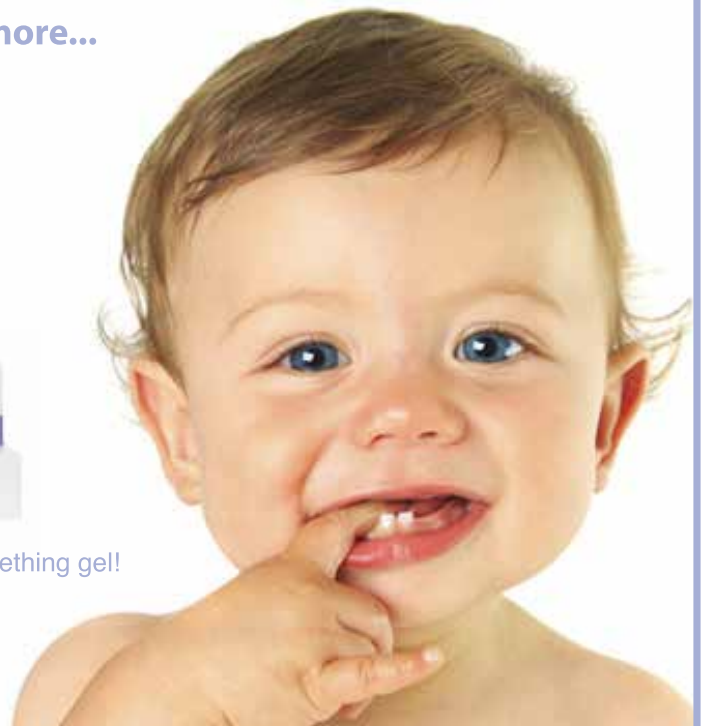
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This is because the **protective effects of breastfeeding** are also associated with reducing SIDS. The protective effects of breastfeeding increase with exclusivity. However, research has shown that any breastfeeding is protective against SIDS than no breastfeeding (AAP, 2011). Although the protective effects is yet undetermined, research has also revealed that giving a dry (not coated with anything sweet or sticky) **pacifier** for naps and at night significantly lowers the risk of SIDS. Having said this, if a mother is breastfeeding one should wait until breastfeeding is established before trying a pacifier. If using a pacifier, it should not be hanged around the baby's neck or attached to his/her clothing as this may increase the risk of strangulation.

When discharged from hospital, parents should be encouraged to follow health care provider guidance on baby's **vaccines** and regular health checkup. This is because although there is no evidence of a relationship between vaccines and SIDS, research shows that immunizations can reduce the risk of SIDS by 50% (AAP, 2011).

To conclude, **media and advertising messages** contrary to safe-sleep recommendations might create misinformation about safe sleeping practices. With this in mind, the AAP strongly recommends all health care professionals working in hospitals, nurseries and child care centers to be well informed and practice such recommendations. Our goal is to ultimately eliminate infant deaths.

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Grieving Parents: What am I to do?

Whatever the event, be it a "miscarriage", "stillbirth", "perinatal loss", or an "infant death", the loss of a baby is said to be the most traumatic experience in anyone's life. While every situation is different and each person's experience and coping is unique in this article I will try to depict the grief that the parents experience with the hope of better understanding how we, as health care professionals, can support them.

As soon as a pregnancy test results positive the new parents build an endless stream of thoughts and expectations about what the future will bring. When a baby dies the parents are left grieving for the child who will never grow up and in contrast are left with an endless list of questions and feelings (Cacciatore, DeFrain, & Jones, 2008). (McClain, Arnold, Longchamp, & Shaefer, 2004)

One never dreams of outliving one's children. The reality and intensity of loss is too painful. It not only extends to the family but to all somehow involved. A significant member has been lost, the family which was inevitably changed by



**"Memorial for Unborn Children,"
Sculptor: Martin Hudáček;
Banska Bystrica, Slovakia**

his/her presence has once again been changed dramatically and the feeling that they can never be whole again often prevails.

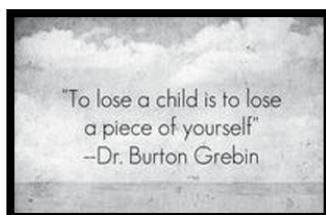
This is probably the first time that they are faced with death. In cases of sudden or accidental death as in 'Sudden Infant Death (SID) syndrome' there is also interplay of trauma and grief (Christ, Bonanno, Malkinson, & Rubin, 2003).

Parents experience shock, numbness and bewilderment along with extreme sadness, emptiness and a feeling of guilt and anger at having failed to protect their child from death (Parkes & Prigerson, 2010). Although the parents are logically aware of the reality it takes time to 'sink in'. There

may be a strong desire to reunite with their baby. Some may also feel foetal movements or signs of pregnancy, hear the baby cry, or wake up believing the baby is still alive amongst others (Väisänen, 1999). They are often apprehensive of expressing such experiences openly believing that they might be "going crazy".

Once the initial shock and numbness wear off, the parents are faced with the emotional reality of the loss and a deep sadness or depressive feeling may set in. They may experience sleep disturbance, loss of appetite

• continued on page 24





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and symptoms of stress such as headache, high blood pressure, irritability and an inability to concentrate and take decisions. They may withdraw and lose their enjoyment in life. Although this does not necessarily mean that they are suffering from a clinical depression, the difference between normal depressive feelings of bereavement and clinical depression is not so marked and it is advisable to seek professional help when such feelings are profound or drag on (Worden, 2009).

When faced with such intense emotions it can be difficult to approach the family even as health care professionals (HCPs). It would be easy for the HCP to avoid the parents or give medication but one needs to learn how to deal with their raw grief.

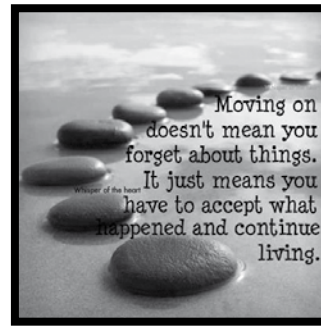
HCPs need to first explore their own attitudes regarding death and grief, so as to gain a better understanding of self. In consequence they will be able to communicate with grieving parents impartially and without constraints (Dunphy & Schniering, 2009), allowing them to take necessary decisions without depriving them of more than they have already been deprived of.

The HCP needs to be aware that grief is unique and several factors can affect the grief experience. Amongst which are:

- Cultural and religious beliefs and practices. Depending also on the immigration status, socio economic status, and extent of acculturation (Oyebode & Owens, 2013), (McLellan, 2013), (Shaefer, 1999)
- Family's composition, roles and social circumstances (Daniel, 1998)
- Manner and cause of death; sudden/expected, natural/accidental, determined/undetermined
- Extent of parents' emotional investment in pregnancy/child (Côté-Arsenault & Dombek, 2001)
- The impact of death on family developmental issues; Was this a first child? Are there other siblings (Şehnaz, 2003) (Black, 2002)
- History of previous losses
- Medical and legal issues especially when there are continuing investigation and/or legal repercussions (Andrew & et.al., 2007)
- Professional and social influences

With this in mind, while using the basic counselling skills of empathy, unconditional positive regard and genuineness the HCP needs to:

- Understand the event and its meaning for the family
- Gain knowledge of the factors that can be affecting the parent's grief
- Try to anticipate the parents' behaviour and expression of grief and structure one's interaction accordingly
- Be able to distinguish between normal and complicated grief reactions
- Assess one's emotional state and ability to care for self and other
- Determine one's needs and sources of support and advice/refer accordingly
- Care for the family with sensitivity, e.g. the collection of mementoes and meaningful photos, providing privacy while remaining available
- Give guidance on decisions that need to be taken, funeral options and organization or the experience of grieving
- Guide re breaking the news to and grief reactions of sibling/s



- Portray grief as a person's unique and lifelong process while maintaining belief that they are capable of going through this

(Douglas, 2010), (Larsen, Edey, & Lemay, 2007) (McClain, Arnold, Longchamp, & Shaefer, 2004) (Van Aerde, 2001)

The bereavement process is fluid and fluctuations, at any time, are both normal and universal. (Hall, 2014) By time, the parents will regain their interest in life, become able to attend to their daily tasks and move forward in time. Grieving is enduring and death is the beginning of a lifelong process of learning to live without the child and simultaneously incorporating his or her memory into their lives.

The experience is life changing and the care given will set the stage for the family's entire grieving process. It is therefore crucial that all involved provide compassionate care. **"The most beneficial commodities that a health care professional can offer to a grieving family are non-judgmental, deep sense of caring and personal involvement"** (Van Aerde, 2001). This does not come without its costs and HCPs themselves may need support to deal with their own feelings of loss and grief.

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**Sandra Castillo
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MSc Abstracts

What are the factors that promote and/or hinder low risk pregnant women from having a natural normal childbirth?

Background: Birth in the last years has been influenced by factors that tend to promote other methods of birth other than natural normal birth. The aim of this study was to identify factors that promote and/or hinder low risk pregnant women from having a natural normal childbirth.

Methods: The study searched for papers about natural/normal birth and thirteen studies were selected. All the papers had a qualitative methodology. These studies discussed different factors that promoted and/or hinder natural normal childbirth. The studies in the selected papers were studies taken from ten different countries (England, USA, New Zealand, Brazil, Iran, Thailand, Italy, Ethiopia, Australia and China). Themes from the studies were identified and sorted. The participants that took part in the thirteen reviewed studies were obstetricians, gynaecologists, midwives, obstetric nurses, mothers and fathers.

Findings: From the thirteen reviewed studies, six themes emerged that promoted and/or hindered natural normal birth. These themes centred around psychological, emotional, physical, social, cultural and economical factors.

The Psychological Factors included: belief, sense of personal control, doubt, thoughts.

The Emotional Factors included: feelings, embodied knowledge, expectations, trust and intimacy, empowerment and responsibility, emotional support, teamwork

The Physical Factors included: environment, atmosphere, advice, coping strategies, knowledge, risks, age, time, staff levels, complications, medical authority, medicalisation.

The Cultural Factors included: ethos, guidelines, tradition, religion and faith, astrology, health system.

The Social Factors included: relationship and support of partner, role models, family shared experiences, lifestyle and background, social class.

The Economical Factors included: costs, income.

Conclusion: The conclusion of this study suggests the need for giving a holistic care to the mothers during pregnancy and labour. Also the six themes that emerged in this study should be taken into account so to give comprehensive care to the mothers and promote natural normal childbirth.

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Does Job Rotation Aid For The Development And Performance Of Midwives Within The Maternity Department – ‘Mater Dei Hospital’, Malta?

The role of the midwife is unique and dynamic; it needs to be so to become competitive and eliminate boundaries that control midwifery autonomy. The aim of the dissertation was to investigate the various issues that lead to a successful job rotation programme to enhance the development and performance of midwives. Consequently, midwives will become well equipped with knowledge to release the art of midwifery from external powers and utilise the philosophy and ideals of the profession. The research study was carried out within the Maternity Department at Mater Dei Hospital in Malta. The literature review was undertaken by looking into the various human resource management debates that were raised by a random sample of 10 midwives who participated in the exploratory interviews. The central hypothesis was studied via a mixed method approach to research, as it was important to gather both qualitative and quantitative information. A pilot study was first carried out to midwives to assess and refine the questionnaire. The data was then collected via a survey distributed to all full time midwives working at ward level. The study looked into the various approaches, methods and strategies to achieve midwifery fulfilment via job rotation. The research study also investigated how midwives perceive job rotation from the development and performance perspective of the midwifery profession.

Four main findings emerged from the study:

1. Although staff midwives did agree that job rotation improves the development and performance of midwives, most agreed that job rotation would cause resistance to change mainly due to lack of preparation and involvement in decision-making.



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2. It was identified that job rotation helps midwives in experiential learning that is important to gain skill mix and enhance teamwork amongst the wards, as staff will understand each other better.
3. Another issue that participants revealed entail that job rotation may cause emotional stress to some midwives due to separation from colleagues, habituation to the ward and moreover to learn new practices.
4. Midwives do agree to practice job rotation as learning, skill mix, teamwork and job satisfaction are enhanced.

The research study tackled the fact that job rotation needs to be practiced within the Maternity Department so that midwives will further enhance the skills needed to distribute safe practice. All this may be supported through teamwork, job satisfaction, flexibility and supervisors of midwives at ward level to help midwives embark on the new ward during the transition phase. Hence, a planning and evaluation programme should be undertaken by the midwifery managers to identify if job rotation is successful and if midwives are prepared for the change.

Keywords: job rotation, development, performance, midwifery

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Going Back To Work After Childbirth: Women's Lived Experiences

This findings of this dissertation have been published in
the journal of reproductive and infant psychology.

This study aimed at understanding the experiences of first-time mothers who returned to work after paid maternity leave. The objective of the study was to explore the challenges new mothers faced during the transition of having a baby, taking fourteen weeks of paid maternity leave and then move on to re-enter the workforce.

The qualitative paradigm was used to conduct the study by using a semi-structured interview schedule at three different phases throughout the experience: prior re-entry at around 12 weeks, immediate re-entry at 16 weeks and again at 20 weeks following childbirth that is, 6 weeks after re-entry into the workforce. The interview guide was specifically designed for the purpose of the study. Ten women were chosen to participate in this study by purposive sampling. All participants took part in the three phases of the interviews which were audio-recorded. Ethical issues were taken into consideration and prioritised. The theoretical framework used to guide this thesis included phenomenology, transitional theory and feminism.

Interpretative phenomenological analysis (IPA) as described by Smith, Flowers and Larkin (2009) was used for the analysing phase. The resulting three super-ordinate themes identified how after childbirth maternity leave is 'a time of preparation and planning ahead' followed by a period when 'lightening strikes on rejoining the workforce' and 'weathering the storm' via an attempt to balance work and family life.

This study identified the struggles and triumphs these mothers encountered during their transition back to work following childbirth. Findings showed that while society encourages mothers to return to work after the birth of their children, few attempts have acutally been made to support them during this delicate transition. This study recognises the dire need to research this phenomenon as it is of crucial importance in our society. It identifies the need to improve local policy with regards to family-friendly measures and the importance of an increase in local maternity leave duration. Moreover, the midwife was identified as an important figure who can help empower mothers and prepare them for what is yet to come. Mothers showed an interest in courses that would help them in their transition to gainful work. Hence, this study recommends the introduction of such courses within the parentcraft education programme.

Keywords: Mother's employment, women's lived experiences, transition to parenthood, women's career issues, social support, midwives' role

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