Malta Midwives' Journal

Malta Midwives Association

Issue 17

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Contents

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Editorial

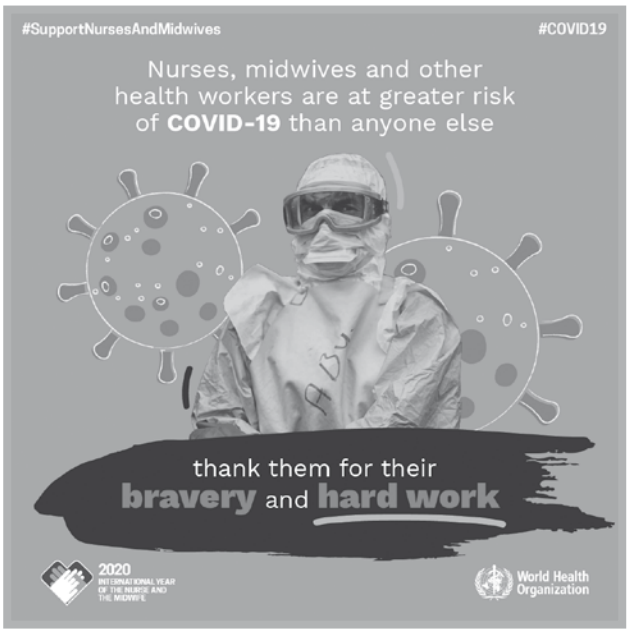
Dear Member,

Here we are, presenting you our issue for March 2021, exactly a whole year since the first case of COVID-19 was introduced on our islands. The past 12 months have been stressful for the entire population but more for those at the frontline offering first-line care to COVID-19 positive patients; especially nurses, doctors and us midwives who had to carry on delivering babies and helping out families while the whole world is dealing with a pandemic. The fear of the unknown at the beginning has been daunting in itself and now, knowing the potential repercussions of contracting COVID-19 poses even more threats on our health care staff, both physically and psychologically.

Midwives are at the forefront of the childbearing speciality and cannot be replaced should staffing crisis hit. On the other hand, midwives as well as our fellow obstetric staff are human and still are at risk like the rest of the population. With the number of active cases still on the rise, hospital staff including those in our obstetric department are continuously abiding to ever-changing policies to ensure safety whilst striving to give the optimal care to our mothers and babies. Finding a balance between ensuring welfare but having a positive childbearing experience has been and still is a challenging concern for both the local and hospital authorities; especially with surrounding opinions from the general public. While great effort is being made, there are a lot of issues that are and will remain a constant challenge such as the fact that our maternity care is entirely provided at Malta's main public tertiary hospital, and having limited space in our department to cater for the increasing childbearing population. Unfortunately, these issues may affect the type of safety measures to be implemented at hospital level, with the risk of jeopardising the childbearing experience for the couple. Changes in policy regarding caring for COVID-19 positive mothers in labour, the inclusion of the partner in all stages and maintaining safety during the postpartum period all have the common aim to ensure a positive outcome for the wellbeing of the mother and baby. However, these are also bound to also negatively affect the individual couple in one way or another.

We feel that the opinions expressed in this editorial are necessary in order to shed light about the current situation, all midwives and obstetric staff are facing at the moment. It is truly with great heartbreak that we have to see families, especially new parents going through such disruption in their childbearing experience. But rest assured, we are doing everything we can in parent's favour to ensure the welfare of the mother and baby – which is the ultimate current priority.

Lauren Marie Grech
Co-Editor



Message from the President

Dear Member,

Welcome to the first edition of the Midwives' Journal for 2021. The beginning of each year brings with it new resolutions and intentions to do better than the previous year. The Covid-19 pandemic has brought disruption in all aspects of our lives and therefore, I hope that 2021 will be a better year than 2020.

The Covid-19 pandemic made us experience uncertainties like nothing we experienced before and we had to adapt to new ways abruptly. A responsibility, we as midwives, had to shoulder in order to provide adequate and necessary midwifery services to the women in our care, as despite what is happenning around us, babies continue to be born every day.

Looking back on 2020, I think that midwives in Malta have risen to the occassion and responded and adapted to the new measures with great responsibility. Listening to midwives from other European countries talking about their experiences of maternity care during this pandemic is an eye opener for me, as it makes me realise how lucky we are to have the healthcare that we do. However, if we are to retain this level of care we need to invest in it.

Maternal Health

This brings me to the question: How is 'maternal health and well-being' measured? In many countries the maternal mortality ratio is considered one of the main indicators of maternal health. Yet despite this fact, the maternal mortality is only a small fraction of the burden of the numerous maternal health morbidities borne by women during pregnancy and the postpartum period.

Maternal morbidity is defined as: "*any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing".* Morbidities have negative consequences for women's financial situations and their ability to support themselves, such as poor physical health which often lead to pain, discomfort and feelings of inadequacy, as well as unwarranted emotional and psychological health, exacerbated by severe and non-severe morbidities which may lead to depression and anxiety.

Relying solely on maternal mortality to assess a country's status in the area of maternal health, overlooks the importance of maternal morbidity, which is not only a precursor to maternal mortality but also a potential cause of lifetime disability and poor quality of life. It is imperative to expand the myopic focus on mortality and to include the experiences of women. This is central to the theme of the Sustainable Development Goals (SDGs) which aspire to look beyond survival to health. In this regard, MMA welcomes a multifactoral approach that defines and measures morbidities as indicators of maternal health.

The International Confederation of Midwives (ICM)

I want to also bring to your attention ICM's Strategic Plan for the next three years, 2021-2023. The overarching goals identified by ICM for the next three years are to:

1. Drive innovation and sustainability for the future of midwifery
2. Develop, strengthen, and support the rollout of a new professional framework for midwifery
3. Foster a movement for midwifery, enabling and strengthening partnerships, advocacy, and communications for midwifery, with women's voices a the centre.

The report outlines a vision for the future of midwifery organisations. It offers an opportunity for MMA to build on its current strengths and successes, while being proactive and innovative about the vision for the future of the midwifery profession, and the critical role that midwives play in supporting mothers and newborns, and in turn families, men and communities. ICM also recognises, values and respects the critical population that it serves – this includes LGBTIQ, adoloscent girls and the varying gender identities that represent the populations served by midwives.

Newly Graduates

I would like to congratulate the newly graduates for their hard work. To the newly graduates, I would like to quote a few lines from one of Sheena Byrom's speeches:

'You are going to be professional servants to the public. More often than not, you will be an uninvited guest to a sacred space where people are vulnerable. What you do and how you do it, what you say and how you say it may be remembered for the rest of their lives.

And as they say, there are two things that will define you, your ***determination*** *when you have nothing, and your* ***attitude*** *when you have everything. So embrace your calling and work with a smile from your eyes and encourage from your heart.'*

Finally, I would like to express my heartfelt gratitude to all midwives who are working tirelessly to provide maternity care during the Covid-19 pandemic. I encourage you to continue being diligent and vigilent in whatever you do, as we hope to look forward to enjoying better days soon.

Malta Midwives' Association
Committee 2021-2022

Pauline Fenech – President

Mary Buttigieg Said – Vice President

Laura Calleja – Secretary

Danika Bilocca – Assistant Secretary

Daniela Buttigieg – Treasurer

Doris Grima – Assistant Treasurer

Gabrielle Grixti – Public Relations Officer

Pauline Borg – Educational Event Officer

Bernice Scicluna – Social Event Officer

Treasurer's Message

Dear Colleagues,

The Malta Midwives Association has developed over the years to reach, assist and provide an excellent service to midwives and couples throughout pregnancy and their journey to parenthood.

Despite being challenged by the COVID-19 Pandemic, the Association sought to deliver its services virtually. All this was possible thanks to the aid and commitment of various members who worked hand-in-hand with the associations' dedicated committee. Here, midwives have once again proved that they have learned and adapted to the ever-changing social and health environments.

During the last couple of years the Association has emphasised on upgrading existing services and provide additional services to midwives. Offering online discussions, sessions and workshops on various midwifery-related topics for both personal and professional growth by local and international speakers to midwives led to this years' service-users positive experience.

Local health psychologist Ms Janet Falzon addressed personal development through a session titled '*Mindfulness for midwives*', while that professional development was stimulated through various webinars including '*Foetal growth restriction: Detection and Management using foetal growth charts*' by Ms Sue Turner, '*Contraception and Family Planning*' by Dr Martina Schembri, '*The Microbiome in Pregnancy, Birth and Beyond*' by Ms Kate Cook, '*When Senses makes sense*' by Ms Emily Hills, and '*Community Midwifery: How continuity of care works across settings*' by Ms Lia Brigante.

Through press releases and letters of recommendations, the Association raised awareness of the importance of the safety for midwives in practice during the pandemic, the continuation of Parentcraft sessions following temporary cessation offered at the local public hospital and the provision of holistic midwifery care. The midwifery profession was promoted during the Midwives' day using videos and activities.

Technology has facilitated communication between the Association and its service users through the creation of an Instagram account, enabled online payments through the website and bank transfers, and also brought midwives together during a well-attended virtual Annual General Meeting. Midwives not only received a meal of their choice at home during the meeting, but were also given a clear picture of last years' activities, plans for the upcoming year, and the treasurers' yearly financial audit. The virtual AGM concluded with a healthy discussion during which members voiced their opinions and recommendations.

The Association has extended its affiliation with the *International Confederation of Midwives* and *National Council of Women*, and participated in meetings and activities organized by the *European Midwives Association* and *International Confederation of Midwives*. Electronic access to the *Midwifery Journal* was distributed to all midwives. Members are currently conducting a COVID-19 research study which will be published in this journal.

This year, midwives together with other healthcare professionals delivered childbirth courses, personalised sessions and bookings, pilates, and first aid courses to couples both online and on-premise, thus premises maintenance was also carried out.

The Association would like to once again thank all midwives who have already settled their membership and invite midwives who would like to renew this years' membership to do so conveniently online to enable the possibility of continuing to offer such services to midwives and couples alike. This can be done through

- the website www.maltamidwivesassociation.com by PayPal or VISA Card payment,
- direct payment using PayPal payable to info@maltamidwivesassociation.com,
- bank transfer to the Associations' BOV account MT02VALL 2201 3000 0000 4002 3734 517
- or by creating a direct debit through online banking or at any bank branch for an automatic yearly renewal of the membership depending on your preference.

Since February 2019, the Association no longer hold accounts with HSBC so members who availed themselves of this membership renewal method can no longer do so and thus can settle their membership through the above-mentioned means. Midwives who have an existing direct transfer with the BOV account will have their membership automatically deducted on the 30th of January of the year. Such membership can be claimed through the Continuous Professional Development benefit using the issued e-receipt.

The membership of the Association will enable its members to be part of this voluntary midwifery group, attend the Annual General Meeting, be eligible to vote, and retain access to benefits such as using the Association's premises, equipment and zoom for educational sessions; free antenatal educational sessions when pregnant, free online discussions, sessions, workshops, and educational seminars from local and international speakers, reduced annual conference fee, an electronic Midwives Journal twice yearly and a complimentary midwives' day function and full-day summer activity that is subject to Covid-19 restrictions.

Over the next year, the Association is envisaging to work on the remodelling of the premises' ambience, continuing to upgrade the website and its design, amendments to the Association's statute, the provision of indemnity insurance to midwives and continuing to advance the activities described above.

If you have any queries or feedback regarding your experience with the Association, contact us on 77237117 or info@maltamidwivesassociation.com.

Thank you once again to the Associations member's commitment and support to the Malta Midwives Association. We look forward to having you as a member for another year!

Daniela Buttigieg

The 'Spiritual Disruption' Caused by the COVID-19 Pandemic

The world is currently in the grip of a pandemic caused by the severe acute respiratory syndrome novel coronavirus 2 (SARS-CoV-2) resulting in COVID-19. The virus was first detected in Wuhan City, China, in December 2019. The virus once reported spread rapidly globally becoming a pandemic, which has had a devastating impact on the normal functioning of everyday life. It has placed tremendous strain on health and social care systems, halted economies, and has had a significant impact on people's lives, relationships, and activities. The response of governments has been unprecedented, costing billions to save lives, reduce the impact on hospitals services, while preserving employment, and education. The World Health Organisation (WHO, 2020) reports that globally, as of 4 November 2020 (09:58), there have been 47,059,867 confirmed cases of COVID-19, including 1,207,327 deaths, reported to WHO. The rapid spread of COVID-19 across many countries has led to an international public health emergency and raised awareness of how countries monitor, prevent, and control the spread of the virus.

The World Health Organization declared 2020 as the International Year of the Nurse and Midwife. The importance and contribution of nurses and midwives has never been more important. Our societies have been affected by this virus causing a pandemic of unimaginable, almost apocalyptic proportions. The virus has disrupted and devastated every sphere of people's lives and existence. The virus has so far resulted in over 1 million deaths globally with many countries experiencing very high mortality rates. Furthermore, the effects of so-called 'long covid' are also yet to be well determined or understood, and the potential future challenges of people requiring on-going care and support (both physiologically, psychologically, and one might imagine spiritually) should not be underestimated (Mahase, 2020).

The virus has also had a massive impact on the economic and financial infrastructures of many nations, with individuals not being able to work, many losing their jobs and livelihoods. Children and young people have been unable to attend school or educational institutions and family members and friends have had to isolate from each other during 'lockdowns.' Civil liberties have had to be curtailed and individuals have had to embrace and endure a wide range of measures that have restricted freedom and everyday living.

The virus has been indiscriminatory, traversing all age and ethnic groups but being particularly devasting to some vulnerable and particularly at-risk groups such older people, those receiving treatment for conditions such as cancer, and those living with long-term conditions. The human suffering has been immense, but this has been compounded by all the restrictions that have had to be imposed to control the rate and spread of the virus. Nursing, midwifery, and healthcare have been at the frontline of the pandemic having to care for some very seriously ill individuals who have required considerable critical care in high dependency units.

When one looks at the impact of the COVID-19 pandemic, the importance of the spiritual dimension of people's lives becomes very clear. As the many definitions of spirituality presented, Mahase (2020)affirms, the concept that concerns those important aspects of people's lives, which might be taken for granted. For example, what can be deemed the ordinary and mundane activities of everyday life, our relationships, employment, recreation, being able to practice one's religion, and ultimately offering support to loved ones who are experiencing illness and approaching the end of life. It is not until the ordinary and mundane things we take for granted are threatened or removed, that we appreciate the significance and value we place upon them and the important structural role they play in our lives. The fundamental attributes of spirituality: meaning, purpose and fulfilment (existential), transcendence, religiosity, relationships, and connections have all been affected, meaning that many individuals are experiencing what could be termed a 'spiritual disruption' to everyday existence.

The 'spiritual disruption' caused by the COVID-19 pandemic has been unprecedented, because every sphere and aspect of people's lives have been devastated and almost dismantled. There has been a shattering of everything that can be deemed normal. Yet, during what could be considered a very bleak and traumatic time, we have witnessed the best of humanity and communities rallying to support each other and especially the most vulnerable. There have been heroic accounts of individuals, nurses, midwives, and healthcare professionals going above and beyond, in the face of great adversity to ensure those affected by COVID-19 receive compassionate care. New and innovative ways of maintaining connections between family members across many sectors of health and social care have had to be created especially those receiving end of life care

Nurses and midwives throughout this pandemic have shown considerable courage and resilience, drawing on their own spiritual resources to ensure those in need of care, feel respected and valued. Yet, the demands on nurses and midwives have been visible, with many having to spend considerable time working under extreme pressure and conditions, wearing personal and protective equipment for long hours, and dealing with situations that are very emotionally and psychologically distressing. The moral injury and spiritual distress caused by the pandemic on those working in frontline services is still to manifest. The long- term cost, impact, and ramifications of the pandemic upon individuals, our nursing, midwifery, and healthcare professions will be significant. The importance of spirituality will play an important part in the recovery and healing both individually and across societies. So is the importance of striving for excellence in spiritual care education and clinical healthcare provision in light of the unprecedented circumstances posed by the coronavirus infection 2019 (COVID-19).

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Hypno… what?

You've probably heard the term hypnobirthing, maybe even taken care of a few couples who have used this technique in labour, but you may still be wondering what exactly is hypnobirthing? Should we be doing anything different while taking care of mothers who are using hypnobirthing? Is it a form of pain relief or an antenatal education course? I too had all these questions in my mind before I picked up Marie Mongans' hypnobirthing book a few weeks before my due date, and then nearly two years later completed the Katherine Graves Hypnobirthing teaching diploma.

Hypnobirthing combines hypnotherapy and tapping into the subconscious mind, together with logic and reason, providing the expectant parents with evidence based information and a range of tools and techniques that reframe and reshape their innermost thoughts and feelings about birth. In todays western society, our innermost thoughts on birth is that of something painful, frightening, dramatic and highly medicalised. Something that is done to you rather than something the body does. This is what has been fed to us by the media, family and society at large from a young age. So why is information alone not enough to change the preconceptions and address fears? Ones thoughts and fears are deeply embedded on a subconscious level, information alone will only reach ones' conscious level. This is where the hypnotherapy comes in, hypnosis and hypnotherapy is not a new concept. In 1955 hypnosis was recognised by the British Medical Association as an effective method of relieving pain during childbirth without altering the normal course of labour.

However only recently has hypnobirthing become so popular. Hypnosis is an altered state of consciousness, which allows the subconscious part of our minds to receive beneficial suggestions. The hypnosis itself is a state similar to meditation or trance where the woman's attention becomes focussed yet she is highly responsive to verbal therapeutic messages or suggestions. Unlike stage hypnosis, which has unfortunately shone a negative light on hypnosis, you cannot make a mother do things against her own will. By using hypnotherapy, the mother works with her body's natural responses, reducing feelings of fear, helplessness, tension and pain. The hypnotherapy most commonly taught is self hypnosis, that the mother can then practice throughout pregnancy and during labour by herself with the help of an audio or her partner. In hypnobirthing the power of hypnosis, including relaxation techniques, the power of words and visualisations, is combined also with evidence based information giving, breathing techniques and use of positive affirmations.

There is often the misunderstanding that hypnobirthing is a form of pain relief, and while it can lead to a more comfortable birth, it is in fact much more than this, it reforms personal beliefs about childbirth. Hypnobirthing works on breaking the fear-tension-pain cycle, which was first described by obstetrician Grantly Dick-Read. Fear stimulates adrenaline release and a fight or flight response. The fight or flight response diverts blood to the limbs and essential organs. The uterus is not an essential organ for fight or flight response, this results in a reduced blood flow to the uterus, tension in the uterine muscles including the cervix, making something physiological become painful. Furthermore the body cannot excrete adrenaline and oxytocin at the same time, one inhibits the other. Therefore, from a hormonal aspect labour is also halted due to fear. On the contrary if we minimise fear and encourage relaxation, oxytocin and endorphins are elevated, blood flow to the uterus is optimal and what was fear and pain becomes comfort and control. This can be achieved with hypnobirthing, thus reducing the need for invasive obstetric procedures, achieving a more positive experience in which the mother retains a greater level of control. Hypnotherapy does not promise to eradicate labour pains, but reduces their dominance and associated negative feelings, turning something painful into something powerful.

A popular misconception is that hypnobirthing is only for mothers who want a natural birth and no pharmacological analgesia. While addressing the fear-tension-pain cycle and the application of hypnotherapy techniques will most likely lead to a more comfortable birth with less intervention, hypnobirthing can be used in conjunction with pharmacological analgesia and during cesarean section. The aim of hypnobirthing is not to set couples up for an unrealistic expectation of childbirth, on the contrary hypnobirthing equips the mother to be a relaxed and informed decision maker, optimising positive birth experiences, even if complicated by clinical needs.

There is a lot we can keep in mind as midwives when caring for couples using hypnobirthing. Firstly and most importantly is the language we use. The words we choose are very powerful. Opting for 'intense' as opposed to 'painful' when referring to contractions. Some couples may choose to refer to the contractions themselves as surges or waves, and wish to avoid using the word contraction all together. Maintaining a quiet and calm birth environment is essential for any birthing couple and in the case of hypnobirthing helps keep the mother in her zone.

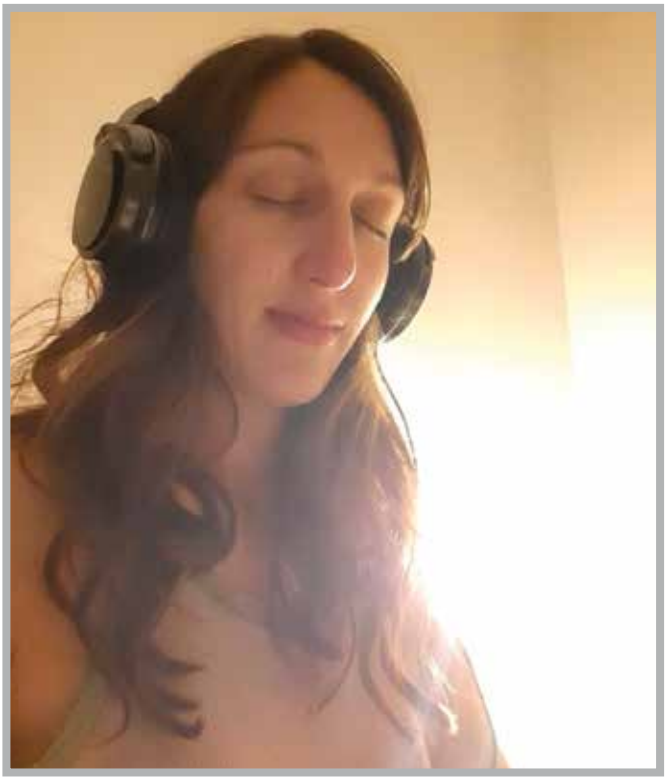
The couple will have practised breathing techniques as part of hypnobirthing, so encouraging and assisting with breathing is key to hypnobirthing. Furthermore it is likely that the couple will bring along a birth plan to labour and are likely to ask questions about benefits and risks of any interventions offered.

The local birth story of a couple who practised hypnobirthing, as told by the mother

I believe our birth story started with approaching Rebecca through Serene Starts hypnobirthing, wanting to get guidance with regards to hypnobirthing. We had heard too many traumatic birth experiences and believed that an alternative was possible. We also wished to avoid the use of any pain relief medication, unnecessary medical interventions and keep the birth experience as natural as possible. We feel blessed that hypnobirthing gave us a very positive birth experience which we shall cherish forever.

Hypnobirthing also gave us the courage to feel empowered to choose what we felt was best for both mother and baby.

We were offered a sweep on the 30th December, which we politely declined after discussing with the gynaecologist.



The estimated due date was the 11th January but on Wednesday 6th January early morning I lost the mucus plug so it seems like things where about to start moving. At 10:00 I attended a routine checkup where this time the gynae checked if I had started dilating. Was offered a sweep again, but declined since I felt that the process had already begun naturally and wished to keep it that way.

Mild surges started at around 11:00, at which point I decided to have a relaxing bath using lavender essential oil and sipping on some raspberry leaf tea. Surges started increasing in intensity by 13:15 and so started recording them on a hypnobirthing app whilst following it's breathing instructions. We remained home until my water broke at around 19:15 and arrived at hospital at 20:00. By 20:15 I was checked by the midwife and used the birth ball for a couple of minutes. It was then suggested I take a squatting position at the edge of the bed for the down stage of labour. Our precious little miracle was born at 21:03 weighing 3.84kg. I had no tears in the process which made my recovery time even faster.

It was truly a beautiful adventure we shared together, not traumatic at all. For that we are truly grateful.

Receiving such feedback from mothers is always very special after hours of working with the couple during pregnancy. It was also wonderful to hear from the midwife who cared for this mother in labour, she expressed how well prepared and empowered the couple were during labour. Practising hypnobirthing has given me the oppurtunity to provide more tools towards empowering and positive birth experiences.

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The Microbiome: A Healthy Start to a Healthy Life

Since the beginning of time, it is postulated that single celled organisms dominated the whole Earth. Humans have coevolved with these microorganisms, so much so that a symbiotic relationship has formed with bacteria, fungi, protozoa, and archaea. Trillions of these microorganisms coexist within us humans making up the microbiome, a symbiotic superorganism that supports human health.

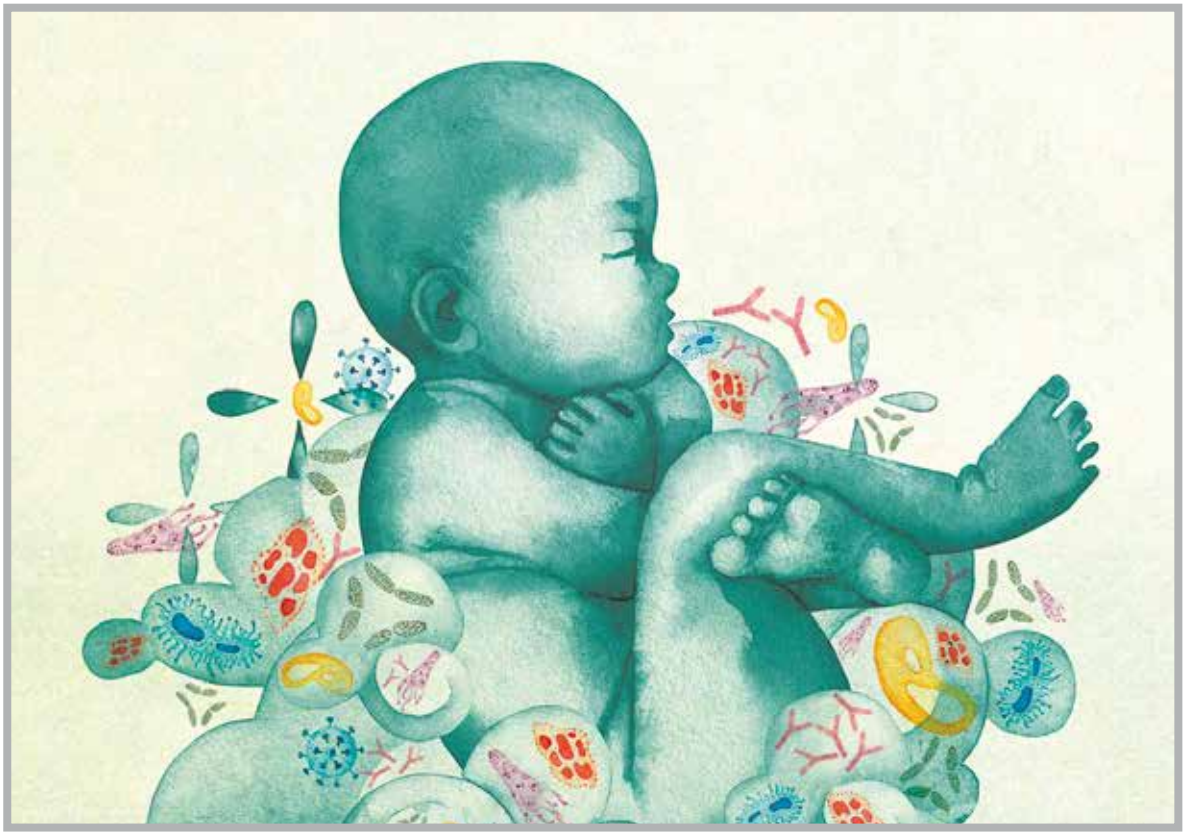
The microbiome enables us to maintain our bodily function and sustain health (Castanys-Muñoz et al., 2016). It stimulates the development of the immune system, breaks down harmful food substances, and synthesises vitamins and amino acids (Harvard T.H Chan, 2021). The microbiota also assists in digestion, with the formation of short chain fatty acids, from the indigestible fibres, which is thought to prevent the development of certain cancers and bowel disorders (Harvard T.H Chan, 2021).

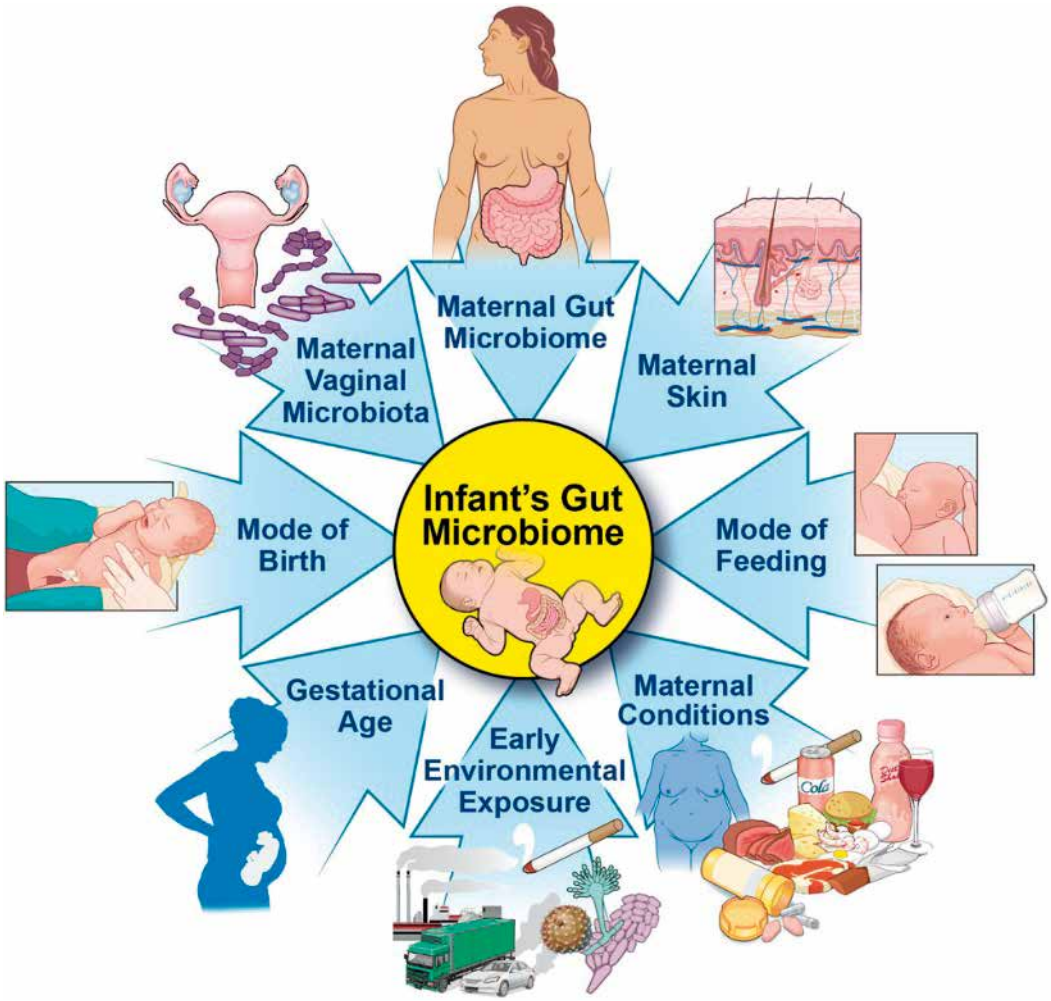
The microbiome consists of both healthy (helpful) as well as pathogenic (harmful) microorganisms which coexist in a peaceful symbiotic relationship (Harvard T.H Chan, 2021). However, through infections, certain diets, and the prolonged use of antibiotics; dysbiosis occurs, where the balance between organisms is disturbed and as a result the person is more prone to develop disease (Harvard T.H Chan, 2021). A clear example of this is bacterial vaginosis. In normal circumstances, the vagina harbours a mixture of bacteria and yeast, with certain bacteria, known as the Lactobacilli, acting to prevent a yeast overgrowth (Ravel et al., 2011). However, antibiotic use, pregnancy, and oral contraceptives, which increase oestrogen levels, may disrupt this balance in vaginal flora resulting in an infection (Ravel et al., 2011).

The microbiome is unique for each individual and a human is first exposed to these microorganisms at birth through the birth canal, from skin to skin, and breastfeeding (Bokulich et al., 2016). However, some studies have found that microbial transfer starts occurring in utero as microbes have been identified on the placenta, fetal membranes, amniotic fluid, and the umbilical cord (Aagaard et al., 2014; Oh et al., 2010). This is thought to be the way the baby is subtly introduced to microorganisms which are essential in priming the immature immune system (Dunn et al., 2017).

Microbes can be found anywhere on the body. However, the gut contains the largest diversity which, in a healthy individual, prevent the overgrowth of harmful bacteria (Harvard T.H Chan, 2021). Studies have found that during pregnancy, the mother's microbiome changes such that the diversity of microbes in the gut and vagina decrease, and the number of Lactobacillus species, Clostridiales, Bacteroidales, and Actinomycetales orders increase (Aagaard et al., 2012). The increase in the lactobacilli helps to maintain low pH levels, limits bacterial diversity, and prevents pathogenic bacteria (Blaser & Domingues-Bello, 2016). These bacteria have also been found to yield high energy levels, possibly acting as an 'energy boost' for the baby (Blaser & Domingues-Bello, 2016). In addition, it is thought that these changes in the maternal microbiome may occur as a natural mechanism to facilitate the transfer of microbes from mother to baby (Dunn et al., 2017).

One can say that the baby's microbiome resembles that of the mother because the microbial species the baby is exposed to are those which are present in the





mother's vagina, gut, and skin (Bokulich et al., 2016). For this reason, it is important to protect the mother's microbiome during pregnancy in order to ensure an optimal microbial transfer to the baby. This can be done by ensuring a healthy diet and lifestyle (Neu, 2016), and by reducing stress and antibiotic use (Dunn et al., 2017).

The three main seeding events which expose the newborn baby to their mother's microbiome are a normal vaginal delivery, where the baby is exposed to the vaginal and gut flora; immediate skin-to-skin, where the baby is exposed to the mother's skin flora; and early breastfeeding, where the baby is exposed to the bacteria present in breastmilk (Bokulich et al., 2016). These events mark the start of the development of the baby's microbiome as well as training of the immune system (Bokulich et al., 2016), such that the early colonisation of 'healthy' microbes provides the immune system with signals distinguishing what is harmful from what is not.

Studies have found differences in the microbiome of babies who were born vaginally from those who were born via caesarean section, as well as between babies who were breastfed from those who were bottle fed (Bokulich et al., 2016). In addition, studies found that babies who were born via a caesarean section and those who were formula fed were found to be at an increased risk of developing allergies (McLean et al., 2015) or becoming obese (Cox & Blaser, 2013). This is possibly because the baby was not exposed to the pioneer microbes, the *Lactobacilli*, that prime the immune system and, as a result, it was not given the opportunity to develop gradually following birth (Bokulich et al., 2016). Therefore, the immune system starts reacting in ways that are unhealthy for us, such as by attacking our own body cells as in autoimmune disorders. For this reason, the baby's exposure to the mother's vaginal microbiome and fecal matter, together with bacteria and microbes from skin-to-skin and breastfeeding are important in protecting the baby's long-term health (Bokulich et al., 2016).

At times, caesarean sections cannot be avoided, and they can be lifesaving for both the mother and the baby. Although studies have shown that it leads to an altered microbiome, there are measures one can take in order to make up for this. For instance, prophylactic antibiotics given to mothers undergoing a caesarean section were found to alter the baby's microbiome (Zimmermann & Curtis, 2020). A recent Swiss, large-scale study, with a total of 55,901 participants, found that administering prophylactic antibiotics to mothers undergoing a caesarean section after the umbilical cord is clamped, rather than before the birth of the baby, does not increase one's risk of developing a surgical site infection (Sommerstein et al., 2020). This suggests that by introducing this practice, the antibiotics the mother is receiving will not affect the baby's developing gut microbiome and immune system.

Skin to skin is another measure that should seriously be considered following a caesarean section. When a baby is born in an operating theatre and handled by the hospital staff, the microbes s/he is initially being

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exposed to are hospital related such as Streptococci and Corynebacteria rather than their own mother's vaginal and gut microbes (Shin et al., 2015). In fact, babies born via a caesarean section are more susceptible to neonatal methicillin resistant Staphylococcus aureus and to developing disease (Dominguez-Bello et al., 2010). By placing the baby skin-to-skin immediately following birth, the baby will get the opportunity to become colonised with some of his own mother's skin microbes. In addition, it helps with the initiation of breastfeeding.

Breastfeeding is more than just nutrition for the baby. Among the lipids, proteins, vitamins and minerals of breastmilk, there are microbes, immunoglobulins, enzymes, and growth factors, among others (Mosca & Gianni, 2017). One particularly important component of breastmilk is the human milk oligosaccharides. These sugars are not digested by the baby, because their role lies in providing the baby's gut microbes with nutrition for them to grow and multiply, colonizing the baby's gut (Mosca & Gianni, 2017) and ensuring a healthy start to the baby's life. In fact, Liu et al. (2019) found that exclusive breastfeeding has the potential to partially restore the dysbiosis created in the microbiota of infants born via caesarean section, such that it becomes comparable with infants who were born vaginally and who were exclusively breastfed. Therefore, it is of vital importance that parents are informed of the importance and health benefits of 'seeding and feeding' their babies with the right microbes when they are making their decisions about mode of delivery and feeding.

Unfortunately, the medicalisation of childbirth has interfered with the contact between the mother and her baby, reducing the baby's opportunity to become colonised with the right microbes from the start. We repeatedly state that our role as midwives is more than just delivering babies. Therefore, it is our responsibility to keep abreast with the latest research in order to update our practice and deliver high quality care, as well as to provide parents with evidence-based information that will ultimately have an impact on their child's future health and well-being. We need to ensure that we offer mothers and families the support they need so that babies are given the maximal protection from the start.

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Images

Source: https://www.the-scientist.com/features/the-infant-gut-microbiome-and-probiotics-that-work-67563

Source: https://onlinelibrary.wiley.com/doi/10.1002/ncp.10490

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Improving Breast Milk Supply with Acupuncture

Many mothers worry about their milk supply, especially in the early stages of breastfeeding. In fact, one of the major reasons why some women stop breastfeeding is because they feel like they do not have enough milk. However, most breastfeeding moms can make a healthy supply of breast milk for their babies. It's only a small percentage of women that will have a true low milk supply.

Even though there are medications to stop milk production, unfortunately there is no medication that can increase breastmilk production. Thus, remedies for those women who truly have a low milk supply are very limited. This is where Traditional Chinese Medicine (TCM) comes in to fill the gaps and offers a treatment option. Recent studies have shown that acupuncture can be effective at increasing milk supply in lactating mothers that are experiencing low milk supply.

According to Traditional Chinese Medicine (TCM) principles, childbirth brings great changes to the reproductive organs and the entire body. The functions of the meridians and viscera are easily maladjusted during the recuperative period. In order to ensure sufficient breast milk production, which is vital to the baby's healthy growth and the mother, it is important to provide a timely differential diagnosis and treatment once a decreased milk supply is diagnosed.

According to TCM principles, postpartum hypogalactia is primarily caused by deficiency of qi and blood or stagnation of liver qi. Deficiency of qi and blood results in insufficient milk production and liver qi stagnation results in coagulation or obstruction of breast milk.

Most major cultural traditions identify a "vital energy" that guides someone's physical and mental processes. Chinese philosophy calls this vital energy 'qi' and describes it as the body's innate intelligence — the intangible yet measurable way we maintain what's known as homeostasis, or the body's ability to regulate its internal environment to create good health. Everything is based on qi. Blockages of qi, deficiencies of qi and too much qi are what cause illness. What happens with acupuncture and all of Chinese medicine is that we try to line up qi. The qi flows in the meridians throughout our bodies and the acupuncture needles stimulate points in order to control the qi.

The research of traditional Chinese medicine (TCM) and acupuncture has increased steadily in the recent years and there is growing research on the use of acupuncture to increase breastmilk supply. Acupuncture at traditional Chinese medicine (TCM) sites used to treat low milk supply has been claimed to cause release of prolactin and oxytocin, although published studies have found mixed results on serum prolactin.

In a randomized controlled study, 60 healthy primiparous mothers with insufficient lactation were randomly divided into three equal groups: group A (control), group B (those who received low-power He-Ne laser beam on both breasts), and group C (those who received electro-acupuncture). All participants received 10 mg Domperidone three times a day and were given advice about lactation, nutrition, and fluid intake. Evaluation was done before and after the treatment program.

The mean serum prolactin, infant weight, and visual analog scale (VAS) score were significantly increased in the three groups post-treatment when compared with their corresponding levels pretreatment. Post-treatment serum prolactin was significantly elevated in group C more than the other two groups. Also, it was significantly elevated in group B more than in group A .The mean value of infant weight was significantly elevated in group C when compared with its corresponding values in both groups A. This study showed that electroacupuncture is more effective than low-level laser therapy in increasing postnatal milk supply (Maged, Hassanin, & Kamal, 2020).

In a Chinese study, women reporting lactation insufficiency were randomized to receive electroacupuncture bilaterally at the SI 1 site (n = 46) or the LI 1 site (n = 46). Women received a total to 10 treatments. The 24-hour milk volumes and morning serum prolactin levels were measured before and after the treatment course. At the end of therapy, all women receiving acupuncture at the SI 1 site had improved milk volumes compared to 70% at the LI 1 site. Serum

prolactin was unchanged from baseline in the treatment group, but was lower at the end of the study in the control group (Wei, Wang, Han, & Li, 2008).

A randomized, nonblinded study in Iran compared maternal breastfeeding education to acupressure among women referred for hypogalactia. At 2 and 4 weeks after initiation, both groups had increased milk output, but the volumes of milk were greater in the acupressure group than in the education group (Esfahani, S, & Valiani, 2015).

A multicenter, single-blind clinical trial in China compared breast fullness, amount of milk produced, neonatal body weight, artificial feeding frequency and volume, urination frequency and crying time of neonates in 276 women randomized to receive either acupuncture at CV 17 or a traditional herbal galactogogue mixture (Tongre Decoction). No instructions on proper breastfeeding techniques or other support were reported. The endpoints were improved in the two groups, with no significant difference between the two groups (He, et al., 2008).

The recent research on the use of acupuncture to increase milk supply shows promising results. However, there are still very few studies to support the notion.

Therefore, more research is needed to find evidence on the efficacy of acupuncture treatment on breastmilk production.

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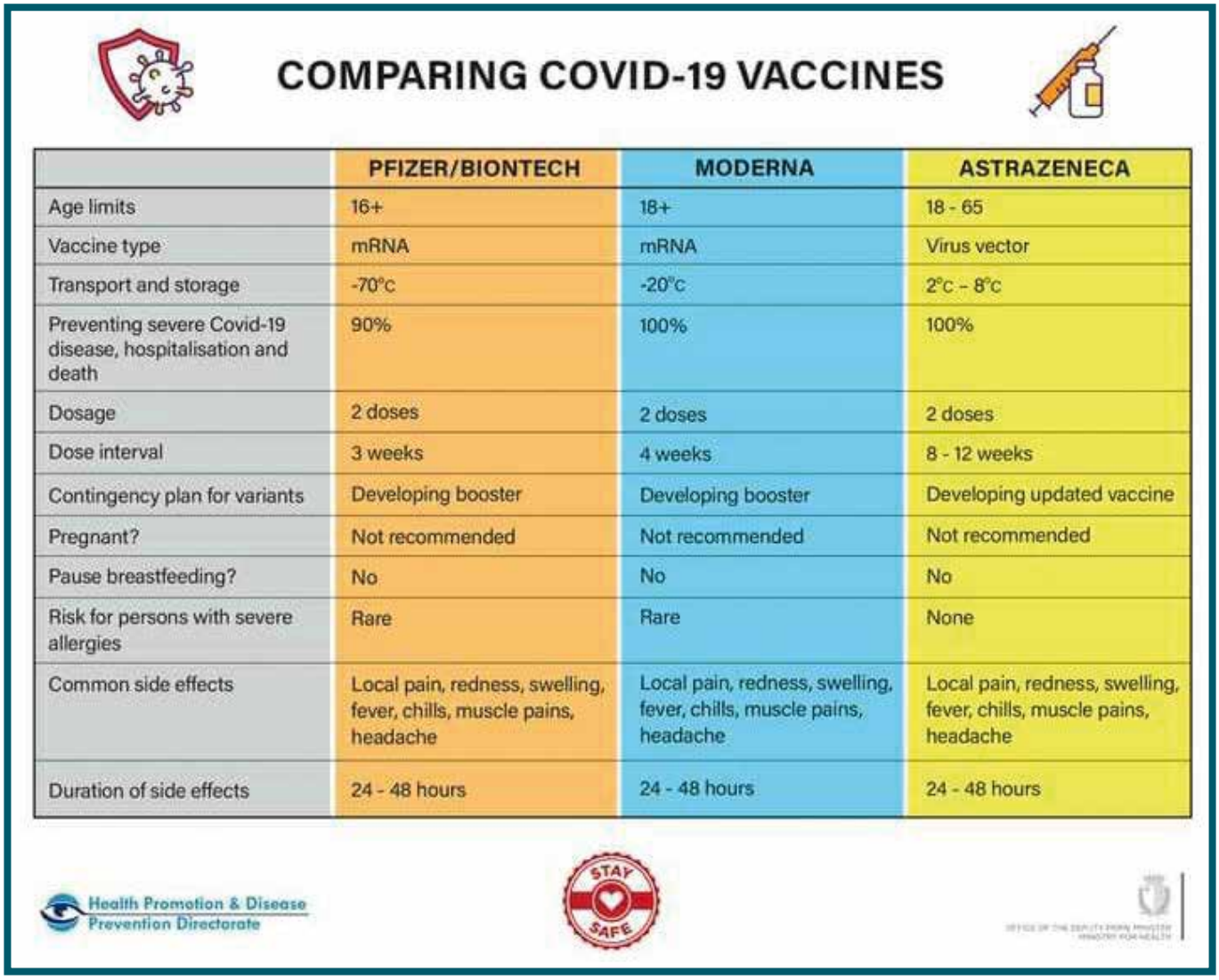


COMPARING COVID-19 VACCINES

	PFIZER/BIONTECH	MODERNA	ASTRAZENECA
Age limits	16+	18+	18 - 65
Vaccine type	mRNA	mRNA	Virus vector
Transport and storage	-70°c	-20°c	2°c – 8°c
Preventing severe Covid-19 disease, hospitalisation and death	90%	100%	100%
Dosage	2 doses	2 doses	2 doses
Dose interval	3 weeks	4 weeks	8 - 12 weeks
Contingency plan for variants	Developing booster	Developing booster	Developing updated vaccine
Pregnant?	Not recommended	Not recommended	Not recommended
Pause breastfeeding?	No	No	No
Risk for persons with severe allergies	Rare	Rare	None
Common side effects	Local pain, redness, swelling, fever, chills, muscle pains, headache	Local pain, redness, swelling, fever, chills, muscle pains, headache	Local pain, redness, swelling, fever, chills, muscle pains, headache
Duration of side effects	24 - 48 hours	24 - 48 hours	24 - 48 hours

Health Promotion & Disease Prevention Directorate

STAY SAFE

Snakes and Ladders: Parenting Children with a Life-Threatening Condition

Parenting may be considered as a wonderful and challenging experience in normal everyday life. Parenting a sick child adds to the normal challenges as parents become caregivers (Moonley-Doyle & Deatrick, 2016). Joy may be replaced with sadness, enthusiasm may be replaced with fear and caring for a sick child becomes a new full-time job (McCann, Bull & Winzenberg, 2015). For this reason, families face numerous stressors when the desired child requires complex care needs. Parents might not have been prepared for this unexpected news.

Children with complex care needs require higher levels of psychological, social, physiological and educational care and support (Muscara et al., 2015). Such children are at an increased risk to have behavioral and emotional conditions which require extensive services beyond that required by children in general (Nygard & Clancy, 2018).

> *"My girl can't live independently. When I got to know, I was shocked. I couldn't believe that someone young and healthy without any complications, at my age, could ever have a disabled child. You imagine yourself, walking around with a nice branded pushchair, taking pictures of your child… but nothing of this happened. Shock… total shock."*

Parents of sick children long for what they perceive to be a normal family life since their parameters of what it means to be a parent and their expectations change dramatically (Curtis, Foster, Mitchell & Van, 2016). Most authors highlight the fact that parents of children with a life-threatening condition must balance the expected parenting roles along with often complicated caregiving roles (Michalik, 2014)

> *"My baby was only four months old and the doctors' first words were… Start thinking of a wheelchair. Buy a corner chair. Arrange your internal doors. I was shocked. So my baby will never walk?"*

Parents' identity changes as their child gets diagnosed by a life-threatening condition (Michalik, 2014). Parents also acquire new responsibilities, face new challenges and their sense of who they are in the world shifts. Parents' lives are often disrupted by the overwhelming psychological distress associated with diagnosis and the requirement for treatment, interventions, hospitalisations and the possible loss of their desired healthy baby. Caregivers experience a turmoil of emotions (Woodgate et al., 2015). The adjustment and the demands of parenting a sick child may put parents at a risk of depression, decreased self-esteem, anxiety, and increased feelings of loneliness and isolation (Muscara et al., 2015). Parents might feel alone and overwhelmed with this caring role that seems like a life sentence or solitary confinement (Collins et al., 2016). Death can ensue unexpectedly and rapidly even if a child appears relatively stable, whilst a very weak child can survive for years. Parents feel powerless in feeling unable to save their child.

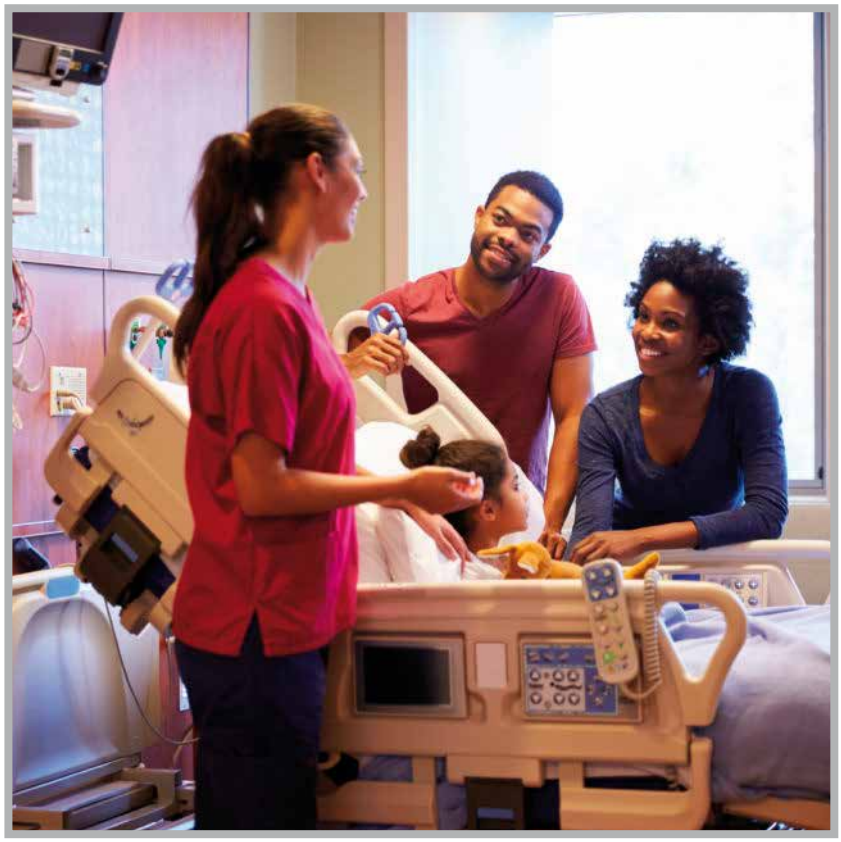
Parents have to face the vicarious distress of witnessing their child being subjected to a variety of painful and upsetting invasive medical procedures as part of their care (Schweitzer et al., 2012). It becomes an unpredictable trajectory. Parents are metaphorically playing a game based on faith; Snakes and Ladders. Parents enter the ward with blank faces as they do not know what might be today's sorrow.

The diagnosis of a sick child can make caregivers confused and weak. These emotions often fade slowly as parents start to accept the reality of the situation and focus on meeting their child's needs (Feeg et al., 2018). Parents tend to keep searching for reasons to put the blame on and often end up blaming themselves for the situation. They keep asking questions to staff on what they could have done better. Sometimes parents have no other option rather than adapting and adjusting to their new life (Glenn, 2015). Parent's adjustment appears to be a dynamic process because of on-going changes in their child's condition and stage of development. When parents see achievements, they tend to become more hopeful.

> *"Our child was hospitalised for the first seven months. I could not hold him, could not breastfeed him, could not take him to mummy clubs… We could not do parenting. Our parenting consisted of medical training. We had to become his nurses, his doctors."*
> *"I used to cry every time I left hospital. I used to say that my son didn't know I was his mother. I could not hold him. He saw million people… How could he know that I am his mum? That hurts."*

A significant feature of living with a severely sick child is the requirement of medical knowledge and nursing skills (Woodgate et al., 2015). Mothers claimed that to take control of their child's condition, parents needed to gain knowledge on the condition and its treatment. Parents need to develop trusting relationships with healthcare professionals so that they could gain information about the disease, services and support networks. Frustration reaches a peak when parents feel outsiders due to the overuse of medical jargon and insufficient information (Woodgate et al., 2015). Parents expect care to be negotiated and want to involved in their child's care.

> *"Travelling with a fragile babe depending on machines is so scary… I could not sleep. Doctors were scared too…He was not fit to fly but we had no other options. It was our only hope. I remember, going up the plane stairs, looking back and saying to myself: Will I be back? Will my son live to be*



back? Will I see my family soon? We didn't want to go, we had to. It was our duty as parents to save his life."

Relationships built on mutual respect and trust endure overtime and provide consistent support for parents going through this juggling of emotions (Nygard & Clancy, 2018). Mothers often strive for positive and normal experiences during their child's hospitalization; wanting to be hands-on parents. Parents need to feel empowered and helped to gain confidence. Hope is an important factor which keeps parents active in this unpredictable game.

"Acceptance. Once you accept that your child will be different, you keep strong. Don't give up. Reach out for help. Don't cry… Be proud of the mission you are doing in this life."

Communication within the family members becomes an asset in trying to cope with all the demands required. Being proactive in managing family needs might be a strain and put parents at risk of marital breakdowns (Bishop, Stedmon & Dallos, 2015). The main barrier is time.

After having gone through some of the latest literature, one can conclude that caring for a child with a life-threatening disease is intensive and challenging. Parents need loads of support ranging from social, financial, physiological and psychological support. Episodes of child sickness and parental frustration made me question the control we think we have over our lives. It is very difficult to accept that children have to suffer and that sometimes our hands are tied by limited options. Life is unpredictable for everyone and we are all playing a Snakes and Ladders game.

"Being a parent is learning about strengths you didn't know you had… dealing with fears you didn't know existed… Sometimes, love is the only medicine that works."

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Fears during Pregnancy, Childbirth and Postpartum Period

Pregnancy, childbirth and the postpartum period are multifaceted experiences, unique for mothers and fathers individually, and as couples, where a multitude of feelings and emotions are shared amongst them (Nilsson et al., 2018; Ryding et al., 2018). Such various emotions are experienced by mothers and fathers at different times and stages of their perinatal journey (Werner-Bierwisch et al., 2018). Research shows that such extraordinary life-changing events influence mothers' and fathers' psychological and physical changes (Hildingsson et al., 2010). Most of the time, feelings of happiness and joy are experienced, but sometimes mothers and fathers experience negative emotions like fear and anxiety as well (Nilsson et al., 2018; Greer et al., 2014). Fear, during the perinatal period, affects not only childbearing women but also their relationship with their newborn infant, their families, and their partners (Ryding et al., 2018).

Studies show that, although maternity care services have improved and are considered safe in most developed countries, fear during pregnancy, childbirth, and the postnatal period is still experienced and is reported to leave a negative impact on mothers' and fathers' health and wellbeing (Nilsson et al., 2018). The prevalence of fear of childbirth amongst women worldwide is said to be around 6 to 10%. Moreover, fathers experience fear during the perinatal period as well, in fact, it is estimated that between 11% and 37% of men experience substantial fears during pregnancy and childbirth (Greer et al., 2014).

What is childbirth fear?

Fear is defined as "an unpleasant emotion caused by the threat of danger, pain, or harm" (Merriam-Webster, 2020). Fear of childbirth is very common among pregnant women, particularly first-time mothers (Molgora et al., 2018). According to Khwepeya et al. (2018), childbirth fear can be defined as "feelings of uncertainty and anxiousness before, during, or after the delivery" (p.2). Childbirth fear can range from inconsequential to very intense fear (Ryding et al., 2015). When individuals experience high levels of fear it is also known as 'tocophobia'. Bhatia & Jhanjee (2012), define 'tocophobia' as "morbid fear of childbirth" (p.1). 'Tocophobia,' sometimes leads women to purposely avoid getting pregnant even though they desperately desire to have a baby (Jaju et al., 2015). Tocophobia can be primary or secondary (Jaju et al., 2015). Primary 'tocophobia' precedes pregnancy and birth and is very commonly reported in first-time mothers, while Secondary 'tocophobia' is often reported by parous women since it is mostly brought about by previous negative birth experiences (Jaju et al., 2015). Although most studies focus on women's fear of childbirth, as mentioned previously, men can also suffer from fear during pregnancy, birth, and the postnatal period (Etheridge & Slade, 2017; Eggermont et al., 2017; Hildingsson et al., 2014). For men, fears related to childbirth often translate into feelings of distress and helplessness (Eggermont et al., 2017; Hildingsson et al., 2014).

Different types of fears

The most common types of fears that mothers and fathers experience during pregnancy and childbirth are;

- Fear of pain,
- Fear of the unknown,
- Fear of normal vaginal delivery,
- Fear of operative births, and
- Fear of injury to the mother or the baby (Etheridge et al., 2017; Jaju et al., 2015; Fenwick et al., 2009).

Research shows that fear of the unknown is one of the most common fears reported by men and women during pregnancy, childbirth and postnatal period (Premberg et al., 2011). Such fear is often related to the women's and men's perceived risks and uncertainties concerning childbirth, usually because they would not have experienced it before (Premberg et al., 2011).

Another major stressor, mostly reported by fathers during the perinatal period is the fear that something goes wrong during labour and birth, which could lead to their partner's death or something wrong happening to the baby (Etheridge & Slade, 2017; Eggermont et al., 2017; Fenwick et al., 2012; Hildingsson et al., 2014; Johansson et al., 2012).

Regarding women's fears, studies report that first-time mothers are commonly afraid of pain and that they would not be able to cope with it (Jaju et al., 2015; Haines et al., 2012). Women very often are concerned about the length of time they need to withstand pain, and studies report that, the longer women have to endure pain the more receptive they are to opt for pharmacological pain relief (Fenwick et al., 2009). Furthermore, research indicates that fathers are also afraid of pain during labour and birth, they mostly worry that their partner would not be able to cope with the pain, or that they would not be able to adequately support their partner because of their fears which are often exacerbated due to the

lack of control they have over the situation (Etheridge & Slade, 2017, Eggermont et al., 2017; Greer et al., 2014; Premberg et al., 2011). Research highlights that fathers often feel anxious and helpless at times, since they are most of the time unable to do anything to alleviate their partner's pain (Etheridge & Slade, 2017; Greer et al., 2014; Premberg et al., 2011).

Inadequate information

Various studies mention that lack of information is one of the factors that increases distress particularly to first-time fathers (Eggermont et al., 2017; Etheridge and Slade 2017; Johansson et al., 2012; Premberg et al., 2011). In fact, fathers report that when they are given insufficient information and advice they feel more frustrated, and feel that it inhibits them from being able to help their partner make informed choices (Premberg et al., 2011). Most fathers want to be informed about procedures, the process of birth, medical and technical equipment, but especially how to involve themselves in labour and childbirth (Eggermont et al., 2017; Etheridge & Slade, 2017; Johannson et al., 2012). Fathers emphasise the importance of receiving information about how they could provide adequate physical and emotional support to their partners so they do not feel helpless (Eggermont et al., 2017; Etheridge & Slade, 2017; Johannson et al., 2012). This is essential information for midwives and other healthcare workers, because men often do not have a lot of places to turn to for support and information during pregnancy and childbirth, except for midwives and other health professionals. Hence, midwives and other health professionals need to be adequately equipped to address both mothers' and fathers' needs (Etheridge & Slade, 2017).

Providing mothers and fathers adequate support and sufficient information is reported as one essential factor to promote a positive birth experience (Etheridge & Slade, 2017; Nilsson et al., 2012; Premberg et al., 2011).

For instance, research shows that when healthcare professionals provide sufficient support to fathers and mothers they are able to trust the healthcare professionals more, and help them cope better and reduce their stress (Johansson et al., 2012).

Mode of delivery

Mode of delivery is another factor influenced by fear of childbirth. Research shows that first-time mothers are mostly afraid of vaginal birth because of pain or perineal tears, hence, they are more likely to prefer a caesarean section instead of normal vaginal delivery (Haines et al., 2012 & Nieminen et al., 2009). For instance, in Hildingsson's (2014) study, 7.7% of the women who participated in the study and 6.9% of their partners preferred a caesarean section as a mode of delivery because they feared vaginal birth. Furthermore, studies report that first-time fathers who were worried about their partner's health and well-being, and did not want to see their partner suffer, were also more inclined towards a caesarean section, claiming that for them it was a "safer," "more controlled" and "easier" option to cope with, rather than the uncertainties and unpredictability associated with normal vaginal delivery (Greer et al., 2014)

Due to an evident global rise in caesarean delivery rates, healthcare professionals, in the past decade sought to find services that can be provided that offer treatment for fear of childbirth and possible better preparation for vaginal births to confront these medicalised birth decisions led by fear (Ryding et al., 2015). These services that offer treatment for childbirth fear are essential since Ryding et al. (2015) and Fenwick et al. (2009) indicate that operative births are often associated with negative birth experiences. It is in fact, commonly reported that women who undergo an operative birth or instrumental deliveries are at an increased risk of experiencing stress and anxiety, leading to more negative birth experiences (Ryding et al., 2015; Toohill et al., 2014).

Impact on relationships and mental health

Consequently, negative birth experiences are associated with long-term effects on both men and women's mental health and can negatively impact the couple's relationship and their relationship with their newborn infant (Etheridge & Slade, 2017; Nilsson et al., 2012). Research states that fear of childbirth does not only impact pregnancy and childbirth, but its' repercussions can be felt up to one year after birth (Nilsson et al., 2012). Nilsson et al. (2012) continue to say that negative birth experiences often impose long-term adverse effects on parent-infant bonding, breastfeeding, and the couple's relationship. Furthermore, fear of childbirth may also influence a couple's views on future pregnancies since, due to a negative experience, a couple may opt to avoid or delay subsequent pregnancies (Nilsson et al., 2012). Hence, research highlights the importance of mothers and fathers being well supported by healthcare professionals to ensure positive birth experiences (Nilsson et al., 2012).

Local research

In view of this information, as a midwife and a researcher myself, as part of my masters of science in midwifery course I carried out a study locally concerning the couples' experience of fear during the perinatal period. Such study was mainly conducted since, a lack of studies was noted that include fathers' experiences of fear during the perinatal period, and especially mothers' and fathers' fears combined and how this effects them both individually and as a couple. Furthermore, findings of this local study were similar to the literature found on the subject, however, unique results were elicited, particular influenced by the local social context and culture. The study concluded that further research is needed regarding mothers' and fathers' experiences of fears during the perinatal period both from their perspectives and the midwives' views, and that maternity practice need to be further developed and improved to provide more positive birth experiences for mothers and fathers. This resulted in recommendations for management and practice that could aid in the improvement of local midwifery practice and facilitate better holistic and reassuring care for mothers and fathers. The study's key recommendations included; continuity of care and carer as well as better antenatal classes that incorporate information on the period after the baby was born.

Conclusion

In conclusion, given that fear of childbirth is a common phenomenon among pregnant women and their partners, which seems to greatly influence their decision-making and childbirth experiences, it is important for healthcare professionals, especially us midwives to be aware of such phenomenon and learn how we can provide better support and reassurance for mothers and fathers especially if it is their first experience in order to promote positive birth experiences.

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Getting Intimate: Primiparous Women's Sexual Health Postpartum

Childbirth is known to bring about numerous changes in a woman's life. After childbirth, primiparous women experience changes in their physical, psychological and social well-being that together may impact their postpartum sexual health. Postpartum sexual health includes the female sexual function, the onset of sexual intercourse postpartum, and the use of methods of birth control (Zhuang et al., 2019).

The female sexual function

The female sexual function comprises of six physical responses to sexual feelings including, desire/ libido, arousal, vaginal lubrication, pain, orgasm and overall sexual satisfaction (Rosen et al., 2000). A woman is thought to have a good sexual function when she is able to resume sexual intercourse and experiences all the physical responses except pain. Contrarily, a woman is known to have a sexual dysfunction if she is lacking any of the following responses; desire, arousal, vaginal lubrication, orgasm and sexual satisfaction, and/or is experiencing pain, all of which may ultimately hinder women from having sexual intercourse (O'Malley et al., 2018). Several studies have shown that in comparison to pre-pregnancy, the sexual function of primiparous women worsens during the postpartum period, and then seems to improve between three to six months postpartum. One of the most common sexual health issues amongst primiparous women is the lack of sexual desire (Amiri et al., 2017; Barrett et al., 2000; Connolly et al., 2005; McDonald et al., 2015; O'Malley et al., 2018).

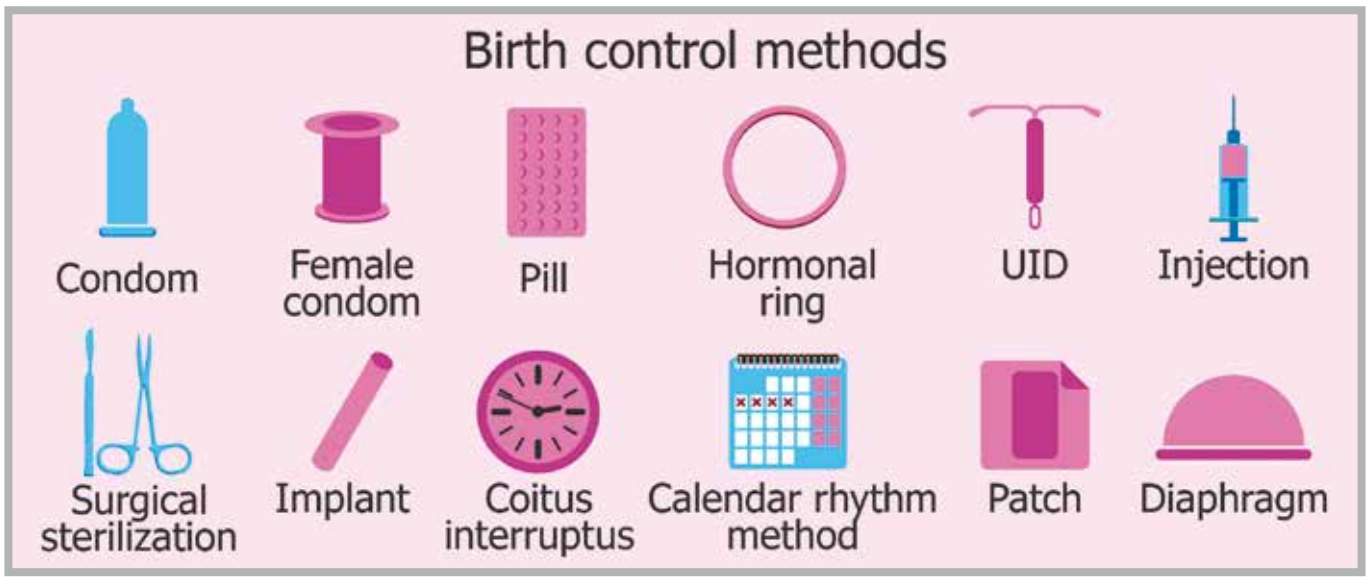
The female sexual function was found to be significantly affected by physical factors that are related to the birth experience. With regards to the type of delivery, at three months postpartum, women who had an assisted/ instrumental vaginal delivery were suffering more from sexual health issues, mainly from dyspareunia (painful sexual intercourse) (Barrett et al., 2000, 2005; O'Malley et al., 2018). As for perineal trauma, at six months postpartum, women who had an episiotomy were experiencing worse sexual functioning than women with an intact perineum or who had unsutured perineal tears. The women who had an episiotomy experienced a significant decrease in orgasms, lack of sexual desire and dyspareunia (Baksu et l., 2007; Barret et al., 2000; De Souza et al., 2015; Eid et al., 2015; O'Malley et al., 2018). Other factors related to the woman's physical and psychological well-being were also seen to be affecting the female sexual function. One of these factors being breastfeeding which tends to bring about a reduction in the oestrogen levels in the woman's body. This hypoestrogenic state in the body can also be caused by a lack of satisfaction with the changes to the body image, fatigue and sexual tension with the partner. All of these factors, as well as having suffered from pre-pregnancy dyspareunia were seen to be the cause for a decrease in sexual interest, lack of vaginal lubrication and hence postpartum dyspareunia (O'Malley et al., 2018).

Onset of sexual intercourse postpartum

The aforementioned factors that were causing a change in the female sexual function were also found to be hindering the onset of sexual intercourse postpartum. Some primiparous women also delayed the resumption of sexual intercourse by up to six months postpartum out of fear of having pain due to perineal injuries or the caesarean section wound, fear of conceiving again, and due to the negative memories of their traumatic childbirth experience (Barret et al., 2000; Ciappara, 2020; El Sayed et al., 2017; McDonald & Brown, 2013; Woranitat & Taneepanichskul, 2007). Moreover, several studies showed that sexual intercourse was resumed by far less women who experienced an assisted vaginal delivery and/or who suffered from any kind of perineal tear that was sutured than by those women who had a normal vaginal delivery with an intact perineum (Barrett et al., 2000; Lydon-Rochelle et al., 2001; McDonald & Brown, 2013; Woranitat & Taneepanichskul, 2007).

Two factors that were found to encourage the resumption of sexual intercourse were menstruation and communication with the partner. With the onset of menstruation postpartum, more women had resumed sexual intercourse (Ciappara, 2020; Zhuang et al., 2019). Vaginal lubrication was seen to increase with the onset of menstruation, making sexual intercourse less painful. Moreover, knowing that their menstrual cycle was back, some women might have felt more at ease to resume sexual intercourse. In addition, a local study reported that a healthy sexual relationship consisted of good communication and a supportive partner who made the woman feel safe and confident with her postpartum body image (Ciappara, 2020). The latter was seen to improve the women's sexual function, and hence encourage the resumption of sexual intercourse.

The National Institute for Health and Care Excellence (NICE) and the World Health Organization (WHO) recommend that consultations between postnatal



women and healthcare professionals regarding the resumption of sexual intercourse and any related sexual health issues should be initiated within the second to the sixth week postpartum. Hence, it is implied that sexual intercourse may be resumed during the postpartum period, this being the first six to eight weeks after birth (NICE, 2015; WHO, 2013). Foreign and local literature were in accordance with these recommendations as they showed that primiparous women mostly resumed sexual intercourse between the sixth and the eighth week postpartum (Amiri et al., 2017; Barbara et al., 2016; Barrett et al., 2000, 2005; Ciappara, 2020; Connolly et al., 2005; Dabiri et al., 2014; Eid et al., 2015; El Sayed et al., 2017; McDonald & Brown, 2013).

The resumption of sexual intercourse between six to eight weeks postpartum was found to be significantly related to the sixth week postnatal visit, the Papanicolaou (Pap) smear test, and to certain religious beliefs (Amiri et al., 2017; Barbara et al., 2016; Barrett et al., 2000; Ciappara, 2020; Dabiri et al., 2014; Eid et al., 2015; El Sayed et al., 2017; McDonald & Brown, 2013; Woranitat & Taneepanichskul, 2007). At the sixth week postnatal visit, postnatal mothers are examined by a midwife or an obstetrician-gynaecologist who assesses their recovery from childbirth by thoroughly examining their physical and psychological well-being. As part of the physical assessment, a vaginal examination is carried out to assess the healing of any possible tears and the healing of the cervix (Barrett et al., 2000; Zahumensky et al., 2010). Locally, the Pap smear test is carried out during the vaginal examination, in order to check for cervical changes (Government of Malta, 2019). Moreover, during this visit, the midwife/obstetrician-gynaecologist also consults on the use of contraception (Barrett et al., 2000; Zahumensky et al., 2010). Given that there was proper healing and that the women may have agreed on using a type of contraception, the healthcare professional usually assures the women that they may resume sexual intercourse. With regards to the religious beliefs, the Islamic religion forbids Muslims from having sexual intercourse prior to the sixth week postpartum (El Sayed et al., 2017).

The use of contraception postpartum

Between three to six months postpartum, literature showed that the majority of primiparous women who had resumed sexual intercourse were making use of contraception (Barrett et al., 2000; Ciappara, 2020; Zahumensky et al., 2010; Zhuang et al., 2019). Foreign studies found out that the barrier method and the oral contraceptive pill were the two most frequently used contraceptive methods postpartum (Amiri et al., 2017; Barrett et al., 2000; Zahumensky et al., 2010; Zhuang et al., 2019). However, in a local study, it was reported that coitus interruptus, also known as the withdrawal method, was the most common method used for birth control. The withdrawal method is an unreliable type of contraception as it is not as effective as the other methods. In view of this, healthcare professionals should advise against its use, especially if the couple wish to space future pregnancies and hence would require a safe method of contraception.

The role of the midwife

Midwives have the duty to educate pregnant and postnatal women about their sexual health (International Confederation of Midwives [ICM] as cited in Council for Nurses and Midwives [CNM], 2005). The Royal College of Obstetricians and Gynaecologists (RCOG) suggests that advice on the use of contraception postpartum may be given during the antenatal period. However, both the RCOG (2015) and NICE (2015) highly recommend contraception advice to be given during the immediate postpartum period (the first few days while the mother is still in hospital) or at least within the first four weeks postpartum. As previously discussed, postnatal women also have the opportunity to enquire about contraception during the sixth week postnatal visit. Several studies elicited the fact that many midwives and obstetricians-gynaecologists either simply did not discuss sexual health issues (mainly those related to the sexual function) or else when women sought help, they did not give the proper advice (Baksu et al., 2007; Banaei et al., 2018; Barrett et al., 2000; McDonald et al., 2015). This can hinder women from speaking up when they really need to, because as per McDonald et al. (2015), more women

were comfortable and willing to discuss sexual health issues when the healthcare provider directly enquired about them. Locally, it has been found that although advice about the sexual function and related issues were not greatly discussed by midwives and obstetricians-gynaecologists during the immediate postpartum period, many primiparous women were still willing to seek the help of the aforementioned healthcare professionals if they encounter sexual health problems (Ciappara, 2020). In view of this, it is of utmost importance for midwives to keep themselves updated with the latest evidence about issues that concern postpartum sexual health.

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Same-Sex Parents and Their Children

Parenting is one of the most compelling roles in the forming of the child's values, morale and perceptions. It cultivates the talents, skills and abilities of the children, in particular, it endows love that promotes consideration and respect to the world, on the way the children will affiliate to social life, how they will cherish their principals and how they will face the future on their own two feet. The parents are predominately the primary caregivers of the children. They are the providers of all essential needs. Parents nourish and teach them rules and limitations that the children must adhere to. They also provide constant emotional background. Subsequently, the advice of the parents will support the children to be more compliant to the calamities of the realities of the world. The failure of the parents to provide guidance will lead to the child's emotional dysfunction, thus it is important that the children are nurtured as they grow. The children are on the threshold of their identity which they will portray to society.

We are living in a world where everything is changing thus society needs to adapt to these changes. We are seeing more LGBTIQ people coming out of the closet and thriving to live a normal life like their heterosexual compatriots. One of the topmost criteria on LGBTIQ community agendas is marriage complimented with children. One finds a number of cons and pros regarding this delicate issue. The welfare and vulnerability of the child are a critical issue on which a number of studies were carried out and are still ongoing.

One finds different pathways in which children make part of a same- sex family. The child could be born from a previous heterosexual relationship, the child could have been conceived by IVF or a child could be adopted. For gay couples there is also the option of surrogacy. The desire to become biological or social parents is considered the expression of a universal human need. Realizing this need depends on numerous individual and social conditions. Studies suggest that the motives for same- sex couples to become parents differ little from those of heterosexual couples. Same- sex parents are however motivated less by social expectations of normality.

Although motives for having children are generally similar for same- sex couples, studies suggest that in comparison to heterosexual couples, same- sex couples are likely to face additional hurdles. They tend to think longer about the desire to become parents and they have to justify their desire more often. For children to have sustainable development, they need to be cherished by healthy family dynamics. Family has evolved to being headed not just by heterosexual parents but by a diversity of same- sex parents. The emancipatation of same- sex families was greatly supported by the rise in gay culture and legal responses. Malta has also adapted to the change with adopting policies and achieving LGBTIQ rights to become an all inclusive society. Same- sex parenting can be one of the following Lesbian parenting, Gay parenting and Transgender parenting.

Parental roles have evolved and the stereotype roles of male and female set up in the family have converged to make way for new fronteers. These new families to have more scope in society, would not have come about, if there was not an inducment towards the rise in gay culture and legal responses. This led to more acceptance of same-sex relationships embellished with changes in laws to fully include LGBTIQ people. The plethora of studies is immense. The results of the no difference prerogative are that children living in these family units are happy, psychologically healthy and suffer no counters backs. The question is, is it high time for fear and moral panic to surrender to knowledge?

The 1970s saw the emergence of children living with lesbian mothers. Women started losing battle of custody. Some studies referring to The No Difference Prerogative report the following: Davies reported no negative consequences (Baumle, 2013) and Ball reported no difference (Ball, 2016). Stacy and Biblarz followed a new pathway with the aim to look for benefits and not disadvantages. Difference existed but this did not mean that children are at a disadvantage (Stacey & Biblarz, 2001). Patterson in a study of 300 children found no difference (Patterson, 2005). Bailey et al reported that children were not influenced by parental sexual orientation (Bailey et al., 1995). Golombok sustained that family strong relationships were paramount (Golombok, 2015). These studies sustain that these children suffer no harmful long term effects. They sustain that there is no evidence that children of same- sex parents differ from other children on emotional adjustment or stigma. Studies which sustain that these children undergo no harm from same- sex parents still have claimed that children suffer from backlash from homophobic attitudes of their peers.

On the other hand Dr Mark Regnerus's New Family Structure Family Study categorized that as children living with broken families, children living in same- sex families fail to achieve optimal standards especially in issues relating to education (Jason et al., 2012), although the root cause of these discrepancies was not found, his findings induced other studies to come about. Dr Donald Sullins used the National Health Interview Survey. This study contains data on mental and physical health, sustained with demographic control variables. He discovered that these children suffered developmental and emotional problems, suffered from stigma and were surrounded by parental psychological distress. He discovered a high incidence of child abuse (Sullins, 2015). Sedlak et al found that family form with a lower rate of child abuse was made up of married man and woman. All other family forms have a higher rate (Sedlak et al., 2010). Cameron et al discovered that their existed a high rate of child abuse in same- sex parents but this research was criticised (Cameron et al., 2017) While Schumm, Regnerus and Sullins, show that the ideal scenario for children to have a healthy development is living with their biological mother and father.

Some have compared this research, with wading into

deep waters. There are those that might consider that the results of the no difference to be biased due to the encouragement of the perspective that same- sex parents make better parents then heterosexual parents. They even claim that same- sex parents embellish their family relationships. The opposing studies portray that these children are at a great disadvantage as they are living in a hostile developmental environment. While the issue of children in heterosexual families is considered as being easy and expected, for same- sex couples the road is more tortuous as they have to fight harder to assimilate a family.

The issue of same-sex parents leads also to the criteria of gender identity and sexual orientation of these children. Gender identity is defined by the Human Rights Campaign as the "innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves" (Jourian, 2015, pg 13). It can mirror what a person was assigned at birth, or be entirely different. Sexual orientation, on the other hand is the "inherent or immutable enduring emotional, romantic or sexual attraction to other people" (Adams, 2017). Someone can be transgender, but also be gay, straight, bisexual, asexual, or a whole host of other sexual identities that exist. While Anderssen et al, one of the scholars that studied the issue of sexual orientation claims that sexual orientation is not an issue with these children (Anderssen et al., 2017). Others like Armesto have sustained otherwise, that the children's sexual orientation is determined by parental sexual orientation (Armesto et al., 2001). Following on to gender identity Michael Lamb sustained that gender identity was an aspect of psychological adjustment but same-sex parentage was not identified with children's gender development (Lamb, 2012). Sarantakos among others on the other hand concluded otherwise (Schumm, 2015). Green and Freedman have explored the issue of fluid parenting practices (Freehling-Burton, 2014). This concerns LGBTIQ convictions that gender is a personal choice and not biologically accorded.

When one considers the feelings of these children they are varied in concept. There are those that are proud of their parents and are willing and strong to fight for their family's rights. They feel strong to counter attack any backlash that might be induced against them, while there are others who live in the shadow of stigma, homophobia and fear of bullying. Their fears are of discrimination and they tend to hide their family relationships.

The evidence of these studies is sometimes difficult to review because of the variety of outcome themes and research method and sometimes there is more than one published report from the same study. Although there are platitudes of studies, no consensus has been reached and the battle still goes backwards and forwards unfortunately sometimes at the cost of the child's health and wellbeing. These children follow a tortuous road as they live in a family environment where there are instances of fighting to survive in the midst of homophobia.

Society still needs a long way to accept the arrival of same- sex parentage. The important thing is that these children are not used as scrape goats to undermine the integrity of their parents. One should consider more the beliefs of freedom of religion, freedom of conscience and equal rights to everyone thus one can reach a consensus on a set of social values that will yield the ground work for cherishing different families. Family ethics should sponsor responsibility, consent, autonomy and integrity.

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Breastfeeding in Public Places: The Perspectives of Young Adults in Malta.

Habituating appropriate breastfeeding practices have been associated with positive long-term effects on both the mother and the child. In fact, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) formulated their infant feeding recommendations that highlight the significance of exclusive breastfeeding. However, Malta reports low exclusive breastfeeding rates. Lack of acceptance of breastfeeding in public places is one reason why women discontinue breastfeeding altogether as perceived social norms can exert a more significant effect on women's breastfeeding outcomes than their attitudes about and knowledge of breastfeeding.

Since Maltese literature lacks studies exploring public support of breastfeeding in public places, this study aimed to determine the perspectives of young Maltese adults on breastfeeding in public places, by exploring their awareness of breastfeeding, their views when encountering women breastfeeding in public, and what they perceive to be a breastfeeding appropriate environment. This study adopted a quantitative research approach, and a self-designed, self-administered, structured, web-based survey was utilised to collect data. The non-random consecutive sampling technique adopted to recruit participants, where a total of 6,359 young Maltese adult students attending University of Malta (UOM) were invited to participate, generated a response rate of 3.31%. A sample of one hundred and eighty-four young Maltese adults (N=184) was considered for this study.

The collected data was analysed manually, and findings revealed that, although this study's sample was moderately aware of breastfeeding, with female respondents being more aware than their male counterparts, the participants accepted the practice of breastfeeding in public places, and no notable differences between male and female perspectives were evident. However, young Maltese adults believe that, when in a public place, women should breastfeed their child discreetly, and despite asserting that breastfeeding should be allowed in all public places, the beach, playground, and shopping malls were perceived as the most breastfeeding appropriate environments, with the great majority of participants agreeing that public places should be equipped with breastfeeding rooms. Collectively and when compared to foreign studies, these findings imply that social norms affect one's perspectives about this issue.

This study recommends the inclusion of breastfeeding education in the academic curriculum of schools that promotes breastfeeding in public places as a social norm. Additionally, the need for governmental policies encouraging breastfeeding friendly environments, and laws protecting women's right to breastfeed in public places are highlighted.

Alison Bugeja

Midwives' Perspectives on Perineal Suturing in Midwifery Practice.

The aim of the small-scale quantitative research project was to investigate midwives' perspectives on perineal suturing in midwifery practice. The objectives set to achieve the aim of the study included: to identify effective ways of teaching and supporting midwives in implementing perineal suturing as a midwifery skill and to identify barriers and facilitators in implementing perineal suturing in midwifery practice. A total of 40 midwives (N=40) recruited by convenience sampling, were selected from the Central Delivery Suite (CDS) of a local general hospital. In total, 35 questionnaires were returned resulting in an 87.5% response rate. Analysis of closed-ended questions was carried out manually using simple descriptive statistics and analysis of open-ended questions was carried out using content analysis. Results suggested that midwives believe that perineal suturing should be carried out by midwives themselves and that they should be the main professional to suture both first-degree and second-degree tears. This would contribute to providing continuity of care to women intrapartum and hence was viewed as imperative in facilitating its implementation. Moreover, this was also seen to facilitate better time management concerning care following delivery. Findings suggested that regular training on perineal repair should be carried out if this were to be implemented. Additionally, midwives believed that around 6-10 repairs should be carried out under direct supervision and that evaluation should be based on each individual's level of competence when performing this skill. Findings showed that midwives believed that student midwives should be given the opportunity to practice perineal suturing during their undergraduate course of studies. Midwives also claimed that obstetric led care and lack of trust between doctors and midwives is a barrier to the implementation of this practice. On the other hand, the provision of training is seen as a facilitator in promoting this midwifery skill. Mainly recommendations generated from the present small-scale study include the introduction of midwives repairing first-degree and second-degree tears as part of their practice with a policy that supports this. Moreover, further studies using a larger, randomly selected sample of midwives practising locally is also recommended so that findings could be generalised. Recommendations for education include the importance of regular perineal repair courses which should be offered as a form of Continued Professional Development (CPD) to enhance the knowledge on the subject and so that any additional updates can be provided

Angelica Abela

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Bacteria
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Falls
minor wounds, cuts &
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Eruptive diseases
chickenpox

Heat
minor burns,
minor scalds

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SOOTHES REPAIRS PROTECTS

Midwives' Compliance with the Standard Precautions of Infection Control in the Maternity Setting

Standard Precautions are the basic measures of infection prevention and control that must be adhered to when caring for all patients irrespective of their infectious status. This study aimed to explore midwives' knowledge and attitude to the Standard Precautions of infection control, understand how the Standard Precautions impact clinical practice, and to identify the barriers to compliance with the Standard Precautions in the maternity setting.

Methodology: Adopting a quantitative approach, using a self-designed, self-administered questionnaire, fifty midwives working at the Obstetric Wards, Central Delivery Suite, and the Neonatal and Paediatric Intensive Care Unit were selected through convenience sampling. All midwives (n=50) returned their questionnaire, generating a 100% response rate.

Results: The midwives' mean knowledge and attitude scores were rather positive. However, participants lacked knowledge of hand hygiene in relation to the use of gloves and their attitude towards the 5 moments of hand hygiene, the use of gloves, and the use of personal protective equipment was rather poor. Results show that while midwives seemed to understand the principles behind the Standard Precautions in clinical practice, their compliance seems to depend on their attitude and certain constraints which they experience, mainly high work-load, time constraints, and lack of regular training.

Conclusion: The midwives' perceived risk and susceptibility are thought to influence their attitude towards compliance with Standard Precautions. Therefore, helping midwives change their perceptions through educational interventions, which address the common misconceptions, are required. The need for regular hands-on training, audits, and immediate feedback, through a multifaceted approach, was highlighted.

Bernice Scicluna

Midwives' Perceptions of Food and Fluid Intake During Labour and Delivery

This small-scale quantitative study aimed to explore midwives' perceptions of food and fluid intake during labour and delivery. The objectives sought to identify how midwives instruct women to eat and drink during labour and to determine factors which influence midwives' choices of recommending different types of oral intake throughout labour and delivery. A self-designed, self-completion questionnaire was dispersed among a convenience sample of forty-five midwives (N=45) working at a Central Delivery Suite of a local public hospital. Forty questionnaires (n=40) were collected, generating a response rate of 88.9%. Simple descriptive statistics were used to manually analyse the data obtained from the close-ended questions. Additionally, content analysis was used to evaluate the open-ended questions. The findings illustrated that most midwives (n=37, 92.5%) permitted oral intake to women in labour. Most midwives (n=27, 67.5%) stated that in the absence of complications, oral intake should be left to the women's discretion as they require energy and hydration and to prevent muscle fatigue. Additionally, most midwives (n=13, 48.1%) believed that when permitted oral intake women are more satisfied with their labours. Results also revealed that some participants (n=14, 35%) were unsure about the availability of a protocol concerning oral intake in labour.

Recommendations for the introduction of educational sessions could be provided to midwives to update their knowledge and enhance the quality of care given to women. Additionally, it is recommended that clear guidelines could be implemented for midwives to provide homogenous care to women in labour. It would be intriguing to conduct future research comparing the views of obstetricians, anaesthetists and mothers with regards to eating and drinking in labour.

Chiara Scerri

Mothers' Awareness on Childhood Immunisation

Childhood immunisation aims to prevent children from acquiring vaccine preventable diseases. Parents' attitudes and knowledge towards immunisation are likely to influence their uptake. This small-scale quantitative study aimed to gain an understanding of mothers' awareness of childhood immunisation through a self-administered, self-designed structured questionnaire. The objectives of the study were to investigate mothers' knowledge of current vaccines given to children in the first year of life, to assess mothers' views on routine immunisation, and to identify mothers' educational needs on childhood immunisation.

A sample of fifty mothers was selected by purposive sampling from the Well Baby Clinic in the local primary health care centres according to the inclusion and exclusion criteria set for the study. Forty-eight of the distributed questionnaires (n=48) were completed, yielding a 96% response rate. The results of the closed-ended questions were analysed using descriptive statistics, while open-ended questions were analysed by means of content analysis. The findings suggest that mothers have a positive attitude towards childhood immunisation, except in some aspects related to vaccination side-effects, mainly fever and any other unknown effects. Moreover, they had limited knowledge of vaccines and immunisation schedules. Mothers feel poorly informed about immunisation, and believe that educating parents would help to obtain a good vaccination coverage across the population. Paediatricians were the mothers' main source of information; however, they

identified the midwife as having an important role in vaccination education, and thus, wish to receive such information from her, as well as from the paediatrician, and the internet. Consequently, recommendations for clinical practice, education, and further research were proposed. The importance of increasing mothers' knowledge through more educational opportunities, such as, an evidence-based website with appropriate information, was highlighted, as well as the need for healthcare providers to communicate more effectively with mothers on childhood vaccination.

Elena Saliba

Midwives' Perceptions on the use of Inhalation Analgesia during the Intrapartum Period

This small-scale quantitative study aimed to explore midwives' perceptions on the use of inhalation analgesia during the intrapartum period. To meet the aim of the study, the following objectives were set: to understand midwives' perceptions on the use of inhalation analgesia as a pharmacological method of pain relief and to investigate the midwives' perceptions on the effectiveness of inhalation analgesia during the process of labour. A self-designed, self-completion questionnaire was distributed amongst forty midwives (N=40) working at a labour ward of a local public hospital, using a convenience sampling method. Forty questionnaires (n=40) were completed, yielding a response rate of 100%.

he data obtained from the open-ended questions were analysed manually using content analysis, whereas simple descriptive statistics was used to analyse close-ended questions. The findings showed that all midwives offered inhalation analgesia to women during labour. All participating midwives confirmed that Entonox® inhalation is the type of inhalation analgesia offered locally. Most participants believed that inhalation analgesia is a very effective analgesic, a lot of labouring women opt for it and does not affect neonatal outcomes. In addition, nausea, dry mouth and drowsiness were the most reported side effects by participating midwives. All participants stated that they instructed women to inhale this analgesic at the beginning of a contraction and to continue up until the contraction pain fades away.

However, some participants were not aware of the correct composition of gases which make up inhalation analgesia. Results also showed how some participants were not aware of the various uses of inhalation analgesia during different stages of labour. Therefore, midwives must be provided with further information-giving opportunities to help them update their knowledge and improve the quality of care they give to patients. It is recommended that a set of written guidelines on the administration and benefits on inhalation analgesia on both maternal and neonatal health are prepared. To allow for generalisability of these findings, future studies with a larger number of midwives from all maternity wards should be carried out.

Elena Marie Carnemolla

"Midwives' Views on Postpartum Sexual health"

Sexual health is an important aspect in the general health and well-being of the woman. Sexual dysfunction can emerge in the postpartum period as a result of events and interventions related to childbirth. Research shows that this may cause personal distress to the woman and relational and interpersonal conflict between her and her partner. Midwives have a particular role in providing sexual health care and information to postpartum women as part of the provision of holistic care. Hence, the aim of this quantitative, small-scale research project is to explore the views and experiences of local midwives regarding the provision of postpartum sexual health. This is done through addressing three objectives: 1) to explore local midwives' experiences of providing sexual health care during the postpartum period, 2) to explore the midwives' role in postpartum sexual health, 3) to identify the challenges that midwives encounter with regards to this aspect of health care.

A self-designed questionnaire was developed through the literature review. Forty midwives (n=40) from various maternity wards at the local general hospital who cared for postpartum women were recruited by convenience sampling. Thirty-one midwives (n=31) responded to the questionnaire, yielding a 77% response rate. Manual simple descriptive statistics were used to analyse the data.

Results showed that local midwives had various experiences in providing postpartum sexual health information and advice. Overall, participant midwives had a less prominent role in providing sexual health care to postpartum women but were competent in addressing the topic of contraception. Other more intimate discussions with the women were avoided due to lack of confidence and stereotyping which often hindered sexual health related discussion and information between midwives and their clients. Other challenges identified by midwives were time-constraints, and lack of education and training in sexual health. Recommendations for practice, education and further research are put forward.

Maria Borg

Mothers' Experiences of Early Breastfeeding after Caesarean Section

There is strong evidence that breastfeeding has multiple benefits for both mothers and their infants, and it is the recommended method of feeding for the first six months of an infant's life and beyond (WHO & UNICEF, 2018). However, the establishment of breastfeeding is not always straightforward, and women who undergo an operative delivery are known to be at an increased risk of having breastfeeding difficulties when compared with mothers who give birth vaginally (Chaplin, Kelly & Kildea, 2016).

In the context of decreasing breastfeeding rates (Gatt & Borg, 2018; Gupta, Dadhich & Suri, 2013) and rising caesarean section rates (Gatt et al., 2016; WHO, 2015), both locally and globally, it was thought important to carry out a study to identify women's experiences of early breastfeeding post caesarean section. The absence of existing local studies on the subject provided further motive for such research. In view of this research gap, this study aimed to explore mothers' experiences of early breastfeeding after caesarean section. The study objectives were to enquire into mothers' thoughts and feelings in relation to early breastfeeding after caesarean section, to outline facilitators and barriers to early breastfeeding after caesarean section, and to identify mothers' perceptions of the breastfeeding care and support received during their postpartum hospital stay.

A qualitative approach was used, with a single, semi-structured, face-to-face interview conducted with eight primiparous, breastfeeding mothers, between 48-72 hours after an emergency or elective caesarean section. The purposive sample was recruited from two obstetric wards in the state general hospital in Malta. Thematic analysis was then used to analyse the data generated.

Findings suggested that giving birth through a caesarean section brought with it several repercussions which complicated the establishment of breastfeeding, including a maternal sense of disorientation, overwhelm, vulnerability and helplessness, as well as a reluctance to feed in the neonate. Collectively, these factors meant that physical and emotional support was considered vital for mothers to persevere with breastfeeding. Despite facing challenges, mothers strongly favoured breastfeeding over formula feeding, citing the numerous benefits of breast milk.

On the basis of the latter results, the researcher came up with a number of recommendations for practice, education and further research. One of the most important recommendations was the need for recruitment of additional ward-based midwives specialising in breastfeeding to enhance and improve accessibility of breastfeeding support. The study also suggests the implementation of frequent refresher courses for all professional caregivers who provide breastfeeding support. This would encourage the provision of consistent, up-to-date guidance and support in breastfeeding. Lastly, additional research with a larger cohort of mothers who had an emergency caesarean section would also be of significant benefit, as many of the issues identified affected this subset of women disproportionately to those who had an elective caesarean section.

Nadege Buttigieg

Midwives' Views on Managing Nuchal Cord during the 2nd Stage of Labour

The presence of a nuchal cord (cord round neck) during the 2nd stage of labour is a common occurrence where it occurs in approximately one third of births. The findings of a nuchal cord in the 2nd stage of labour is commonly associated with adverse neonatal outcomes. Researchers suggest that some interventions adopted in the management of nuchal cord can predispose the infant to increased risk for complications, thus evidence-based practices are crucial in determining the neonates' outcome.

This quantitative study **aimed** to investigate the midwives' trends in the management of nuchal cord during the 2nd stage of labour. The **objectives** identified to address the aim include to explore the midwives' knowledge and views on nuchal cord management, and to identify any educational and research gap/needs. A one time, structured, self-administered and self-designed questionnaire was used.

A **sample** of fifty midwives (n=50) working in the labour ward at the state hospital, were recruited using the convenience sampling method. Forty-one participants returned the questionnaire yielding an 82% response rate. Data was manually **analysed** using simple descriptive statistics (counting and percentages) and presented in tables, bar charts and pie charts. Content analysis of the participants' comments and explanations were presented in a categorised form.

Findings revealed that most midwives routinely check for a nuchal cord in spite of this practice not being supported by evidence. Premature clamping and cutting was viewed unsafe by most participants and only few midwives still adopt this practice. Most midwives loop a loose nuchal cord over the infant's head whereas a hands-off approach is adopted if the cord is tight.

Some participants were unaware of the somersault manoeuvre used to manage nuchal cord. **Recommendations** for further research, practice and management and education were proposed namely increasing the knowledge of midwives and students on the best practices that safely manage nuchal cord during the 2nd stage of labour, through education and training.

Sarah Alexia Tonna

Couples. Experiences of the first Hour after a Normal Vaginal Delivery

This research study aimed to explore couples' experiences of the first hour after a normal vaginal delivery. Objectives were formulated to meet the aim of this study. These included: to explore how couples experience the events that happen during the first hour after a normal vaginal delivery and to explore the couples' thoughts and feelings during the first hour after a normal vaginal delivery. A qualitative research design was used. A self-designed, semi-structured interview schedule was used to gather data via an audio-recorded face-to-face interview. Eight couples were recruited via purposive sampling to conduct interviews with. All the participants took part in the interviews yielding a 100% response rate. All ethical issues were strictly adhered to. The data was then transcribed and analysed using Braun and Clarke's thematic analysis. From the analysed data, three main themes emerged: "Transition to parenthood", "Events experienced during the first hour after birth" and "Thoughts and feelings during the first hour after birth". The couples experienced varying levels of bonding with their infant, depending on the environment, events occurring during the first hour after birth and the people surrounding them. The couples described their experiences of skin-to-skin, breastfeeding and suturing as the three main events that happened during the first hour after the birth of their infant. The couples also described a wide range of emotions experienced during the first hour after a normal vaginal delivery using words such as "enthusiasm", "happiness", "confusion, "fear" and "love".

The couples' feelings varied from positive to negative, where some felt extreme hapiness, while others felt a disconnect with their infant during this first hour after birth. Given these findings, recommendations for education, practice, management and research were proposed. A recommendation for education was to increase education to midwives and student midwives about the importance of the first hour after birth. A recommendation for management was to include continuity of carer in maternity services which was found to be very desired by the couples. A recommendation for research was to conduct a study to explore the first hour after a caesarean birth to compare the experiences.

Stephanie Attard

Mothers' Experiences of Induction of Labour

This study aimed to explore the mothers' lived experiences of induction of labour (IOL). The objectives of the study were twofold: firstly, to understand how mothers experience IOL, and secondly, to explore mothers' feelings and reactions to IOL. The qualitative paradigm was used to investigate this phenomenon and a convenient sample of eight primiparous mothers was selected from two of the Obstetrics wards at the state hospital. Participation in this study was not obligatory and all the mothers who were approached consented to take part. Thus, a 100% response rate was yielded. The tool utilised to gather the data was a self-designed, semi-structured interview schedule. These interviews were audio-recorded with the participants' consent and the mothers were given a pseudonym to ensure confidentiality.

Data were then transcribed verbatim and analysed using thematic analysis. Findings identified that mothers were often lacking sufficient information before their IOL. Additionally, mothers often seemed to be quite submissive about the fact that the decision to opt for an IOL was made for them. Although unsuccessful, most mothers attempted to use natural methods to go into labour spontaneously before their scheduled IOL date. Findings also revealed that some mothers felt that IOL affected their mode of delivery, while others went on to blame themselves for their body not being able to deliver vaginally.

In light of these findings, the student researcher proposed several recommendations: primarily it is being suggested that the IOL protocol is revised and updated according to the latest evidence. Furthermore, further research on the efficacy of natural methods in initiating labour is required. It is also recommended that a leaflet gathering information about the IOL process is formulated.

The importance of preparing mothers better for the reality of the process was highlighted in this study, as their hopes and expectations were usually unmet.

Ylenia Gauci

University of Malta

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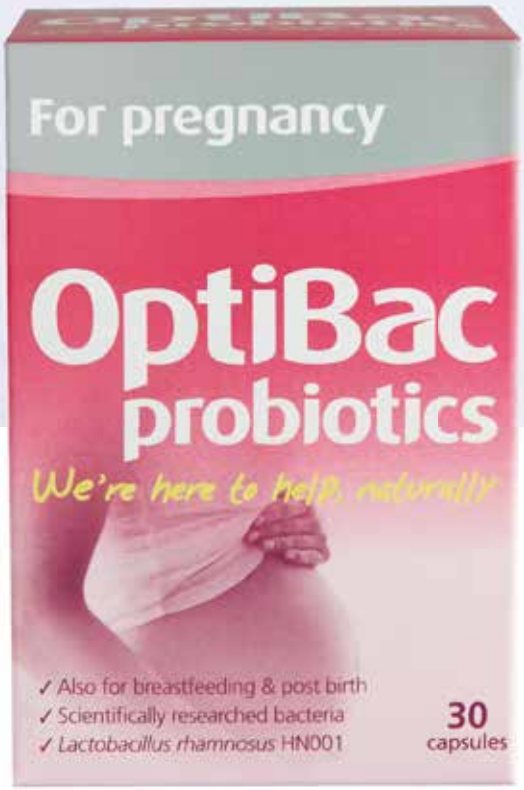

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