Malta Midwives' Journal

Malta Midwives Association
Issue 19

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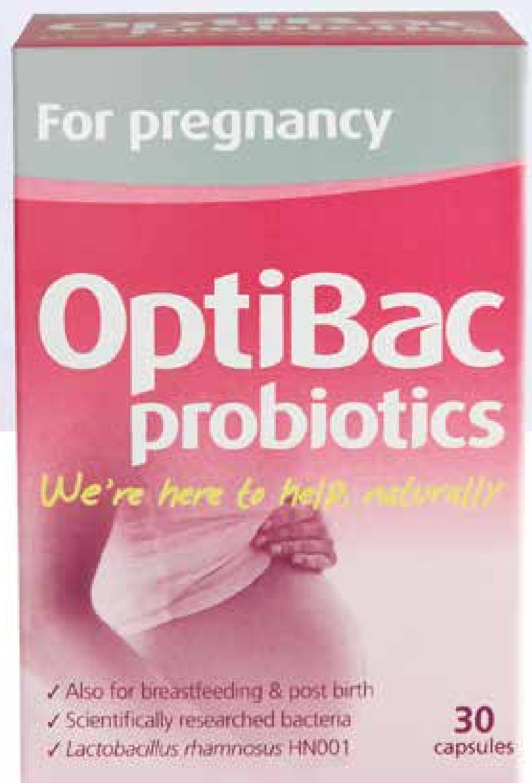

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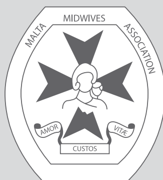

62, Office 1, Triq il-Kunċizzjoni, Msida MSD 1839

Editor
Pauline Fenech

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

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Cover Photo:
Censina Deschrjver & Maria Spiteri Staines

Editorial

Welcome to the 19th edition of the Malta Midwives Journal. It is the start of a new year and we were hoping to be returning to pre-pandemic living. There has been a perceptibly cautious progress that the threat of the COVID-19 virus is coming to an end. But apparently this is not the case as the numbers are showing otherwise. It has certainly felt a different year from what we were used to in pre-COVID-19 time. Meanwhile, MMA acknowledges how hard it is to provide midwifery care in a health system as the pandemic continues.

How the marketing of formula milk influences our decisions on infant feeding

The World Health Organisation (WHO) and the United Nations Children's Fund UNICEF) issued a report on: How the marketing of formula milk influences our decisions on infant feeding (2022). This report draws on the experiences of over 8,500 and 300 health professionals across eight countries on the aggressive marketing practices used by the formula milk industry. This report highlights how the marketing of commercial milk formula influences and impacts the families' decision on how to feed their babies and young children. Formula milk marketing is powered by enormous budgets and the deliberate misuse of science. This report describes how marketing of commercial formula is driving over-consumption of formula milk and discouraging breastfeeding. It is also undermining women's confidence and cynically exploiting parents' instinct to naturally feed their infants.

The report draws attention on the State of the World's Midwifery Report, 2021 and the Strategic Direction for Nursing and Midwifery Report, 2021 which emphasises that midwives are the main providers of care for women, newborns and their families before, during and after pregnancy. Advice to women on breastfeeding and formula milk is not just limited to the time of birth, but is provided throughout the reproductive continuum.

Formula milk has its place for those women and parents who are not able or do not want to breastfeed, often the result of other factors – such as employment - that are not supportive of breastfeeding.

As breastfeeding/marketing of formula milk is a quality of midwifery education and care priority, this is clearly part of the WHO-UNFPA-ICM Framework for Action/7-step Action Plan for strengthening quality midwifery education:

- Step 1: Midwifery Leadership – improving breastfeeding /addressing marketing of formula milk is a key activity for all leaders
- Step 2: Gather data and evidence on midwifery – understanding what is going on with breastfeeding/marketing formula milk is a key deliverable
- Step 7: Monitor and evaluate – what is the baseline, what is changing and how are we measuring this from a midwifery perspective?

This report clearly lays out the issues at stake and points to the actions needed to protect infants and families, from robust domestic legislation, to responding to digital marketing practices, to highlighting the need for broader investments in breastfeeding.

Reference

Strengthening quality midwifery education for Universal Health Coverage 2030: Framework for action. (2019). https://www.who.int/publications/i/item/9789241515849

World Health Organization and the United Nations Children's Fund (UNICEF), 2022 ISBN (WHO) 978-92-4-004460-9 (electronic version)

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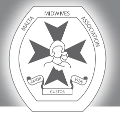


Message from the President

Dear member,

We are at the beginning of a new year! We never thought that we will still be living through a pandemic! It has been over two years already since the first reported case of COVID-19 infection in Malta. During these unprecedented times, the midwife was amongst the front liners and contributed towards the provision of outstanding care to women and their families. With so much going on in our lives, at work and around the world, we can easily suffer from physical and/or psychological ill health. Thus, it is important that we develop ways of self therapy to balance our thoughts and find ways to cultivate positive attitudes. Surrounding ourselves with positive persons, having role models that inspire us, reading books, allowing time during the day for excercise or taking up a hobby are ways to safeguard our mental health and wellbeing.

Activities

With this in mind, MMA will be organising three events:

- the half day activity for Lent on the 7th April;
- an Easter Egg Hunt Picnic on the 17th April; and
- a main event on 5th May. Yes, we are also planning the long awaited activity that commemorates the midwife. MMA looks forward to welcoming many midwives to meet and socialize on Midwives' Day – 5th May.

Details of these events can be found on MMA website. We encourage you to book through the website. The booking system helps us effectively and efficiently plan the events. We look forward to meeting you all!

Annual General Meeting

On the 25 February, MMA held its Annual General meeting. This was held virtually because of the COVID-19 restrictions and attendees were provided with a free meal. This was delivered at their home. Committee members reported on the main events that were held during the past year and the Treasurer updated us with the Financial report. All reports were endorsed. Of particular significance was the updating of the Statute. During the discussion, several important and valid points were discussed and debated. These points will be included in the draft that was tabled during the meeting. The Statute, as updated during the AGM, will be presented once again during an Extraordinary General Meeting. This extraordinary meeting will be called during the coming months and members will be asked to approve the new Statute.

For this year, MMA has plans to hold several educational activities for its members. Keeping ourselves updated on innovative midwifery practices and learning new midwifery skills will enrich the profession. The Committee works very hard to hold these sessions and offer them at a subsidised rate, or for free, for members. We encourage you to look out for these activities and participate.

I take the opportunity to thank the two midwives who ended their term in the Committee, Ms Daniela Buttigieg and Ms Gabrielle Grixti, for their outstanding work. Both of them have had a positive impact, and collaborated and contributed towards the advancement of the Association. Thank you and good luck for your future endevours!

The Committee welcomes back Ms Marie Borg Barthet, who has the role of secretary and new Committee member Ms Alison Bugeja who will be responsible for the website.The website will once again go through further developments this year. For this reason, just as it did last year, MMA applied to the Summer Student Programme Scheme for Voluntary Organisations. This involves a considerable amount of co-ordinated work but we are determined to continue to improve on the existent website.

Finally, this is the 19th edition of this journal. When I first started this journey as editor, little did I think on how this will develop. My aim was to share knowledge and to encourage midwives to research topics to update and change practices. This could not have been possible without the contributions of several midwives. I wholeheartedly thank those midwives who willing share their knowledge and provide articles for publication. Over the years, the journal has gone through several changes and I hope that we will continue to ameliorate this publication, in order to reflect the academic standard of the Maltese midwife.

Take care and keep safe.

Pauline Fenech

Executive Committee 2022/23

Pauline Fenech
President

Mary Buttigieg Said
Vice President

Marie Borg Barthet
Secretary

Doris Grima
Treasurer

Laura Calleja
Public Relations Officer

Pauline Borg
Educational Activities

Danika Bilocca
Social Activities

Bernice Scicluna
Childbirth Education

Alison Bugeja
Website

Treasurer's Message

I wish to kick off by thanking our colleague Daniela Buttigieg for her sterling service, as Treasurer for the past year. Quite frankly she improved a lot of things and has made life easier for her successors, meaning me! Payments can now be made through the MMA website and hence the handling of cash has been eliminated. Meaning there is now more transparency and a great deal of time has been saved. I would also like to thank the new committee members for having, once again, trusted me with this task.

As we are all aware, the past two years have been a great challenge for all organisations and businesses since the Covid-19 pandemic negatively impacted all services. However, despite the challenge, the financial impact was softened, although it could not be totally eliminated. We managed to cushion the losses by shifting services to an on-line mode. Several courses were still held but at the same time, a noticebale decrease in participation was noticed, as was to be expected. Also, the personal touch, a trade-mark of our services, was missing. Hopefully we will soon be able to revert to utillising our premises.

The Committee has also taken the opportunity to upgrade the premises. Here also thanks to the myriad of ideas that the Committee members came up with to make the premises more welcoming.

The MMA can only thrive if the Committee members continue to offer their voluntary input. All roles have their own particular challenge, but one of our biggest challenges is to keep this organisation financially afloat. That is why we depend on your particiaption in the educational and also social events that we organise. The courses offered to our clients are a good source of income. However this has to be supplemented by funding through the memership fee and your participation in social events.

The costs are not light. The main costs are

(a) the rent for the two premises runs into thousands of euro a year, even though it is a discounted rent;
(b) ARMS bills - only one office-space could be serviced by photovoltaic panels;
(c) mainenance and regular cleanliness; and
(d) professional fees as, quite rightly, NGOs are today heavily regulated to ensure good governance.

The Midwives' Day event, which, God willing, be held again this year following a two-year absence, including the occasional gifts distributed to midwives, also come at a cost.

The Committee is not afraid of the challenges. However midwives' support is essential. We would like to see greater participation, be it in the educational and scoial events, as well as participation in the organisational structure of the Associaiton. But we also appeal to all midwives to pay up their membership fee. That is the minimum that is expected of our colleagues.

I have been out of contact with most of you since my retirement. So this is a good occasion to wish you all, best of health and best regards to you and yours.

Doris Grima

European Midwives Association

Statement of support for women and midwives in Ukraine

Dear friends, dear colleagues, dear midwives,

The 24th of February 2022, war has struck Ukraine, we were petrified. A humanitarian tragedy is unfolding.

We are so grateful that countries along the borders of Ukraine have opened their borders to protect and comfort the thousands fleeing their homes. Citizens from countries further away from the conflict zone are getting ready to help. Behind these numbers, there is huge suffering, fear, shattered dreams, separated families and desperate farewells. Women and children are often the first victims in armed conflict. Ukrainian mothers are now giving birth in shelters and metro stations during air raids.

EMA hopes that the rights of civilians will be respected at all times. That Peace will push back the brute force of arms. That intelligence and humanity will stop this madness.

We know that health professionals, the midwives will, as they always have, protect and care for the women and families fleeing war. The European Midwives Association will do everything it can to support their colleagues during these difficult times and forward the voices of the midwives involved in this turmoil.

With all our hearts

Agnes Simon
President of the European Midwives Association

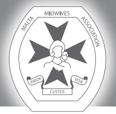
Melania Tudose
Vice-president of the European Midwives Association

Joeri Vermeulen
Secretary of the European Midwives Association

Eva Matintupa
Treasurer of the European Midwives Association

Gergana Nikolova
Board member of the European Midwives Association

Burçu Yurtsal
Board member of the European Midwives Association



Medicalisation of Infant Feeding

Introduction

The medicalisation of infant feeding is contributing to the demise of breastfeeding and the increase in overfeeding. Babies at the breast are mostly able to self-regulate their intake unlike with a bottlefeed, where the care giver is generally the controller. Fearing poor breastfeeding has led many health professionals to distrust infant behaviour and, rather than observe and assess feeding, a regime of measuring, timing and charting are generally implemented based on a prescribed and dictated regime (Li et al., 2010). With newborns such regimes do allow cluster feeding before the stipulated time. However these do not allow infants to go beyond a 3-hour period without feeding. This is a common documented form of overfeeding (Watchmaker et al., 2020).

Obesity is a serious public health problem with more than 2 million overweight or obese children worldwide (Skinner et al., 2018). One of the most important factors that predicts overweight in childhood and adulthood is early growth. Rapid weight gain in early life due to improper feeding practices increases the risk of being obese at the age of three by fourfold (Weng et al., 2013). Overeating can be learnt in infancy as early as the first day of life, so it is becoming more and more imperative that postnatal care focuses on teaching parents the skills on interpreting their infants' cues rather than timed interval feedings (Woo et al., 2016).

Overfeeding

Unfortunately, both health professionals and parents do not consider that young infants can be overfed. The focus on feeding infants has become a coercion to target milk consumption, timed feeds and/or achieve certain behaviours which generally leads to overfeeding. The focus of infant feeding to parents should be that of nurturing, feeding a baby is not just an act of putting milk in his/her stomach it should be close, intimate and interactive. Ideally parents should learn to recognise and distinguish hunger from other stress cues whilst engaging in the use of soothing techniques to manage crying. Food should not be the first response to all crying. Rarely infant cues are well interpreted, and caregivers make assumptions of feeding frequencies and volumes along with 'good' baby behaviours (Savage et al., 2018).

If newborns are not fed frequently enough they are at high risk of underfeeding but as babies experience fluctuations in their energy requirements, cue feeding makes it easier for infants to increase or decrease their intake as needed. Milk supply and milk quality also varies throughout the day and babies have days of accelerated growth which need additional energy intake. Demand feeding helps the baby cope with these challenges (McNally et al., 2016).

Breastfeeding

Spencer & Fraser (2018) conducted a phenomenological study using in depth interviews to explore women's views of their breastfeeding experience. Mothers described feelings of being pressured, judged and scrutinised with regards to breastfeeding. Health professionals were described as being obsessed with weight loss and gain and mothers felt their bodies were incapable of providing for their infants. Mothers also expressed their dislike of hands-on help. Having a health professional touching them especially their breasts, without asking for permission first, was seen to be intrusive and distressing. (Spencer & Fraser., 2018).

Leaving mothers feeling stressed, anxious and doubtful interferes with oxytocin release and in turn with breastfeeding. Care should be focused on self-efficacy, teaching mothers normal newborn behaviour, normal sleep patterns, how to soothe newborns and the intense needs of a newborn. By understanding normal infants, mothers and health professionals can more easily identify actual problems rather than create them (Palmer, 2012).

Responsive Feeding

Although many health professionals consider that babies should be fed on demand it is common that this demand is thought to be at 3 hourly intervals. This follows 'nest' mammal behaviour where the mother leaves and returns to the nest to feed after several hours having milk high in fat and protein. Humans are 'carry' mammals meaning that they are still immature and totally dependent on their mother for food, warmth and safety. The milk of carry mammals is low in fat

and protein causing the infant to feed frequently (Konner, 2005). Therefore, it is expected that newborn human infants will naturally need to feed little and often. However, the 3 hourly rule has created normal newborn behaviour to be abnormal and in turn leaves mothers concerned that there is something wrong when the baby needs to feed more frequently.

One of the signs of a healthy, well newborn is the ability to suck which is integrated as a reflex action. Any object that exerts pressure on certain areas in the baby's mouth will involuntary trigger sucking action. However, in general, newborns do not actually know if they are hungry, uncomfortable or frightened; they just know that sucking makes them feel better. Parents and even many health professionals tend to interpret any crying as a sign of hunger. The baby becomes relaxed through suckling, readily accepts feeding when distressed, validating the interpretation of hunger. It has become incredibly common for parents to use feeding as the only means of soothing the baby (Ventura et al., 2021)

Bottlefeeding has been marketed as a freedom ticket; its quick and anyone can give a feed. Fast feeding will

cause overfeeding as the stomach does not have time to signal that it is full, just as in the case with adults. It is up to health professionals to change the method of bottlefeeding to be interactive and slower. Paced bottlefeeding, when done properly, gives a slower, relaxed feed and should be how all babies are fed when using a bottle. Paced bottlefeeding with the bottle in a horizontal position rather than upright allows the baby much more control over feeding, allowing for breathing pauses rather than piston feeding in response to stimulation of the sucking reflex and a fast flow of milk. Quantities on tins should be viewed as a guide, and many babies grow appropriately and are satisfied drinking smaller volumes especially if they prefer to feed more often than the number of feeds recommended on the tin. It is quite common that recommended volumes shown in large print are adhered to but the smaller print that gives the weight that amount is based on and the number of feeds in 24 hours is frequently ignored (Ventura et al., 2021).

Conclusion

Whilst feeding a baby can be viewed as a naturally occurring behaviour following childbirth, realistically it has been complicated by numerous medical, social and cultural factors. Midwives and nurses caring for new families should provide consistent evidence-based advice rather than continue with a myriad of different systems according to the individual carer. It is time that the focus of supporting new parents with infant feeding become based on helping them to understand and respond to their infant's cues. Parents should be encouraged to look at their baby, recognise his or her needs and respond appropriately. This will help to increase confidence and promote positive interactions. In turn this helps infant feeding to be a close and intimate, focused on nurturing rather than weight gain and other medical issues.

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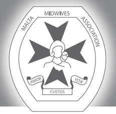
Helen Borg
RM, MSc, IBCLC



Providing Care with Compassion

Ask the woman, she will tell you everything you need to know.
- Ina May Gaskin

Over the last decade we have heard and read how compassionate care should be at the heart of high quality, person-centered care. The importance of providing compassionate care has been extolled as a cornerstone of quality healthcare by clients, families, healthcare professionals and policy makers alike. In fact, explicit reference to compassion as a fundamental professional value has been noted by some professional bodies including local ones (Council for Nurses and Midwives Malta, 2020; Nursing and Midwifery Council, 2010 and World Health Organization, 2016).

If we had to ask a healthcare professional why they chose this career path, most will probably say it is because they love to help and care for others. The idea of healthcare professionals being there to fix and help their clients is a far cry from what we should be doing. In fixing and helping our clients we are implying that we are in control, our clients are helpless and that they can come to us and we can provide them with a quick fix for their symptoms and/or condition. Although this kind of attitude may help in some cases, for most medical issues this will not benefit the client. Instead we should focus on serving our clients whereby we shift the power relationship. It's the patient who will set out the agenda and we, as well trained professionals, will use our experience, skills and expertise to serve our clients. Serving is divergent from helping. Helping is not a relationship between equals. A helper may perceive others as weaker than them, needier than they are, and clients often feel this inequality (Remen, 1999).

In order to do this we must be humble enough to understand and believe that the client is in fact in possession of their own healing power. Rather than just focusing on the problem and best treatment to cure it we must listen actively and deeply and let go of our judgements. We must see each client as a human being full of capacity for health, healing, wellbeing and resilience. Shifting our focus to the strengths of our client. Moving away from the belief that we have to fix patients, when in fact certain things cannot be fixed (Youngson, 2012).

This reminds me of a personal experience I had a few years ago whilst caring for a woman in labour whose epidural was not working; even though it was sited twice and several top-ups were given. The woman was very distressed and my whole focus was on getting the epidural to work as I believed this was what the woman needed at the time and that only a good epidural block will help her to cope with her contractions. The anaesthetist did come and review the woman however after explaining that they did all they can do with regards to getting the epidural to work and this seems to have been unsuccessful, she took the time to sit next to the her, held her hand and empowered her by telling her that she is doing a great job and that although we are not able to take all the pain away she is strong and we will support her to pass through this.

I was very skeptical about this interaction as although I appreciated the care and compassion that the anaesthetist was providing I felt that this woman needed a working epidural more than anything. However, what followed had surprised me as the woman looked calmer and coping better. As I reflected on this I realised that many women are not disappointed if we are not able to 'fix' things or require medical interventions as long as the healthcare professionals show respect, empathy, compassion and communicate honestly. All it took was a few minutes of sitting down and speaking to the woman, getting to know her and discussing her needs. This might have looked like time consuming to me as we weren't actively doing something to help alleviate her discomforts but in fact we were doing exactly that by slowing down, sitting next to her and listening. Compassion is a powerful intervention.

A qualitative study by Menage, Bailey, Lees and Coad (2020) that examined women's lived experience of receiving compassionate care from midwives brought light to the fact that the participants were able to easily identify compassionate care and this had a positive effect for relieving their suffering. The authors described three themes that represented the ways in which women experienced compassion from midwives. 'Being with' and 'in tune' with the woman's wishes was an important theme highlighted by the participants. Moreover, the authors talked about how women also reported empowering interactions helped women to feel the midwives' compassion. These included, information giving, teaching and guiding women in a non-authoritarian way. The findings of this study also suggest that compassion was experienced through the midwife's ability to balance the conflicting demands or competing factors or paradoxes around childbirth and maternity care.

Patterson, Hollins Martin & Karatzias (2019), who researched women's and midwives' experiences related to traumatic births describes how the strongest predictors for the development of post traumatic stress disorder following childbirth are interpersonal factors, with a woman's negative perception of interacting with her healthcare providers being significant. The participants in the study explained how they sometimes felt threatened by midwives, either physically or verbally, leaving them feeling fearful for their safety and of their baby. This came as a surprise to these women who could not believe that being in a hospital which is perceived as a place of safety left them feeling this way and shattered their thrust irrespective of the process and outcome of birth. On the other hand, midwives also reported unrelenting workplace pressures together with undermining and unsupportive behaviors by their colleagues. This left the midwives in this study feeling 'torn in two' between the importance of 'being with' women and meeting their needs and meeting the exigencies and expectations of

the organisation and their colleagues. An emphasis is made on the importance of having the correct and timely support for employees who experience clinically challenging or traumatic events.

As we can see, both studies (Meange et al., 2020 & Patterson et al., 2019) highlight the basic human need for connection, respect and to feel safe and well supported. We are well aware that childbirth intensifies these needs as it is a time of great vulnerability; physiologically and psychologically.

As midwives we also work in a complex risk-focused maternity service which feeds fear for both the woman seeking safety and the midwife responsible for maintaining safety. Both students and newly qualified midwives are passionate about providing positive experiences for women and their families within the context of keeping them safe (Davies & Coldridge, 2018). However, midwifery is a highly demanding job both physically and emotionally. International studies have reported worrying levels of stress, burnout and depression amongst midwives. When midwives are passing through difficult periods they will be inhibited in responding to the emotional needs of others. This may result in midwives detaching themselves emotionally and although will provide appropriate levels of care and interventions this kind of care is not particularly characterized by engagement, individual response, generosity and trust.

You can't pour from an empty cup.

We work in an environment that praises hard work and productivity, celebrating the idea of 'soldering on'. Self-care is very important. We are often highly critical of ourselves. If we learn to be kind and forgiving towards ourselves, we will soften our exterior too. We must not neglect ourselves to rush and help others. We need to make balanced life choices to ensure we have enough time to spend with our friends and families, doing activities we enjoy. Sometimes looking after yourself is the best gift you can give to others. Kindness is contagious. If as colleagues we bring an intention of caring, compassion and kindness to our colleagues the whole workplace culture can change for the better. Getting the right level of support and empathy from colleagues and the organisation helps midwives to deal with emotional stress better (Cankaya, Aksoy & Yilmaz, 2021 & Sheen, Slade & Spiby, 2014).

The good thing is that everyone is able to provide compassionate care, do not worry if you are an inexperienced student or midwife you have a fully formed heart and a capacity for compassion and caring. Even if you feel uncertain of your technical knowledge and skills, compassionate caring can influence patient outcomes as much as medical treatment (Youngson, 2012). In fact from my experience, young midwives are generally the most compassionate as they are full of enthusiasm on embarking on their new role. As years pass some might struggle to maintain the same level of compassion as they might succumb to the exhaustion and cynicism of their colleagues.

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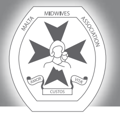

The Contribution of Midwives to Environmental Sustainability

Introduction

Midwifery gives me the opportunity to touch the future with my own hands every minute of the day. In my daily work, when I hold a baby, I feel I am holding the future. Their twinkling eyes and tiny hands, hold our hope for a better future. But, is their future being threatened by our daily actions? Are we ensuring to leave them a better world than we have been handled by our parents?

1.1 The role of midwives in reducing plastic pollution

There are several threats to the world as we know it. One of this is plastic pollution or the accumulation of non-biodegradable plastic objects and particles in the Earth's environment, which negatively affects the habitats, wildlife and eventually humans. This is particularly significant in our marine environment, with approximately 99% of microplastics finding their way into the seas and oceans (OSPAR,2017). Although the health impact of plastic pollution, especially of microplastics and polycarbonate plastics (e.g., bisphenol A) is unknown (WHO, 2019), there is limited evidence of plastic-associated cancer marine wildlife, intrauterine foetuses and in adults (Meyer-Rochow, 2015).

The health care organisations and industry are partly to blame for the single-use of plastic. For example, a case study of single use infant formula bottles in an Irish maternity hospital found, that there are several challenges but also opportunities for the reduction of single use plastics in healthcare (Leissner et al., 2019). Midwives have an important contribution in reducing plastic pollution. These are some practical examples of how we can achieve this goal:

As midwives or nurses working in maternity wards, we meet new parents during the maternity period who are keen for our advice. During parentcraft classes, we can advise the to-be parents to prepare their hospital bag with biodegradable products (e.g., cotton wool) and reduce the use of non-biodegradable plastics and products, such as wipes. Moreover, we could encourage them to use washable nappies rather than plastic non-degradable nappies, knowing that they may take hundreds of years to decompose and may end up in our marine habitats causing massive damage to sea life. Other produces that can be promoted are washable pads to mothers.

In maternity wards, midwives can encourage the appropriate separation of waste especially of plastic products which can be properly recycled. Alternatively, midwives can lobby for the reintroduction of glass bottles, for example intravenous glass bottles that can be recollected, resterilised and reused. As any other health care staff, midwives can promote recycling practices by encouraging the hospital organisation to use washable cutlery and plates or water dispensers in staff rooms; thereby reducing the use of single-use plastic bottles and products.

Lately, a positive initiative in our maternity wards was taken, to encourage parent to bring their own bottles for bottle feeding thereby reducing the use of prefilled bottles. An alternative practice could to ask parents to bring their own powdered milk. In this way, besides reducing prefilled bottles provided by the hospital, parents who wish to introduce artificial milk, can be

- Be aware of the scientific consensus that global climate change is occurring and that human behaviours are making significant contributions.
- Incorporate the health implications of climate change for childbearing communities into midwifery education and professional development.
- Recognise the importance of midwifery input in climate change policymaking at national, regional, and global levels and aim to achieve representation wherever possible.
- Encourage government agencies to strengthen public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently within childbearing communities.
- Encourage midwives to serve as role models for promoting environmental sustainability and play an active role in educating women and their families on sustainable practices.
- Conduct research to further inform the climate change agenda in relation to both midwifery practice and the impact of climate change on the childbearing community.

Table 1. Recommendations from the position statement on the impact of climate change by the International Confederation of Midwives (ICM)

taught how to prepare a bottle using their preferred milk powder in the hospital.

Becker and Ryan-Fogarty (2019) argued over 60% of the ready-to-use breast feeding substitutes purchased at maternity services remain unconsumed and end up being wasted. Together with the increased use of plastic teats and packaging, breast feeding milk substitutes increase environmental and plastic pollution. Consequently, she argues that one way how to reduce this environmental impact of infant feeding is by promoting and supporting exclusive breastfeeding. Breastfeeding is the most environmental food on the planet as it produces 'zero' waste for its production. Since there may be reasons why this is not possible, viable alternative solutions to reduce environmental effects of infant feeding are needed, like the measures highlighted above, to reduce demand and waste of plastic and waste of infant products.

1.2 The role of midwives on climate change

The increase carbon foot-print, partly released by burning fossil fuels, causing an increase in greenhouse gas emissions, that are changing the climate and increasing global temperatures which are estimated to rise by at least 1.5 degrees Celsius by 2030. This global warming already having a devastating impact on climate change with heatwaves, floods and droughts becoming more common and intense. This will subsequently have a considerable effect on global health in view of its effect on social and environmental determinants of health such as clean air, safe drinking water, sufficient food and shelter. However, with immediate action, it is possible to reduce and possibly reverse these negative outcomes and improve global health. According to the WHO (2021), it is estimated that between 2030-2050, climate change is expected to cause approximately 250 000 additional deaths per year, from malnutrition, malaria, diarrhoea and heat stress.

What is the role of midwives on climate change? On the occasion of the COP26 Summit (from 31-10-21 to 12-11-21), the International Confederation of Midwives (ICM, 2021) issued a position statement that highlighted impact of climate change on women, new-borns, the family and midwives and identified a number of recommendations to member associations, summarised in Table 1.

Based on the above recommendations, there are a number of practical strategies and initiatives by midwives to act as role models, promote environmental sustainability and reduce climate change. Similar to the Nursing department at the University of Malta, the Midwifery Department can commit themselves to prepare midwifery students to address the current threats and health issues by including this in their educational curriculum. Moreover, professional development to qualified midwives, need to be organised to increase awareness about the effect of climate change and sensitize them about what they can do and how they can contribute. The use of scenario-based learning significantly improved nurses and midwifery students' knowledge and attitudes towards climate change in a UK university school of nursing and midwifery (Richardson et al., 2017). Locally, as part of the International Nurses' Day of 2019, the Department of Nursing at the University of Malta, organised an event to increase awareness about the challenge of climate change to nurses in Malta. Similarly, midwives in Malta, need to be proactive and champion this cause by raising awareness across the profession.

Midwives can make small but important changes that can make a big difference to environmental sustainability and climate change. One approach is to always reflect about the use of plastic gloves and other protective equipment and whether they are justifiable or not. It is evident that the Covid-19 pandemic has increased substantially the use of single-use gloves and masks. It is important that whilst midwives take all the necessary measures to maintain infection control principles, overuse of these products is prevented and they are disposed of appropriately.

Midwives can also think of ways how to do engage in recycling initiatives. For example, bottle caps of bottles

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and saline bottles can be easily recycled. Moreover, they can participate in energy-saving initiatives; for example, by making sure to adjust the air conditioner's temperature to a higher temperature, unplugging electronic equipment and appliances when not in use and switching to renewable sources. It is encouraging that the cars used by the Discharge Liaison Midwives (DLM) to visit parents, are now electric cars. However, health care professionals, including midwives can support the reduction of carbon footprint by changing our transport practices through car-pooling or using other means of transport to go to work. This requires a considerable culture change in our Maltese context where we are so much used to travelling using our private cars.

Besides the emission of carbon dioxide, increasing the carbon foot-print, another gas implicated in climate change, is nitrous oxide which is used in anaesthesia in surgery and by women during labour in the form of Entonox (nitrous oxide and oxygen) Nitrous oxide is 300 times more potent as a greenhouse gas than carbon dioxide. Consequently, efforts need to be made to reduce the use of Entonox. Midwives can contribute to identify alternative types of pain relief including the use of non-pharmacological interventions such as the use of water in labour. Besides, the use of Entonox during labour has also other negative effect on the mother's health such as nausea, vomiting, dizziness and drowsiness (Likis et al., 2014). Whilst, the use of Entonox is well established in the management of labour pain, a greater awareness about the environment may ensure that alternative measures are utilised.

Conclusion

Midwives have an important contribution to environmental sustainability through the reduction in plastic pollution and reducing the effects of climate change. By doing small changes in the way we practice at work and at home, we can make a big impact on environmental sustainability. Moreover, we can act as role models to teach and support parents and the general public to become environmentally friendly, reduce the carbon footprint and plastic pollution and reuse, reduce or recycle; thereby encouraging a circular economy. In this way we can ensure a better world for our children.

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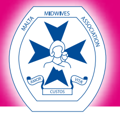
Audrey Scerri
Dip. Midwifery, SSRM

Anthony Scerri
Ph. D (Melit). M. Sc.
HSM (Melit) M. Ger (Melit)
B. Sc (Hons), SRN.



2020 perinatal statistics

Nationality:
69.4% of mothers of Maltese Nationality
30.5% of mothers of non-Maltese Nationality

140 mothers used Assisted Reproductive Technologies

6.9% babies born preterm (<37 weeks)
1.3% babies born very/extremely preterm (<32 weeks)

Mean birth weight - 3205g
Macrosomia - 0.4% (4.5kg and over)

ONSET OF LABOUR:

SPONTANEOUS ONSET **57.4%**

INDUCTION OF LABOUR **26.7%**

ELECTIVE CAESAREAN SECTION **15.9%**

62.3% Normal Vaginal Births

2 births at other sites then transferred to hospital

4469 births (99.7%) occurred in a hospital

10 homebirths

49% of babies breastfeeding exclusively on discharge

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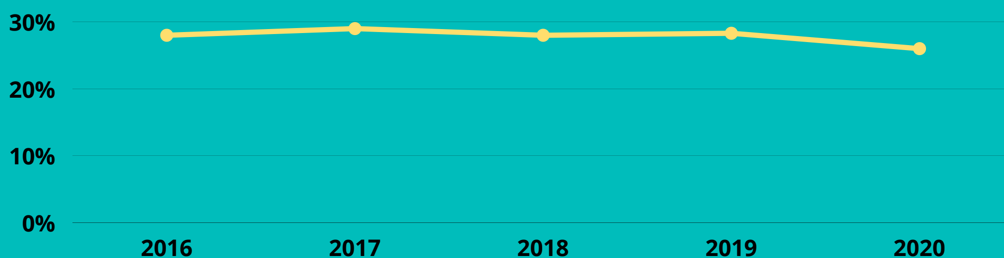
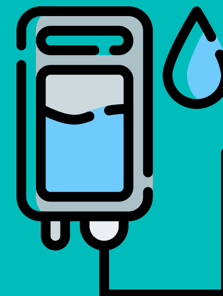
GENDER DISTRIBUTION:

48% FEMALE 52% MALE

Birth interventions - over 5 years

INDUCTION OF LABOUR





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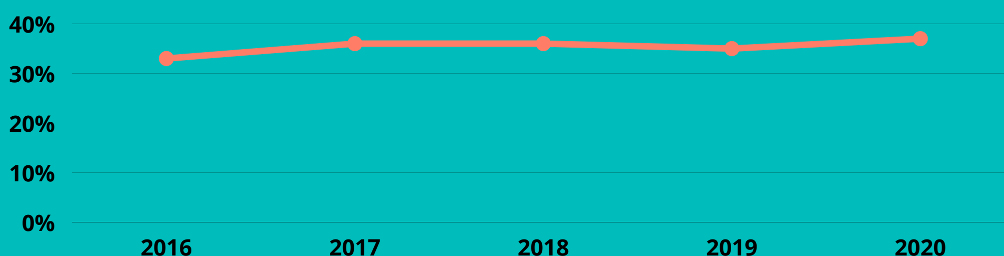

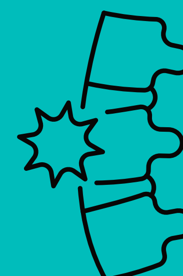

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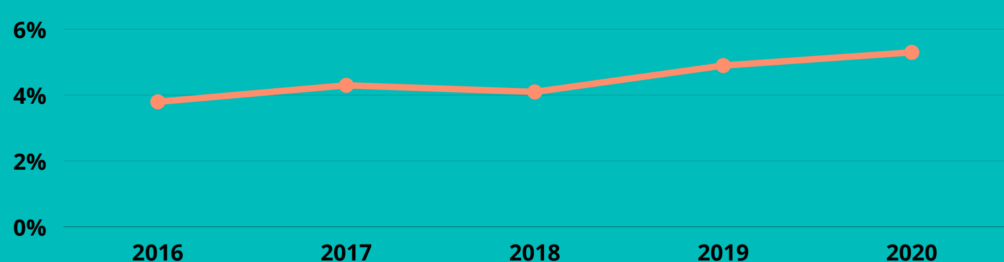
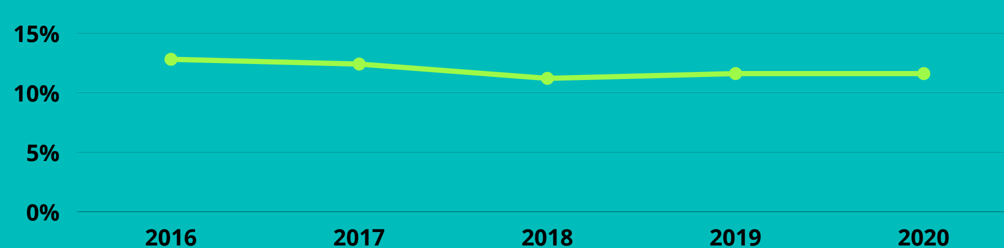
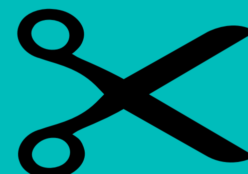
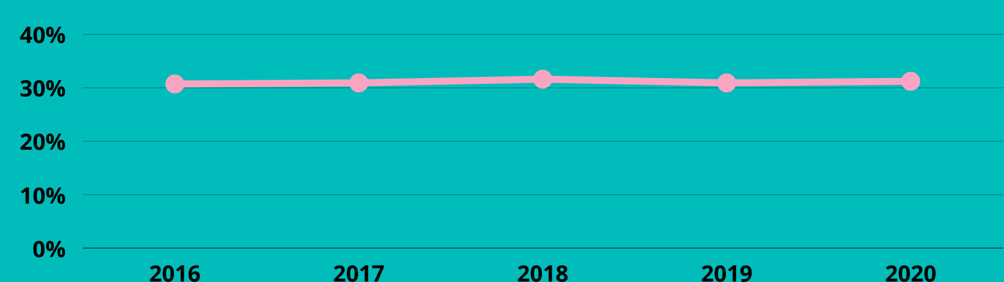


EPISIOTOMY





CAESAREAN SECTION



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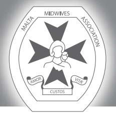

Withdrawal and Withholding of Care in the Neonatal Intensive Care Setting

Over the last decades, there have been significant advances in medicine worldwide that are permitting the survival of more neonates born at risk[1-5]. Several of these, however, remain dependent on medical technology or overtly fragile, often requiring repeated admissions and treatment, creating ethical conflict[6,7]. Notwithstanding the increase in the use of aggressive treatments, the outcome for some of these infants is still feeble[3,8-9].

The Neonatal Intensive Care Unit faces a certain degree of complexity, as well as uncertainty, regarding the treatment and care of these critically ill babies[6]. This reality brings up serious ethical questions that healthcare professionals providing care in the Neonatal Intensive Care Unit have to face[10,11]. Ethical principles, as they were known, have become far outdated due to the technology available nowadays, particularly in the Neonatal Intensive Care Unit[3,8].

Within the NICU, the majority of deaths are due to decisions to withdraw treatment or life support[12-15]. The contentiousness of these decisions comes from the fact that these infants might survive with the treatment provided, albeit with great difficulties and a reduced quality of life[13]. Whether life is worth living or not is controversial and, at times, confusing as a concept.

Ethical and moral debates have arisen regarding the prolongation of life due to overtreatment and the quality of life obtained, delving into the futility and viability of the treatment plans when considering the best interests of the neonate[9-11]. Parents and relatives have become more dependent on these same technologies and may fail to see the deterioration and frailty of their child in these situations[16].

In certain instances, it would not be appropriate to continue to attempt all that is medically possible, and the focus of treatment should be redirected towards the well-being of the patient in their current situation, rather than at the prolongation of life whatever the cost.[12-13]. Nevertheless, until recently, even though these issues are hugely debated, there has been a very limited amount of knowledge regarding what the actual practices in such situations are and what governs these practices[5,17].

Over the years, different controversies and debates were brought up on the subject. The 'pro-life' perspective states that human life must be protected at all costs because a life with disabilities or impairments is better than no life at all and any practice that brings about death is not ethically justified. On the other end of the spectrum is the 'quality of life' perspective based on probability of survival and quality of life which includes practices of both withholding at birth, or withdrawing at a later stage.

The quality of life perspective in itself must balance out against the burdens of life where, decisions may be taken to withdraw treatment when it is presumed that the burdens of life would be more than the benefits. There might be situations where it would not be appropriate to continue to attempt all that is medically possible and that the focus of treatment should be the wellbeing of the patient in their current situation rather than at prolonging life whatever the cost.

This led to the idea that some conditions of existence are worse than death, and the leading principle in all decisions relating to withdrawal of care in the neonatal intensive care was said to be the best interests of the neonate, creating a shift from disease-oriented care to patient-oriented care.

Several studies started out, where the perception was that intensive care and treatment was at times carried on for too long. Overtreatment can be as detrimental to under-treating a patient in some cases, as the disease in itself will still lead to death inevitably sooner or later. A distinction between ordinary treatment, defined as routine, readily accessible, affordable and acceptable as not imposing a burden on the patient; and extraordinary treatment defined as invasive, dangerous, painful, difficult to access and not known to provide particular benefit respectively must be made.

An integrated model of palliative care which can be used concurrently with curative-oriented treatment has been suggested to emphasise the importance of palliative care in the intensive care setting with the hope of its inclusion earlier on[18]. Individualised decision-making on clinical condition is increasingly insisted upon in the literature, with arguments that having a cut-off (zero-line view) based on estimated gestational age is not accurate or ethically just with regards to the neonate[19-21].

Research suggests developing a threshold view for withdrawal of care, similar to the classification of treatment for premature infants, where treatment is considered mandatory above a certain weight or gestation, unreasonable below a certain weight or gestation and optional in between, depending on the circumstances[13].

The infant's quality of life in the former instances is a motivator and accepted justification, as the neonates' best interests appears to have a significant effect on health professionals' actions[21,22]. Neurological impairments

related to congenital abnormalities or asphyxia are often considered of a greater consequence leading to increase in limitation of treatment in such cases. This is not the case with pre-term infants, since healthcare professionals are less likely to withhold treatment[1,23]. Withholding tube feeding is also not often documented in the literature, as well as being dubbed as psychologically burdensome on all involved[24]. While religious background, personal values and situational factors play an important role towards attitude regarding end-of-life decisions[10].

Many healthcare professionals are also reluctant to perform resuscitation against parental wishes for a preterm born at 24 weeks of gestational age with low heart rate and Apgar. They are often also likely to change their perspective and agree to parents' decision should the infants' condition deteriorate, be it a case of prematurity, mental disability or physical disability. This parental involvement and higher acceptance of inclusion of parents in decision-making have also increased between earlier and more recent studies[23,25].

Proper training and education on such case scenarios could improve the emotional well-being of the professionals involved and the effects on their personal lives[17,26,27]. Decision-making becomes a personal decision without appropriate precise regulations etc[22]. Physicians came up with own standards for decision-making in the absence of official ones[1,11,28]. The presence of numerous guidelines, rather than specific instructions, increases dilemmas for healthcare professionals[29].

Currently, end-of-life care and practices are steadily becoming very important, and no longer just mentionable. Therefore they hold a prominent place in today's clinical research, stressing the need for further research and educational opportunities on the subject[26]. Available therapies and clinical facilities, together with previous outcomes and staff experience, should serve as an indication of the local unit policy. Threshold for significant harm fitting holistic palliative care, early discussions, and parental involvement should also be included.

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Katrina Dimech
MSc (Melit) Medical Ethics
PGC Patient Safety & Clinical Risk Management
PGC Management
BSc (Hons) Midwifery

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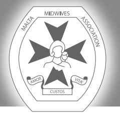
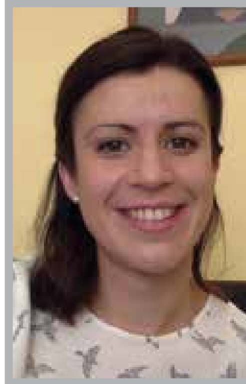


Doctoral Study
Parents’ Experiences of Conceptualising and Relating to their Unborn Child: A Constructivist Grounded Theory”



Antenatal thoughts and feelings about the fetus are thought to be somewhat predictive of the later parent-child relationship. The parental-fetal tie is, however, poorly understood. The field is plagued by disagreement in existing conceptualisations, conflicting results in efforts to identify predictors, correlates and consequences of the tie, and a dearth of research looking into the phenomenon from a paternal perspective. In response to these issues, the purpose of the current study was to construct a substantive theory of expectant parents’ fetal conceptual and relational experiences.

Following the receipt of ethical approval, constructivist grounded theory was used to explore data generated through semi-structured individual interviews conducted with a purposive and theoretical sample of nine first-time expectant mothers and their male partners, in early, middle and late pregnancy. Data analysis, involving techniques of coding, constant comparison and memo-writing, resulted in the development of a theoretical model.

The parental-fetal tie is characterised as an evolving phenomenon which takes a convoluted and individualised path to reach maturation. Coming to think of the fetus as a known other and as part of the intimate family unit are vital in achieving a sense of relatedness. An increasingly tangible fetus facilitates such an outlook. Nevertheless, the development of the tie is limited by restricted access to the unborn child, as well as by difficulties in perceiving fetal reciprocity.

The results suggest that expectant mothers and fathers conceptualise and connect to the unborn child in comparable ways, despite physical disparities in the pregnancy experience. Given the nature of the tie, it is thought that assessing it through self-report instruments may not be feasible. Providing inclusive care to the parental dyad will encourage engagement with the fetus. Further longitudinal research spanning the transition to parenthood is needed to understand the postpartum sequelae of the processes observed antenatally.

Dr. Nicole Borg Cunen
Lecturer
B.Sc. (Hons.) (Melit.), M.Sc. (QUB), Ph.D. (Hull), R.M.

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A Midwife's Doctoral Journey

Back in 2004, I was frantically trying to decide whether I wanted to study Archaeology and History of Art or Midwifery. In the end, I opted for the former but within a year I was already missing midwifery even though I had not tasted it yet. Soon enough, I was sitting for my interview and when I was asked why I was choosing midwifery, my response was simple. I already knew that women were experiencing traumatic childbirth experiences and I wanted to bring an end to it. My interviewer said that it was very ambitious but I had reiterated that I wanted to dedicate my life to women and their families wherever that may take me. I wanted to bring an end to suffering.

Nothing had prepared me to the degree of suffering that women and families can experience during their maternity care journey. When I qualified as a midwife in 2010 and witnessed firsthand the significant influence that a single person like myself can have on a woman's rite of passage, it fueled my dedication to women, birthing individuals and their families even further. I could make or break an individual's experience in a matter of minutes. I knew that my personal development could never wane if I was truly to put women at the centre of my care, end the suffering and help them achieve transcendental experiences.

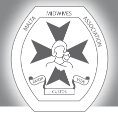
One shift at a time, one woman at a time, one family at a time. I cannot believe how quickly I felt that this was simply not enough. How could I raise even more awareness of the powerful position that as midwives we are in to end women's suffering or potentially be the causative factor? How could I help others understand the influence we can have to avoid traumatic birth experiences or how to support women following previous trauma?

I felt I could only achieve this through further study and research. I embarked on a MSc focusing on traumatic childbirth but it only opened my eyes further to the significance of traumatic events. When I finished my MSc in 2012 and published with success, I knew that more needed to be done. In 2014, I was awarded a PhD scholarship, so I engaged in more research, started teaching in Higher Education, presented in conferences worldwide, made connections with strong women whom I looked up to and I never looked back. I had found my true passion, my route to supporting as many women and families as possible by informing, educating and inspiring fellow midwives and health care professionals, policy holders and the future workforce.

My PhD work involved looking at birth from a salutogenic perspective, to understand how it can be transcendental, traumatic or how it can be somewhere in between. The purpose was to understand how women can achieve beautiful, positive experiences so that it can inform health care professionals on how we can reduce traumatic experiences for all birthing individuals. The women who participated in my study taught me so much, led me to question even more and to act more than ever. I humbly admit that I would never have guessed that continuous presence during childbirth is valued more than continuity of care, that birth can equally be neutral for so many reasons, that the care women receive during an induction of labour and postnatally is at times more important than the birth itself and that birth plans can potentially make things a lot worse. I was overwhelmed by the challenging new data that can potentially shape the future of maternity care. Today, I am using what I learned from my PhD and working alongside some brilliant minds in the United Kingdom to re-look at birth plans, reframe them to make sure that they are what women, birthing individuals and families need them to be. To support them to achieve a positive birth.

I thought my PhD would be the end but it turned out to be the very first step that marked my academic journey. A journey which I treasure deeply and would happily revisit any time. It was nowhere near easy but every step I took, every challenge and hurdle I overcame, I was able to manage because I was not doing any of it for me. It was all for the women because for me, it is always about them. I like to think that I have kept my promise to my interviewer, embarked on a very ambitious journey but will continue to dedicate my life to women and their families.

Dr Giliane McKelvin
PhD, MSc, PGCert THE, PGCert Normal Birth,
BSc (Hons) Midwifery, RM, FHEA.
Senior Lecturer in Midwifery and Joint Programme Lead at the
University of Bolton, UK.



University of Malta
Bachelor of Science: Dissertation Abstracts

Midwives' Experiences of Providing Intrapartum Care to Women with Female Genital Mutilation

Due to increasing numbers of migrants from countries where female genital mutilation is performed, local midwives are facing challenges when providing intrapartum care to women affected by female genital mutilation. Since these challenges have not been explored in Malta for a substantial number of years and never through a qualitative approach, this study aimed to explore midwives' experiences of providing intrapartum care to women with female genital mutilation.

The objectives of this study were to: explore the midwives' views and knowledge of female genital mutilation, to understand the midwives' experiences of providing intrapartum care to women with female genital mutilation in Malta and to identify the needs of local midwives when it comes to caring for women with female genital mutilation. To fulfil this, a qualitative study was carried out, using a self-designed semi-structured interview schedule consisting of open-ended questions. The sample consisted of six midwives working at the delivery suite of the local general hospital and the sampling technique chosen was purposive sampling. The data generated through these interviews were analysed using thematic analysis.

The findings of this study indicate that midwives working within the local setting lack knowledge of female genital mutilation, which leads to a lack of confidence when providing care to women with female genital mutilation. Midwives acknowledged this lack of knowledge and brought forward recommendations to raise further awareness of female genital mutilation and receive more education on the topic.

The overall experiences of midwives providing intrapartum care to women with female genital mutilation, was described as being challenging. Midwives experienced feelings of shock, uncertainty and fear when providing care to these women. Among challenges faced when providing care to women with female genital mutilation was difficulty when performing procedures such as catheterisation and vaginal examinations. Midwives specifically associated fear with performing deinfibulation. Another challenge encountered by all midwives was the issue of communication and language barriers. Results from this study were critically discussed and compared with other studies on the topic.

Recommendations from this study include the need for midwives to increase their awareness and knowledge of female genital mutilation as well as overcoming communication and language barriers that hinder optimum care provision to these women. Suggestions for further research include: the conduction of a similar study using a mixed methodology approach using a larger number of participants, formulation of subsequent in-depth studies on the separate objectives and the exploration of perspectives of mothers, doctors, obstetricians, and other local health care providers on the care of women with female genital mutilation. Exploring the psychological impact on both the women and healthcare providers would also be interesting, taking into consideration the strong emotions that were mentioned in the findings.

Maria Bajada

Midwives' Experiences of Normalizing Childbirth in Malta

The concept of normality and its impact during childbirth, is a highly debated topic between healthcare professionals in the maternity setting worldwide. Despite this, little is known about the experiences of midwives locally, on normalizing childbirth. The aim of this qualitative study was to explore midwives' experiences of normalising childbirth. The objectives of the study were to identify midwives' perspectives of factors which promote normality in childbirth and to determine midwives' views of factors which hinder normality in childbirth. To accomplish these objectives, a qualitative approach was adopted and one-time, semi-structured, face-to-face interviews were conducted with a purposive sample of eight midwives using an interview schedule which was self designed by the researcher. All the midwives who met the inclusion criteria for participation and were approached, participated voluntarily. The interviews were audiotaped and transcribed verbatim. The transcripts were analysed using thematic analysis as described by Braun and Clarke (2006).

Findings of this study indicate that midwives' understanding of normality in labour varies greatly, although their main aim being the optimum health outcomes of the mother and infant is similar. Moreover, the participants' experiences around the concept of normalisation during childbirth locally are affected greatly by more hindering factors, as opposed to promoting factors of normality. Findings also revealed that although a lot of efforts are made by the midwives to promote normality during childbirth, there are too many barriers that hinder their efforts. The barriers mentioned include: the lack of midwifery-led model of care, absence of midwife-mother rapport, medicalised environment, omitted information about natural alternatives during birth and the medicalisation of childbirth. The main conclusions and implications are that the barriers are suppressing the promoting factors of normality during childbirth locally, and that improvements are needed to increase the normalization of childbirth.

In view of these findings, recommendations for practice, education and research were proposed. Recommendations for practise and education included: the introduction of midwifery-led care, the provision of continuity of care with the midwives, the encouragement of midwives to take further courses in alternative therapies and to educate and empower mothers and their partners on their right to an informed choice thereby enabling the couple to feel more involved in the decision-making during childbirth. A recommendation for further research is to conduct similar qualitative research with different participants, such as the mothers in labour.

Rebecca Borg

Midwives' Experiences of Caring for Infants with Neonatal Abstinence Syndrome

The study aimed to explore midwives' experiences of caring for infants with neonatal abstinence syndrome at the neonatal and paediatrics intensive care unit. Furthermore the study's objectives were to explore midwives' thoughts and feelings relating to infants affected by neonatal abstinence syndrome, gain insight into the care needs of these infants and into midwives' experiences of providing such care, and to explore midwives' approach to supporting the infants' parents. A qualitative approach was used. Face-to-face, semi- structured interviews were conducted with a purposive sample of six midwives. A 100% response rate was achieved. The interviews where audio-recorded and transcribed verbatim. Thematic analysis, as described by Braun and Clarke (2006), was used to analyse the data generated.

The findings of this study indicated that midwives had various reactions towards infants affected by neonatal abstinence syndrome. While these infants were perceived to be challenging to care for, providing this care was also perceived as satisfying. Midwives became emotionally attached to the infants and worried about their future prospects. In caring for these infants, midwives needed to adapt routine care, watch for signs of withdrawals and provide pharmaceutical support. Midwives' views of, and approach to, the parents of NAS-affected infants differed according to the cause of the infant's condition and the parents' reaction to the diagnosis. Building a constructive relationship with these parents was not always easy and the midwives needed to liaise with other services to secure holistic care for these families.

Thus, caring for infants affected by neonatal abstinence syndrome appears to be complex and multi-faceted, as well as both challenging and rewarding. Based on the results, a number of recommendations for further education, research, and practice are suggested, including the formation of a discharge liaison team associated with the NPICU to help support the transition home for these infants and their parents.

Martina Brincat

Neonatal Skin Care: Staff Awareness and Practice within the Neonatal Unit

Maintaining an intact skin barrier is necessary for all newborns, during the adaptation from intrauterine to extrauterine life; however, this is particularly challenging for premature and full-term newborns requiring intensive or special care. The skin is subject to potential disruption and trauma during clinical practices, such as bathing, diaper changing and umbilical cord care. Hence, the aim of this small-scale, quantitative research project is to investigate neonatal staff awareness and neonatal skin care practices in the neonatal unit. The objective set to achieve the overall aim of the study involves determining neonatal staff awareness of and practices concerning neonatal skin cleansing, antisepsis and the use of skin care products, the prevention of diaper dermatitis, and umbilical cord care.

A total of 50 nurses and midwives (N = 50) recruited using purposive sampling, were selected from the neonatal intensive care unit (NICU) of the local general hospital. In total, 38 questionnaires were returned, resulting in a 76% (n = 38) response rate. The analysis of the closed-ended questions was carried out manually using simple, descriptive statistics. The results are presented in the form of absolute numbers, calculated percentages, pie-charts, bar-graphs, and frequency tables.

The findings suggest that the neonatal staff carry out good practices in relation to skin cleansing, the prevention of diaper dermatitis, and umbilical cord care. Despite this, some practices, such as neonatal bathing and diaper changing, are done routinely, every three to four hours, and not according to evidence-based recommendations. Most of the participants seemed to be unaware of the possible harm of antiseptics, and emollient use in the unit seems to be inconsistent. There was lack of agreement between participants when they were asked about the availability of neonatal skin care protocols on the unit. Furthermore, while the midwives seemed to be more aware on the importance of vernix and the use of emollients, the nurses seemed to be more knowledgeable about antiseptics.

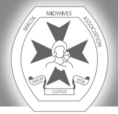
The main recommendations generated from the present small-scale study include the introduction and promotion of evidence-based protocols in the neonatal and intensive care unit. The researcher also recommends the implementation of a practice nurse or midwife who specialises in neonatal skin care. Such professionals could promote the neonatal skin care guidelines in the unit and aid staff when they are faced with any skincare-related queries. Comparative studies should be undertaken, before and after the implementation of a practice nurse or midwife, in order to perceive the possible benefits and limitations. In view of the fact that evidence-based skin care guidelines are always changing, it is recommended that neonatal staff members are kept updated through regular neonatal skin-care courses. Moreover, further studies using a larger, randomly selected sample of neonatal staff is also suggested so that the outcomes can be evaluated.

Laura Bugeja

Mothers' Knowledge, Attitude and Practice of Exercise during Pregnancy

The American College of Obstetricians and Gynecologists (ACOG, 2020) claims that exercising during pregnancy is safe and beneficial for mothers without medical or obstetric complications. This study, therefore, aimed to explore women's knowledge, attitude and practice of exercise during pregnancy. The specific objectives were to: identify maternal knowledge and information sources about exercise during pregnancy, explore pregnant women's attitudes towards exercise and seek the current level of maternal exercise during pregnancy.

A quantitative approach was adopted utilising a self-designed, self-administered, one-time questionnaire, which



was distributed via social media. A convenience sample of 50 pregnant mothers attending virtual parentcraft classes, participated in this study, achieving a 100% response rate. Collected data was analysed manually using simple descriptive statistics and content analysis.

Findings of this study transpired that the majority of mothers were knowledgeable about antenatal exercise. The most frequently reported sources of information about exercise during pregnancy were the internet, parentcraft classes and advice from midwives. Most participants showed a positive attitude towards exercise during pregnancy since they perceived exercise as beneficial. This study also revealed that the prevalence of physical activity among mothers was higher throughout pregnancy compared to the pre-pregnancy period. Walking was *the most popular activity to engage in before and during pregnancy.* An identified issue of concern was that expectant women mainly exercised 2-3 times weekly for 15-30 minutes a day, which is not in accordance with the ACOG (2020) recommendations. The main reasons which motivated mothers to exercise in the upcoming weeks of their pregnancy were maternal/foetal health benefits, preparation for labour and birth, as well as information provision. Barriers to physical activity faced by mothers included safety concerns/fears, tiredness, pregnancy discomforts, time constraints, bleeding and environmental conditions, such as the coronavirus disease 2019 (COVID-19) pandemic.

Several recommendations for practice, education and further research were proposed. These include the need for providing evidence-based information about antenatal exercise to pregnant mothers, providing pre-registration training and education on exercise for midwifery students and the need for a large-scale qualitative study to obtain in-depth information on the study phenomenon.

Lara Caruana

First-time Mothers' Experiences of Antenatal Education during the COVID-19 Pandemic

This study aimed to explore the mothers' lived experiences of antenatal education during the COVID-19 pandemic. The objectives of the study were: to explore the experience of antenatal education in relation to the pregnancy; to explore the influence of antenatal education on the childbirth experience, and to explore the experience of antenatal education in relation to the postpartum period. The qualitative paradigm was used to investigate this phenomenon and a purposive sample of nine primiparous mothers was selected from the breastfeeding clinic at the main state hospital via an intermediary. Participation was voluntary and all those mothers who were approached consented to take part, yielding a 100% response rate. A semi-structured interview schedule was specifically designed for the purpose of the study. The interviews were held virtually and were audio-recorded with the participant's consent. Pseudonyms were used for ethical purposes.

Data were then transcribed verbatim and analysed using thematic analysis. Results showed that antenatal classes were considered an essential source of information, especially during the COVID-19 pandemic. Although most women attended virtual antenatal classes their overall learning experience was described to be satisfactory and most reported appreciation in this regard. Despite this, participants highlighted how antenatal education did not fully prepare them for the realities of their labour, birth and parenthood experiences. It transpired that the COVID-19 pandemic created a heightened sense of anxiety, fear and stress amongst most participants. Despite this, participants praised their antenatal educators for their constant relaying of information regarding COVID-19 related measures being put in place. Moreover, participants gave their suggestions on how local antenatal education classes could be redesigned to encourage discussion and increase attention.

This study put forward several recommendations to improve practice, education and for further research. The findings of this study suggest that antenatal education should start earlier on during pregnancy to offer gestation specific advice. It is being suggested that education should continue in the postnatal period as well. A regular course evaluation will also help to improve women's learning experiences. Furthermore, further research on the effectiveness of antenatal education during the COVID-19 pandemic from the perspectives of all service users including women and men together with the experiences of antenatal educators is warranted.

Elizabeth Cassar

Midwives' Views on Infant Feeding Methods in the Early Post-partum Period

The aim of this research was to explore midwives' views on infant feeding methods in the early post-partum period. The objectives were to explore midwives' thoughts about, and experiences of, supporting mothers in their infant feeding choices, as well as to inquire into circumstances that influenced the advice that midwives give to mothers about infant feeding. To fulfil the aim and objectives, a qualitative approach was adopted, with individual, face-to-face, semi-structured interviews used to generate data. The purposive sample comprised eight participants who worked at one of two postnatal wards at a local general hospital, representing a response rate achieved of 100%. The interviews were audio-recorded and transcribed verbatim. Data gathered was analysed using thematic analysis, as described by Braun and Clarke (2006).

The findings that emerged from the study suggested that while most midwives preferred breastfeeding over formula-feeding, they were also conscious of the importance of supporting mothers in their feeding choices. Common challenges met by mothers in establishing breastfeeding were identified, some of which were attributed to inadequate preparation during pregnancy. Finally, barriers to the provision of adequate infant feeding support were discussed. These included a lack of time and resources, feeling unprepared to support mothers in certain aspects of feeding and a working within a culture that discredited breastfeeding. Although offering infant feeding support is regarded as an important part of their role, midwives often feel that they do not have the adequate training and time to dedicate to this task. Based on the results that emerged

from this study, a series of recommendations for practice, education and further research are suggested, such as the need to increase the number of midwives on the ward to decrease each individuals' workload.

Noelene Debono

Body Image in Pregnancy: A Qualitative Study

This study aimed to explore pregnant women's views of self during their first pregnancy. Its objectives were threefold, which included; exploring women's feelings and thoughts about their bodies during pregnancy, understanding if and how lifestyle adjustments influence pregnant women's body image, as well as, recognising the influence made by society and media on women's perception of self. A qualitative approach was used to investigate eight Maltese, primiparous women, who were recruited by purposive sampling through intermediaries, from the obstetric wards at the general state hospital. Informed consent was gained from all participants and a 100% response rate was produced. A self-designed, semi-structured interview schedule was utilised to generate the data via online interviews. Audio-recording was carried out with participants' consent and participants' names were pseudonymised for confidentiality purposes.

Data was transcribed verbatim and thematically analysed. Findings concluded that whilst pregnancy was a generally positive experience, various negative factors affected pregnant women's perception of themselves and their overall well-being. Women's perceived level of attractiveness varied, however, all were accepting of the inevitable process of a changing body once pregnant. A desire to gain control over their appearance was exhibited amongst participating women, especially during the third trimester. Pregnancy's lifestyle adjustments were difficult for some to uphold, challenging women's body image. Moreover, the Maltese society did play a toll on some women's self-perception, encouraging social comparison. When it came to media, participants were aware of the false depictions of pregnant women and their bodies. However, some could not help but question their pregnant appearance. Ultimately, despite the hardships met in terms of body image, participants were generally happy during their first pregnancy and were motivated to meet their baby.

This small-scale study put forward several recommendations, which included giving due importance to discussing body image during pregnancy and prioritising the information given to mothers about support services available to them. Additionally, it was recommended to educate women and midwives on pregnancy's impact on women's views of self. Lastly, the student researcher recommended further research on the topic so that a more comprehensive understanding of issues surrounding body image in pregnancy are made available to professionals and women alike.

Claire Galea

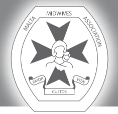
Midwives' Knowledge, Skills and Attitudes Related to Pelvic Floor Exercises to Postpartum Mothers

Pregnancy and vaginal birth are considered contributors to pelvic floor dysfunction and pelvic floor trauma. Pelvic floor exercises (PFMEs) during the postnatal period could strengthen and rehabilitate the pelvic floor muscles whilst improving women's health and quality of life. The study explored the midwives' knowledge, skills, and attitudes related to pelvic floor exercises for postpartum mothers. This was achieved through the following objectives; explore midwives' knowledge of pelvic floor exercises for postpartum mothers, identify the midwives' skills in teaching pelvic floor exercises to postpartum mothers, and explore the midwives' attitudes towards the advantages of pelvic floor exercises for postpartum mothers. Ethical approval was granted by FREC. A qualitative approach was selected for this dissertation. Seven midwives who worked at the local hospital as Discharge Liaison Midwives were recruited for this study. Semi-structured, face-to-face interviews were carried out with the participants. Data was transcribed verbatim and analysed using Burns and Grove's (2017) approach to content analysis. The findings revealed how midwives working in the community were knowledgeable on pelvic floor exercises. Midwives highlighted the relevance that postnatal mothers perform PFMEs to minimise pelvic floor dysfunctions. Additionally, midwives emphasised their vital role in providing advice related to pelvic floor exercises. Findings exposed how midwives were concerned about the lack of policies and guidelines on PFMEs within the local hospital's maternal services. Midwives also discussed how by collaborating in a multidisciplinary team, midwifery postnatal care and advice could positively contribute to a better quality of life for women. Findings of the study were discussed with relevant literature, which indicated that Maltese midwives working in the community seemed competent on the significance of pelvic floor exercises and how to educate the mothers in the community. The discussion highlighted how the midwives' concerns on the lack of policies and guidelines on PFMEs were disregarded throughout the years, yet they could help postnatal mothers from pelvic floor dysfunction. Recommendations for education, practice and research were proposed for this dissertation. This included the provision of regular sessions and courses on PFMEs for postpartum women and midwives. The importance of adhering to the latest research, development of policies and guidelines on PFMEs, along with the giving importance of future research concerning the possibility of combining PFMEs with other exercises, were also mentioned.

Kimberly Grech

Exploring Maternal Expectations of First-Time Childbirth

The aim of this study was to explore first-time mothers' expectations of childbirth. To meet this aim, the study enquired into women's expectations for their emotional and behavioural responses to the childbirth process, assessed women's expectations for care during labour and childbirth and identified sources of influence on maternal expectations for childbirth. A quantitative approach was adopted. A convenience sample of 48 expectant mothers, representing a response rate of 96%, completed a questionnaire which had been designed specifically for the purposes of the



study. Data was manually analysed and is presented using descriptive statistics, bar graphs and pie charts.

The majority of expectant mothers expected childbirth to be an overall positive experience, although many were frightened by the prospect of the event. They largely anticipated that they would be able to cope with the labour pain with the use of pharmacological measures. The presence of their partner during labour and delivery was expected to be of great comfort. In relation to care, the participants had confidence that midwives would spend significant amount of time with them during labour and involve them in decision-making. Information gained from prenatal classes were said to have had the greatest impact in their expectations, followed by information obtained from online sources. Results suggest that expectant mothers expect their childbirth experience to be positive overall. Several recommendations for practice, education and further research are proposed. These include further research on the topic using a qualitative approach.

Ann Marie Rapa

Midwives' Experiences of Assessing and Managing Neonatal Pain

The assessment and management of pain in neonates cared for at the Neonatal and Paediatric Intensive Care Unit (NPICU) are very crucial aspects of care provided on a daily basis in order to safeguard their wellbeing. The **aim** of this study was to explore midwives' experiences of assessing and managing neonatal pain at the local NPICU. The **objectives** were to explore how midwives identify and assess neonatal pain and to explore how midwives manage neonatal pain. The study adopted a qualitative research approach. Data was collected via a one-time, face-to-face, semi-structured interview using a self-designed interview schedule. Participants were selected by purposive sampling from a target population of qualified midwives who have a minimum of two years working experience at the NPICU. Seven midwives who satisfied the inclusion criteria participated in this small-scale study. Data collected was transcribed verbatim and analysed by means of thematic analysis. **Findings** revealed that midwives assess behavioural and physiological indicators of neonatal pain. However, neonates' inability to self-report their pain, time and work constraints, and the lack of use of established neonatal pain assessment tools seem to hinder midwives from carrying out a thorough pain assessment. Most midwives agreed that their assessment would improve by using objective guidelines. While participants reported using both non-pharmacological and pharmacological pain management strategies, some barriers are also encountered, such as parents' fears, Covid-19 restrictions, neonates requiring intensive care and the desensitization to pain. In **conclusion**, midwives agreed that their neonatal pain assessment and management practices can be improved. Therefore, the implementation of educational and practice interventions, together with the introduction of pain assessment guidelines are being recommended.

Lynn Scicluna

Midwives' Views and Attitudes of Amniotomy to Accelerate Spontaneous Onset of Labour

Amniotomy, through which the amniotic membranes are intentionally ruptured, is an obstetric intervention performed during labour. The aim of this study was to explore midwives' views and attitudes of amniotomy to accelerate spontaneous onset of labour. The objectives sought to explore midwives' attitudes regarding amniotomy performed to accelerate spontaneous onset of labour, to identify the midwives' views on the advantages and disadvantages of this procedure, and to outline the midwives' views on the ethical implications when performing amniotomy to accelerate spontaneous onset of labour.

A descriptive survey design was chosen for the study. Data was collected through a self-designed questionnaire using open- and closed-ended questions. The sample consisted of 30 midwives (N=40, 75%) working at the Delivery-Suite of the local State hospital, selected through convenience sampling. The data was analysed via Microsoft Excel, using both descriptive statistics and content analysis, and was presented in diagrammatic graphs and tables.

The findings suggested that, even though amniotomy is a commonly performed procedure, most midwives do not perform this intervention during spontaneous labour when not indicated. Furthermore, the risks of complications following amniotomy were considered to be minimal. All the participants emphasised informed choice and gaining consent prior to performing the procedure. However, information giving was not always consistent among the midwives. The midwives also believed that women do not always have adequate knowledge of amniotomy prior to the procedure. Similar to other studies, the participants agreed that amniotomy is performed in situations as prolonged labour, compromised fetal condition, and locally, prior to administering pharmacological pain relief.

Strengths and limitations were outlined. Several recommendations for practice, education, and further research were proposed, including information about amniotomy during antenatal education, and continuous professional development of midwives with regards to the latest literature on amniotomy. In conclusion, recommendations were put forward for further research using a qualitative approach to study the experiences and perspectives of both midwives and mothers concerning amniotomy.

Rebecca Wismayer

The Effects of Opiods During Labour on Breastfeeding: Midwives' View and Experiences

Opioids use during labour and early postpartum period may affect the initiation and establishment of breastfeeding due to opioids side effects (Lim et al., 2018). The aim of this study is to explore the views and experiences of midwives on the effects of opioids during labour and early postpartum period on breastfeeding. The objectives of this study are

to explore the midwives' views on the effects of opioids on breastfeeding; to seek the midwives' experiences of breastfeeding when the mother has received opioids during labour; and to identify the midwives' management of breastfeeding in the presence of opioids side effects. A qualitative approach was adopted for the study using face-to-face, semi-structured interviews. A target population of eight midwives, working at the obstetric wards in the local general hospital, were chosen by convenience sampling. A response rate of 100% was achieved. The interview recordings were transcribed via verbatim transcription and data was analysed by using Braun and Clarke (2006) thematic content analysis framework.

The findings demonstrated that midwives are faced with several maternal and neonatal problems due to opioid use during labour and early postpartum period; such as maternal fatigue and sleepy, lethargic babies. The type of opioid used and the time when opioids were administered, according to the midwives, played an important part in the severity of problems with breastfeeding, but which were usually resolved within 24hours. However, participants claimed that the mother's will power to breastfeed superseded the ill effects of opioids. Participants identified skin-to-skin contact, providing the mother with adequate support, assisting with different breastfeeding positions and finger feeding, may all help in initiating breastfeeding. In comprised situations a gastric washout and an opioid antidote are strategies used to initiate and establish breastfeeding. Ongoing care for the breastfeeding mother may also be needed through referral to the paediatrician and the breastfeeding clinic. Several recommendations for practice, education and further research were presented, namely; education of mothers on opioids effects on breastfeeding and further education of the midwives on the challenges and strategies to establish breastfeeding. More in-depth larger scale research is also recommended.

Christina Zerafa

From left to right
Back Row:
Maria Bajada, Martina Brincat, Elizabeth Cassar, Lara Caruana,
Lynn Scicluna, Rebecca Wismayer, Laura Bugeja
Middle Row: Ann Marie Rapa, Kimberly Grech, Rebecca Borg, Noelene Debono, Claire Galea
Bottom Row: Christina Zerafa

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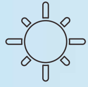
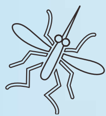
LA ROCHE POSAY
LABORATOIRE DERMATOLOGIQUE

Skin irritations in children and babies
Protect against daily aggressions



Sun
solar erythema

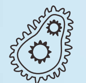
Rubbing
nappy rash,
chafing



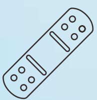
Insects
bites

Cold
chapped skin, dry patches

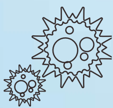
Saliva
irritative dermatitis
angular cheilitis



Bacteria
impetigo



Falls
minor wounds, cuts &
grazes



Eruptive diseases
chickenpox

Heat
minor burns,
minor scalds

CICAPLAST
BAUME B5
SOOTHES REPAIRS PROTECTS

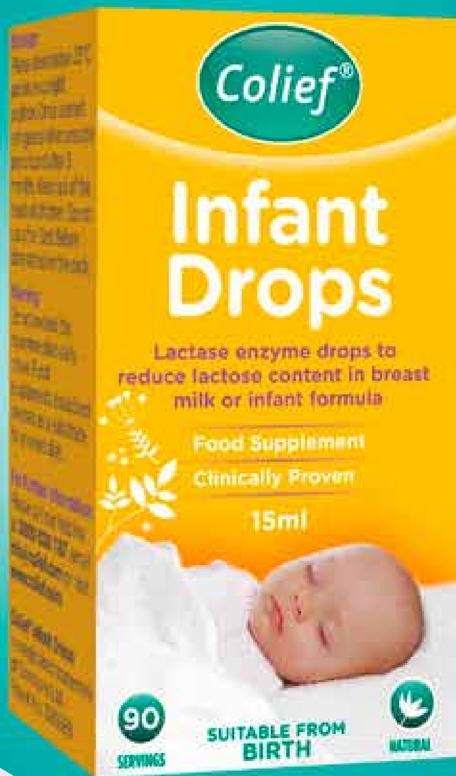
Infant Colic Drops

Lactase Enzyme Drops

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

Prevents & Treats Colic

Natural



4

4 drops with every feed

Safe from birth

Effective

Breathe Easy Patch

Soothing patch for easy breathing

Eucalyptus & Peppermint

Breathe Easy Roll-on Vapour Rub

Soothing rub for easy breathing

Eucalyptus & Menthol