Malta Midwives' Journal

The Stork

Malta Midwives Association

Issue 9 February 2017

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Pauline Fenech

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

Front cover:
With courtesy of Ms Sharon Schembri Bunce and her 10 month old daughter Lexi

Annual Membership €20

Dear Member,

This publication marks the beginning of a new year. Whilst we must reflect on the previous year and on how we could have done and tackled certain issues better, we must also look forward and focus on the challenges ahead and try to turn these into opportunities.

I think it is essential to point out and acknowledge the fact that we are experiencing an increasing state of multiculturalism on our wards. We are currently facing situations where we are working with people from various countries as well as caring for women coming from all over the world. I understand that at times this situation may be challenging because of issues such as language barriers that often make communication difficult. However, when us midwives are caring for pregnant women, we need to remember that no matter what colour, belief, religion, rich or poor these women are, ultimately all of the same race – the human race.

On another note, it is my pleasure to announce that the MMA is giving the opportunity to two midwives to explore the Netherlands' maternity services. More details on this will be communicated during the annual general meeting and can also be found in this publication.

MMA is also very pleased to welcome the introduction of a new midwifery service in the health care system: that of the perinatal and postnatal mental care midwife. The provision of the practice mental health midwife will be a reference point and support for many women going through psychological difficulties during their pregnancy and postnatal period.

Additionally, the MMA would like to congratulate the newly graduated midwives and wish them a fulfilling career.

Finally, I would like to thank all midwives who contributed to this publication. Your work is greatly appreciated and I look forward to identifing new topics for the coming issues.

Pauline Fenech
Editor

Annual General Meeting

24th February 2017 @ 18:00

Introduction to acupuncture in midwifery care

Ms Monique Abela and Ms Clara Spiteri

Refreshments

Executive Committee
2016-2017

Ms Mary Buttigieg Said	President
Ms Pauline Fenech	Vice President
Ms Marie Sorler	Secretary
Ms Charlene Attard	Vice Secretary
Ms Doris Grima	Treasurer
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Message from the President

Childbirth is a delicate and crucial point in the human life. It may positively influence the health over a life span or create damage that may persist over a lifetime and even generations.

We are the key caregivers that can renovate maternity care, which is currently focusing only on preventing death and possibly physical ill health. In reality, we midwives has been implicit into medicalisation, we have accepted it. We need to wake up and start smelling the coffee. Saving life is really important but it is just a component of the whole picture. It has become vitally important to shift from medicalisation to humanisation. We need to recognise the complex and delicate equilibrium of psychology and physiology. We need to focus not only on avoiding mortality but also use our energy to prevent morbidity, facilitate attachment and family integrity.

Our philosophy should be based on the framework for quality maternal and newborn care (Renfrew, Mcfadden, Baston et al in the Lancet series 384, 1129 - 1145, 2014). We must aim to optimise the biological, psychological, social and cultural processes. We must be practitioners who combine the clinical knowledge and skills with the interpersonal and cultural understanding. Our care should be based on the individual needs of the women.

Midwives it is our responsability to address the women's concerns, the fear of birth. Always offer the listening ear. The mother need to feel safe and understood, no checklist will manage to tackle the mother's emotions and feelings. Midwives we are in a unique position to know the women's views and concerns. Colleagues being responsive to women led conversation, provides us with mechanism that secures the mother's confidence, helps her feel in control and builds trust in us.

Midwives, keep on being the advocate of the women, continue to persist in the implementation of the evidence based care. Put into action the midwifery led model of care in Malta. System were the care given to the expectant parents, would be family centred and based on the principle, that pregnancy and childbirth are normal life event. Mothers would be cared for in the holistic model based on trust and trustworthy relationship where the woman is seen as a composite of all that surrounds her. The care is aimed to optimize the degree of wellbeing and articulate her wisdom, to strengthen her resources to care for the baby. Unfortunately our practice is based on the technocratic model of care were the women's body is being seen as an engine, were emotion do not fit. It is the equipment and the medicine that care for her body. Midwifery is an invitation for human growth. Midwives need to be the pillars for the mothers, be there, standing for the women, strengthen them and hold their hands.

Colleagues, be sensitive and understanding, engage with the women, build the relationship with the mother, open the door of trust, guide them to connect with the baby, Unnecessary interventions disturb the maternal connection with the baby. Women are being birth abused, being deprived from the most intimate and essential moments in their lives. Professor Paul Lewis in his article 'Small Act of Kindness Humanise Maternity Care' highlights that being busy; midwives are caught up in the task, focusing on the problem and not on the person. Competing demands isolate us from what is really important, creating a situation in which we are no longer able to care. Circumstance that may account for the high rates of distrust, detachment, fatigue and burnout, which is seen, discussed and increasingly expressed within our modern health care system. Heffernan clearly express in her book Wilful Blindness: Why are we ignoring the obvious at our pearl, when such a dehumising process takes place, we are unable to take care of ourselves and unwilling or incapable of caring for others.

Mothers and midwives need to regain personal power to humanize childbirth in line with scientific evidence. Together with our international counterparts we are in total agreement with the International Federation of Gynaecology and Obstetrics (FIGO) who continue to emphases that many induced labours should be avoided. Midwives, we need to be instrumental on extending safety which is limited by the medicalisation. We must minimise the damages to health which interferes with the autonomy of the women, the development of the family relationships and the transition to parenthood.

Colleagues, we own a huge bag of valuable resources. It is vital that midwives think outside the box and utilise the numerous assets available, to promote effective and efficient stategies that consolidate positivity.

- Listen to the evidence, evidence is on our side, be aware of it, use it, unite to fight for its implementation.
- Utilize indispensable tools such as the lancet series, let scientific evidence be the basis of our care.
- Build up continuity of care system were normal is considered as physiological process rather than been questioned and even seen as deviant
- Develop valuable scientific practices such as non pharmacological pain relief, including complementary therapies and positive birth support .
- Be the advocate for the mothers, babies and their families.
- Empower women to trust their body and involve them in their care.
- Nurture yourself and your colleagues, respect reduce the need of strong psychological pain relief and avoid traumas at the place of work
- Celebrate good practice

Midwives continue to work hard to transmit the message, to the multidisciplainary team, hospital management, policy makers, expectant parents and society in general. We need to highlight the scientific evidence, facilitate understanding, that midwifery led care offer benefits to the birthing women, with no additional risk to the infant. Midwifery Led Care increases the likelihood of spontaneous, uncomplicated birth with a good outcome for the mother and the infant compared to women who gave birth in an obstetric unit.

Midwifery care during the antenatal period is crucial. Maltese mothers are being deprived from receiving continuity Midwifery / shared antenatal care were the couple could be guided and given tailor made care to meet their individual needs. Maltese Midwives are being discriminated from their midwifery colleagues around the world who have the opportunity to care for the mother from the preconception period to the perperuim. The Maltese society, you and me, are being unjustly charged to cover the expenses of the technocratic model of care. The care which now has become essential to possibly cure, the short and long term traumas and complications that arise of its consequence. As recommended by the Royal College of Obstetricians and Gynaecology a life-course approach to women's healthcare should be adopted, utilising every interaction a women has with the health services, to promote health and lifestyle, rather than the constant fire fight against disease and illness.

Midwives and women have the right to a system of regulations that will ensure a safe, competent and autonomous midwifery workforce for women and their babies. Midwives need to provide care that is organised around the principle that women's and children's right are human rights (Ina May Gaskin). Ina May, the first midwife who was awarded the Right Livelihood Award urges governments and midwives to; "Take positive action to reverse this trend, place women at the centre of our politics and place midwives at the gate of maternity care, instead of being introduce to women late in pregnancy or childbirth. Women's confidence to give birth and breastfeed could be enhance or diminished by every person who give them care and the birth environment.

Midwives, guide them, deal with their emotions and empower them to trust their body. Women's bodies are design to give birth".

Colleagues be strong in what you believe.

We must take every opportunity to maximise our contribution, be involved in decision making on the delivery of services and make sure we have clear understanding of the issues affecting women and their families.

The Malta Midwives Association (MMA) is guiding the way. The committee is taking extraordinary measures to facilitate the transfer of knowledge to all midwives. A commitment that demands hours of intensive voluntary work to make ends meet and replace the costly funds invested in learning. Thousand of Euro are continuously being invested on midwifery educational resources. More interesting projects are planned for 2017. Be an active participant. The MMA philosophy is to empower midwives to grow and provide safe care for the women, babies and their families even if this demand ending up in financial loss. What matters is that our energy **is invested in the implementation of** acquired knowledge into a high quality evidence based care, evidence is on our side, use it.

Only knowledgeable, courageous, compassionate and determined midwives who practice in effective services are essential for humanisation of birth.

Mary Buttigieg Said
President

Treasurer's Message

2016 was yet another bumper year. It is by now, more than evident that a number of individuals are seeking our services. The product we are offering seems to be going down well with parents-to-be. We are also having a number of repeat clients.

This is quite heartening but we cannot rest on our laurels. In fact it would be a mistake if we forego the drive to augment our services. Indeed, the Associations' Committee is in a process of discussing how to expand the range of service already on offer.

One particular phenomenon that is creeping in is that mothers-to-be are seeking, more and more, individualised care. This is probably symptomatic of the way our culture is changing. Given this demand, it would be suicidal to ignore this need.

Obviously, the more personalised services and one-on-one sessions on offer, the greater the pressure on our human resources. As stated in the past, the Association relies heavily on your input. Thankfully there are a number of midwives who already render their services. But I am sure that more can join the ranks. We rely heavily on your support, presence and participation. Bottom line is that even a few hours every now and then would help alleviate the pressure and allow us to widen our range of sevices without deleting those already on offer.

Please do come forward as soon as possible.

Now for some more mundane details.

The supply of samples and materials is thankfully on the increase. It is obvious that our success has been noted also by the main suppliers. This has necessitated the installation of a new wall-to-wall cupboard for storage space.

Moreover, now that both floors are equipped with the necessary facilities, particulary an overhead projector, meetings have been held and educational sessions carried out on both floors. It is our policy to maximise the use of the premises.

I therefore end with a final appeal – do take note of the dates of the upcoming activities and, as of now, book them in your dairies. And please, do answer the emails as it is not easy to plan ahead if one does not have a clear indication of the numbers of participants invovled in a particular activity.

All this success comes at a premium, not least, as already stated, the load on human resources. However with your continued support and commitment, personal sacrifice and dedication. Your membership fees and individual input gives all the team the energy to go on.

Doris Grima
Treasurer

Organizazzjoni Studenti Qwiebel

Organizazzjoni Studenti Qwiebel, or as it is commonly known OSQ, is the official students organisation that represents midwifery students at the University of Malta. OSQ was founded in 2009, where midwifery was still a Division within the Institute of Health Care. At that time there were no student's organisations for students enrolled in courses within the Institute of Health Care. This set four midwifery students, today qualified midwives; Rebecca Mizzi, Ruth Marie Xuereb, Francesca Cachia Galvagno and Stephanie Cauchi, working to build a midwifery organisation.

After a series of petitions and meetings, OSQ became the first ever midwifery student organisation and the first organisation amongst all of the other Division within the Institute of Health Care. Within one year of its foundation, OSQ obtained recognition from the Senate of the University of Malta and became approved as a student organisation. When the Institute of Health became the Faculty of Health Sciences and the Midwifery Division the Department of Midwifery, an association representing all the students studying at the Faculty was founded.

This association goes under the name of Malta Health Science Association (MHSA). Today, OSQ is still the only student's organisation within the Faculty of Health Science and it falls under the health science student's organisation MHSA.

OSQ is a non-profitable organisation with its own executive board with a minimum of four committee members; the president, the secretary general, the public relations officer and the financial officer. As an organisation, OSQ closely collaborates with MHSA on educational, health and leisure events. In fact every year OSQ gets invited to participate in the annual MHSA health day. Working in collaboration with MHSA provided OSQ the opportunity to work with other associations such as the Malta Medical Students Association (MMSA). For these collaborations, OSQ was recognised and further nominated for the annual Kunsill Studenti Universitarji (KSU) Kokka Night, to which together with MHSA and MMSA won the Kokka Sahha Award 2016.

Setting these collaborations aside, OSQ also works very well on its own. At the beginning of each academic year, OSQ participates in the University Fresher's Week, where it welcomes new midwifery students and provides them with useful information and freebies. Other yearly activities includes; going on the wards and treating mothers to a small gift on Mother's Day and celebrating the International Day of the Midwife by educating the public on the midwife's role, promote aspects related to midwifery, and recognising and congratulating student midwives and midwives for their vocation. Working on these activities together as one team, aids in our personal development, improves communication and collaborative skills, characteristics which are beneficial and useful to our midwifery studies and career in midwifery.

I can say that one of OSQ's unforgettable events was back in July 2015, where Her Excellency the President of Malta Marie Louise Coleiro Preca invited OSQ at her palace for tea. Here OSQ presented Her Excellency with a poster (done by OSQ executive board members) on breastfeeding tips. The president open heartedly accepted the poster and today one can find this poster framed in the palace's breastfeeding room. It is with no doubt that this event will remain one of OSQ proudest achievements.

The work being done by OSQ in the interest of its current and future student midwives and the promotion of midwifery is endless. Such events and initiative not only help shed a bright light on our course and future profession, but also help us grow personally, academically and professionally. Today, while we encourage more students to join our society, as this year's executive we will put up a united front and follow in the footsteps of those who were here before us and work hard to maintain the value and integrity that OSQ holds.

Lauren Marie Grech
OSQ President 2016-2017

Malta Midwives Association
announces sponsorship for Two Midwives
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The Impact of Immigration on the Public Health Services in Malta

Background

In recent years, cross-border migration has gained substantial attention from policy makers around the globe. According to data published in 2014 by EUROSTAT, the number of long-term immigrants (EU and non-EU nationals) arriving in Malta has increased from 533 in 2002 to 8,428 in 2013. In relation to the size of the resident population, Luxembourg recorded the highest rates of immigration in 2013 (39 immigrants per 1 000 persons), followed by Malta (20 immigrants per 1 000 persons) and Cyprus (15 immigrants per 1 000 persons). (Eurostat, Migration and Migrant Population Statistics, 2015). In December 2015, the EUROSTAT issued a news release regarding foreigners living in EU countries. 5.9% (25,097) of the Maltese population are foreigners with the five most frequent nationalities residing locally include the British (33%), Somalis (5%), Italians (5%), Bulgarians (4%) and the Germans (4%).

Rationale for the Study

In January 2015, MISCO, an independent consulting firm, interviewed a representative sample of the Maltese population. According to the participants the two main problems that Malta is facing are immigration (39%) followed by health (17%). Thus studying immigration and the impact on health services is considered timely given that the topic is a major issue our country is facing momentarily.

In October 2015, the first part of the European Parliament Eurobarometer was released. While unemployment was identified as the main challenge faced by the European Union, in Malta only 30% of the respondents identified it as a main challenge. However, for immigration, the number stood at 83%. This was the highest percentage recorded in all the participating countries and contrasts with the results published in June 2013, where only 36% of Maltese respondents rated immigration as a major challenge. One must remark that in 2015, the European union faced a 'migrant crisis' where by September 2015, 710, 000 migrants crossed the EU external borders compared to 282, 000 migrants in the previous year. (Frontex, 2015).

Adapting health systems to be more migrant-responsive is complex, requires a lot of resources and involves a multi-sectoral approach. Healthcare workers should have adequate skills to deal with multiculturalism. (Jakab, 2015). Although some literature exploring migrants' point of view regarding healthcare services does exist, there is still little evidence that thoroughly examines the viewpoint of the service providers. (Priebe et al., 2011 & Suphanchaimat et al., 2015).

Thus, this dissertation analyzes the service providers' point of view as there have been few published international studies which focus on the service provider's perspective, therefore, investigating a gap in the literature. This is the first study in Malta which addresses the service provider's perspective. Therefore, the main aim of the study is to explore the perceptions of service providers regarding the provision of healthcare services to migrants in the public health sector.

Methodology

The study employed a qualitative case study approach based primarily on semi-structured interviews. The target population was Maltese health care professionals (HCP's) working in primary care, mental health, maternity department and accident and emergency. The study focused on the public health services only. The tool had already been used in a large study by Priebe et al., (2011) featuring sixteen European countries. Data for this study was collected between July 2015 and March 2016. Nvivo Software was used to code the interviews. Local and international documents pertaining to migration and the Maltese healthcare system were analysed.

Results

Twenty interviews were conducted yielding a response rate of 83%. Data for this study was collected between July 2015 and March 2016Ten major themes emerged from the interviews. These were: Historical perspective, Diversity of Migrant Profiles, Financial Issues, Accessibility, Medico-Legal Issues, Integration in Society, Mutual respect in the healthcare professional-patient relationship, Challenges in providing good quality care, Health services in the community and Barriers to Implementing research. Thirteen documents were analysed and most of the findings from the documents were congruent with the findings from the interviews.

Discussion: Findings unique to the Maltese healthcare system

Certain findings from this study were not previously described in the international articles. It is possible that they are specific to the Maltese healthcare system.

First of all, the participants mentioned that foreigners may be perceived as being a *'burden'* or '*taking up space'* in the Maltese hospitals. One must take this in context of Malta's geographical site and the Maltese healthcare system Malta is the smallest state but with the highest density in the European Union. (Health Systems in Transition, 2014). The publicly funded healthcare system is the main provider of the Maltese healthcare services. According to the HIT report the number of beds for acute hospitals is below the EU average, and they have declined by 28% on the last decade. One of the major challenges the Maltese healthcare system is facing is its sustainability and in fact this was highlighted in the European Semester Process. (Azzopardi- Muscat,

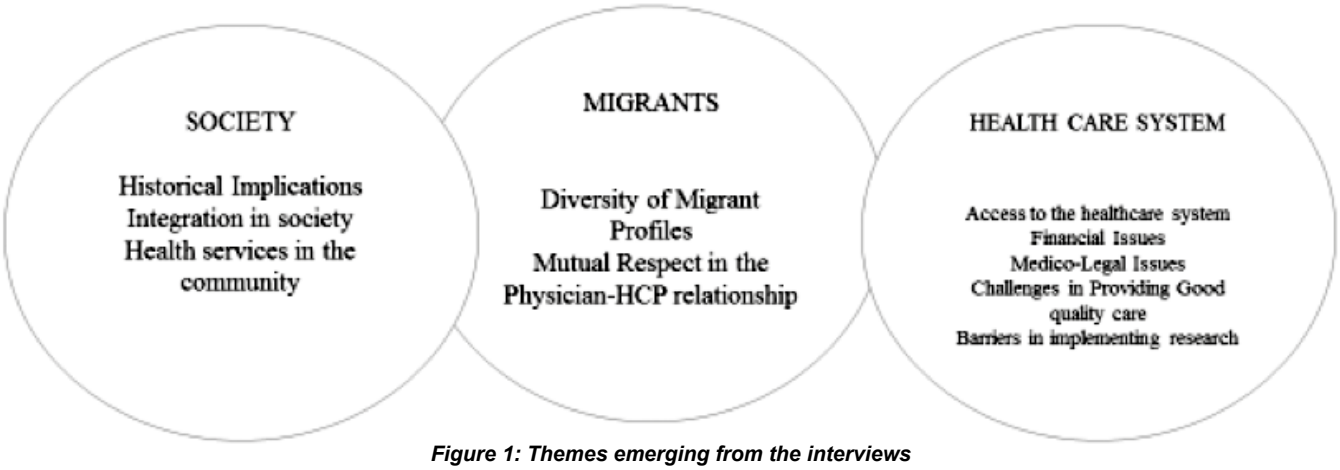

Figure 1: Themes emerging from the interviews

Clemens, Stoner and Brand, 2015).

Another issue which was mentioned was the increase in foreigners at the Accident and Emergency Department especially in the summer months. This main increase is due to tourists and students visiting Malta. Also, Malta is increasingly being considered as one of the most attractive locations to learn the English Language. A news release published by the National Statistics Office in April 2016 reports that in 2015, 75,254 foreigners chose Malta to participate in an English language course. One must also point out that the largest amount of language students are 15 years or less therefore being minors. This presents issues with obtaining consent as usually these minors are not accompanied by their next of kin.

Another important issue which was brought up by the Maternity Department is foreigners requesting the morning after pill. At the time of the study Malta was the only European country that does not offer it as it is illegal

Upcoming Conferences

2nd UN International Day of Women and Girls in Science
10th & 11th February, 2017. The theme for this event will be Gender, Science and Sustainable Development: the Impact Media. Malta
http://womeninscienceday.org/

12 European Conference of the Commonwealth Nurses and Midwives Federation. Recent Advances in Nursing and Midwifery: Towards a Safer Future.
17th World Congress of the Academy of Human Reproduction
15th - 18th March 2017; www.humanrep2017.com

1st World Congress on Maternal Fetal Neonatal Medicine
24th – 26th April 2017. London, UK
www.worldmfnm.eu

European Congress on Intrapartum Care (ECIC)
' Making Birth Safer'
Stockholm - Sweden. 25th-27th May 2017
www.ecic2017.org

31st ICM Triennial Congress: Midwives - Making a difference in the world
Toronto (Canada)
18 - 22nd June 2017; www.midwives2017.org

"4th World Congress on Midwifery and Women's Health"
(Midwifery Congress 2017).
20th-22nd July 2017, Melbourne, Australia
http://midwifery.conferenceseries.com/asia-pacific/

11th International Normal Labour and Birth Research Conference
will be held at the Grange Hotel, Grange over Sands, Lake District, UK.
2nd - 4th October 2017
http://www.uclan.ac.uk/conferences

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in this country. Therefore, HCP's experience frustrated foreigners that are used to having access to particular services in their own country which are not available in Malta. As of recently, this issue has been lifted higher up on the political agenda. In June 2016, 102 Maltese women filed for a judicial protest to call for the licensing, importation and distribution of emergency contraception. This decision has been heavily criticized by pro-life awareness groups as 'an attempt to legalize abortion'. (Diacono, 2016). The morning after pill is now available over the counter in Malta.

As mentioned earlier, one of the major challenges of the Maltese healthcare system is its sustainability. Maltese HCP's pointed out how foreigners are adding costs to the Maltese healthcare system. Some diseases which require expensive treatment such as HIV/AIDS and tuberculosis were mostly predominant among foreigners. In 2012, there were 30 new HIV, 5 AIDS cases and 41 cases of tuberculosis in Malta. For HIV and AIDS, 22 accounted for foreigners while 13 were Maltese. With regards to Tuberculosis 28 out of 41 cases were in foreigners. (Times of Malta, 2013). The figures particularly for HIV continue to rise in Malta. In 2012 there were 20 new HIV cases while in 2015 there were 50 new cases of HIV recorded up till 30/10/2015. (The Malta Independent, 2015).

Undertones of prejudice

During the interviews, some of the comments from participants had elements of prejudice. One must also take into account that during this year, migration has been high on the international political agenda. Nevertheless, some established names in politics have remarked how migrants are of a burden to societies. This was especially highlighted in Europe especially in the United Kingdom and Austria. In 2016, Norbert Hofer, a populist, far-right freedom party politician came very close to win the presidential election in Austria. Leville (2016) addresses the fact that Hofer took an anti-immigration stance and proposed that Austria protects its borders by having a 'barrier'. Immigration was also high on the agenda in the United Kingdom especially during the Brexit Referendum in June 2016. On the 24th of June 2016, the results of the referendum were announced, where the United Kingdom opted to leave the European Union. One of the main proposal of the 'Leave' Campaign was a change of the movement of foreigners in the country.

Moreover in July 2016, the results of Szazadveg Project- 28 were announced. This project consists of a statistically significant survey, which targets the challenges faced by Europe. When interviewing the Maltese, 73% of participants believe that an increase in immigrants increases crime rate while 65% of the population agree that an increase in immigrants raises the threat to terrorism. 60% of the Maltese participants are of the opinion that immigrants will bring about change in the Maltese culture.

Conclusion

The participants of this study discussed the main challenges that Maltese healthcare professionals face in their daily practice. Specific difficulties associated with the small size of a country such as Malta were also highlighted by the participants. The Maltese healthcare system needs to better adapt to the influx of migrants and healthcare professionals need to be further trained in cultural competence. Key recommendations include introduction of a migrant health policy and better structured services.

References:

Azzopardi Muscat N., Calleja N., Calleja A., & Cylus J. (2014). Malta: health system review. *Health Systems in Transition*, 2014, 16(1):1–97.

Azzopardi-Muscat, N., Clemens, T., Stoner, D., & Brand, H. (2015). EU Country Specific Recommendations for health systems in the European Semester process: Trends, discourse and predictors. *Health Policy*, *119*(3), 375-383

Critical Appraisal Skills Programme (2013). *10 questions to help you make sense of qualitative research.* Retrieved from http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf on 18th February, 2016.

Diacono, T. (2016, June 16th). Women's rights group goes to court to demand morning-after pill. Retrieved from http://www.maltatoday.com.mt/news/national/66550/womens_rights_group_goes_to_court_to_demand_morningafter_pill#.V4l-gfl97IV on 18th June, 2016.

European Parliament Eurobarometer (EB/EP 84.1). (2015). *The main challenges for the EU, migration, and the economic and social situation*. Retrieved from http://www.europarl.europa.eu/pdf/eurobarometre/2015/2015parlemeter/eb84_1_synthese_analytique_partie_1_migration_en.pdf

EUROSTAT. (2014). *Total number of long-term immigrants arriving into the reporting country during the reference year*. [Table]. Retrieved from http://ec.europa.eu/eurostat/tgm/table.tab=table&plugin=1&language=en&pcode=tps00176 on 21st, February, 2016.

EUROSTAT. (2015). Foreign Citizens Living in EU Member States. [Press Release]. Retrieved from http://ec.europa.eu/eurostat/documents/2995521/7113991/3-18122015-BP-EN.pdf/d682df12-8a77-46a5-aaa9-58a00a8ee73e

FRONTEX. (2015). *710,000 Migrants Entered EU in the First Nine Months of 2015*. Retrieved from http://frontex.europa.eu/news/710-000-migrants-entered-eu-in-first-nine-months-of-2015-NUiBkk on 20th February, 2016.

Jakab, Z. (2015). World Health Organization. Statement: *The challenges of Migration require migrant-sensitive health systems for today and for the future*. Retrieved from http://www.euro.who.int/en/about-us/regional-director/speeches-and-presentations-by-year/2015/statement-the-challenges-of-migration-require-migrant-sensitive-health-systems-for-today-and-for-the-future on 27th February, 2016.

Leville, D. (2016, May 23rd). *What the narrow defeat of Austria's far right means for Austrians, refugees and Donald Trump.* Retrieved from http://www.pri.org/stories/2016-05-23/what-narrow-defeat-austrias-far-right-means-austrians-refugees-and-donald-trump on 20th June, 2016.

MISCO (2015). *Personal Income, Immigration are Main Personal Concerns in Malta.* Retrieved from http://www.miscomalta.com/content.aspx?id=387493 on 21st February, 2015.

National Statistics Office (2016). *Teaching English as a Foreign Language. [Press Release].*

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., ... & Riera, R. P. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC public health*, *11*(1),187.

Project28.(2016). Retrieved from http://preview.marketsoul.cz/project28/results/ on 10th July, 2016.

Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W., & Prakongsai, P. (2015). Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens. *BMC health services research*,*15*(1), 1.

The Malta Independent. (2015, December 1st). *50 cases of HIV and one case of Aids in 2015; spike in numbers over the previous years.* Retrieved from http://www.independent.com.mt/articles/2015-12-01/local-news/50-cases-of-HIV-and-one-case-of-Aids-in-2015-spike-in-numbers-over-the-previous-year-6736149446 on 1st November, 2016

Times of Malta. (2013). *Increase in HIV/AIDS.* Retrieved from http://www.timesofmalta.com/articles/view/20131029/local/increase-in-hiv-aids.492407 on 7th July, 2016.

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Colostrum Harvesting in Diabetic Pregnant Women

It is widely known that babies born to pregnant women with gestational diabetes, as well as those with pre-existing diabetes, are at an increased risk of hypoglycaemia soon after birth. As cited in *East et al. (2014)*, a baby born to a diabetic pregnant woman is used to higher glucose levels in utero. To meet this demand, higher levels of insulin are produced throughout the pregnancy, which levels will remain consistently high throughout the first few days after birth.

Since these babies are at greater risk of hypoglycaemia, it is of utmost importance to establish immediate effective feeding. In a fact sheet produced by the WHO, it is noted that exclusive breastfeeding for the first six months is essential and beneficial to both the infant and the mother (*WHO, 2016)*. However, at times, women are faced with a challenge. As cited in *Neubauer et al.(1993)*, diabetic women may have delayed lactogenesis leading to difficulties in breast feeding soon after birth. In such cases, many women would have to consider giving artificial formula to their infants. In recent years, studies have been looking at a new suggested strategy known as milk harvesting, aiming to aid breast milk production and prevention of hypoglycaemia in babies born to diabetic women, hence avoiding the use of formula feeds or intravenous glucose (*Soltani & Scott, 2012*).

Milk harvesting is the expression and storage of colostrum in the antenatal period. This new strategy encourages women to express colostrum from 36 weeks gestation onwards, as breast stimulation before 36 weeks may increase the risk of pre term labour (*Forster et al., 2014*). Colostrum expression should be done manually since it is initially secreted in small amounts. Each breast should be expressed twice during each session. Colostrum can then be collected two to three times each day in the same syringe, storing in the fridge between uses. This should be then labelled and stored in a freezer, until the baby is born (Gestational Diabetes UK, 2016).

Manual expression technique explained

The *Dorset Breastfeeding Policy (2013*) suggests that once harvested colostrum is given to the infant, it ensures that increased glucose requirements are met in order to stabilise glucose levels and consequently avoiding the use of artificial formula, which significantly increases the risk of infants developing type one diabetes later on in life.

However, in the case were any abdominal cramps are experienced, expressing should stop immediately (Gestational Diabetes UK, 2016). Moreover, as cited in the Diabetes & Antenatal Milk Expression trial (DAME) information sheet, manual expression should also stop if any bleeding is noted or in case of decreased foetal movements (*Forster et al., 2014*). Additionally, diabetic women who are expressing or breastfeeding at a in higher risk of developing hypoglycaemia. Therefore, women participating in the latter trial were also advised to check their blood glucose levels following manual expression. Women were also advised to start expressing half an hour before they usually check their blood sugar level, in order to avoid extra blood glucose testing (*Forster et al., 2014*).

Milk harvesting is a new growing concept, on which information is easily found online and is also already introduced in some hospitals worldwide. However, recent studies have been pointing towards the safety and efficacy of colostrum harvesting. In a randomised controlled trial (DAME), the aim was to establish the effects of milk expression on NPICU admission rates, as well as secondary outcomes, such as breast feeding outcomes and gestational age, when a group of diabetic pregnant women expressing colostrum antenatally were compared to a group of women provided with standard care (*Forster et al., 2014*). Results of the latter trial were supposed to be presented to clinicians, policy makers and study participants. Additionally, another retrospective cohort study, *Soltani & Scott (2012)* concluded that antenatal milk expression is associated with lower gestational age at birth. Moreover, an alarming rate of babies being admitted to the NPICU was observed in the milk expression group.

To conclude, in a Cochrane systematic review of studies, *East et al. 2014* observed a lack of significant studies focusing on safe outcomes of antenatal milk expression. Additionally, a thorough evaluation of antenatal milk expression is needed before any new concepts are introduced widely. Hence, further studies are needed in order to provide safe and evidence-based advice to diabetic pregnant women.

References

Dorset Breastfeeding Policy Strategy Group, (2013) Dorset Breastfeeding Policy. *The Child and Maternal Nutrition Guidelines for Dorset*. [online] Available from: http://dorse-48577-001.dvs.demon.net/patients/wards-depts/maternity/dorset-breastfeeding-policy.pdf [Accessed on 2nd of December 2016].

Forster DA. *et al.* (2014) Safety and efficacy of antenatal milk expressing for women with diabetes in pregnancy: protocol for a randomised controlled trial. *British Medical Journal Open, 4: e006571*.

Gestational Diabetes UK (2016). Colostrum Harvesting [online] Available from: http://www.gestationaldiabetes.co.uk/colostrum-harvesting/ [Accessed on 4th December 2016].

Neubauer, SH. *et al.* (1993) Delayed lactogenesis in women with insulin-dependent diabetes mellitus. *American Journal of Clinical Nutrition*, 58, 54–60.

Soltani, H. and Scott AMS. (2012). Antenatal breast expression in women with diabetes: outcomes from a retrospective cohort study. *International Breastfeeding Journal, 7, 18.*

WHO (2016) *Infant and young child feeding. [online] Available from:* http://www.who.int/mediacentre/factsheets/fs342/en/ [Accessed on 5th December 2016].

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The Fate of the Undescended Testis

Introduction: An undescended or a cryptorchid testis, means that the testis does not lie at the base of the scrotum, and it occupies an alternative position, either in the groin or within the abdominal cavity. Undescended testis (UDT) can be classified as either congenital or acquired.

Congenital undescended testis affects 2-5% of newborn males decreasing to 1-2% by 3 months of age, as about half will descend shortly after birth ([1],[2]). Currently, the recommended age for orchidopexy is at around 12 months of age ([3],[4],[5],[6],[7]). The primary cause of an undescended testis is thought to be secondary to insufficient pituitary or placental stimulation causing inadequate production of insulin-like hormone 3 and androgens in the developing testis. Androgens are thought to act via the two genitofemoral nerves with minor deficiencies affecting one side more than the other leading to unilateral pathology.([8]) Other risk factors include intrauterine growth retardation, prematurity, excessive oestrogen exposure and smoking during pregnancy ([9]).

Acquired or ascending undescended testis present later in childhood. The incidence is of 1-2% ([10]). In these cases, the testis has been clearly documented to be within the scrotum in infancy but does not remain there over time. It is thought that ascent of the testis occurs as failure of the spermatic cord to elongate, secondary to a persistent fibrous remnant of the processus vaginalis as the child grows, causing the testis to ascend out of its previously occupied scrotal position ([11]). Boys with delayed testicular descent are at higher risk of acquired undescended testis and are kept under annual review for surveillance ([12]).

Management of UDT aims to preserve testicular function (spermatogenesis) and prevent the increased risk of seminoma. The position of the testis is classified as; 1. palpable being normal, high scrotal, supra-scrotal or retractile or 2. non-palpable. The management varies in palpable and non palpable testis. Newborns with cryptorchidism and associated bifid scrotum and/or hypospadias require immediate investigation as the clinical findings may represent a from of disorder of sex development ([13]). Furthermore, those with bilateral impalpable testes require careful consideration and karyotyping is necessary to confirm male gender.

Surgical Management. The aim of the surgery for UDT is to mobilise the testis on an adequate blood supply before relocating it within the scrotum. Examination under anaesthesia remains an important part of the surgeons' skill set and facilitates the diagnosis as well as planning for surgical approach in patients with both palpable and impalpable testis. ([14]). Congenital UDT is approached via the two incision approach while a trans-scrotal orchidopexy is accepted for acquired UDT. An impalpable testis is managed by laparoscopy were if an intra-abdominal testicle is visualised, and depending on the intra-abdominal position a single or two stage procedure is performed.

Complications of Surgery : Surgical success following orchidopexy is defined as a testis in the scrotal position with no evidence of testicular atrophy. Complications include infection, haematoma and wound breakdown, testicular atrophy or obstruction/trauma to the vas. Orchidopexy complication rates vary between 1.2% to 6% ([15]), with outcome dependent on the position before surgical intervention and previous surgery.

Conclusion: Congenital and acquired UDT account for a large burden of disease in children. Surgical correction remains a necessity with the surgical approach dictated according to the position of the UDT.

References:

1. Bradshaw CJ, Corbet 0 Burcher G Hitchcock R. Age at orchidopexy in the UK: has new evidence changed practice J Pediatr Urol. 2014; 10(4):758-762.
2. Berkowitz GS, Lapinski RH, Dolgin SE, Gazella JG, Bodian Ca, Holzman IR. Pediatrics 1993; 9291):44-49.
3. Kolon TF, Herndon CD, Baker LA, et al. Evaluation and treatment of cryptorchidism: AUA guideline. J Urol 2014:192(2):337-345.
4. Pastuszak A, Lipshultz LI. AUA guideline on the diagnosis and treatment of cryptorchidism. J Uro. 2014; 192(2): 346-349.
5. Toppari J Paediatrics: new cryptorchidism guidelines reach a consensus. Nat Rev Urol 2014;11 (8) 432-433.
6. Kollin C. Ritzen EM. Crytorchidism: a clinical perspective. Paediatr Endocrinolo Rev. 2015;111(suppl 2)240-250.
7. Steinbrecher H. The undescended testis: working towards a unified care pathway for 2014. Arch Dis Child 2014;99(5)397-398.
8. Hutson JM, Southwell BR, Li R, et al. The regulation of testicular descent and the effects of cryptorchidism. Endocr Rev. 2013;34(5):725-752.
9. Hakonsen LB, Eenst A, Ramlau- Hansen CH, Maternal cigarette smoking during pregnancy and reproductive health i children: a review of epidemiological studies. Asian J Androl, 2014;16(1):39-49
10. Van der Plas EM, Zijp Gw, Froeling FM, et al. Long-term tesituclar volume after orchidpexy at diagnosis of acquired undescend testis. J Urol. 2013;190(1):257-262
11. Clarnette TD, Rowe D , Hasthorpe S , Hutson JM. Incomplete disappearance of the processus vaginalis as a cause of ascending testis. J Urol. 1997;157(5):1889-1891.
12. John Radcliffe Hospital Crptorchidism Study Group. Cryptorchidism: an apparent substantial increase since 1960.Br Med J (Clin Res Ed). 1986;293(6559);1401-1404.
13. Hutson JM, Warne GL, Grover SR. Disorder of Sex Development: An integrated approach to management. Berlin: Springer 2012.
14. Bianchi A, Squire BR. Transscrotal Orchidopexy: orchidopexy revised, Pediatr Surg In 1989;4(1): 189-192.
15. Gordon M, Cervellione RM, Morabito A, Bianchi A. 20 years of transcrotal orchidopexy for undescended testis: results and outcomes. J Paediatric Urol. 2010;6(5):506-512.

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Counting the Drop: A step Forward Towards Managing PPH

Postpartum haemorrhage [PPH] is one of the leading causes of maternal mortality worldwide (Patel et al., 2006), with 99% of all maternal deaths occurring in low-income countries (Say et al., 2014). This high percentage could be attributed to the rudimental obstetric care which is available in such countries. However, in reality, high-income countries are not faring much better since the incidence of severe PPH is increasing and is considered as one of the leading causes of maternal morbidity (Lutomski et al., 2012; Knight et al., 2009). It is inconceivable that in the 20th century, despite advances in obstetric care, women are still being severely affected or, worse still, face death as a consequence of PPH. Where are we going wrong?

Gabel and Weeber (2012) argue that to determine if an obstetric haemorrhage is occurring, primarily there needs to be a clear understanding among professionals of how to define obstetric haemorrhage. The Royal College of Obstetricians and Gynaecologists (2016) identifies primary postpartum haemorrhage, which is the most common form of major obstetric haemorrhage, as the loss of 500ml of blood or more from the vaginal tract during the first 24 hours following childbirth (Mousa et al., 2014). PPH can be further classified as minor (500ml-1000ml) or major (more than 1000ml) (RCOG, 2016). Major PPH can be further subdivided into moderate (1001ml-2000ml) and severe (more than 2000ml). Hence, estimation of blood loss is one of the crucial steps towards early diagnosis and appropriate management of PPH. Delays in the diagnosis and treatment of PPH are thought to have a direct effect on the severity of bleeding, the development of complications such as coagulopathy and resulting rates of maternal morbidity and mortality (Driessen et al., 2011).

The current worldwide standard practice of blood loss estimation following childbirth is visual estimation (Schorn, 2010; Larsson et al., 2006; Patel et al., 2006). Healthcare professionals usually observe blood lost during and after the delivery, and make a quantitative or semi-quantitative estimate (Patel et al., 2006). However, repeated studies have shown that this method is inaccurate and that healthcare professionals should seek more accurate methods of blood loss estimation (Schorn, 2010; Patel et al., 2006). Larsson et al. (2006) reported visual underestimation and overestimation errors in vaginal births and predominantly overestimation errors in caesarean births. Similar findings were reported by Prasertcharoensuk et al. (2000) who compared visual estimation with direct measurement of blood loss during vaginal births. The incidence of PPH was underestimated in the visual estimation by 89% (Prasertcharoensuk et al., 2000). Earlier studies by Brant (1967) and Duthie et al. (1990) also found that the actual blood loss was higher than that estimated during vaginal births; the underestimation increasing with increasing blood loss volumes. On the other hand, Razvi et al. (1996) report an overestimation of blood loss in vaginal births when compared to the actual blood lost. Nevertheless, consistent with Prasertcharoensuk et al. (2000), the tendency to underestimate blood loss increased when blood losses were measured to be > 300ml.

Evidence has shown that midwives are relatively accurate when estimating blood loss (Schorn, 2010). Kavle et al. (2006) found that nurse-midwives were able to estimate blood loss accurately compared to laboratory determination of haemorrhage. However, it was reported that the greater the blood loss, the higher the imprecision of the estimate by under- or overestimation (Kavle et al., 2006). Similarly, Glover (2003) also found that midwives were able to accurately estimate blood loss during a simulated birth; however, the error increased when the blood loss was > 600ml. Such inconsistencies can severely jeopardise the mother's health. Underestimation of blood loss can result in prolonged or inadequate resuscitation measures from being set into motion, increasing the risk of hypovolemic shock triggering a cascade of events resulting in disseminated intravascular coagulation and myocardial infarction (Karpati et al., 2004). Overestimation of blood volumes can also have significant implications (Bose et al., 2006). Unnecessary cross-matching of blood is a waste of time and resources, especially at a point when blood is becoming an increasingly precious resource, whilst over transfusion exposes women to the known risks of blood products (Bose et al., 2006).

Midwives are at the frontline when it comes to estimating blood loss during childbirth and as such they need to be adequately trained in estimating blood loss as accurately as possible. Patel et al. (2006) designed a blood collection drape to assist in estimating blood loss in low-resource settings. Figure 1 shows a funnelled and calibrated pouch attached to a plastic sheet that is placed under the woman's buttocks immediately after delivery, to prevent the collection of urine, faeces and amniotic fluid (Patel et al., 2006). Two belts attached to the upper end of the drape are tied around the woman's abdomen to optimise blood collection (Patel et al., 2006). Calibration levels indicate the volume of the blood collected by the drape (Patel et al., 2006). According to Patel et al. (2006), the collection drape has the potential to provide an objective measurement of the blood lost following childbirth, therefore allowing a more accurate diagnosis of PPH compared to visual estimation. However, a study comparing visual estimation of blood loss with the use of a collector bag after vaginal delivery found that the latter did not significantly reduce the risk of severe PPH (Zhang et al., 2010). Thus, it can be argued that the drape collection bag should be judiciously used in

Figure 1: The BRASS-V Drape, a specially designed blood collection drape with a calibrated collection puch.

conjunction with other aspects such as the assessment of clinical signs and symptoms of hypovolemia.

The RCOG (2016) also recommends participating in clinical reconstructions which may encourage early recognition of PPH and thus trigger prompt treatment and management. Using written and pictorial guidelines, such as those in Figure 2, may help staff working in labour wards to better estimate blood loss (Bose et al., 2006).

Blood loss during childbirth has been and continues to be a significant issue which needs to be adequately addressed. Estimating blood loss following childbirth continues to challenge healthcare professionals, while severely compromising women's health as a result of delayed management of PPH. Large volumes of blood loss are the most underestimated, thus methods to accurately measure blood loss and PPH are needed (Schorn, 2010). Direct measurement through the use of a blood collection drape, and weighing are a combination of two methods which might help account for the majority of the blood lost (Schorn, 2010). Multidisciplinary education and training on simulated scenarios help familiarise healthcare professionals with the multifaceted aspects of PPH (Gabel and Weeber, 2012). Communication amongst healthcare professionals and with the mother, along with collective team effort, helps to potentially save lives and reduce injuries. Future research is needed to evaluate the effect of more accurate identification of blood loss in preventing maternal morbidity and mortality from postpartum haemorrhage (Gabel and Weeber, 2012).

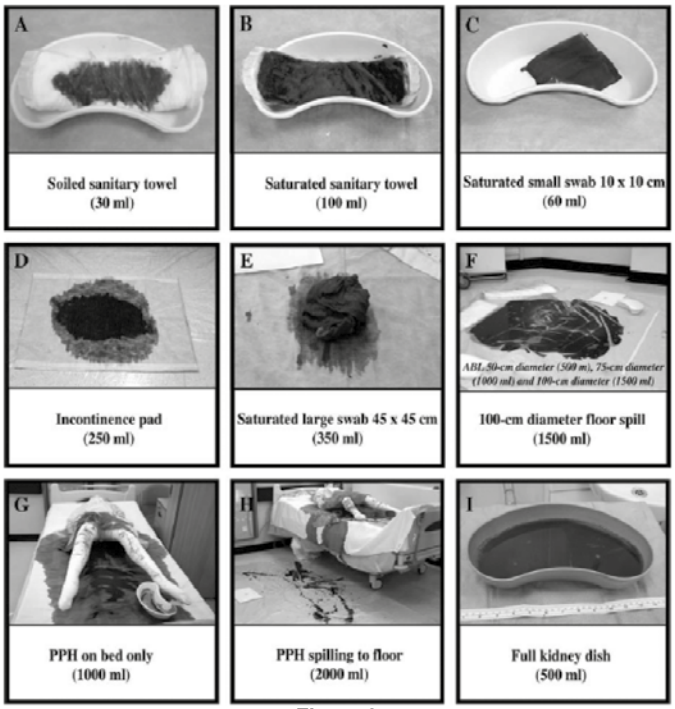

Figure 2

References:

Bose, P. et al. (2006) Improving the accuracy of estimated blood loss at obstetric haemorrhage using clinical reconstructions. *British Journal of Obstetrics and Gynaecology*, 113(8), 919-924.

Brant H.A. (1967) Precise estimation of postpartum haemorrhage: difficulties and importance. *British Medical Journal*, 1(5537), 398-400.

Driessen, M. et al. (2011) Postpartum haemorrhage resulting from uterine atony after vaginal delivery: factors associated with severity. *Obstetrics and Gynecology*, 117(1), 21-31.

Duthie, S.J. et al. (1990) Discrepancy between laboratory determination and visual estimation of blood loss during normal delivery. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 38(2), 119-124.

Gabel, K.T. and Weeber. T.A. (2012) Measuring and communicating blood loss during obstetric hemorrhage. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 41(4), 551-558.

Glover, P. (2003) Blood loss at delivery: How accurate is your estimation? *Australian Journal of Midwifery*, 16(2), 21-24.

Karpati, P.C. et al. (2004) High incidence of myocardial ischemia during postpartum haemorrhage. *Anesthesiology*, 100(1), 30-36.

Kavle, J.A. et al. (2006) Measurement of blood loss at childbirth and postpartum. *International Journal Gynecoly Obstetrics*, 95(1), 24-28.

Knight, M. et al. (2009 Trends in postpartum haemorrhage in high resource countries: a review and recommendations from the International Postpartum Collaborative Group. *BMC Pregnancy Childbirth*, 9, 55-65.

Larsson, C. et al. (2006) Estimation of blood loss after cesarean section and vaginal delivery has low validity with a tendency to exaggeration. *Acta Obstetricia et Gynecologica Scandinavica*, 85(12), 1448-1452.

Lutomski, J.E. et al. (2012) Increasing trends in atonic postpartum haemorrhage in Ireland: an 11-year population-based cohort study. *British Journal of Obstetrics and Gynaecologists*, 119(3), 306-314.

Mavrides, E. et al. on behalf of the RCOG (2016) Prevention of postpartum haemorrhage. *British Journal of Obstetrics and Gynaecology*.

Mousa, H.A. et al. (2014) Treatment for primary postpartum haemorrhage. *Cochrane Database of Systematic Reviews*, 2, CD003249.

Patel, A. et al. (2006) Drape estimation vs. visual assessment for estimating postpartum hemorrhage. *International Journal of Gynecology and Obstetrics*, 93(3), 220-224.

Prasertcharoensuk, W. et al. (2000) Accuracy of the blood loss estimation in the third stage of labor. *International Journal of Gynaecology and Obstetrics*, 71(1), 69-70.

Razvi, K. et al. (1996) A comparison between visual estimation and laboratory determination of blood loss during the third stage of labour. *The Australian & New Zealand Journal of Obstetrics and Gynaecology*, 36(2), 152-154.

Say, L. et al. (2014) Global causes of maternal death: a WHO systematic analysis. *Lancet*, 2 (6), e323-e333.

Schorn, M.N. (2010) Measurement of blood loss: review of the literature. *Journal of Midwifery & Women's Health*, 55(1), 20-27.

Zhang, W.H. et al. (2010) Effect of a collector bag for measurement of postpartum blood loss after vaginal delivery: cluster randomised controlled trial in 13 European countries. *British Medical Journal*, 340, c293.

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Pregnant Women as Research Subjects: Ethical Considerations

Why research on humans?

The aim of research is to provide practitioners with knowledge of physiology, disease processes, best methods of diagnoses and effective treatment, which can then be applied to the wider population.[1] Although a certain amount of research can be carried out without involving human subjects, ultimately humans have to be involved as some information can only be gained in this way. This raises questions concerning consent, voluntariness, and the balance between avoiding undue harm to participants and the need to gain more information, which ultimately will benefit human beings.

Research and vulnerable persons

For the purpose of research, certain categories of people are regarded as vulnerable. These include children, the elderly, those with mental illness or infirmity, prisoners. Pregnant women are also considered as vulnerable, not because they lose capacity and therefore are vulnerable per se, but because the fetus has to be included in the equation. Because of the fear of harming the fetus, pregnant women are frequently, almost automatically, excluded from clinical trials, therefore as a category they are under-represented.[2] [3] This exclusion impacts on the practice of evidence-based medicine.[4]

The importance of research in pregnancy

In 2002, the Council for International Organizations of Medical Sciences (CIOMS) issued ethical guidelines for research involving human subjects which specifically addressed research involving pregnant women. Guideline 17 states:

"*Pregnant women should be presumed to be eligible for participation in biomedical research. Investigators and ethical review committees should ensure that prospective subjects who are pregnant are adequately informed about the risks and benefits to themselves, their pregnancies, the fetus and their subsequent offspring, and to their fertility.*

Research in this population should be performed only if it is relevant to the particular health needs of a pregnant women or her fetus, or to the health needs of pregnant women in general, and, when appropriate, if it is supported by reliable evidence from animal experiments, particularly as to the risks of teratgenecity and mutagenecity."[5]

Being pregnant does not confer on the woman any immunity from illness or disease. A not inconsiderate number of women become pregnant while they are suffering from certain conditions, some of which are chronic, and thus will need new treatment or adjustment to their regular treatment. As women are postponing having children, maternal age will also impact on this. The older the mother is the more likely she will have a chronic condition or develop something while she pregnant, leading to an increase in the use of drugs for treatment.[6]

During pregnancy there is an alteration in the anatomy and physiology. Some of these changes are obvious, such as the enlargement of the uterus to accommodate the growing fetus, which places pressure on and to a certain extent displaces surrounding organs. Other changes, sometimes less obvious, include hormonal changes, increased blood volume leading to slight anaemia, oedema, slower digestive system and absorption, altered metabolism, and changes in the way the immune system works. Although all these are a normal, necessary response to pregnancy, it means that it sometimes can be more difficult to diagnose concurrent disease in a pregnant woman. Besides this, information about how treat pregnant women who are concurrently suffering from medical conditions is severely limited. In addition, drugs also can work differently during pregnancy, and can be more, less or not effective or unsafe. Therefore being pregnant can make it more difficult for the mother to get the correct diagnosis, or the right treatment at the right dose, leading to over-treating or under-treating.

There is a dearth of research regarding pharmacodynamics and pharmacokinetics to inform practice. Few drugs are approved to be used by pregnant women, thus most drugs prescribed are off-label. The harm of prescribing drugs to pregnant women must be balanced by the harm of not treating. Certain conditions or diseases can be worse than the treatment prescribed, not only for the woman herself, but also for her unborn child.[7] The impact that treating or not treating will have on health over time should also be considered.[8] There are also conditions which only affect pregnant women, such as pre-eclampsia and eclampsia. These conditions can severely affect both the mother and her fetus, and can cause severe harm and even death. Research in better diagnostic techniques and best treatment in these cases can only be done on pregnant women.[9]

Any study which poses a greater than minimal risk to unborn children tends to be problematic among researchers, boards of ethics and the prospective participants.[10] While it is important that pregnant women and their unborn children are protected from avoidable harms that could be caused by research, there are several reasons which justify their inclusion in clinical trials. There is the need for evidence gained under rigorous scientific conditions. Participating in a study may be safer than using drugs in a clinical setting where knowledge of that drug's effects are lacking. Thus less women and children would be placed at risk than the greater number who would be exposed when medications are placed in the market.[11]

In spite of this there is still some reluctance to include pregnant women, or those who can potentially become pregnant, in clinical research. Farden (2010)[12] argues that there is a moral urgency in including pregnant women and that it is unjust if they are excluded. When pregnant women are excluded they are denied any direct

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benefit which emerges from actually being included in a clinical trial. This does not only affect individual women but also pregnant women as a group. Pregnant women should be represented in clinical trials in proportion to their numbers in the general population. If however the research focuses on how certain conditions or medications affect pregnant women, and/or unborn children, the trails have to include a greater number of pregnant women.

Informed consent

When enrolling pregnant women to participate in research, there must be informed consent. This process must meet the highest standards. Prospective participants must be informed of potential risks to their own health and any hazards which the study will pose to their child.[13] This process of informed consent shows respect to a person's autonomy. But informed consent is not an objective process. The communication of information is subjective to emphasis and interpretation. One person may describe the risks and benefits of a particular research study in a completely different way to another, and yet both may be convinced that they gave unbiased, realistic and sufficient information so that the prospective participant can make a really informed choice.[14] There needs to be a discussion about the aims of the research study, including any benefits and risks in both accepting and declining to participate. It is the researcher's duty to ensure that all pertinent information is imparted.[15] Some risks will affect only the woman herself while being beneficial or neutral to the fetus, others may affect only the fetus but not the mother, while others will impact on both. Occasionally, it might be in the direct interest of the mother to participate in therapeutic research, if she has a rare condition, and refusing her as a research subject to protect the fetus might impinge severely on the quality of life or even limit her chances of survival.[16] Certain potential or possible risks or harm may be deemed as acceptable to some mothers, while others will perceive them as unacceptable.[17]

Pregnant women who do consent to participate in therapeutic research seem to value early access to the medicine, perceive an advantage regarding safety of the drug and also want to help advance knowledge in science. Significant risk of harm to the woman herself or to the child, or a requirement to drastically change planned therapy behaviour would disincline pregnant women to consent to take part in research.[18]

The language used when giving information, both spoken and written, should be a language which the woman can understand, not just the language spoken but in simple, everyday terms as far as possible.

Is the consent of the child's father necessary?

Obtaining informed consent for inclusion in a research study when the participant is a pregnant woman can be complicated by the question of whether the child's father also needs to give his consent. The Council for International Organizations of Medical Sciences suggests that if the research is directed at the health of the fetus it would be advisable to obtain the father's consent as well, where possible.[19] The American Congress of Obstetricians and Gynecologists states that the father's consent may be required if the research is intended to benefit the fetus, but if he is unable (not unwilling) to give his consent, then the mother's alone is enough.[20] In most cases the woman's consent to participate should be enough.

Conclusion

Although research involving pregnant women can be a sensitive issue, it needs to be carried out. Excluding pregnant women eliminates the problem of possible harm to the fetus. But incorrect or untimely diagnoses of conditions during pregnancy and prescribing off-label drugs can cause more harm than the research itself. Devising a rigorous methodology, and giving the prospective research participant information so she can make a real informed choice are safeguards to assure that no unnecessary risks are taken and to gain the knowledge necessary to inform practice.

References

1 David I. Shalowitz and Jeffery L. Ecker. "Research in Pregnancy: Back to First Principles," The American Journal of Bioethics 11, no. 5 (2011): 56-57.

2 Anne Drapkin Lyerly, Margaret Olivia Little and Ruth R. Farden. "Pregnancy and Clinical Research," Hastings Center Report 38.6 (2008), accessed May 11, 2015, https://muse.jhu.edu.journals/hastings_center_report/summary/v038/38.6.lyerly.html

3 Anne Drapkin Lyerly and Ruth R. Farden. "Mothers Matter: Ethics and Research During Pregnancy," AMA Journal of Ethics 15, no. 9 (2013): 775-778, accessed May 11, 2015. journalofethics.ama-assn.org/2013/09pfor1-1309.html

4 David I. Shalowitz and Jeffery L. Ecker, The American Journal of Bioethics.

5 Council for International Organizations of Medical Sciences. "International Guidelines for Biomedical Research Involving Human Subjects" (2002). Accessed May 18 2015. www.coims.ch/publications/layout_guide2002.pdf

6 Anne Drapkin Lyerly and Ruth R. Farden. AMA Journal of Ethics

7 Anne Drapkin Lyerly, "Direct Benefit to Pregnant Women." In Pregnant Women: Issues in Clinical Research. An ORWH 20th Anniversary Event Research Forum (2010): 15-19. Accessed May 11th, 2015, orwh.od.nih.gov/resources/policyreports/polf/ORWH-EPW-Report-2010.pdf

8 Ruth Macklin, "Enrolling pregnant women in biomedical research." The Lancet vol 357 (2010), accessed May 11, 2015. www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2810%2960257-7.pdf

9 American Congress of Obstetricians and Gynecologists, "Research Involving Women." ACOG Committee Opinion no. 377 (2007), accessed May 11, 2015. www.acog.org/resources-AndPublications/committee_opinions_committee-on-ethics/Research-Involving-Women

10 Anne Drapkin Lyerly and Ruth R. Farden. AMA Journal of Ethics

11 Ruth Macklin. The Lancet.

12 Ruth R. Farden, " Justice in Health Research: Beyond Protection From Risks." In Pregnant Women: Issues in Clinical Research. An ORWH 20th Anniversary Event Research Forum (2010): 20-23. Accessed May 11th, 2015, orwh.od.nih.gov/resources/policyreports/polf/ORWH-EPW-Report-2010.pdf

13 Ruth Macklin, The Lancet.

14 Martin G. F. Lupton and David J. Williams, "The ethics of research on pregnant women: is maternal consent sufficient?" BJOG: an International Journal of Obstetrics and Gynaecology 111 (2004): 1307-1312.

15 American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion.

16 ibid.

17 Rachel Reid, Daniella Susic, Shanthi Pathirana, Sally Tracy and Alec W. Welsh, "The ethics of obtaining consent in labour for research." Australian and New Zealand Journal of Obstetrics and Gynaecology 51 (2011): 485-492.

18 Anne Drapkin Lyerly, Emily E. Namey, Beverly Grey, Geeta Swamy and Ruth R. Farden, "Women's view about participating in research while pregnant." Ethics and Human Research 34 no. 4 (2012): 1-8. accessed May 18 2015. www.thehastingscente.org/Publications/IRB/Detail.aspx?id=5918

19 ibid.

20 27 American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion.

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What is the Experience of Being Pregnant in an English Prison?

Women in prison in the UK

There are 12 female prisons in the United Kingdom. Six of these prisons have Mother and Baby Units (MBUs) alongside (Kennedy, Marshall, Parkinson, Delap, & Abbott, 2016). The female prison population in the UK is around 5% of the total prison population (Carlen, 2013). It is appraised that roughly 6% of the UK's female prison population are pregnant at any one time(Albertson, O'Keeffe, Burke, Lessing-Turner, & Renfrew, 2014; Baldwin, 2015; Corston, 2007; North, Chase, & Alliance, 2006). The majority of women in prison are sentenced for non-violent crimes and often serve short sentences(Baldwin, 2015; Carlen, 2013). It is understood that many women who are incarcerated have a history of trauma in their lives, including sexual abuse, domestic violence, poverty and substance abuse (Albertson et al., 2014). Several women get to know of their pregnancy on reception to prison(Abbott, 2016). My curiosity in researching the experiences of pregnant women in prisons has been sparked by my professional interest as a midwife as well as having an interest in sidelined and excluded groups of women who often do not have their voices heard.

Doctorate study; initial findings

My doctorate study has been looking at the experience of what it is like to be pregnant in an English prison. I was able to interview 28 women who were pregnant or who had babies in prison. Seven of these women also agreed to have further follow up interviews with me. Initial findings showed that women feel stressed, worried about being separated from their babies and not having basic biological needs met. Many women interviewed talked about feeling hungry and fatigued. Women do have some good access to midwifery care in prison in the UK and some women who have disordered lives outside of prison will often receive better healthcare in prison. This is thought to be because women may be able to keep appointments more easily(Knight & Plugge, 2005). There is irregularity when it comes to antenatal groups(Kennedy et al., 2016). Women stated that they gained most of their information about labour, birth and breastfeeding from other women prisoners.

"Although you are pregnant, a part of you forgets that you are pregnant. Because you're in there because there's a lot to deal with. It's terrible really because you don't focus on what you should be focusing on". Jane, reflecting on her experience of being pregnant with her first child. Post release interview.

Stress and hunger

A number of women were unsure of their rights to apply for a mother and baby place. This echoes the findings of the charity Birth Companions (Kennedy et al., 2016). Women who did apply often did not find out about a place until late on in pregnancy. This was especially stressful, leaving women feeling fearful and sometimes blocking out emotions of love for their unborn due to anticipating potential separation. Some women have talked about how they continue to work until they are almost at their due date and occasionally beyond. Although the prison system does have guidance with regards to maternity leave, women are concerned with regards to the reduction in pay once a woman is not able to work. Food is a particular issue for pregnant women and new mothers: feeling hungry, having cravings and feeling nauseous are all difficult to manage in prison. Pregnancy "packs" of extra food are available in some prisons but the quality varies(Kennedy et al., 2016). Women often rely on the support and kindness of other prisoners and staff in order to get extra provisions.

"Sometimes in the night I can't sleep because I am hungry; I need food". Kirsty, 30 weeks pregnant with her second baby.

Evidence from a number of research studies shows that stress has a direct effect on the unborn baby. This in turn leads to high cortisol levels crossing the placenta, potentially leading to behavioural problems as the child grows up. It is crucial to consider the effect that the deprivation of entitlements, leading to fear and stress in some women in prison may have on the unborn baby.

"It is, and stressful, and there's…I don't want to feel stressed, because I don't want that transferring to my baby". Selma, 26 weeks pregnant with her first baby.

Some women find the support, care and shelter of prison a safe place for them, away from abuse, violence and the cycle of addiction they may be experiencing. For these women, prison may offer a better experience than on the outside. However, more provisions need to be

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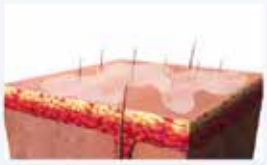
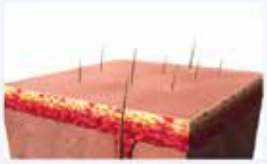


2. Applying BabyBene Gel to the dry scalp loosens the dry flakes.

3. With a few drops of water the oil-sebum mixture becomes a water-soluble emulsion.



4. After rinsing with plenty of water the baby's head is clean and neat again and has a pleasant smell.

Important: Please remove the dandruff first!

The formation of dandruff on the surface of the skin is common for many skin changes. This dandruff not only prevents the evaluation of the skin below but also make topical treatment more difficult. Therefore, the first step is always the gentle, skin-friendly removal of the dandruff.

BabyBene Gel – naturally special!

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- A skincare product based on natural ingredients
- Cradle cap is removed with the first application

High quality oils and plant extracts...

Naturally free of preservatives

Easy and quick application

Easy application, for instance with cradle cap

1. Apply the gel to the affected skin in a circular movement.

2. Depending on dandruff tenaciousness incubate for a few minutes, if necessary overnight.

3. Apply a few drops of water at a time and distribute with a circular movement. This will create an emulsion.

4. Rinse the emulsion with plenty of lukewarm water.

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available outside of prison to prevent this revolving door. Reducing the revolving door effect will have an impact on society, economically and upon the women and her children.

"Well, prison, for me, has been life-saving". Elsa, ex substance abuser, post birth interview on a MBU.

During the lead up to my research, I trained as and volunteered with the charity Birth Companions who provide support for women who are pregnant and becoming mothers in prison. I was also able to observe the work of the Born Inside project. The support from these charitable organisations is absolute, non-judgmental and delivered whether or not women are being separated from their babies or remaining with their baby. The Birth Charter, written by Birth Companions and based upon experience and research evidence was launched in May 2016(Kennedy et al., 2016). It calls for consistency and evidence based recommendations to be benchmarked throughout the UK.

The initial findings from my research echoes much of what Birth Companions have found over the years(Kennedy et al., 2016; Marshall, 2010). Early outcomes are demonstrating that there is a need for pregnant women in prison to feel less stressed and to have their pregnancy needs met regardless of their crime, whether they are being separated from their babies or joining an MBU(Abbott, 2016). Early analysis of the interviews is demonstrating that some women may find prison a safe place, especially those who are substance abusers. However, the majority of women find that prison exacerbates levels of stress that basic needs such as feeling hungry, are often not met and anticipation of separating from their unborn baby causes anguish and suppression of love for the unborn baby.

References

Abbott, L. (2016). Becoming a mother in prison. *The Practicing Midwife*.

Albertson, K., O'Keeffe, C., Burke, C., Lessing-Turner, G., & Renfrew, M. (2014). Addressing Health Inequalities for Mothers and Babies in Prison. *Health and Inequality: Applying Public Health Research to Policy and Practice*, 39.

Baldwin, L. (2015). Mothering Justice: Working with Mothers in Social & Criminal Justice Settings.

Carlen, P. (2013). *Women and Punishment*: Willan.

Corston, J. (2007). *The Corston report: a report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system: the need for a distinct, radically different, visibly-led, strategic, proportionate, holistic, woman-centred, integrated approach*. (1847261779). Home Office.

Kennedy, A., Marshall, D., Parkinson, D., Delap, N., & Abbott, L. (2016). Birth Charter for women in prison in England and Wales. In: Birth Companions.

Knight, M., & Plugge, E. (2005). Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review. *BMC Public Health, 5*(1), 111.

Marshall, D. (2010). Birth companions: working with women in prison giving birth. *British Journal of Midwifery, 18*(4), 255.

North, J., Chase, L., & Alliance, M. (2006). *Getting it Right?: Services for Pregnant Women, New Mothers, and Babies in Prison*: Lankelly Chase.

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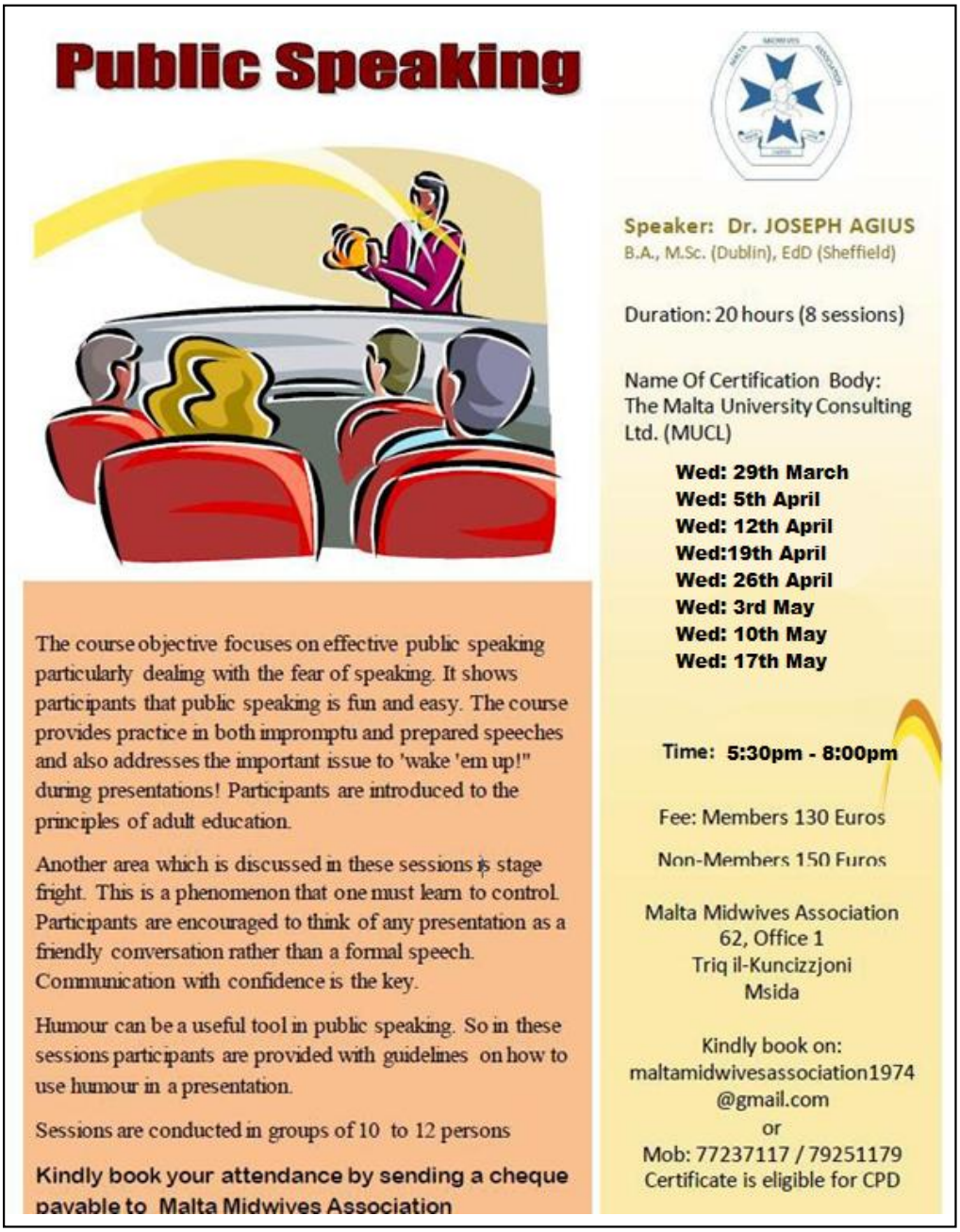

B.Sc Midwifery Abstracts – University of Malta

Quality Antenatal Care in the Local Public Health Sector- Midwives' Views

Quality of antenatal care is a significant determinant of the prosperity and safety of motherhood. The Institute of Medicine suggested a working definition of 'quality' in healthcare, in which the fundamental factors were highlighted: safety, timely, efficiency, women-centred, effectivity and equitable (Institute of Medicine, 2001). The aim of this study was to explore the midwives' views of the quality of antenatal care in the local public health sector. The objectives of the study were to seek the midwives' views and understandings on the factors that constitute quality antenatal care and to identify the midwives' strategies in improving the factors that constitute quality of antenatal care.

To fulfil the study's aim and objectives, a qualitative study was carried out, using self-designed semi-structured interviews, consisting of open-ended questions. The sample consisted of six midwives working at the outpatient's antenatal clinic, at the local general hospital and the sampling technique chosen was convenience sampling. Data was analysed by content analysis using Braun & Clarke (2006) framework.

The findings of this study demonstrate, that midwives are not acquainted with the notion of quality, as they failed to directly identify the six factors emphasised by the Institute of Medicine (2001). Notwithstanding this, in relation to their views on the local antenatal care services, all of the midwives identified that the provision of antenatal care locally, needs to better its quality.

Moreover, midwives were aware of the obstacles preventing the provision of quality care, and in view of this, proposed recommendations towards developing state of the art antenatal care services. This thus exhibits, that midwives do have a basic understanding of the multi dimensional concept of quality, however they might need further education and training in this regard. For this reason, the researcher proposed recommendations for education, clinical practice and further research.

Christine Borg

Women's Expectations of Antenatal Care in the Local Public Sector

Antenatal care is an important aspect of care given to pregnant women and includes the monitoring of maternal and foetal health, the provision of advice and information, and the required medical investigations to ensure a healthy outcome for the mother and baby, together with a positive experience of birth.

A quantitative study using a self-designed questionnaire was conducted to explore women's expectations of antenatal care in the local public health sector. The study seeks to meet three objectives; to explore women's views on the importance of antenatal care, to explore women's personal experience of the care provided, and to identify changes women may feel appropriate in their antenatal care. Forty women were recruited by convenience sampling to take part in this study. All participants completed the questionnaire; yielding a 100% response rate.

The results of the closed-ended questions were analysed by simple percentages, while open-ended questions were analysed by thematic analysis. The findings suggest that women think that antenatal care is an important aspect of care to ensure foetal development and the wellbeing of the mother and baby. The positive attitudes of midwives and the provision of useful and understandable information were elements which the participants were mostly satisfied with. On the other hand, the participants were mostly disappointed by the long waiting time, overcrowding, rushed visits and the lack of continuity of carer. Strategies to overcome these problems were suggested by the participants. Recommendations for practice, education and further research are proposed in the conclusion of this study.

Ruth Borg

Community Midwives' Views of Postpartum Emotional Wellbeing

The aim of this small scale study was to gain insight on midwives' strategies in dealing with women's postpartum emotional well-being, within the local community setting. The objectives explored midwives' knowledge of mothers' postpartum emotional well-being and also explored the midwives' role in dealing with emotional well-being of newly delivered mothers.

A convenience sample of six qualified midwives, having at least 4 years working experience and working with the Discharge Liaison Midwives (DLM) in the community sector, participated in a semi-structured, face-to-face, audiotaped interview. The data collected was transcribed verbatim and analysed using content thematic analysis as described by Braun and Clarke (2006).

Two main themes emerged from the midwives' accounts and included: 'Midwives' Knowledge on Postpartum Emotional Well-being' and 'Strategies in dealing with Emotional Distress'.

The findings demonstrated that midwives had different perspectives on knowledge of emotional well-being and have highlighted the need for further training to improve their competency in recognising women suffering from postpartum emotional distress. Specific training in conjunction with a standardised tool such as the Edinburgh Postnatal Depression Scale (EPDS) can improve early detection and adequate referral. Flexible, one-to-one midwifery-based postpartum care also had a preventive effect together with continuity of care and telephone based support system. Recommendations for further research practice and management and education were devised.

Roanne Camilleri

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Maltese Midwives' Views on Midwifery-Led Care

There is currently an emphasis on adopting a more natural approach to childbirth care. This approach is what is better known as midwifery-led care. Midwives, being the expert professionals of normal childbirth play a major role in this regard. Therefore in order to gain a better insight on how to increase normality during childbirth in the local scenario, Maltese midwives' views on the subject must be investigated. Hence, the aim of the study was to explore Maltese midwives' views on midwifery-led care. The objectives included: to define and explore Maltese midwives' understanding of midwifery-led care, to explore midwives' knowledge on the different models of midwifery-led care and to evaluate Maltese midwives' views of introducing midwifery-led care in the local scenario. A qualitative research design utilising a self-designed, semi structured, face-to face interview schedule was opted for. Ethical approval was sought and granted. Six Maltese midwives who met the inclusion criteria participated in this study, achieving a 100% response rate.

Interviews were audio-recorded and transcribed verbatim. Data analysis was conducted using the thematic analysis framework as suggested by Braun and Clarke (2006). Two themes emerged, namely: Maltese midwives favour midwifery-led care and Implementing a midwifery-led care approach to childbirth. The findings revealed that Maltese midwives prefer a midwifery-led care philosophy to childbirth rather than the obstetric medicalised approach to care presently adopted.

Participants believe that a midwifery-led care approach will yield greater job satisfaction for the midwife and a better quality care for the mother and her family. Barriers to implementing a midwifery-led care approach by local midwives were also identified. Recommendations for clinical practice, education and research are proposed.

Danica Chetcuti

First-Time Mothers' Experiences of Antenatal Visits

The exploration of womens' experiences with regards to antenatal visits has developed as a subject of research interest over the years as it is often viewed as indispensable to a healthy pregnancy. Awareness on the importance of antenatal visits has led to a reconsideration of antenatal care to meet women's needs, which is crucial in the development of a clear understanding of women's experiences of their antenatal visits.

A quantitative study was carried out, using a self-designed questionnaire, to explore first-time mothers' experiences of antenatal visits. A sample of 30 first-time mothers was selected by purposive sampling from the obstetric wards at the local general hospital. The objectives of this study were to identify the health care professionals, to assess the quality of care and involvement in decision making, and to assess the professional advice given to mothers regarding their wellbeing during pregnancy, labour and the postpartum period at the antenatal visits. The response rate was 100% (n = 30). Open-ended questions were read thoroughly and any connections between ideas and emerging themes were identified. Ethical considerations were maintained throughout the study.

This study revealed that the obstetrician is the preferred health care professional in the provision of antenatal care. Moreover, participants in this study reported that they expressed satisfaction with the quality of care received and felt involved in decision-making regarding their care generally. Participants in this study, also believed that not enough information was given during the antenatal visits regarding their wellbeing during pregnancy. Furthermore, this study revealed that mothers yearned for greater involvement in their care during their antenatal visits.

The importance of providing more awareness on the midwife's role during the antenatal visits also emerged in this study. The provision of resources in order to promote the midwifery profession would be greatly beneficial. Also, educational visits to antenatal clinics where antenatal care is provided by midwives would provide our local midwives with the opportunity to experience how midwives in other countries carry out their roles during the antenatal period. Added to these recommendations, qualitative and longitudinal studies which explore first-time mothers' experiences of antenatal visits are also recommended to be carried out locally.

Analise Cini

Mothers' Experiences of Mobility and Positon in the First Stage of Labour

The aim of this study was to gain insight into mothers' experiences of mobility and positions in the first stage of labour in the local, general hospital. The study's objectives were to explore mothers' perceptions about mobility during the first stage of labour, to explore mothers' experiences of adopting different positions and to explore how mothers perceived that mobility and/or positions adopted influenced how they coped with pain. To accomplish these objectives, a qualitative approach was adopted and self-designed, semi-structured, face-to-face interviews were conducted with a purposive sample of six Maltese mothers. These mothers made use of mobility and different positions in the first stage of their labour. Interviews were audio-recorded and then transcribed verbatim. Data was analyzed using thematic analysis as described by Braun and Clarke (2006). The findings demonstrate that most women were aware about the importance of using different positions and mobility during the first stage of labour. Participants obtained information from two main sources: parentcraft classes and midwives. Overall mothers shared their positive experiences. Mothers used mobility as a coping mechanism, helping them feel more in control of themselves and their labour. Participants also perceived that the birthing ball, stool and the on-all-fours position helped to relieve pain, increased their satisfaction and shortened their duration of their first stage of labour. Moreover the role of the midwife was highlighted as some mothers experienced positive and negative experiences which influenced their perception of labour. Finally, the importance of being supported from their partner during this time also emerged. In view of these findings, recommendations for practice, education and research were proposed, including conducting the study on a larger scale, with participants of different ethnic groups, with the use of pedometers and to assess the effects of midwives' roles on women's choice regarding mobility and adoption of different positions during the first stage of labour.

Anthea Cucciardi

Midwives' Experiences of Cardiotocography during Labour

The main aim of this qualitative study was to explore midwives' experiences of cardiotocography during labour. The study's objectives were to identify the different circumstances in which cardiotocography is used, as well as, to explore the thoughts and feelings of midwives with regards to cardiotocography. To achieve these objectives, a sample of eight midwives voluntarily accepted to participate in this study. The participants included in this study have been working within the labour ward at a local general hospital for more than a year. A self-designed, semi-structured interview schedule was used to conduct face-to-face interviews with each participant. Interviews were audio-recorded, transcribed verbatim and analyzed using thematic analysis as suggested by Braun and Clarke, (2006). All ethical issues were adhered to throughout the conduct of the study. Three themes were elicited from the semi-structured interviews conducted with the midwives. These were, 'Interpreting CTGs', 'Continuous cardiotocography versus intermittent auscultation', and 'Drawbacks of cardiotocography'. The participants discussed that intermittent auscultation is the preferred type of monitoring with low-risk women whereas continuous cardiotocography is the preferred type of monitoring with high-risk women. Despite this, midwives have agreed that continuous cardiotocography is being used "across the boards for all mothers". However, all participants agreed that the main problem with continuous cardiotocography, is the limited number of positions a mother can adopt during labour. In view of these results, recommendations for practice and management, education and further research were proposed, which included the need for better midwifery education regarding the standardisation in the interpretation of CTG traces, better management for low-risk and high-risk pregnant mothers during labour as well as conducting a similar study on a larger scale, and exploring the experiences of cardiotocography during labour from the mother and the birthing partner's perspective.

Lara-Marie Gilford

Midwives' Experiences of Caring for Obese Women in Labour

The aim of this research study was to explore midwives' experiences of caring for obese women in labour. Objectives were formulated to meet the aim of this study. These included: to describe midwives' feelings towards maternal obesity and to examine midwives' challenges and concerns of caring for obese women in labour. A qualitative research design was used. A self-designed, semi-structured interview schedule was used to gather data via an audio-recorded face-to-face interview. Eight midwives were purposively recruited from a local general hospital's labour ward. All ethical issues were strictly adhered to. The data was then transcribed and analysed using Braun and Clarke's (2006) thematic analysis. From the analysed data, 3 main themes emerged. The findings brought to light midwives' experiences of identifying obese women in labour. Whilst some midwives identified prejudice, other midwives advocated non-judgemental care when caring for obese women in labour. Obesity discussion was not a priority for midwives when caring for obese women in labour due to its sensitive nature. However they felt that the discussion of obesity would empower the woman and prevent further generations of obesity. Midwives experienced several challenges and concerns when caring for obese women in labour. These included challenges in practice, challenges in promoting normality as well as the associated risks and concerns when caring for obese women in labour. These findings were then discussed and critiqued with other existing literature. In view of these findings, recommendations for education, practice, management and research were proposed. Perhaps one of the most important recommendations is the need for education and training on both the discussion of obesity as well as the risks associated with obesity in labour. Other suggestions include the need for preconception care as well as the importance of increasing the midwife's presence antenatally and in the community to facilitate the discussion of obesity. Moreover, local guidelines need to be developed for the management of obese women in labour. Suggestions for further research include repeating the study with other HCPs, repeating the study with obese women and researching ways in which normality can be encouraged in obese women during labour.

Keywords: 'obesity', 'labour', 'midwives' and 'experiences'

Claudine Grech

Mothers Early Experiences Following the Discharge Home of their Premature Infant

The aim of this study was to explore mothers' early experiences following the discharge home of their premature infant from the Neonatal and Paediatric Intensive Care Unit (NPICU). The objectives were to explore mothers' thoughts and feelings, and experiences of support, during this period. A qualitative approach was selected and self-designed, face-to-face semi-structured, interviews were carried out with a voluntary, purposive sample of six mothers. Participants were required to have given birth at between 24 to 34 completed weeks of gestation, with the infant having been cared for at the NPICU of the local, general hospital. A 100% response rate was achieved. The interviews, held at approximately two weeks following the infant's hospital discharge, were audio recorded, transcribed verbatim, and analysed though thematic analysis as described by Braun and Clarke (2006).

The findings demonstrated that a general sense of preparedness for infant care at home was sometimes shaken by a perception of infant fragility. Maternal self-assurance was bolstered by knowledge gained, and infant care skills practiced, while at NPICU. Positive aspects of caring for the infant at home included increased opportunity for maternal-infant bonding, a gradual growth in confidence, and pleasure gained from infant's progress. Negative aspects related to anxiety regarding infant's health, led to needs for reassurance. Support received from family and healthcare professionals during this period was considered essential in aiding the transition.

Hence, it is recommended that midwifery community visits are concentrated in the very early period following the infant's discharge, when need for support is most acute. The need for further research exploring the experiences of mothers with infants born prior to 24 weeks is identified.

Ann Marie Meilak

Mothers' Experiences of trial for Vaginal Birth after a Previous Caesarean Section

The aim of this qualitative study was to explore mothers' experiences of trial for vaginal birth after caesarean section (VBAC). The study's objectives were to explore how women made the decision to try for VBAC and to explore their understanding of the experience in relation to the method of birth.

A purposive sample of six adult mothers who experienced a trial for VBAC voluntarly participated in a semi-structured, face-to-face, audio-recorded interview. A 75% (n=6) response rate was obtained. The data collected was transcribed verbatim and was analysed thematically, as described by Braun and Clarke (2006).

The findings show that participants gained most knowledge about VBAC from their obstetrician but additional sources included self-initiated research and parentcraft classes. The obstetrician was also considered the most influencial figure in the decison to attempt VBAC. During the decision-making process, emotional and practical considerations such as a desire for natural birth, and implications for recovery were taken into account. Successful VBAC was associated with emotions of satisfaction and pride, while failure to achieve VBAC sometimes led to disappointment. Previous and recent experiences of birth and associated pain were compared. Support from midwives and other health care professionals during the birth experience was viewed as essential. The women had differing views about preferred birthing method in a hypothetical future pregnancy. Recommendations for practice, management, education and further research are proposed, such as the need for longitudinal research over the course of pregnancy following an LSCS, to allow for clearer insight into how and when the decision regarding birthing method is made.

Vanessa Micallef

'Couples' Experiences of an Emergency Caesarean Section

This study aimed to explore couples' experiences of an emergency caesarean section. The objectives were to explore couples' thoughts and feelings in relation to an emergency caesarean section and their perceptions of the care and support received from midwives throughout the operative delivery. A qualitative research design was used, with data generation achieved through audio-recorded, semi-structured, face-to-face interviews with a voluntary, purposive sample of seven couples (7 men and 7 women), who had experienced an emergency caesarean section. Participants were required to be partnered or married adults, where the male partner was present for the operative delivery. A 100% response rate was achieved. Thematic analysis, as described by Braun and Clarke (2013), was used to conduct out data analysis. Couples going through an emergency caesarean section experienced a range of emotions, both negative and positive. The predominant feelings immediately prior to the caesarean section were fear and concern about maternal and fetal wellbeing. These feelings were replaced with emotions of relief and happiness upon the birth of the infant. However a sense of helplessness related to a loss of control, and disappointment at failure to achieve vaginal delivery were also evident. The significance of mutual support within the couple was evidenced by their strong desire to stay together throughout the experience. Midwives' attentiveness, knowledge and competence were regarded as vital, and where communication with the midwife was lacking, the birth experience was negatively affected. Recommendations for practice, education and research are proposed, including the need for antenatal education that better prepares couples for the possibility of emergency LSCS.

Graziana Pulis

Postnatal Mothers' Experiences of Using Entonox® in their First Stage of Labour

The use of inhalation analgesia, Entonox®, may provide adequate pain relief for partuating women. It helps women to retain control over their bodies and mobilise during their labour because it does not have any effect on the individual's muscle tone. The aim of this study is to gain an understanding of postnatal mothers' experiences on the use of Entonox® in their first stage of labour. The key objectives are to explore mothers' thoughts and feelings on the use of Entonox® during their first stage of labour and the mothers' sources of education on the use of Entonox® during labour.

In this retrospective qualitative study, semi-structured face-to-face interviews were conducted with 7 postnatal mothers who were selected by convenience sampling. The interviews were audio-recorded, transcribed, and translated into the English Language and then analysed thematically (Braun & Clarke, 2006). The three main themes are Labour pain and Entonox®; Entonox® in labour and the Mothers' Knowledge of Entonox®. Entonox® did not directly relieve every mothers' pain, but its sedative effects distracted mothers from their pain during labour. Entonox®'s side effects, which were of minimal severity and disturbance, were tolerated well by the mothers in this study.

Further, Entonox®'s simplicity of use was welcomed by mothers and also enabled them to mobilise and maintain control of their own bodies during labour. The mothers appreciated the midwives' teaching on Entonox® and also their demonstration of the use of Entonox®. The limitations of this small scale study are highlighted in the last chapter of this study, with the main limitation being its small scale.

Jessica Richards

Midwives' Experiences in Reducing Perineal Trauma during Spontaneous Birth

Women who give birth vaginally commonly sustain trauma to the perineum. Midwives use different clinical skills with an aim to protect the perineum, thus preventing physical and psychological maternal morbidity (Albers et al., 2005). The aim of this qualitative research project was to explore midwives' experiences in reducing perineal trauma during spontaneous birth. The objectives were; to identify the clinical skills that help reduce perineal trauma, to explore which of these skills midwives prefer to use and feel satisfied with, and to explore the advice given to mothers in attempting to minimise perineal trauma.

Five midwives, with 4 to 29 years of experience within the local Delivery Suite, were chosen by convenience sampling. Midwives voluntarily participated in an in-depth, self-designed, face-to-face, semi-structured, audiotaped interview. A response rate of 100% was achieved. All data collected was transcribed verbatim and thematically analysed (Braun and Clarke, 2006). The two main emerging themes included: 'Midwives' Practice' and 'Midwife and Mother: Partners-in-care'. 'Midwives' Practice' included an overview of the use and preference of a variety of clinical skills to decrease the chance of perineal trauma, ultimately resulting in professional satisfaction. The theme also included midwives' reflection on cases where perineal trauma was not prevented. In 'Midwife and Mother: Partners-in-care', importance was given to the midwife-mother relationship since this is fundamental in improving perineal outcomes. This relationship is developed and promoted by effective communication and individualised care.

A number of recommendations for practice and management, education, and possible future research were proposed. With regards to practice and management, opportunities for midwives to share their experiences would promote the use of successful practices, hence helping other midwives to consider more effective practices. Furthermore, the encouragement of continuous professional development via education programmes developed from evidence-based studies would ensure the use of best practices. A list of possible future studies include the auditing of clinical skills being applied in delivery rooms, assessing the effects of perineal trauma on women, and repeating this research project on a larger scale.

Isabelle Sammut

Postnatal Mothers' Experiences of their Pain in Labour

Labour pain is a subjective, unique and "*unpleasant sensory and emotional experience*" (IASP, 2012) that categorizes amongst the most agonizing forms of pain (Beigi, et al., 2010; Conell-Price, et al., 2008; Ibach, et al., 2007; Pirdel & Pirdel, 2009). Studies show that labour pain is relative to the orientation in which labour is carried out. This retrospective qualitative study aimed to explore postnatal mothers' experiences of their pain in labour. The objectives of this study sought to: explore mothers' experiences of pain in labour and to explore how mothers coped with their pain during their first stage of labour.

A convenience sample of five postnatal mothers (N=5) within the maternity wards of one local general hospital, voluntarily participated in a self-designed, in-depth, semi-structured, face-to-face, audio-recorded interview consisting of open-ended questions. A 100% response rate was achieved. The collected data was transcribed vertabim whilst Braun and Clarke (2006) thematic analysis was used to analyse the data.

Four themes were derived from the mothers' accounts, namely: Women's Experiences of Labour Pain; Inhibitors of Successful Coping; Coping with Pain Enhancers; and Midwifery Approach of '*being with women*' in Pain. The findings demonstrated that postnatal mothers have very strong views and often hold a mixture of emotions with regards to their experience of labour pain. In retrospect, the experience of labour pain was often viewed as meaningful and empowering. The experience of pain was highly dependent on the mother's perception, attitude and outlook towards labour pain and its purpose. Additionally, the experience of labour pain was greatly influenced by an array of physiological, psychological and environmental factors that acted as stressors or motivators. Women yearn for an optimal women-centred environment and a positive midwifery atmosphere, to facilitate a more satisfying maternal labouring experience.

In view of time constraints, the study recruited a small sample size. However, given the qualitative research design, the small sample size strengthened the study because it enabled a deeper understanding of the mothers' experiences. Recommendations for practice and management, education and future research included, the need for: introduction of antenatal community midwifery; establishment of continuity of care and carer to facilitate the formation of a trusting midwife-mother relationship; the provision of personalised woman-centred care; better quality midwifery education and establishment of compulsory and continuous professional development (CPD) courses regarding the most updated research on intrapartum management of pain; and finally, conduction of the study on a wider scale, using a mixed method research design, and perchance also adopting a longitudinal approach.

Krystina Zahra

First-Time Mothers' and Fathers' Post Birth Views of Antenatal Classes

The aim of this study was to explore first-time mothers' and fathers' views on antenatal classes once they have gone through the experience of childbirth. The objectives of the study were to explore how attending antenatal classes affected mothers' and fathers' childbirth experience, and how useful the information was in preparing them for childbirth.

A convenience sample of ten participants (five couples) voluntarily took part in this research. To fulfil the study's aim, a self-designed schedule was used to collect data through face-to-face, semi-structured interviews during the postpartum period. A 100% response rate was obtained. The collected data was first transcribed verbatim and then analysed using thematic content analysis as described by Braun and Clarke (2006). All ethical issues were taken into consideration as stipulated by the University of Malta Research Ethics Committee.

Three major themes emerged from the analysis of the findings, namely; the need to learn, preparation for birth, and factors influencing satisfaction with antenatal classes. The findings demonstrated that mothers and fathers were satisfied with the overall content of the antenatal classes. It was clear that the couples learnt a great deal from the information they were given on childbearing and childbirth. This study showed that this information prepared couples for their upcoming birth experience. The findings also revealed several characteristics of antenatal classes which caused dissatisfaction, mostly related to the course structure.

It may be recommended that better time management and balance of information on childbirth and parenthood preparation should be adopted. Furthermore, the provision of postnatal education classes should also focus more on hands-on sessions dedicated to practising baby care skills. Other suggestions include exploring the views of non-attenders, and repeating this research on a large scale. The need for qualified midwives to be kept up to date with current, state-of-the-art practices, is also recommended.

Enya Zammit

Bottom Row: Left to right
Gail Galea, Enya Zammit, Isabelle Sammut, Christine Borg, Maja Leontijevic, Claudine Grech
Top Row: Left to right
Krystina Zahra, Graziana Pulis, Ruth Borg, Ann Marie Meilak, Jessica Richard, Anthea Cucciardi, Danica Chetcuti, Lara Marie Gilford, Vanessa Micallef, Annalise Cini, Roanne Camilleri

Half Day With A Difference

Date: 5th April 2017

Time: 8.45am – 1.00pm

Dar il-Hanin Sammaritan,
Santa Venera

Service conducted by:
Fr Franco Fenech OFM

Doris Grima: 2545 5170/6 • 7723 7117
Pauline Fenech: 7925 1179

Refreshments available

Donation of € 5.00

Malta Midwives Association

Nasal hygiene

The essential act **for baby care**

During the first months of life, babies' breathing is almost exclusively nasal and they cannot blow their noses. Their natural defences, which are still immature, make them delicate individuals. The solution in order to protect them: STÉRIMAR® baby. A simple act of daily hygiene for a healthy nose.

An act that puts a smile back on a baby's face

Babies feel very bad about having a blocked nose since they cannot readily breathe through their mouths. As soon as the mucosae become obstructed, they sleep poorly, become grumpy, turn down their meals and also run the risk of becoming dehydrated. Used every day during washing, STÉRIMAR® baby ensures a perfect lavage of the nose. From the first spraying onwards, they breathe more easily and recover their smile. A genuine alternative to physiological saline, STÉRIMAR® baby therefore helps to prevent disorders of the ENT sphere (colds, rhinopharyngitis and otitis…) by reinforcing the natural defences of a baby's nasal mucosa.

A pampered little nose...

Rich in trace elements and mineral salts, STÉRIMAR® baby is an isotonic seawater solution that does not irritate a baby's nasal mucosa since its salt concentration is similar to that of the cells of a baby's body. Its baby nozzle, equipped with a collar, has been specially designed to be gentle on a baby's nose. So, right from the earliest months, make STÉRIMAR® baby a daily habit!

Very gentle spray • Baby's nozzle •

EASY • SIZE 50 ml • TO CARRY AROUND

Washing a baby's nose: instructions

Lay the baby on his/her side or in a sitting position with the head tilted to one side:

- spray once to prime the system,
- gently insert the nozzle into the baby's nostril,
- administer one spraying and allow the surplus solution, which should contain the mucus, to drain away and wipe the nose,
- clean the nozzle with soapy water, rinse and wipe,
- repeat the operation in the other nostril.

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