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Malta Midwives' Journal



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Midwives Day
2015



Malta Midwives Association

Issue 6 Jul 2015

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Nasal hygiene



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



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

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Editorial

Welcome to the 6th edition of this bi-annual journal. The aim of this publication is to build a close working relationship between midwives and the Association as well as to provide a reliable source of information for practice. By keeping abreast of innovative practices, midwifery in Malta will be improved.

After receiving several name options for this publication, it was agreed that it will be changed to 'Malta Midwives Journal'.

This issue features a number of interesting articles and the launch of a project called 'The Sexual and Reproductive Health Project' co-ordinated by Ms Ruth Marie Xuereb where the MMA is collaborating with Integra and Kopin organisations.

A brief history on how midwifery was practiced during a time when maternity services were scarce and homebirth was considered the norm is written by Ms Janice Cassar. Contrastingly Ms Antonella Ellul discusses the importance to retain and preserve our basic midwifery skills to modern technology while Ms Analisa Agius explores how to improve intrapartum practices by developing a reflective tool to evaluate these practices in childbirth. Additionally, the article by Ms Pauline Borg explores the care of prelabour rupture of membranes in a term pregnancy and gives a critical overview on how these women are being managed on admission to hospital. Ms Alice Cassar highlights the importance of probiotics and prebiotics and how these can be acquired and enhanced while Ms Adriana Zammit writes on optimising the care of NPICU babies by implementing supportive positioning for optimal development.

This issue rounds off with five MSc abstracts. It is very encouraging to note that more midwives continue to study after their degrees. Congratulations to all for your achievements.

I hope you enjoy this issue and if you have any feedback or ideas, do let me know.

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Pauline Fenech

Forthcoming events

**Malta Midwives Association presents:
 Early Neonatal Behaviour Assessment Conference:
 18th September 2015.**

International speaker Ms E. Hills. Dolmen Hotel, Qawra.

**1st Congress of Joint European Neonatal Societies (JENS):
 16th - 20th September 2015. Budapest, Hungary.**

The 9th International Conference for Brain Monitoring & Neuroprotection in the Newborn: 1st -3rd October. Cork, Ireland.

XXI FIGO World Congress of Gynecology and Obstetrics. Quality Care for Women throughout Life: Partners for Health. 4th - 9th October 2015. Vancouver, Canada.

Midwifery Today Conference: "Pillars of Midwifery: Insight, Information and Intuition": 21–25 October 2015. Bad Wildbad, Germany.

Baby Friendly Initiative Annual Conference: 18-19 November 2015. Harrogate International Centre, UK.



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³ D. McKenna (Royal Victoria Hospital) et al. 'a randomised trial investigating and iron-rich natural mineral water as a prophylaxis against iron deficiency in pregnancy' in Clinical and Laboratory Haematology, 2003, 26 99-103.

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Message from the President - July 2015

Colleagues I am writing this message as our prospective midwives are sitting for their exams.

Exams, very often lead to stress and anxiety but it is also the time to examine the knowledge acquired throughout the long journey of preparation towards professionalism. It is important to assess and evaluate the competencies necessary, to certify the final year student as a safe practitioner.

Certainly, profound knowledge is essential, excellent proficient skills and practices are fundamental, but these do not include the whole perspective. Our professional care will have a valuable meaning if we apply the shared purpose to acquired excellent health and wellbeing of the families. Care based on empathy, respect, and dignity.

We need to be committed to provide optimal, evidence based care in order to meet the **holistic needs** of our service users. We need to have the courage to be advocates for the best interest of the mothers and babies. We need to have the personal strength and vision to innovate and to embrace new ways of practice. Midwives we need to give to the mother and child our skills of the **heart, mind and hands**.

Collective efforts will facilitate implementation of new practice. Reflective practice and continuity of care throughout pregnancy, childbirth and beyond will support the necessary transformation of maternity care towards physiology of birth. Individually we are only a drop of water, together we are an ocean.

A midwife should consider herself a safe practitioner unless she provides professional care that truly meets the holistic needs of the mother and family. Active contribution to the process of change is crucial, if the midwifery profession is to provide care that is appropriate to the art and science of the 21st century.

We need to move forward to become the **lead professional** for women with no complications and the **coordinator of care** for all women as envisaged by Midwifery 2020. This vision could only be a reality if care provided is built on values, attitudes and behaviour that place the women and her family at the centre. Values based on caring, compassion, excellence, empowering, collaboration and safety should be an integral part of our professionalism. Care provision should meet the criteria of being a qualified safe midwife at all times. This Vision and strategy should be the mission of every student, novice and experienced midwife.

On behalf of MMA I wish all students a future of hard work and success, following an academic year of intensive work. A final word and a warm welcome to the newly qualified midwives; you are the ones who in collaboration with midwives in the field will take the midwifery profession forward. Colleagues I wish you all a memorable well deserved break and quality time with your family.

Mary Buttigieg Said



Early Intervention and Assessment of the Neonate A Day Conference

● **Lecturer:** Ms Emily Hills

Neonatal Occupational Therapist,
Royal Free NHS Foundation Trust, Barnet
Hospital.

● **Date:** 18th September 2015

● **Venue:** Dolmen Hotel



The Conference will cover:

- NIDCAP model of developmental care.
- Sensory Development and the environment.
- Family centred care.
- Brazelton Neonatal neurobehavioral assessment scale.
- Regulatory disorders and irritable babies, case studies.
- Moving and handling of the preterm.
- Positioning, Swaddling and Kangaroo Care.
- Neurological assessment and early identification of Cerebral Palsy.
- Developmental Follow-up using Bayley scales.

For further information contact us on:
maltamidwivesassociation1974@gmail.com

Teaching will be through
video demonstrations and lectures



Treasurer's Message

Six months on, it is again time to provide colleagues with a resumé of activities held over the past few months. We have had a relatively successful and intense six months of activities.

It is heartening to note that membership is still on the increase. And speaking of membership, allow me to remind you that membership can be financed through the CPD. Obviously membership should lead to active involvement in the Association and not just passive adherence.

Hence we continue to encourage you all to participate in the seminars, talks and other activities organised by the MMA.

It was good to note that the number of midwives and student midwives who attended the Buffet Dinner help on Midwives' Day was substantially greater than in past years.

It was also the first time that Midwives' Day was, as is only fitting, celebrated in Gozo. Another initiative to mark Midwives Day was the distribution of cakes in all those

wards where midwives were on duty on the day, and hence could not participate in the social gathering.

Turning our attention to the premises at Msida, given the ever increasing popularity in the use of the premises, the MMA decided to upgrade. We invested in a set of 60 new chairs to replace the old ones that had been in use for quite some time. Also, we bought more pillows as, due to popular demand, the Pilates sessions had to be increased. You will recall that originally we started off by holding one session a week. Now three sessions are being held weekly.

These successes are only possible thanks to your contributions, be they through membership and/or voluntary efforts. And it is only fair to end this short report by thanking each and everyone of you who has somehow contributed for the continued success of the Association's activities.

Doris Grima
Treasurer

Secretary's Message

Dear Colleagues,

Firstly I would like to thank all our members for believing in us and contributing during the activities organised by the association. This means a lot to us as, without each and everyone's contribution we will not be able to continue our work.

Earlier this year the MMA has organised its Annual General Meeting, where we discussed what has been done during the previous year and what our future plans are. One of the discussed issues was the possibility of changing the name of our magazine, after a general request from our members. The new proposed titles were published and circulated thus I encourage you to give your input and suggestions.

Also, the MMA would like to thank its previous members, Ms Rebecca Gilson, Ms Analise Gingell and

Ms Stephanie Cutajar for giving their valuable time and input throughout their time as committee members. With pleasure, I welcome our new committee members Ms Charlene Attard, Ms Monique Abela and Ms Emma Beck, who have already given their valuable input throughout the past weeks.

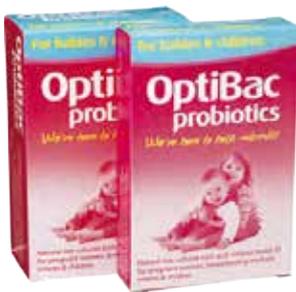
The MMA welcomes any feedback; you can do so by sending us an email or contacting one of our committee members. Furthermore, if you wish to be listed in our mailing list please forward us your information via email on maltamidwivesassociation1974@gmail.com

Marie Soler
Secretary

2015 – 2016 Committee

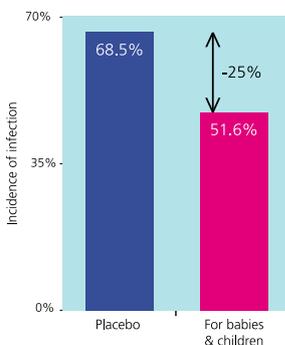
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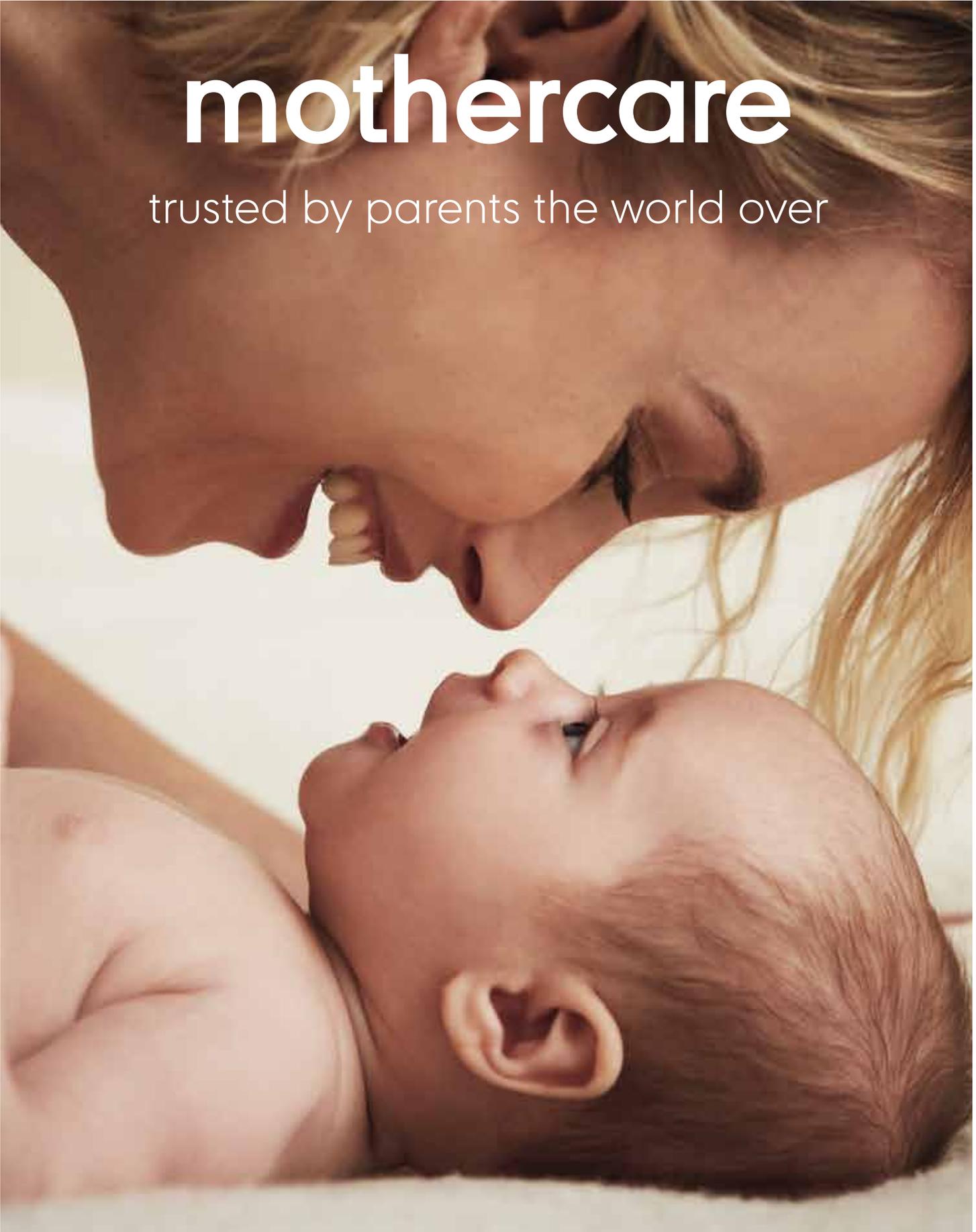
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The Sexual and Reproductive Health Project

In collaboration with the Integra Foundation, KOPIN has launched a new Sexual and Reproductive Health Project supported by the Julia Taft Refugee Fund and the US Embassy in Malta. The Sexual and Reproductive Health (SRH) project was developed in response to the steady influx of refugees reaching Malta since 2002. According to UNHCR, more than 14,500 refugees have arrived in Malta by boat between the years 2002-2011, mainly hailing from Sub Saharan countries, with 13% of total arrivals being women (UNHCR, 2012). The majority of arrivals are between the ages of 18-30 years, that is, at the peak of their reproductive years. In 1994, at the International Conference on Population and Development. (ICPD), reproductive rights were clarified and endorsed internationally and became recognised as a basic human right of all men and women, including children and adolescents, throughout life. Shortly after, in 2000, there was the establishment of the Millennium Development Goals (MDG). to be reached by 2015 and more than half of these goals focus directly or indirectly on Sexual and Reproductive Health. Hence, this is a primary concern for Malta as well as refugee women and their families who reside in Malta.

The project aims to address the area of pre/post natal care and to build on a number of initiatives that have been implemented in Malta to date, including inter alia KOPIN's European Refugee Fund (ERF) financed Project: Empowerment and Self-Reliance of Women Refugee in Malta (2011-2013); the 2013 seminar Exploring Cultural Competency of public staff working in the area of Midwifery and Obstetrics; and the Senperforto Sensitization Kit .

Moreover, this project aims to improve and develop the provision of sexual and reproductive health services for refugee women and their families residing in Malta. More specifically, the project aims to:

- Provide a holistic service that facilitates communication and strengthen relationships between refugee women and Mater Dei Hospital (MDH) staff in Malta.
- Contribute to the learning needs of MDH staff with regard to the sexual and reproductive needs of refugee women.
- Contribute to the sexual and reproductive health learning needs of refugee women.

The Sexual and Reproductive Health Project adopts and promotes a participatory and collaborative approach

that not only privileges the knowledge base of refugee women and their families, but also provides for their learning needs in a meaningful way that promotes dignity and well being. In this way, female refugees and their families are engaged in the learning process as active agents: knowledge producers rather than knowledge consumers. At the same time, the project aims to facilitate a dialogical and democratic relationship with health care providers, more specifically public sector nursing and midwifery staff working in the area of Midwifery and Obstetrics in order to provide a more sensitive, engaged, competent and holistic practice.

Through this project, Kopin and the Integra foundation teamed up with the Malta Midwives Association. Together, they organised a showing of a documentary, 'Suspended Lives' produced by the Jesuit Refugee Service Malta (JRS Malta) focusing on the hardship faced by asylum seekers and forced migrants in Malta. The purpose of showing this documentary was to show the deep scars which asylum seekers carry throughout their journey; to reveal the realities of their hopes, fears and hardship that they face every day and their resilience; and to reflect on how we, as health care professions to better understand so we can improve the quality of care given to refugee women residing in Malta.

When it comes to caring for such families, one of the main barriers is language. Due to the lack of Cultural Mediators, MMA together with Kopin and Integra Foundation started working on a phrase booklet. The idea is to have some words and phrases commonly used (including: *Hello, how are you?, Always have your blue card with you, Contractions, Nappies etc*) translated in different languages including Somali, Tigrigna, Ahmaric, Arabic, French, and Turkish. Through this initiative, communication with such groups is made easier. In the near future we will be carrying out phonetics talks and lessons by experts which will further help facilitate the use of the phrase book. Moreover, we are planning to have the hospital list and the hospital visiting hours translated into languages, and coordinate and conduct antenatal classes or talks on pregnancy, childbirth and childcare to refugee and migrant families. This project is still relatively new and the MMA is open to all suggestions, ideas and a helping hand.

Ruth Marie Xuereb
Elizabeth Tratnik
Daniela Grech

Letter

For the occasion of the International Day of the Midwife, the Malta Midwives Association thought to organise a dinner for its colleagues in Gozo. The dinner was held at the Cornucopia Hotel in Xaghra Gozo. It proved to be a lovely night out filled with lots of laughs, wonderful food, good wine but most importantly great company. The Association also bought banoffee pies for those carrying out their duties at the Maternity Ward in Gozo and hence could not be with us for the event. On behalf of all my colleagues here in Gozo, I would like to thank the Malta Midwives Association for its efforts in organising this event.

Ms Georgette Spiteri

The Midwife and Her Skills Since the 1900s

The concept of midwifery was always the same since the very beginning of humanity, that of helping woman give birth. However, the role of the midwife during pregnancy, birth as well as the practice of care for mother and baby after birth has changed.

Along the years, research and development regarding medical practices may have brought progress and influenced the mortality and morbidity rate, however, it may have affected less positively the skills of the midwife. Today it is hard to imagine a midwife delivering a baby in an underground shelter during an air raid, having only a small petroleum lamp which may go off with every falling bomb! It is hard to imagine how the midwife travelled on foot on a daily basis from one locality to another carrying a heavy bag whilst visiting women to deliver their babies. Most often the midwife of the 20th century had to prioritise to those women who were most likely to deliver their baby sooner than others or else having to deal with multiple labouring women simultaneously.

The majority of the midwives who practiced between 1900 and 1959 were always 'on call' providing their service on a 24 / 7 basis in order to deal with all the pregnant women's needs! The midwife's role included: assisting deliveries in all possible environments and circumstances, providing ante natal care to pregnant women as well as providing daily post-natal care to mother and baby at home. During the postnatal period the midwife offered her services to help the mother care for her baby and support her to adjust into her new role as a new mother.

Moreover, I have to point out that the midwives of the 20th century used to work autonomously. They used to summon the doctor only when the progress of birth was not considered to be as expected, in situations of midwifery emergencies such as antepartum haemorrhage, fetal distress, abnormal lie or during the event where the neonate required resuscitation. Contrastingly, today most babies who present as breech, twins or face, are routinely delivered by C-section in hospital. The midwives of the past had the experience and the skills to deal with such occurrences during homebirths. Although in such situations it was not always the best option for the mother and baby for a vaginal delivery, the midwives used to do their best to safeguard both lives as sometimes having a home birth and vaginal delivery were the only possible options.

Medical provisions, housing and hygiene were very limited during the First and Second World War, hence being a midwife during that period meant that one had to improvise. They used to depend on natural remedies and alternative methods, for example, giving a mixture of Rum, sugar and warm water to stimulate the baby to cry. Another asset in midwifery which was not easily available before the Second World War was analgesia (general, local or inhaled) hence women had to tolerate all the pains during suturing, manual manipulation and manual removal of the placenta. The midwives of the 20th century had to work hard in order to influence the mother psychologically during any painful

procedure including labour. They used compassion and faith – praying and the use of 'touch therapy' in order to help the woman go through painful procedures and labour.

Environmental features in the house may have influenced the women's perspective regarding childbirth. Having a 'birthing room' incorporated as part of the structure of the house and having close relatives during birth may have reduced the fear of anticipation for the expectant mother. Moreover, the midwives of the 20th century were well known by the locals and very much respected. Every woman depended on the service of the local midwives whilst the midwives were obliged to help everyone and at any time. It was not unusual for these midwives to provide their service for free especially to the refugees who travelled away from the harbour area to seek shelter from the bombardments of war. Midwives especially those in Zejtun spent hours on their knees in the mass refugee camps assisting women in labour whilst these women had to lie uncomfortably on the floor as beds or mattresses were not always available.

What would childbirth be like if today's midwives used to work like the midwives of the 20th century? What are those factors which inhibit the present Maltese midwives from assisting home births as former midwives used to assist, even though all the necessary equipment and analgesia are nowadays easily available?

Did medical advances bring regress as regards childbirth or did the midwives slowly let go of the precious skills which

they used to possess? Will the Maltese women ever have the opportunity to deliver their baby at home again?

Being pregnant in the early 20th century meant that women delivered their babies at home, surrounded by close relatives, assisted by the local midwife. Analgesia and/or c-section were not an option. Being pregnant from the year 2000 in Malta means that women will deliver their babies in hospital, have only one relative to accompany them, will be assisted by a midwife which they may never have met before. In addition, women may consider and choose to be delivered by a C-section.

Let's all praise the skills of the midwife of the 20th century while thrive to maintain and develop the skills of the present midwife for the benefit of mother and baby as well as the midwifery profession.

The Author, would like to thank all the midwives who attended for her presentation. She would also like to thank the many midwives and their relatives who accepted to be interviewed and were willing and passionate to share with her their midwifery experiences. Their encouragement and their support was greatly appreciated and she looks forward to continuing to complement this research on the role of the midwife in Malta.

Janice Cassar

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CDS



NPICU



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The Value of Revisiting the Art of Midwifery Skills

The midwife can be defined as the health care professional who is responsible for the woman from preconception to the postpartum period. It is within the midwife's role to care for the woman and her family in many ways so as to attend to the various needs arising in relation to childbearing (ICM, 2014). This central role has remained consistent over time however the way it is actuated has changed, in that midwifery practice is now heavily influenced by technology and the hospital setting. Therefore, it is imperative for one to reflect and reconsider strengthening the role of the midwife in terms of valuing hands on care. Are we giving the necessary importance to midwifery skills? A report by Ina May Gaskin (2004) discerns her concern on the current situation that we are surrounded by, that is, of losing our midwifery skills over other distracting dilemmas in midwifery. Eliciting a self-critical analysis of what is done to mothers on a daily basis, one can reflect that we are fast forwarding our care at the expense of appropriate hands on care.

interaction between the midwife and woman, making this experience less of a routine and less medicalised (Johanson, 2002).

The fundamental art of the midwife includes giving spiritual care its due importance. This can be demonstrated whilst helping the woman to feel self-worth in a sensitive time, by being patient and giving her the necessary time to express herself (RCN, 2011). Midwifery goes beyond the physical approach to a deeper skill of learning on how to listen carefully to what the woman needs to express and making one-self available, someone she can feel safe with (ICM, 2012). This is a chance for the midwife to assess and understand maternal well-being appropriately. The complexity of this can be dynamic enough to be demonstrated indirectly through nonverbal communication. One can notice how the woman expresses herself, whether she is still in control of herself, tone of voice, physical behaviour, and other nonverbal cues which contribute to a better assessment (RCN, 2011).



Appropriate physical examination of the woman is sometimes overlooked. For instance, the use of automatic machines to measure maternal vital signs, not always give an appropriate reflection of the maternal well-being. With regards to pulse rate for example, it is not only about the rate but one should also look for the rhythm and volume (Johnson & Taylor, 2010). Undertaking an appropriate antenatal abdominal palpation is sometimes being skimmed through. This includes the ability to identify the fundal height, lie, presentation and position, together with the descent of the presenting part. This should be performed prior to any other examination (NICE, 2014).

What about going back to basics? How often do we perform a complete antenatal and postnatal examination? Moreover, before carrying out the physical examination the midwife needs to observe and assess the emotional and psychological aspect of the woman (Boenigk, 2015). Holistic care is what the midwife should provide, so let us not be blind folded but open our eyes wide enough to understand who we have in front of us. It is within the midwife's professional role to build a trusting relationship with the mother, who in response will be able to confide and find support during the whole process, as described in 'The Philosophy and Model of Midwifery Care' (ICM, 2014). Developing good communication facilitates the

Auscultation of the fetal heart by a Pinard stethoscope is another basic skill which identifies us midwives from other health care professionals (NICE, 2014). However, this is correctly done when the midwife palpates the maternal pulse concurrently to identify the difference between the two and avoid any misinterpretations. Apart from being competent in completing appropriate physical care, the midwife has to master her ability in communicating the findings to the mother and explain appropriately (ICM, 2012).

Further reflection also leads us to ask; are we moving towards a medicalised approach ourselves? Are we describing pregnancy and childbirth as normal



life events, or are we changing this normal process into a complicated one? Let us think thoroughly on what is happening and what is contributing to these changes in our skills. The 'midwifery model of care' as described by The Jewish Childbirth Network (n.d.) emphasises the importance of hands on care.

Part of the midwives model of care advocated for a decrease in technological interventions. Gaskin (2004) describes that the introduction of machines has led to a more medicalised approach. Let us instantly reflect on the fact that when a woman is with a cardiotocograph (CTG) our attention goes primarily on to the trace rather than towards developing an in depth assessment of the whole situation. Gaskin (2004) states that technological interventions have '...blinded literally hundreds of millions of people to the importance of human contact, feeling, experience and judgement in maternity care,' which is concerning as the use of electronic foetal monitoring has increased worldwide (Thacker, 2002).

Another aspect which midwives need to achieve is appropriate, accurate and detailed documentation. Many find it difficult when it comes to document the continuous hands-on care given to the mother hence this can be considered as an obstacle. It can be difficult to record each aspect of the whole contact that midwives have with the women. However, this needs to be excelled so as to give a clear picture to those who were not present, should the need arise.

Documentation and narrative writing also can be a way for midwives to narrate their witnessing of amazing experiences with other women by reliving these moments. According to Gaskin (2004) this is the ideal way for women to learn other aspects of birth, hence moving towards normality. She (Gaskin, 2004) has included the concept that the birth environment does affect maternal progress. This can be substantiated by having the midwife document each aspect of maternal progress and the current situation in the birth room. For example, how having other people coming in and out the room can affect maternal confidence, intimacy and privacy, frequently bringing contractions to a standstill.

Regrettably, one can also point out that sometimes midwives adapt their practice to a technical environment. This increases mothers' risks of complications, generated through the cascade of interventions (Midwifery 2020, 2010). In Gaskin's (2004) article it was also argued that the introduction of CTG has given the illusionary belief that concurrent monitoring reflects the fetal situation, eliminating intermittent auscultation and underestimating

midwifery notes. Not to mention the decreased contact between the woman and the midwife by assessing fetal well-being from the desk console. This makes us ask ourselves whether birth is being assessed appropriately or whether we need to improve? Unfortunately, a long strip trace is being considered as a present witness during the maternal experience.

The real question is; are we considering the woman holistically or just a routine or a procedure that has to be done? Are we considering that the woman has other factors which might contribute to her current situation? This cannot be measured by any technical equipment but it is us midwives who need to learn to be good observers of what is happening around us, so let us commit to a full appropriate maternal assessment once we have made contact with the mother. Let us start from the very beginning, what we have learnt? Sit down with the mother, look at her, give her the necessary time, and have an appropriate detailed history. Back to basics...let us start from the booking visit and take it all the way to postnatal care!

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Developing a Reflective Tool for Practice

Have you ever, as a midwife, felt that you could have done more for a mother? Have you ever doubted yourself but at the same time felt you could not think of other things you could have done at the time? I know I certainly have and this is how this reflective tool came to my mind.

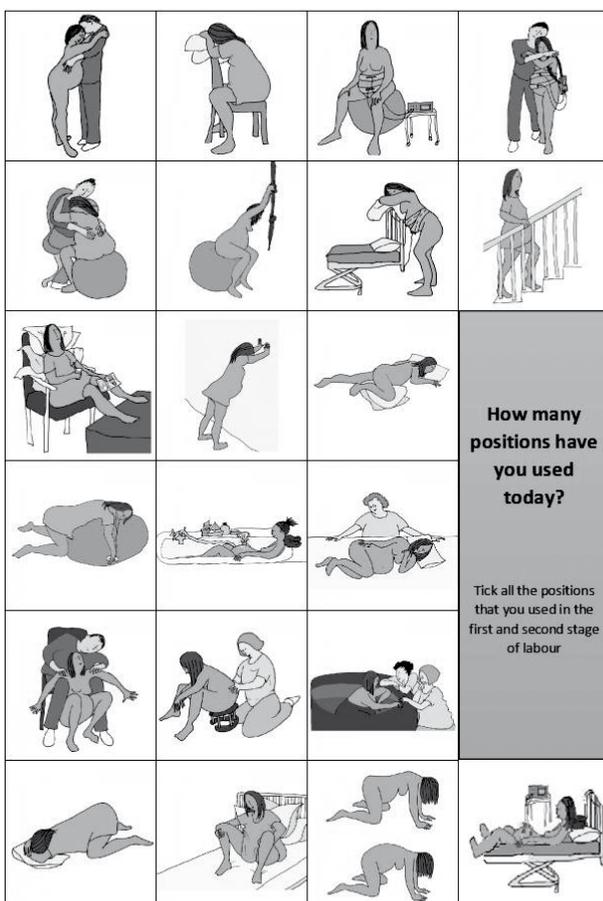
Mobility and upright positioning have now been encouraged for years due to the countless benefits they provide to mother and foetus (Lawrence et al., 2013). There has also been an emerging issue regarding women wanting to feel in control of their own birth experiences (Ford et al., 2009). Some studies suggest that sense of control is related to freedom of movement and choice in birthing positions (Green et al., 1990; Ford et al., 2009). Support by the persons present at birth also seems to help women achieve a better birth experience (Parratt and Fahy, 2003). A reflective tool was created based on information gathered on what effects birth experience and how could normality be achieved by reflecting on the way we practice.

The 'normal' vision of giving birth lying in bed people have become accustomed to, has resulted from the modernisation and medicalization process (Dahlen et al., 2008). The real normal position to give birth used to be the upright position (Westbury, 2014) but it appears that

women have grown accustomed to the semi-recumbent position and as many as 49 percent give birth in this position (RCM, 2010). Despite the Royal College of midwives recommendations to get women 'off the bed' and the National Institute for Clinical Excellence (NICE) guidelines for midwives to help mothers adopt different positions (NICE, 2007) women still feel labouring on a bed is what is expected of them (RCM, 2012). This might be attributed to the central positioning of the bed in the room (Walsh, 2012) or because women might feel it is more convenient for staff if they do so (Lawrence et al., 2013). Either way, midwives must recognise that although they play an important role in the birth experience of a mother, their own needs and judgment must not overshadow the woman's wishes and needs.

Many advantages surrounding the use of mobility and upright positions have been discussed in the literature such as improved bearing down impulses (Walsh, 2012), increased mobility of coccyx for increased diameter of pelvic outlet (Michel et al., 2002) and decreased supine postural hypotension syndrome (Johnstone et al., 1987). A recent systematic review of 25 studies, has shown that mobilisation in the first stage of labour can result in one hour twenty minute reduction in length of labour (Lawrence et al., 2013).

10. Birthing positions used



Adapted from RCM website: <http://www.rcmnormalbirth.org.uk/birthing-positions-in-practice/visual-aids-for-birthing-positions>

Aims and Objectives of Tool

The aim of the tool is to increase normal birth occurrence and improve maternal birth experiences. The tool will achieve these aims by targeting the following objectives:

- Reflective practice
- Midwives pursuing areas in their own philosophy of care that need to be worked upon to change practice
- Improve use of alternative equipment rather than the bed
- Improving the use of different positions in labour

Development of the tool

A thorough literature search of systematic reviews and recent findings on the use of upright positioning during labour revealed very favourable information. Guidelines and policies suggest the use of various positions as much as possible (RCM, NICE). Despite the positive forces, many women are still not making informed choices when it comes to choosing positions in labour (De Jong et al., 2008). The different models of care provided in a particular setting may also have an impact on the type of care women receive. The tool will help midwives reflect on their practice or experience in supporting a woman during labour. The reflection process along with the imagery of the different positions outlined within the tool should make midwives aware of other possible options to help women in labour. In turn, the midwife will think of the positions and the things that are limiting her use of the alternative positions and work on them with the next

Normalising Birth using Positions Tool

This tool should ideally be used by midwives for each labour experience. It is a reflective tool to make midwives more aware of equipment and make good use of skills in facilitating normal birth. Please answer the following questions.

Philosophy of care

1. Do you **feel confident** in using different positions during labour?

YES

NO

2. Do you offer **women various choices** in birthing positions during all stages of labour?

YES

NO

3. Do you **provide women with all the information** regarding the benefits of using other positions rather than the semi-recumbent position?

YES

NO

4. Do you feel you have as much **experience** to try different positions with mothers?

YES

NO

5. Does your **working environment** encourage you from using different positions?

YES

NO

If you have answered any of the above as 'NO' think about the areas in **bold**. Reflect on the things that need to be improved and how the philosophy of care can be adjusted into welcoming the use of different positions in labour.

For example, if you have answered 'NO' to question 1, think about why aren't you feeling confident? What can you do to improve your confidence?

Care into Labour

Give a score of 1 to every 'YES' answered. Score a 1 for each position ticked in question 10. The higher the score the better you are getting at facilitating the use of positions in labour.

mother in labour. The positive outcomes related to the different positioning in labour will be achieved and this will eventually lead to midwives' increased confidence in using various positions in labour.

Use of Tool

Every midwife knows the feeling of going back home after a twelve hour shift with an aching back from bending over to constantly support a moving mother. Admittedly, sometimes we enjoy the occasional 'straight-forward-on-a-bed birth.' This tool is designed to make midwives remember that the 'on-a-bed-birth' should remain a singular event and what is sometimes easy practice for us, does not necessarily lead to what is in the best interest of the mother. We also know what it feels like to feel disappointed and disheartened at the end of a day when we reflect on our practice and think of what we could have done differently. It is sometimes difficult and time consuming to answer all the questions a practice reflective tool offers. This tool has been designed in such a way that it is not very time consuming or difficult to go through to try and encourage its use. Midwives should ideally use this tool after a labour experience that they have not felt gratified about. It has been designed to make midwives more aware of equipment and make good use of skills in facilitating normal birth.

A positive birth experience not only contributes to woman's sense of fulfilment and well-being (Green et al., 1990) but also enhances maternal-child attachment (Green et al., 1990). However, negative birth experiences have been associated with a depressive moods (Zaers et al., 2008, Ayers and Pickering, 2001), negative

1. Have you discussed birthing positions with the mother and partner beforehand?

YES

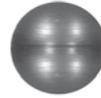
NO

2. Has the mother been provided with all the information, surrounding positions in labour?

YES

NO

3. Has the mother made use of any of this equipment?



Ball



Mat



Stool



Bath / Foot

YES

NO

4. Have you involved the partner as much as they wanted to be involved?

YES

NO

Think and reflect about this birth:

- Was the mother satisfied with her birth experience?
- What could have been done differently to make it better?
- What have you learnt from it?
- What are you willing to take with you to other births?
- What are the things that have limited your capability of experimenting with positions?

effects on relationships (Elmir et al., 2010), avoidance of subsequent pregnancies (Porter et al., 2006) and wishing for caesarean section for subsequent births (Tschudin et al., 2009). Midwives have a crucial role in supporting women during labour. Understanding their needs and supporting the use of positions that help women cope better helps to contribute to the women's positive birth experience (Nieuwenhuize et al., 2013). This tool aims to make midwives aware of their contribution to the mothers' experience. The use of positioning during labour has been associated with an increased incidence of normal births. However, this tool is also designed to help midwives make the woman's birth experience a better one even if the outcome does not result into normal birth.

This is a reflective tool, which means midwives must find the time and willingness to do it. It is very personal and midwives must work on the issues that they answered as 'No' for it to be effective. This tool can only be successful if midwives accept the need to change the way they are practicing and are willing to make the necessary changes

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An appraisal of intrapartum care for term Prelabour Rupture of Membranes [PROM]

Terms & Prevalence

PROM is an abbreviation for Prelabour Rupture of Membranes, referring to those term pregnancies (≥ 37 weeks gestation) whereby the amniotic sac ruptures before the start of regular contractions i.e. before the onset of active labour.

It is essential to differentiate PROM from **preterm** rupture of membranes. Preterm rupture of membranes occurs prior to 37 weeks gestation and hence comprises the risk of neonatal prematurity. To distinguish between the two, most refer to the latter as PPRM (Preterm Prelabour Rupture of Membranes) (Royal College of Obstetricians & Gynaecologists [RCOG] 2010).

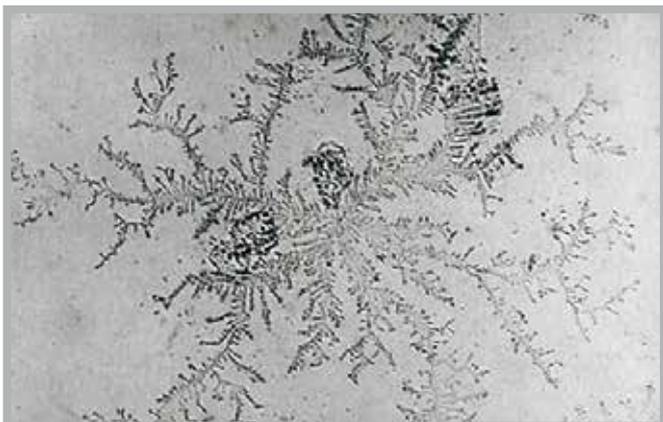
PROM occurs in approximately 6-19% of all term pregnancies (Ekin et al., 2000). The precise aetiology of PROM is still largely unknown. However, labour ensues spontaneously for approximately 60% - 70% of women by 24 hours (National Institute of Clinical Excellence [NICE] 2014; The Royal Australian & New Zealand College of Obstetricians & Gynaecologists [RANZCOG] 2014), and for 90% of women by 48 hours (Ekin et al., 2000).

Potential complications

The incidence of complications from PROM is low (NICE 2014; Association of Ontario Midwives [AOM] 2010) however, it is essential to note the problems which may arise. The primary concern in PROM is maternal and neonatal infection due to bacteria ascending from the vagina into the uterine cavity. This may present with maternal fever (>38 degrees Celsius), uterine tenderness, maternal or fetal tachycardia and foul-smelling liquor. This would suggest **chorioamnionitis**.

Infection may also present postpartum, in the form of **endometritis**, which would be characterised by fever, lower abdominal pain, uterine tenderness and possibly subinvolution and foul-smelling lochia.

Neonatal infection is a rare complication (NICE, 2014). This should be suspected when the newborn exhibits reduced activity, less vigorous sucking, respiratory distress, vomiting, inadequate thermoregulation, diarrhoea, apnoea, bradycardia, abdominal distension, jitteriness, seizures and jaundice.



Evidence-base for the management of PROM

Initial research on PROM was characterised by poor methodological quality (Ekin et al. 2000). Several studies failed to differentiate between PROM and PPRM, hence reported invalid high rates of infection (Lanier, as cited in AOM 2010, p.5). Further studies sought to identify the ideal length of time for expectant management (Ezra et al., 2003) as well as the risks of infection (Dare et al., 2006; Hannah et al., 1996).

With regard to neonatal infection, studies reported that there was no difference between expectant management (for 24 hours) and induction of labour [IOL] (Yasmin et al., 2013; Dare et al., 2006; Hannah et al., 1996). Drawing from a secondary analysis of the Term PROM study (Hannah et al., 1996), the latest NICE guidelines (2014) concluded that after 24 hours the risk of neonatal infection rose from 0.5% (as for intact membranes) to 1%. Expectant management for 24 hours was not correlated to increased neonatal infection rates (NICE 2014; Ezra et al., 2004).

Studies reported a lower risk of postpartum maternal fever and endometritis with IOL (Dare et al., 2006; Hannah et al., 1996). However, a contentious issue within the research was the fact that few trials limited the number of digital vaginal examinations. In the Cochrane review by Dare et al., (2006) only 2 out of the 12 trials included had restricted digital vaginal examinations. Frequent digital vaginal examinations [VE] are the primary cause in the ascent of bacteria from the vagina into the cervical canal. The Term PROM study emphasised the fact that performing >8 digital VE (vs. <3) was the strongest predictor of chorioamnionitis (Hannah et al., 1996).

Limited research was conducted in reference to the use of antibiotic prophylaxis for chorioamnionitis. In a systematic review on this issue, Flenady & King (2002) concluded that the data available was insufficient and not reliable enough to draw recommendations for practice.

Management of PROM

Initial Assessment

Women admitted/being seen for potential PROM will need the standard complete assessment. The midwife would perform a holistic assessment which would commence by listening to the woman's account of events, presenting signs/symptoms and assessing her emotional wellbeing. This would be followed by a review of the history and antenatal records, parameters checking, urinalysis, antenatal abdominal examination and fetal heart rate.

Digital vaginal examination should be avoided if no contractions are present.

Diagnosis of PROM

Methods for diagnosis of PROM include:

Clear maternal account of SROM and evident liquor observed leaking from the vagina

Sterile speculum examination to visualise pooling of amniotic fluid in the vagina or leaking from the cervix

Nitrazine swab (nitrazine exhibits a colour change to dark blue in reaction to the more alkaline pH of amniotic fluid). Nitrazine swabs are associated with false positive results in reaction to other alkaline substrates such as blood, semen and antiseptics

Fern test (amniotic fluid is smeared on a slide to exhibit fern-like crystallization which can be observed under microscope)

Amnisure ROM™ test (swab detects placental alpha microglobulin-1 protein in vaginal fluid).

Ultrasound examination of the amniotic fluid volume [AFI] may also be utilised to obtain further data.

Ongoing Maternal & Fetal Observations

Oral maternal temperature every 4 hours (fever: $>38^{\circ}\text{C}/\times 2$ episodes $>37.5^{\circ}\text{C}$ 1 hour apart)

Colour and odour of amniotic fluid (observe for presence of meconium)

Inform the woman to abstain from sexual intercourse.

Baths/showers are safe

Fetal movements

Considering the need for IOL

As noted above, the evidence-base for expectant management vs. IOL exhibits a degree of consensus, yet further research is also warranted. The recommendation in clinical guidelines is that, in the absence of abnormal findings, expectant management for 24 hours is as appropriate as IOL (NICE 2014; RANZCOG 2014; AOM 2010). In case of abnormal findings, such as in Group B streptococcus positive or meconium stained liquor, early initiation of IOL is recommended (NICE 2014; RANZCOG 2014).

With reference to the latest NICE guidelines (2014) one should note and inform the woman that:

60%-70% of women with PROM will go into labour within 24 hours

IOL is advisable approximately 24 hours after rupture of the membranes

The risk of serious neonatal infection after 24 hours is 1% in PROM vs. 0.5% with intact membranes.

Administration of prophylactic antibiotics

Limited evidence is available on the use of prophylactic

antibiotics for PROM. In the absence of abnormal findings NICE guidelines (2014) do not recommend the use of prophylactic antibiotics. The RCOG also follow this recommendation (RCOG 2012).

Local context

In Malta the majority of women who decide to seek intrapartum care for PROM will present themselves by self-referral to the state hospital. Here women are seen by midwives and obstetricians and are given care accordingly. IOL is done using prostaglandin or oxytocin however, initiation of IOL may occur at different time intervals. The average time given for spontaneous labour is 4-6hours, the maximum being 8 hours if PROM occurs during the night. This demonstrates a low threshold for expectant management in comparison with the international guidelines (NICE, 2014). In spite of this, the local Labour Ward Protocol recommends a speculum examination to diagnose PROM, no vaginal examinations and IOL 24 hours from ROM (Labour Ward Protocol, n.d.). With regard to the administration of antibiotic prophylaxis, this remains at the physician's discretion, the trend being that antibiotics are frequently prescribed for those occasional cases where PROM exceeds 12-24 hours.

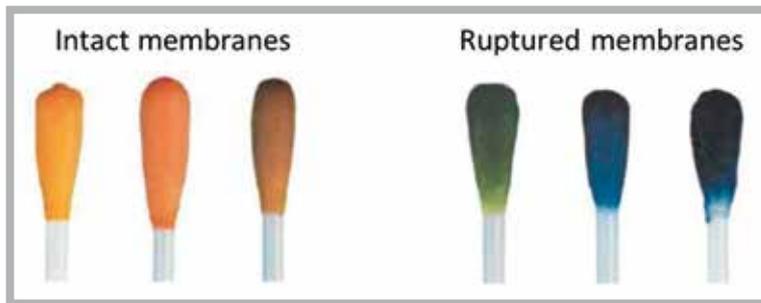
Critical discussion on decision-making in PROM

In Malta the sociocultural trend is inclined towards a paternalistic mind-set where 'doctor/health professional knows best' in an ubiquitous medical power relation (Foucault 1977, 1976; Illich 2003, 1976). Expectant women and their partners do not characteristically question alternative options for management. Nevertheless, due to increased access to information and a move for people to take ownership for their own health (Turner & Khondker, 2010), some women do ask for the option of waiting for spontaneous onset of labour. Risks of infection are the primary concern for expectant management but, as noted above, with appropriate management this risk can be well controlled. Moreover, in reflection, it is surprising why locally this risk is considered so significant when one considers the rising rate of Caesarean sections, which are actually the primary cause of puerperal infection (Conroy et al, 2012).

Women who opt for expectant management could be met by critique due to an internalised medicalised approach of 'getting labour going'. These women may be seen to be lingering in the labour ward with not much going on. On the contrary, it is likely that much is going on; the initiation of the natural latent phase to prime the body for labour. This may progress into labour and otherwise enable the woman's body to be more favourable for subsequent IOL. This could contribute to a potentially easier and faster birth. In effect, studies indicated that women in the expectant management group were less likely to use analgesia/epidural anaesthesia (Ekin et al., 2000; Grant et al., as cited in AOM, 2010, p.9; Hannah & Tan, 2007).

So far the research conducted has not identified a correlation between IOL and Caesarean section (NICE 2014). On the other hand, IOL compels the use of synthetic prostaglandins and oxytocin, technological





intervention, such as continuous electronic fetal monitoring (Ekin et al., 2000; Hannah & Tan 2007), and the associated risks of these procedures (NICE 2014; Alfirevic 2006; Kho, Sadler & McCowan 2008). This may be an appropriate and personal choice for some women, as noted in the Cochrane review (Dare et al., 2006) and Term PROM studies (Hannah et al., 1996); where women were satisfied with IOL. Other women desire a more natural physiological birth and would opt for expectant management. In order to provide women-centred care, in-line with the latest evidence-base, maternity care centres will need to provide individualized management according to the woman's choice.

Recommendations for practice

Reference to evidence-based guidelines which details both Expectant management and IOL for PROM.

Information-giving which is correct, complete, truthful, documented and impartial.

Shared decision-making with the woman and her partner.

Midwives have a responsibility to empower women with the information and awareness needed to enable them to make a fully informed decision. Successively, midwives need to act as advocates for the women in their care. Culture is rapidly changing and women and couples are eager to learn more and formulate opinions. This change should be a welcome avenue since it allows health professionals to share the task of decision-making by involving the couple.

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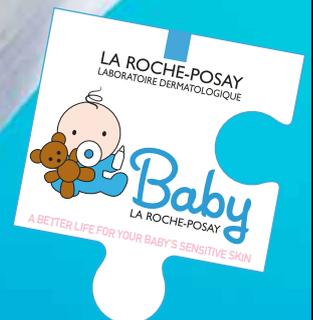
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Probiotics...Prebiotics

– Aren't they one and the same?

Two popular words which were not so common not long ago, are probiotics and prebiotics, and no they are not the same word, and definitely not a misprint! Explained simply, probiotics are harmless living microorganisms that inhabit our digestive tract, helping in digestion as well as offering other benefits, while prebiotics are non-living, non-digestible carbohydrates that serve as nourishment for probiotics (Weingarten, 2013). In this article I aim to provide a more detailed explanation of what these probiotics and prebiotics are, as well as point out their usefulness related to our practice.

Probiotics

At birth, the full term newborn's gastrointestinal tract is sterile. Soon after delivery, it starts to be colonized by harmless bacteria generally derived from the mother's gut and vaginal tract. These bacteria are referred to as **probiotics** which are defined by the WHO as "live microorganisms, which, when administered in adequate amounts, confer a health benefit by producing gut microbiota on the host". In other words, probiotics help in modifying intestinal microbial populations in such a way as to benefit their host. Colonization of the newborn's gut by probiotics is thought to be affected by mode of delivery, early feeding strategies, and hygienic conditions at birth. (Özdemir, 2012) In a normal vaginal delivery, newborns are being exposed to the mother's vaginal and intestinal flora, as they pass through the birth canal. During pregnancy, the composition of bacteria in the mother's vagina changes and there are higher concentrations of *Lactobacillus* which helps in the digestion of milk (Levy, 2013). Children born by vaginal delivery are therefore being exposed to this type of bacteria earlier than those infants born by caesarean section (Das, 2011). Early breastfeeding also enhances colonization of the newborn's gut as breast milk itself contains specific probiotics such as lactic acid bacteria, and Bifidobacteria, whilst the newborn also gets other useful bacteria from the mother's skin. All of these probiotics provide a barrier against other antigens which could be harmful and which may lead to systemic allergic symptoms. Therefore, any interference to this balance, such as with early environmental insults to the

newborn, formula feeding, increased use of antibiotics, gastrointestinal diseases and stress, could all contribute in damaging microbiota, hence increasing the risk of inflammatory and allergic diseases (Özdemir, 2012).

Probiotics have been found to be responsible for a number of different roles. The gut barrier is matured by probiotics as the existent harmless intestinal microbes provide immunity against other harmful bacteria. Probiotics balance the generation of pro- and anti-inflammatory cytokines in the gut, and stabilize the gut microbial environment and permeability barrier by increasing the degradation of enteral antigens and changing their immunogenicity (Pessi et al, 2001). Anti-inflammatory cytokines limit the immune response to pathogens to prevent damage to their host. Probiotics are even accountable for the increased production of these cytokines. Moreover, probiotics have been found to suppress Th-17 cells which are known for the development of several allergic disorders. In addition, some species of Bifidobacterium genus were found to help in the development of neonatal dendritic cells, stimulating T-cell responses, leading to the production of more anti-inflammatory cytokines. Furthermore, probiotics are known for the immunoregulation of T regulatory cells, as they are thought to cause Th2 stimulation and a low-grade inflammatory response. These assist in the activation of Treg cells that normally suppress allergic inflammation. TLR's (pattern recognition receptors) are known to act on the gut lymphoid and epithelial cells mediating innate immune responses. Probiotics have also been found to stimulate TLR's, producing mediators that help protect against allergic diseases (Özdemir, 2012).

Probiotics found in breast milk have been shown to potentiate the defensive mechanisms of preterms, contributing to a better immune defense against infectious agents. This is because breast milk contains immunologic and non-immunologic factors, and immunomodulatory factors, such as the bifidogenic factor. All of these promote the development of *Lactobacillus bifidus*, which by competition promotes the decrease of intestinal pH, and inhibits growth of *Escherichia coli*. Although maternal milk must be fortified for preterms it is by far the best option to consider for preterms, when compared to preterm formulas that do not contain the bifidogenic factor (Betta and Vitaliti, 2012). In addition, probiotics have been shown to protect infants against necrotizing enterocolitis. This is a serious anoxic and ischemic disease that particularly affects preterm infants. It affects the ileocolic area, with bacteria proliferation, and production of gas inside gastric walls, and is associated with edema and inflammation. Risk factors increase with prematurity, low birth weight and colonization with pathogens such as *Clostridium*, *Escherichia*, *Pseudomonas*, *Streptococcus* and *Staphylococcus aureus* among others. Intestinal immaturity, decrease in intestinal motility, increase of permeability of macromolecules, and excessive volumes of milk also increase its incidence. Breastfeeding once

The Difference Between Probiotics and Prebiotics

This is your gut (intestines)



Probiotics



Prebiotics

Probiotics are alive!
Usually bacteria or yeast
Aid digestion & other health benefits
Good sources are:
Yogurt, kefir, buttermilk, aged cheese, sauerkraut, kimchi, sourdough bread, miso, tempeh, kombucha, beer, wine

Prebiotics are a form of fiber
Serve as food for probiotics!
Good sources are:
Chicory root, Jerusalem artichoke and dandelions
Foods you'll actually eat:
Garlic, leeks, onions, whole wheat, fruits, vegetables, legumes

again shows exceptional protection against it as proven by the decreased incidence of NEC in breastfed infants when compared to formula-fed. Moreover, probiotics, which can originate either from breast milk or through supplementation, prove their usefulness in the protection against NEC. This is because they are thought to increase the production of anti-inflammatory cytokines, probiotics block the passage of bacteria and their products through the mucosa, they compete with some of the pathogens, they modify the host's response towards microbial products, improve enteral nutrition, and decrease the duration of parenteral nutrition which may be responsible for late sepsis (Betta and Vitaliti, 2012).

Prebiotics

Breast milk contains an abundance of oligosaccharides responsible for nourishment of probiotics. These oligosaccharides, referred to as **prebiotics**, are very different from probiotics. Probiotics are live microorganisms that maintain the natural balance of microflora in our intestines, while prebiotics are non-digestible carbohydrates that help to stimulate the growth and activity of probiotics (Arabi, 2013). Probiotics and prebiotics can both be found in supplement forms but also through natural sources. Apart from in breast milk, probiotics are best found in yogurt, buttermilk, aged cheese, sauerkraut, sourdough bread, beer and wine among others; while prebiotics can be found in raw chicory root, raw Jerusalem artichoke, raw garlic, leeks and onions, whole wheat, fruits and vegetables, and legumes (Weingarten, 2013). Aside from increasing probiotic growth, prebiotics are known to improve bowel regularity, increase the absorption of calcium and magnesium, increase stronger bone density, enhance immune factors in the colon, reduce triglyceride level, control appetite and reduce weight, decrease in growth of harmful bacteria (correction of dysbiosis), decrease or cessation of offensive flatus smell, and correction of leaky gut and endotoxemia (Jackson, 2015).

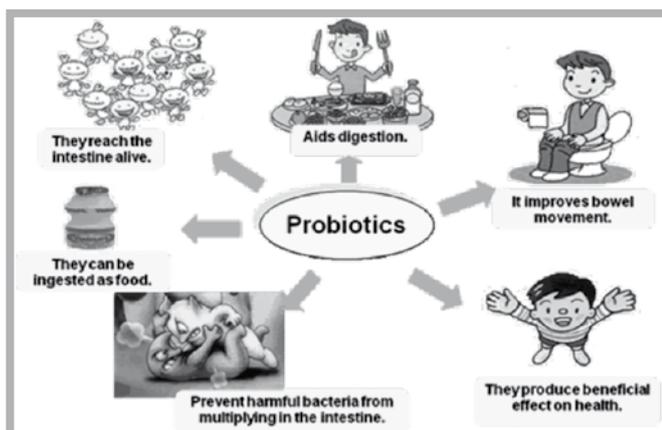
In adults, probiotics improve metabolism since they promote good bacterial growth in the colon, and help in a more effective absorption of substances in the gut. Moreover, probiotics help to avoid constipation and improve bowel regularity. Fibre is the substance with which the lower gut depends on to create soft, bulky and regular stools. Insoluble fibres found in whole wheat bread form the basis of stools, while soluble fibres which include beneficial prebiotics such as inulin and oligofructose, produce gases that fertilize the healthy bacteria found

in the gut. These insoluble fibres together with soluble fibres, when consumed in adequate quantities, can lead to improved constipation, mineral absorption, immunity to disease, prevention of symptoms of inflammatory bowel disease, anxiety, and appetite control, among others. In addition, prebiotics prove their usefulness in the correction of a leaky gut. The leaky gut syndrome is brought about through exposure to environmental toxins, food additives, pesticides, sugar, refined carbohydrates, medications such as NSAIDs, antibiotics, anti-inflammatory drugs, acid-blocking medications and alcohol. These exposures all lead to dysbiosis. This refers to the development of gaps between the brush border of the small intestine, leading to leakage of food particles into the bloodstream, creating endotoxins. These endotoxins can induce an immune response ranging from allergies to full blown autoimmunity. The leaky gut syndrome can be prevented by eliminating the above mentioned substances that can lead to dysbiosis, as well as through the use of prebiotics. This is because prebiotics help to restore the balance of the gut microflora, protect the digestive wall so that it works optimally, and encourage the growth of good bacteria (probiotics), which in turn lead to the growth of enzymes responsible for the digestion of food (Muedin, 2014).

In light of the above, the importance of probiotics and prebiotics cannot be ignored. Once again, avoiding excessive use of medications, surgical deliveries, and unnecessary use of infant formula seems to be the way forward to our practice. Health professionals should strive to promote natural birth, believing in the woman's own innate powers, and promoting breastfeeding so that all infants have the opportunity to acquire natural immune and protective factors from these useful probiotics and prebiotics intended for them naturally. Furthermore, a good healthy balanced diet with foods rich in these substances could be promoted to pregnant women, mothers and their families to contribute towards a healthier society.

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Supportive Positioning for Infants in an NICU Setting

Babies born prematurely have been deprived of the natural enclosure, support and environment created within their mothers' womb. Caring for a baby at NICU should therefore attempt to recreate a similar environment in which these babies can develop and mature. Care should be taken to reduce negative stimuli such as light and noise, minimizing negative effects of illness and the undeniable impact of parent separation (Fanaroff & Fanaroff, 2013).

In pregnancy, the fetus is curled up within the womb which allows for restrictive movement helping the foetus to develop stronger muscles. Research has concluded that it is only until the 36th week that babies develop posture known as physiological flexion which enables them to support themselves to maintain their body in the midline position with all limbs flexed (NHS, 2012). This curled up position enables the baby to feel more comfortable and secure, discovering how to control its movements and behaviour in order to feel safe and calm; a process called self-organisation (Als *et al.*, 2003). Babies born prematurely have not yet developed such muscle tone and therefore require more supportive positioning to counteract the gravitational pull, causing them to flop into a frog-like position, with shoulders and hips flattened onto bedding. If premature babies are allowed to rest in this position for prolonged periods of time, the over rotation and abduction of shoulder and hip joints will result in an imbalance where groups of muscles gain strength whilst others remain weak (BLISS, 2005). This imbalance will consequently give rise to poor or delayed developmental mobility in the future, affecting milestones such as crawling and hand-mouth co-ordination. It also increases incidence of flat-head moulding (NHS, 2012).

The following is a brief outline of the guidelines and information as provided by the NHS (2012) regarding supportive positioning.

The NHS (2012) recommends that babies should be maintained in a flexed position with head in midline position taking care to prevent over extension. Soft towelling, bedding, blankets and/or positioning aids should be used to establish and maintain good positioning providing some resistance to movement without being

too restrictive. A **nest** with feet placed **inside the nest** provides the baby with a boundary to push on, creating a sense of security. This can be achieved by separately rolling two towels and placing them on the mattress so that they complete an oval shape adequate in size to contain the baby within. A sheet should then be placed over the rolls, and tucked in so that the rolls stay in place. Avoid placing rolls directly below an infant's bottom since this tends to cause limbs to flail up in the air, providing little or no support.

"A nest promotes a flexed posture of the limbs with abduction of shoulders, facilitates elegant wrist movements and movements towards and across the midline and reduces abrupt movement and frozen postures of arms and legs."

(Ferrari *et al.*, 2007)

When in the **prone** position, a rolled up towel tucked firmly around the lower limbs maintains them in a flexed position under the baby. A folded towel placed under the baby's torso and abdomen help counteract the gravitational pull, avoiding elevation of shoulders and limbs being pushed sideways in a frog-like manner. The prone position has been shown to increase periods of quiet sleep, encouraging babies to consume less energy for movement and in turn improving weight gain (Masterson *et al.*, 1987). In a systemic research review, Gillies *et al.* (2012) found that in infants with acute respiratory distress, when compared to positioning in supine, the prone position decreased tachypnoea and marginally improved oxygen saturations. The prone and lateral positions were also proven to significantly reduce the severity of gastro-oesophageal reflux (Ewer *et al.*, 1999). However, one must point out that the prone position with head positioned to the side encourages bilateral flattening of the head due to the pressure exerted by the mattress on the poorly mineralised skull bones of the premature infant.

When in **lateral** position, a rolled up blanket should be placed behind the baby's back and head to maintain it in a curled up position. Providing a soft blanket or sheet for the baby to curl up around may help induce a sense of security (BLISS, 2005). This position encourages the baby to draw its limbs towards the midline, thus the baby can easily explore its face and hands improving fine motor skill development and self-comfort.

When positioning in **supine**, the head should be supported in the midline position in alignment with the spine; however it should occasionally be turned laterally to maintain roundness of the head. This position allows for easier observation and provision of nursing care and is recommended to reduce the risk of Sudden Infant Death Syndrome (SIDS) (FSID, 2007).

The Mattress surface should be angled at a



Image 1: "Infant positioning" using positioning aides.
Can also be achieved using towels, blankets etc



utmost importance that we give these infants as much of a good start in life as possible, diminishing negative effects whilst promoting familial bonding and eventually empowering parents to take care of their own infant at home.

Notice:

It is important to note that babies at home should only sleep in the supine position, without positioning aids or elevation of the head, with feet to foot of the cot, since this has been proven to reduce the risk of SIDS (FSID, 2007). The above mentioned positions and suggestions are only applicable to infants within an NICU setting with continuous cardiorespiratory monitoring.

30° angle, since elevating the head will relieve pressure of abdominal organs on the lungs improving respiratory capacity; encourage gastric emptying and decreasing gastric reflux. Care should be taken to prevent baby from sliding down the mattress, to avoid trauma from pulling and/or dislodgement of an endotracheal tube, CPAP prongs or nasal prongs. This can be achieved by placing a rolled up towel/blanket under the mattress sheet in the form of a U. Avoid putting rolled-up bedding between the baby's legs in the form of a sling since this will probably be uncomfortable and may cause muscular imbalance.

Infants' position should be altered every 2-3 hours alternating between prone, supine, left and right lateral (Fanaroff & Fanaroff, 2013) whilst keeping record to ascertain that the baby was placed in a variety of positions over a 24 hour period. This decreases possible skeletal deformities and fixed positioning especially in the preterm infant (Sweeney & Gutierrez, 2002). When a baby does not tolerate a particular position well, attempt to give shorter periods in this position (or as much as tolerated) since this relieves joints and limbs.

Care should be taken to avoid the baby being laid on any tubing, sheet folds and/or other items which may cause increased pressure on particular skin areas. When repositioning, changes in skin integrity of pressure areas should be assessed and noted.

Nursing care and other interventions should be clustered together when possible, aiming for minimal handling. Activities should be performed in a slow and steady manner not to distress the baby, preventing excessive tugging on invasive equipment and tubing possibly causing dislodgement. Gently touching and talking to the baby warns the baby that handling is about to occur and this may also reduce distress levels.

Caring for infants in NICU requires individuals who are skilled in their field of work. All actions and the manner in which they are performed (or avoided, if needed) impact these little human beings. Kangaroo Care and Containment Holding can help calm infants, encouraging parental involvement in the care of their baby. It is of

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Adriana Zammit
BSc Midwifery

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Mothers' Experiences in Adapting to Parenthood following successful fertility treatment - An interview study in Malta

This study aimed at understanding the experiences of Maltese first-time mothers' transition into parenthood after having conceived through artificial reproductive therapy methods.

A qualitative approach was used to conduct this study by using a semi-structured interview schedule. Participants were interviewed after one year they had delivered their infants. Four women were chosen to participate in this study by purposive sampling. The theoretical framework that was used to guide this dissertation included phenomenology and identity theory as described by Olshanky (1987). Interpretative phenomenological analysis (IPA) as described by Smith, Flowers and Larkin (2009) was used for the analysis phase. The resulting themes identified how mothers had to deal initially with a failing body system and adjust their relationship with others. Whereas after the baby was born there was a focus on the couples' relationship and maternal relationship with the child. An element of faith and religion, pertinent to the cultural context mother live in came out throughout the interviews and was also discussed. Finally, the type of support systems were also considered.

This study identified the struggles mother go through to accept that they need to resort to IVF and the unresolved feelings they maintain even after becoming mothers. Findings showed that whilst society sees the mothering role as the main one for women, there is still some judgment and stigma in relation to IVF. This may result in this particular group of women feeling

ostracized. Few attempts have been made to support this particular group into this delicate process of transition to parenthood, despite the struggles they face as couples and as they build a relationship with their child. This study recognises the dire need to research this phenomenon within the specific cultural context it is happening. It identifies the needs to improve local postnatal services and to improve local policy with regards to family-friendly measures. Mothers showed interest in support groups that would help them share the burden of that whole experience and make them feel less isolated. Hence, this study recommends a better preparation to parenthood and couple dynamics before initiating IVF therapies, as well as a support group throughout the whole process of IVF and later transition to parenthood.

This research was carried out under the supervision of Professor Christine McCourt. This degree was carried out following the award of a MASTER it! Scholarship. The scholarship was part-financed by the European Union. European Social Fund (ESF) under Operational Programme II – Cohesion Policy 2007-2013, "Empowering People for More Jobs and a Better Quality of Life".



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Defence Against Trauma: Women's use of defence mechanisms following childbirth related trauma

Objective: To explore and identify women's use of defence mechanisms in the aftermath of a traumatic birth.

Background: Following childbirth related trauma women adopt a range of unconsciously mediated functional and dysfunctional responses in their attempts to 'cope' with their complex emotions.

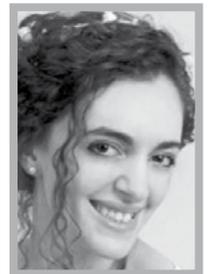
Methods: A secondary analysis was undertaken on existing qualitative research (n=13) that considered women's psychosocial responses following a traumatic birth, using Freudian defence mechanisms as a conceptual lens. Analysis involved repeated readings of defence mechanisms literature together with the findings in the selected studies. A framework of defence mechanisms was developed and extracted findings were mapped against these headings until saturation and consensual validation occurred.

Results: Ten defence mechanisms were identified to resonate with women's trauma related responses. Women tried to 'repress' and 'suppress' their memories of childbirth and used 'avoidance' to protect themselves from reminders. 'Sublimation' and 'undoing' were adopted in attempts to

convert their negative emotions into more constructive responses and to present themselves as good mothers. However, the pervasive impact of a traumatic birth was evident through 'displacement', 'somatization', 'reaction formation', 'turning against the self' and 'regression' with women expressing anger and hostility towards themselves, their infants, partners and others.

Conclusion: Training and context-related screening processes to identify defence related responses are needed. Raising awareness of defence mechanisms could provide reassurance of the 'normality' of women's psychological responses in the short-term. Recognition of how long-term adoption is indicative of undesirable and unhealthy behaviours may also promote and encourage access to suitable psychological support.

Keywords: childbirth; trauma; PTSD; mother's; qualitative methods, defence mechanisms.



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Exploring the Knowledge and Practices of Midwives on the Labour Ward in Relation to Promoting Skin to Skin Contact Between Mother and Baby in the Immediate Postpartum Period

Skin-to-skin contact following the birth of a healthy term infant provides short and long term benefits for both the mother and newborn. Skin-to-skin care has the potential to influence the mother's experience of birth and the postnatal period; and provides adequate care for the newborn. For this reason, it is essential that midwives promote, utilise, and support mothers in skin-to-skin contact postpartum. Considering this, the study aims to explore the knowledge and practices of midwives working on the labour ward in relation to promoting skin-to-skin care postpartum. The objectives sought to ascertain the midwives' knowledge and understanding of skin-to-skin contact, to identify their attitudes towards skin-to-skin care and to determine the midwives' current practice of skin-to-skin contact in the immediate postpartum period.

A quantitative research design using a structured questionnaire was employed, to reach these objectives. The participants were recruited by purposive sampling from a target population of qualified midwives working in the local labour ward for more than six months. A response rate of 85.7% was yielded, as in all 60 midwives participated. Data for this study was

collected and analysed manually. Descriptive statistics were employed to represent the results to the close-ended questions.

Results indicated that midwives were knowledgeable about employing skin-to-skin care in practice. However differences were noted in the exposure of skin-to-skin contact between vaginal deliveries and caesarean sections. The duration for skin-to-skin contact was according to recommendations, but the period for skin-to-skin contact in operative deliveries was also seen to vary. Midwives were noted to discuss skin-to-skin contact with the mothers and they encountered few mothers refusing this care. Finally, midwives were willing to modify skin-to-skin care according to the mother's needs, and encouraged the inclusion of fathers in their care. In addition, midwives were willing to be further informed and educated on this area of study. Nonetheless, in view of these results various recommendations relating to practice, management, education and research were put forward.



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An Evaluation of the Acceptability, Transferability and Effectiveness of Antenatal Breastfeeding Programmes for Mothers and Staff in Malta.

It is generally accepted that, by improving mothers' knowledge of breastfeeding antenatally, the rates and duration of breastfeeding would increase. This study aimed at analysing what is known about the delivery of the different antenatal breastfeeding educational interventions that had been shown to be effective in increasing breastfeeding initiation rates. However, what works in one setting may not necessarily be implemented or give the same results in another setting. These reasons prompted the objectives of this study, that of assessing effective antenatal breastfeeding interventions for applicability and feasibility in Malta for a needs assessment that may be required for the programme to be implemented in Malta.

The Cochrane Library was searched for systematic reviews addressing antenatal education. Only studies conducted as randomised controlled trials (RCT) in the last ten years (2003-2013) were included and were conducted alongside an evaluation of processes: comparison between intervention and standard/routine care to increase breastfeeding initiation. Intrapartum and/or postpartum interventions to increase breastfeeding duration were not included. All the interventions were conducted by health professionals in developed countries. Key terms used were: 'breastfeeding' and 'antenatal' in title and abstract.

A total of seven RCTs were evaluated for effectiveness of intervention. Data of key elements of each intervention was presented in a table format for ease of comparison of interventions. The total population of the participants was 4,066 pregnant women, recruited during antenatal visits. Four studies yielded statistical significant findings towards increasing the initiation of breastfeeding, women's breastfeeding self-efficacy and women's breastfeeding confidence. These four studies were further appraised for applicability and transferability to the local setting.

The teaching strategies used as interventions to promote breastfeeding included visual aids, printed material, individual counseling (through lactation consultants (LC), healthcare professionals (HP), a combination LC-PC team, telephone support, and group educational sessions (either a single educational class or a combination of educational sessions). Findings suggested that breastfeeding initiation rates were increased when teaching adopted an adult teaching approach which recognise that adults are self-directed, self-motivated and come to learn with past experiences. Moreover, the social cognitive theory based on Bandura's principles suggested that women learn to breastfeed through observing others' breastfeeding – modelling and gaining embodied knowledge. Finally, an intervention which adopted a social marketing approach yielded statistically significant results. The intervention was developed to meet women's needs and wants. Furthermore, findings identified a positive attribute when women had access to a short consultation with a lactation consultant during the antenatal period.

The evaluation did not reveal any one particular intervention that would be completely applicable and transferable to the local setting. However, effective interventions may be applied by allowing some modifications to suit the local setting. The study identified the need that health professionals must keep updating themselves with innovative teaching skills and equipped with appropriate resources to meet the needs of their audience. Based on the findings, a list of attributes for a new intervention was proposed, taking into account the Maltese set-up.



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The effectiveness of nutritional advice in controlling gestational diabetes mellitus

Background

Gestational diabetes mellitus (GDM) has been defined as an episode during pregnancy, during which glucose intolerance and high blood sugar is first recognized. In order to prevent consequences to mother and baby, one should emphasize the importance of early diagnosis of GDM and of providing adequate nutritional advice in order to prevent it.

Objectives

To assess the effects of adequate dietary advice on good glycaemic control, and minimisation of foetal and maternal morbidity in women with GDM.

Search Methods

The literature search was carried out on: Cochrane database of systematic reviews; MEDLINE; Cinahl Plus with full text; AJOG (American Journal of Obstetrics and Gynaecology); Pubmed; Google scholar; and e-journals, searching for studies done between January 2003 and November 2013.

Selection criteria

Randomised controlled trials, a cross-sectional comparative study and a retrospective cohort study using a quantitative approach, which studied the effect of nutritional intervention in GDM, were included.

Data collection and analysis

Only one author producing this systematic review conducted data extraction and quality assessment.

Main results

Eight studies, which included 5985 pregnant women, were used in this study. In 3 studies no effects on perinatal outcomes were reported, however one study shows a significant lower rate of serious perinatal outcomes among infants in the intervention group. Significant lower birth weights and a significant lower rate of LGA babies were reported in the intervention

group in 3 studies.

Effects of nutritional advice showed a significant lower maternal weight gain in the intervention groups in 4 studies, with another study showing less weight gain in women following a LGI diet.

There were no significant differences noted for women delivering by LSCS or induction of labour in 2 studies. However, another study showed a significantly higher IOL rate in the intervention group. Similar LSCS rates in both groups were noted in 2 separate studies. On the other hand, a separate study showed no difference in IOL rates but a significant lower LSCS rate in the intervention group.

Adhering to a LGI diet has not been proven to reduce the need for insulin therapy. However, in another trial, fewer women in the LGI group vs. HGI group needed insulin treatment. Additionally, another study showed that fewer women with GDM needed insulin therapy whilst the majority were treated with diet and exercise only.

The effect of nutritional advice on the actual nutritional intake and knowledge analysis resulted that one study showed a significant increase in PUFA, vegetable oil based, and fibre intake in the intervention group. Another study reported that women with GDM scored the least amount of knowledge about the effects of whole wheat bread, low fat milk and unsweetened fruit juice have on blood glucose levels.

Author's conclusions

Results in this review were inconclusive due to the limited and small number of studies and participants included. It reflects on the urgent need for nutritional counselling and early referral to dieticians



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