Malta Midwives' Journal

Malta Midwives Association
Issue 15

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MALTA MIDWIVES ASSOCIATION
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Editorial

Dear Members,

We welcome you into 2020 and to our first issue of the year. This is a remarkable year for us midwives, as it marks the bicentenary of the birth of the renowned nurse Florence Nightingale. Nightingale was a founder and pioneer in modern nursing. Thus, to honour her work, 2020 is being celebrated as the International Year of the Nurse and Midwife, as declared by the World Health Organisation. More about this occasion and the great impact of midwifery care as stated by the International Confederation of Midwives, are discussed in a paper in this issue.

As much as this is a year for celebration, this year also proved to be a tough one for us midwives and health care professionals; with the outbreak and global spread of the novel coronavirus, named COVID-19, in earlier months. This outbreak has been declared as a global pandemic by the World Health Organisation, as more than hundred countries around the world have been affected, resulting in thousands of infected cases and even deaths. Unfortunately, this virus also infiltrated into our country very recently. Healthcare professionals who are at the frontline, government officials and the Ministry for Health have all been working around the clock ever since, to safeguard our population as much as possible.

As midwives we have a fundamental role as educators to prospective or new parents and families about the importance of hand hygiene and avoiding large crowds; especially, to safeguard their newborn. This is general advice when caring for a newborn baby but this is also very imperative during this crucial time. In addition to hand hygiene, it is also vital to emphasise the importance and beneficence of breastfeeding. As we know, exclusively breastfeeding has many benefits, especially feeding colostrum during the first days of life. Amongst other beneficial factors, colostrum is rich in antibodies, aiding in strengthening the immune system of the baby and protecting it from infectious diseases. With proper encouragement and education from us midwives, new mothers should use this to their advantage and make their utmost to breastfeed their child.

To continue strengthening our knowledge, in this publication we present more diverse, significant papers written by leading professionals, which all midwives will find beneficial in their line of duty; including the emphasis on hand hygiene, hypoglycaemia in neonates, caring for the opioid-misusing mother and more. These all discuss topics and issues, all midwives face at one point or another in their careers. By sharing education amongst one another, we can make a great difference in the quality of the care we provide. Thank you to all authors for their contribution in this issue and to all sponsors who make this publication possible. On a final note, I address all midwives and healthcare professionals to stay safe and lead by example.

Lauren Marie Grech
Co-editor

MEMBERSHIP FEE

Annual Membership Fee is €20

You can settle pending membership fees
by contacting one of the Committee Members
or by Revolut payment

Message from the President

Dear Members,

Welcome to the first publication for 2020. On the 28th February, the Association held its Annual General Meeting (AGM) during which an overview of MMA activities was given, accounts presented and the findings from the midwives's questionnaire were presented and discussed. I would like to thank those midwives who took the time to fill the questionnaire. The AGM is an opportunity to share with members the activities held by the Association, discuss issues, dissiminate ideas whilst taking note of suggestions for the coming year.

My appreciation goes to the committee members for their continuous committment and dedication towards the Association and to Ms Doris Grima who personally donated a robot machine cleaner. This machine will surely help us to keep the Association premises cleaner.

Two members from last year's committee could not continue: Ms Marie Soler and Ms Francesca Cachia Galvagno. On behalf of the Association I would like to thank them for their service. In view of this, in January, nomination forms were sent to all members to fill the vacant committee posts. The two nominations received were of: Ms Danica Bilocca and Ms Daniela Buttigieg. Election was not required as the two nomitated midwives took office from the previous resigned members.

The World Health Organisation (WHO) declared the year 2020 as '***The Year of the Nurse and the Midwife'***. In doing this, the Board is honoring for the first time the "State of World's Midwifery" report. This report will describe midwifery workforce in global member states and hopefully lead to policy dialogue as well as raise awareness of the profile and the potential for midwives to elevate women's health across the world. In the present time, 2020, women and their families want more from childbirth than simply emerging from the process unharmed. There is a global consensus on the need to ensure that, for every woman, newborn and family, pregnancy and childbirth is not only safe, but is a memorable and rewarding experience filled with love and fulfilment.

On a similar note the theme chosen by the International Confederation of Midwives (ICM) is: ***Midwives with Women*****:** '*Celebrate, Demonstrate, Mobilise, Unite.* ICM urges midwives to:

Celebrate our accomplishments and achievements, not to sit on our laurels but to serve as impetus to push ourselves forward.

Demonstrate through evidence the impact midwives have on maternal health and wellbeing when we are allowed to work to our full potential.

Mobilise midwives, associations, stakeholders and women to become advocates for the profession in support of midwives and midwife-led continuity of care.

Unite: midwives and women require that we work together towards a common goal of gender equality.

Midwifery in Malta has progressed over the past decades. Academically, the midwifery profession has made a huge leap from the standard diploma qualification to University degrees, to Masters and Doctoral qualifications. This awgurs well to the midwifery profession to have a well educated workforce. Within the clinical area, we have seen the introduction of specialist midwives to work as practice development, midwives specialising in breastfeeding care, in perinatal mental health, in bereavement and midwives working in IVF clinics. In the clinical areas, midwives are providing sterling work, they are dedicated and committed in making an impact towards the well-being of the mother, her baby and her family. Midwives are on the 'front line' for maternity health and often referred to as the backbone of effective maternal and newborn care. We should be proud of our midwifery achievements as well as in the diversity and in the numerous services midwives provide for the benefit of our profession and our society.

On the 6th of March, I was invited to the launch of 'Il-Majjistra u t-Twelid fil-Komunità Maltija fis-Seklu 20' researched and written by Ms Janice Caruana, at San Anton Palace. This publication provides a historical narrative and a social picture of midwifery practice during the 20th century, a period where Malta endured two world wars, famine, many households lacked sanitation facilities, lack of transportation and people did not have any means of telecommunication. Janice through her interviews with retired midwives and their relatives shows how midwives were able to support women during the pregnancy, birth and the postpartum period. Most women birthed at home. During this period, women had many children and therefore the midwife's advice and care were in high demand. Midwives worked hard and earned the respect of the women under their care and in their communities. This book provides an understanding on the living history of the local midwifery profession.

The Association has cancelled all the scheduled sessions because of the global pandemic Corona Virus situation. Due to these circumstances, the Association is working on providing the sessions using virtual communication technologies. It is our duty that we continue to provide education, assistance and midwifery care to pregnant and childbearing women during this pandemic period.

Also, in this regard, the 32nd ICM Triennial Congress that was going to take place in Bali, June 2020 was cancelled and rescheduled for next year, May-June 2021 in Bali, Indonesia.

Finally, I end this message by urging every midwife to take the necessary precautions to stay safe for the benefit of herself and her family during this pandemic of Covid 19, in order to continue to render midwifery services to our community.

Pauline Fenech

Assistant Treasurer's Message

Dear colleagues

It is with a heavy heart that I compile the 2019 annual report. As I have been occupying the position of Treasurer for the past six years, I have to relinquish the position in terms of the MMA statute. This is therefore my last report.

I have to start off by thanking the current and past Presidents and Committee members for the trust they have shown in my regard. I never felt threatened and or shackled in my duties. I honestly tried to carry out to the best of my abilities. It is also somewhat of a satisfaction that the Association's accounts are in a healthy state. This healthy balance is due to members' co-operation. Your continued support is truly appreciated.

In this regard, I appeal to those who have not yet paid their membership to do so at the earliest opportunity. Usually the membership fee is collected during January. As from this year, besides the BOV direct transfer facility, members can also settle their membership through the website. The website was revamped during 2019. It is now possible to settle the membership by sing Paypal or the virtual Revolut card.

Having mentioned the website, I am confident that all are in agreement that the revamp has been successful and the MMA now has a professional and modern site. However having a website is not enough. It is essential that members access the site. Indeed any suggestions for improvements are always welcome. Also, this would help us appreciate what is on offer. And that way members can encourage others to use the MMA's services. The only way to make the Association viable is to ensure that its services are availed of.

The services being offered by the MMA, again thanks to the collaboration of a number of our colleagues, are quite vast. There is a marked difference since some years back. Those who attended the Annual General meeting in February were given a specific review of these services.

In conclusion, I once again thank all those who supported me during these past years. I augur that the new Treasurer will find the same level of support that I received from all my colleagues, be they committee members or not.

Doris Grima

Committee 2020 - 2021

Pauline Fenech - President
Mary Said Buttigieg – Vice President
Pauline Borg - Secretary
Danica Bilocca – Assictant Secretary
Daniela Buttigieg – Treasurer
Doris Grima – Assistant Treasurer
Gabrielle Grixti – Public Relations and Communication
Josephine Xuereb – Educational Activities
Laura Calleja – Social Activities

26 -27 -28th November 2020
'INNOVATIONS AND CARE: Maternal & Women's Health Conference'
SAVE THE DATE

Press Release on COVID-19 Pandemic – 31st March 2020

Midwives: Consistently Provide Pregnancy, Birth And Postpartum Care

Babies will continue to be born every day, including during these challenging times. Healthcare systems in Malta and Gozo are actively working to address the COVID-19 pandemic, and within this scenario midwives continue to be with women and families through their childbearing journey. The midwifery profession's aim is to give the best possible perinatal care, whilst minimising the spread of COVID-19.

Evidence and guidance on the novel corona virus is continually being updated and, as all other healthcare professionals, midwives are keeping themselves up to date as the situation evolves. The Malta Midwives Association supports its midwives, who as health professionals, are fully apt to follow the necessary infection control measures.

The childbearing experience leaves a lifelong physical, psychological and emotional impact on families. Therefore, the Malta Midwives Association is in agreement with the World Health Organisation guidance that all women, regardless of COVID-19 infection, have the right to a safe and positive childbirth experience, and that breastfeeding helps a baby to thrive.

The Malta Midwives Association urges all families to continue abiding by the advice of the public health department including good hand washing techniques, social distancing, cleaning high-touch areas, coughing/ sneezing etiquette, avoiding touching the face and staying at home when possible. Expectant parents and new parents should be cautious at this time, and should not delay seeking midwifery or medical assistance when needed.

The Malta Midwives Association will continue to support families during the pandemic by providing many of its services online. This will include 'speak with a midwife' consultations, online childbirth education courses and prenatal & postnatal pilates. More information can be found on our website https://maltamidwivesassociation.com

Diskors minn Pauline Fenech fl-okkażjoni tat-tnedija tal-Ktieb ta' Janice Caruana:

'Il-Majjistra u t-Twelid fil-Komunità Maltija fis-Seklu 20'

6 ta' Marzu 2020

Eċċellenza President, Sinjura Vella, Sinjuri u Kollegi

Il-ħeġġa u d-determinazzjoni ta' Janice Caruana, illum nistgħu ngħidu li ħallew il-frott. Il-ħolma tagħha saret realtà. Meta Janice kellha x-xorti tkun preżenti għat-twelid ġewwa d-dar waqt il-qadi ta' dmirijietha nibtet kurżita li ma ħallithiex bi kwieta. U grazzi għal dawn l-esperjenzi u l-ammirazzjoni ta' Janice għall-ħidma tal-majjistri, illum qegħdin hawn għat-tnedija tal-ktieb tagħha 'Il-Majjistra u t-twelid fil-Komunità Maltija fis-Seklu 20'.

Ms Janice Caruana donates a book to the Malta Midwives Association

Il-ktieb joħodna lura fis-seklu għoxrin u rridu niftakru li f'dan is-seklu, Malta għaddiet minn żewġ gwerer dinjin. Dawn ġabu magħhom diffikultajiet u tbatijiet f'kull qasam tal-ħajja. Il-ħajja ma kinitx faċli għal ħafna ommijiet u wisq inqas għall-majjistri. Il-maġġoranza tat-twelid kien isir fid-dar, fl-ambjent tal-omm, imdawra bis-sapport u bl-għajnuna tal-familjari tagħha: esperjenzi li tlifna minn mindu t-twelid beda jsir fl-isptar. Fiż-żmien li qed nitkellem fuqu, il-familji kienu kbar u naħseb ma nkunx qed ngħid ħazin li x-xogħol tal-majjistra kien imfittex ħafna. Il-majjistra kienet tkun il-punt ta' referenza meta mara toħroġ tqila. Il-mara mill-ewwel kienet tavża lill-majjistra meta tinduna li hi tqila peress li ħafna nisa ftit li xejn kienu jkunu jafu x'hinu mistenni minnhom fit-tqala u t-twelid.

Il-fatt li dawn il majjistri kienu jassistu għal ħafna twelid, kienu jsiru esperti f'xogħolhom, kienu jaħdmu fil-kapaċità indipendenti tagħhom u kienu awtonomi. Kienu jirrikorru biss għall-assistenza tat-tabib tal-familja meta l-affarijiet ma jkunux kif mixtieqa. Il-majjistra kienet tagħraf kif qiegħda il-pożizzjoni tat-tarbija mingħajr il-kumditá li għandna llum tal-magni tal-'ultrasound'; idejha kienu l-ultrasound u widnejha d-doptone jew il-monitor tal-llum. Is-sitwazzjonijiet li kienet tħabbat wiċċha magħhom kienu joffru ċertu sfidi, bħal nuqqas ta' faċilitajiet, nuqqas ta' iġjene, u jekk tiġi mgħajjta bil-lejl it-tarbija titwieled bid-dawl tal-lampa. It-trasport u l-mezzi ta' telekomunikazzjoni li nafu llum ma kinux għadhom jeżistu.

Ftit li xejn għandna dokumentazzjoni dwar dawn l-esperjenzi sbieħ u xi wħud koroh li ġraw f'dawn iż-żminijiet, ħlief esperjenzi bill-fomm li għaddew minn ġenerazzjoni għall-oħra. Personalment, jien dejjem prattikajt il-professjoni ta' majjistra ġewwa l-isptar u għalhekk inħoss li dan il-ktieb se jkun ta' nteress għalija u għal ħafna majjistri bħali li ma għixux dawn l-esperjenzi.

Dan il-ktieb joffri kuntrast bejn it-twelid u t-trobbija ta' ulied bejn tal- imgħoddi u tal-preżent, fejn inħoss li mhux kollox kien ħazin jew li ma għadux tajjeb. Ir-riċerka turina li meta l-omm ikollha kuntatt mall-majjistra waqt it-tqala, tnaqqas iċ-ċans li twelled qabel iż-żmien, tnaqqas iċ-ċans ta' ħlas ċesarja, tnaqqas iċ-ċans li fit-twelid tintuża l-għodda (ventouse/ forceps) u l-esperjenza għall-mara tkun iżjed pożittiva. Ir-riċerka turi wkoll l-importanza u l-ħafna benefiċċji tat-treddiegħ, kemm għat-tarbija kif ukoll għall-omm, prassi li nixtiequ li terġa tiżdied ħafna aktar f'Malta.

Xi ħaġa nteressanti għalina l-majjistri tal-llum hija, il-mod kif kienu jtaffu l-uġiegħ tal-ħlas. Irridu niftakru li ma kellhomx il mediċini u l-epidurals li qed nużaw illum. Meta l-omm tkun preparata biex it-twelid isir id-dar, imdawwra b'persuni li hi komda magħhom u bil-kumditajiet ta' darha, ser tgħinha biex tnaqqas il-biżà u l-anzjetà u żżid iċ-ċans li l-proċess tat-twelid jimxi tajjeb. Meta l-omm tkun ġo darha, hija se tkompli tagħmel l-affarijiet tagħha, tibqa xi ftit jew wisq attiva. Illum nafu li l-uġiegħ tal-ħlas jittaffa meta l-mara ma toqgħodx fis-sodda, li tiċċaqlaq, timxi, isserraħ il-quddiem fuq xi ħaġa, toqgħod komda u tkun irrilassata. L-użu taż-żjut u sħanat ukoll kienu joffru soljef mill-uġiegħ u dawn kultant inaqqsu l-bżonn ta' ħafna mediċini kontra l-uġiegħ. Illum qed nerġgħu naraw li hemm rivolta għal rimedji naturali minn xi ommijiet, biex inaqqsu l-bżonn li jieħdu l-mediċini.

L-edukazzjoni tal-majjistri dejjem ingħatat importanza kbira. F'dan il-ktieb, fost affarijiet oħra, Janice irnexxielha tikseb informazzjoni minn żmien il-kavallieri li tixhed dawl dwar il-kwalifiċi li mara kellha bżonn biex tkun majjistra. Il-mistier tal-majjistra minn dejjem kien regolat u kienet trid tinħareġ liċenzja biex din tkun tista' tipprattika, prassi li għadha hekk sal-llum. Fil-preżent, il-kors ta' majjistra huwa terzjarju, fuq erba' snin u wara tista' tibqa' tistudja biex tikkwalifika b'Masters degree u anke dottorat. Illum il-ġurnata l-maġġor parti tal-majjistri kollha jaħdmu ġewwa l-isptar u l-irwoll tagħhom huwa mifrux mill-kliniċi tal-IVF sal-visti li l-majjistri jagħmlu fi djar tal-omm wara li din toħroġ mill-isptar bit-tarbija.

L-irwoll tal-majjistra ma huwiex biss biex tgħin il-mara twelled iżda l-irwoll tagħha kien u nħoss li għadu meħtieġ fil-komunità bħala parti biex tipprepara lill-mara għat-twelid, tagħmlilha l-visti tat-tqala, u filwaqt li tkun tista' tippromovi s-saħħa pubblika. Meta mara tkun qed tistenna tarbija, hija tkun iżjed lesta li tagħmel tibdiliet għal ġid ta' saħħitha u għal saħħet it-tarbija. Il-kuntatt li l-majjistra jkollha mannisa tqal u ommijiet bi trabi, huwa żmien opportun biex tippromwovi ħajja sana: teduka kif tipprevjeni l-mard, tippromovi t-tilqim, tagħti nformazzjoni dwar ikel nutrittiv u dieta bilanċjata, l-importanza li tevita t-tipjip u l-konsum tal-alkoħol u l-importanza tal-eżerċizzji fiżiku. Ukoll, illum il-ġurnata qed tingħata ħafna importanza lis-saħħa mentali. It-tqala hija żmien ta' ħafna tibdiliet u li tista' twassal għal ħafna stress u anzjeta fl' omm u bejn il-koppji. F'dan iż-żmien tat-tqala l-majjistra tista' tkun il- persuna li tinduna b'ċerti anomaliji fl-imġieba tal-omm u tgħinha biex tieħu l-kura meħtieġa.

Fl-aħħar nett, l-Assoċjazzjoni tal-Qwiebel, tħoss li dan il-ktieb jimla spazju vojt tal-istorja tal majjistri lokali fil-kuntest ta ħajja soċjali, tradizzjonali u ekonomika li kienu jgħixu dak iż-żmien. Huwa wkoll rikonoxximent xieraq għax-xogħol, għal-ħiliet u d-dedikazzjoni li biha l-majjistri wettqu dmirijiethom fil-komunità għall-ġid tal-familji Maltin u Għawdxin fis-seklu għoxrin.

F'isem il-majjistri nirringrazzja lil Janice tal-ħidma sfiqa tagħha għaliex bir-riċerka li rnexxielha tiġbor, il-ħidmiet ta' ħafna majjistri li ġew qabilna ser jibqgħu magħrufin. Grazzi.

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The International Year of the Midwife: ICM leads midwives in 2020

The World Health Organization selected the year 2020, as the year of the nurse and the midwife. An important milestone for our profession at the start of the new decade; a determined and firm assurance towards attaining our sustainable goals by the end of this decade. The International Confederation of Midwives (ICM), considers this year as an excellent opportunity to celebrate midwives, advocate for more midwives, for more access to midwives, for midwives to have a supportive working environment and for gender equality (ICM, 2019).

ICM envisions a world where every childbearing woman has access to midwifery care for herself and her new-born. ICM's mission focuses on ensuring that women irrespective of where they live, and their economic status have access to right and respectable maternity care.

ICM is very much on the global arena, and continuously growing, presently consisting of 142 midwives Associations from 123 countries and speaks on behalf of more than 1,000,000 midwives. ICM also works on a local level with Midwives Associations, regionally within the six ICM/WHO regions, and collaboratively with our partners including the WHO, UNFPA, FIGO, ICN, at local, regional and global levels. Since 2011, ICM's strategic directions focused on three main pillars that constitute a strong profession: education, regulation and Midwives Association, supported by research and consolidated with Quality, Equity and Leadership.

Two key positions underpin ICM's strategic directions: Women's rights and midwives' rights are human rights. A woman's right to access a midwife throughout the childbirth continuum is a human right and a midwife's right to the respect, recognition, education, regulation and support needed to practice professionally and to work to her potential is also a human right. ICM believes that if these core messages are reflected in our policies, partnerships, and calls to action, we can combine all efforts to create high quality and equitable health outcomes for women and newborns and a strong midwifery profession that leads with honesty. However, maternity care can only change if future midwives, acquire all the necessary competencies and are enabled to practice the full scope of their profession. We also need to harmonize midwifery education and regulation, which vary widely across countries.

Midwifery is as old as humanity, yet "widespread misunderstanding of the role and scope of midwifery exists at all levels of policy, health services, academia and funders". (Renfrew, et al 2019 p 396; Horton, et al 2014). Midwives do far more than catch babies (Ten Hoope-Bender, 2013) The impact midwives have, is not just on pregnancy outcomes, as is often understood, but extends from preconception, antenatal, intranatal and postpartum, to newborn and infant care, breastfeeding, family planning and early child development amongst other aspects of adolescents', women's sexual and infants' health.

Our profession is now in the forefront of global attention, an excellent opportunity for the world to make a significant and decisive effort for more midwives globally, especially in middle- and low-resource countries. Bearing in mind that while maternal mortality rates have fallen by 45% in the past 2 decades, approximately, three hundred thousand women still die each year because of pregnancy, childbirth and postpartum period. This is considered as the highest inequity in the world.

We have now compelling evidence that when midwives are educated to international standards (ICM, 2019) and within an appropriately operating health system, midwives can provide 87% of the care essential for women and newborns (SoWMy, 2014) and according to WHO (2019) if midwifery includes the provision of family planning, it could prevent more than 80% of all maternal, neonatal and stillbirth deaths. Midwives also have the potential to reduce maternal and newborn deaths by 67% (SoWMy report 2014). Additionally, Homer et al, (2014), said that a 25% increase of competent midwives in developing countries would result in a 50% reduction in maternal deaths.

We need more competent midwives, we need the opportunity to deliver high quality midwifery care, during the perinatal period, a time which is acknowledged as a transformative transition in the lives of all mothers, fathers, infants and families. However, to date this is contingent to where the woman lives given that most deaths occur in low and middle-income countries.

Additionally, the world is also committed to the achievement of the Sustainable Developmental Goals (SDGs), by 2030. The evidence, as previously mentioned, points to midwives as playing a significant role in the achievement of SDG 3 good health and well-being and SDG5, gender equality in particular, yet, there is a dire shortage of midwives in most countries!

One of the key messages from the report Working for Health and Growth – investing in the health workforce by WHO (2016), addresses the need to scale up transformative high-quality education and lifelong learning so that in our case, midwives would have skills that match the health needs of the population and they could work to their full potential. The report emphasizes the importance of matching the education system of midwives with the needs of the health system of the country. Therefore, midwives should practice the competencies identified by ICM, (2019), learnt within an accredited midwifery education programme and regulated to provide the full scope of midwifery skills within the country.

However, are midwives being educated and regulated to provide the full scope of midwifery skills, the competencies identified by ICM globally? And where midwives are competent and regulated are, they actually exercising those skills to their full potential? These are very pertinent questions! – many midwives world-wide would say no! to both questions.

Midwives often feel disrespected and underestimated in the workplace and in their community, which limits their ability to meet the needs of women and newborns (WHO, ICM, and WRA, 2016). Furthermore, given that most midwives are women, gender inequality underpins the low

status of midwives, including their salaries.

The high levels of illiteracy in the world could also be a contributory factor, most midwives are women, and nearly 2/3 of the world's illiterate adults are women, a proportion that has remained unchanged for the past 20 years (UN World's Women 2015). Hence, this is interpreted as lack of educational opportunities for women and a contributory factor to the recruitment of midwifery students in low and middle resource countries.

Additionally, in a recent publication entitled 'Midwifery is a vital solution - what is holding back global progress*?'* the authors argued that "The population midwives serve, women and children, are often disempowered, discriminated against, and seen as low priority by decision-makers." (Renfrew et al 2019, p.397). Midwives are mostly women, so they are subjected to the same discrimination as other women in their societies" (United Nations Population Fund, (UNFPA), SoWMy, 2014). The international year of the Midwife, 2020 has opened the door for change, throughout this year and throughout this decade, every second counts and is irreplaceable.

According to WHO, the world needs 9 million more nurses and midwives if it is to achieve the universal health coverage by 2030, (WHO 2020). In a recent joint report by ICM, WHO, UNFPA and UNICEF (WHO, 2019) proposed three strategic priorities with a seven-step action plan. There is a dire need for this framework for action and the collaborative effort between partners is sorely needed; we need action, we need to invest in more competent and regulated midwives; to ensure that they work in a supportive environment, we also need to enhance our commitment towards gender equality.

The health sector is a growing employer of women and education is key towards the training of more competent midwives. Consequently, we must invest in literacy and educational programmes with a special focus on girls and adolescents in low and middle resource countries. This can also, significantly contribute to the enhancement of gender equality given that women are the main providers of care. The road to the accomplishment of these ambitious goals will clearly affect the future of appropriate maternity care. (Filby, et al, 2016).

How can we make the best of this year? Ample research has portrayed midwives as a 'best buy' asset for delivering high quality maternal and newborn care, also contributing to a 16-fold return on investment (Renfrew et al, 2014, UNFPA, ICM and WHO 2014) in the provision of respectable and appropriate maternity care globally.

Throughout this year and beyond, ICM plans "to build on the global momentum and spotlight" on midwifery to:

- "Drive policy change and public action to achieve increased commitments to building a sustainable workforce of qualified midwives and consequently increase women's access to quality midwifery care
- Further stimulate pertinent discussion about relationships between midwives and women as advocates for each other
- Highlight the role of midwives as gender champions in their communities
- Delineate the challenges and barriers midwives face globally and disseminate evidence about the vital need for midwives as key to quality maternity care.
- Advocate to governments to ensure that all midwives work in a supportive environment, which enables them to deliver quality midwifery care to women, newborns, families worldwide." (ICM, 2020, p1)

ICM is also celebrating the work of midwives globally, a drive to celebrate life, recognize the work of midwives; celebrate the human to human relationships, the touch of a midwife during pregnancy, during birth, the miracle of life, and highlight how midwives will make a difference in saving human's lives and amplify the voices of midwives on social media.

In addition, ICM will "launch a global campaign to unify women and midwives as partners, working together locally, nationally and globally to lead women's rights to care from midwives. The campaign will target 3 groups of stakeholders: women, midwives and governments". (ICM, 2020, p 5)

The momentum is here, the time is now, the world is focusing on midwives, their work, their vision, their mission, the difference they are making in the world; the potential they have to make the world a better place, to save lives, to save women's, and infants' lives, to strengthen the family, to ensure a world where every childbearing woman has the right to access a competent midwife for her care.

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Il-Qabla: May Pecorella

May Pecorella comes from a family of midwives. Her grandmother, mother and two younger sisters were midwives. She started working as a qualified midwife in 1944 when she completed her two years nursing course followed by an 18-month midwifery training programme. As a midwifery student, she performed her clinical training at Ċini Hospital which also served as a boarding school for students. Ms Pecorella practised midwifery around the island. She travelled around Malta with her Ford V8 to provide antenatal, intrapartum and postnatal midwifery care. Unfortunately, the family tradition of midwives has ended with her generation, although she is proud to have her niece Dr Corinne Ward Scicluna in nursing. She also has many other nieces and great-nieces mostly women who are doctors and dentists in the UK and dreams that one day one of them will continue the Pecorella Midwifery legacy.

Although she never had children of her own, she is considered to be the Matriarch of the Pecorella Clan amounting to more than 100 nieces and nephews. With Italian origins, her father hailing from Southern Italy, family get-togethers are sacred and Sunday is still a family day with her family gathered around her. Until not long ago she was also the one cooking or contributing to these extended family lunches.

Antenatal Care

Ms Pecorella emphasised the valuable input of midwifery care during the antenatal period. She stressed the importance of a detail booking visit in early pregnancy. She considers the listening ears of a sensitive midwife as a fundamental pillar to midwifery care. Ms Pecorella highlighted that the mother's trust facilitates the development of a strong midwife-mother relationship which enhances pregnancy outcomes. Professional rapport will facilitate the possibility of health promotion and empower women to be the protective lead of the child by being more responsive to do the necessary lifestyle changes during pregnancy.

She used to commence monthly antenatal visits at her home until seven months of pregnancy and subsequently performed antenatal examinations weekly. Antenatal visits involved close monitoring of the maternal and foetal wellbeing. Health promotion and education were considered as highly important.

In those days, although consuming natural healthy food was the norm, women still believed in the misconception of eating for two and other food associated myths such as the need to eat some food smelled or seen to avoid the baby being born with a birthmark in the shape of that same food.

> *"Kien hemm dik l-użanza, 'isma' ħi kul din li ma mmurx jiġi bix-xewqa'. U n-nies dak iż-żmien iktar ikel sustanzjuż mil-lum.*
>
> *"There was this custom, 'listen, eat this so that he doesn't come with a desire'. And people used to eat more nutritious food than today.*

Ms Pecorella highlighted that diligent monitoring during the antenatal period was a must especially given that most families gave birth to their children at their own home assisted by a midwife. She explained that midwives used the pelvimetry to exclude cephalopelvic disproportion to ensure a safe homebirth.

Homebirth

During her time, it was the norm that young children were not aware of their expected brother or sister. Pregnancy was considered as an adult matter and was hidden under baggy skirts. She reminisced on how the children of expectant parents used to portray her presence as the midwife.

> *"Meta t-tfal kienu jarawni ġejja bil-basket tal-ħlas kienu jgħidu l-mamà ser ikollha tarbija".*
>
> *"When children used to see me coming with the delivery bag, they used to say mum is going to have a baby".*

Ms Pecorella indicated that in her days, midwifery care was more focused on the women's needs. The expectant mothers were fully supported by a compassionate midwife and two immediate family members. In most circumstances, labouring women used to cope very well with psychological support and natural methods of pain relief. In rare instances, when pharmacological pain relief was required, Trilene inhalation was used late during the first stage of labour while on the odd occasion intramuscular Pethidine or Pethilorfan were administered following communication with the obstetrician.

During this interview, Ms Pecorella brought to light the challenging life midwives experienced during World War II. Honourably, she explained that midwives always rose to the occasion. She recalled instances when she assisted women who gave birth with oil lamps or candles as the only light source.

> *"Kemm wellidt tfal bid-dawl tal-lampa jew bix-xema fil-gwerra!".*
>
> *"I delivered loads of children with light from oil lamps or candles during the war!".*

Whenever possible women preferred to give birth at home and later proceed towards the shelter for protection. There were instances when she assisted women who gave birth in a shelter. She illustrated occasions when she had to go for the obstetrician herself as the driver was afraid to drive during air raids.

When asked to recall an unforgettable challenging event that happened during her midwifery practice, Ms Pecorella, proudly answered with a smile that she recalled two experiences that occurred a few hours apart, the night before and after her final clinical

examination. She considered herself as a privileged midwifery student that had the opportunity to be exposed to many birth experiences in the labouring women's homes as she accompanied her mother for home births. This gave her the possibility to sharpen her midwifery skills since her early days of training. Her enthusiasm to midwifery care overcame the anxiety of her final clinical examination the following morning when together with her mother they responded to a woman's call for support during childbirth. As soon as Ms Pecorella palpated the women's gravid uterus, she suspected that the unborn child was an encephalus. Professionally, she discussed the case with her mother whereby an obstetrician was immediately informed. She stressed the importance of the midwife's skilled practice and meticulous examination. She stated that the obstetrician praised her in front of the two examiners.

"Dik tagħmlilha xejn eżami għax dan il-lejl hi bagħtet għalija u hi ndunat li kien encephalus".
"You don't need to perform her exam since during the night she sent for me and she noticed that he was encephalus".

This memorable challenge was not over with the birth of the stillborn encephalus baby at the mother's home nor with her final clinical examination. Nostalgically, Ms Pecorella recalled her first delivery as a qualified midwife just hours after her clinical examination where she assisted a woman who gave birth to a healthy triplet instead of the expected birth of a singleton baby. She explained that she reassured and supported the astonishing couple by visiting them three times daily for the first 8 days after birth and weekly after that.

Postnatal Care

Postnatally, Ms Pecorella used to visit the mother at home twice daily for 8 days after childbirth. This involved a postnatal and neonatal examination, baby weighing, assistance with breastfeeding and support with baby care. She highlighted that the midwife was always an active listener in times of need.

Ms Percorella explained that in those days it was a common practice for women to wear an abdominal binder immediately after childbirth to support the uterus.

"Dari konna kif iwelldu, kont nagħmilhom faxxa bis-'safety pins' biex ittellgħalhom l-utru 'l fuq".
"In those days, as soon as they gave birth, I used to make a binder for them with safety pins to support the uterus".

Ms Pecorella wrapped up her midwifery career at the age of 78 years by practising postnatal midwifery visits with the Malta Memorial District Nursing Association (MMDNA). She considers mentoring newly qualified midwives as one of her strong attributes to midwifery.

Independent Community midwife

Ms Pecorella communicated that, at the time, the midwife was a key person in the community. Society perceived the midwife as the point of referral not only for physical needs related to pregnancy and childbirth but also for social circumstances. She recalled two instances of pregnancies occurring out of wedlock where she supported these women with the adoption process. She provided ultimate confidentiality whilst taking into consideration the wellbeing of the child by selecting the appropriate adoptive family. Later on, throughout the years, she was also approached by the children of these women who wanted to know their birth parents.

"I came to see where I was born. I wish to see my mother".
"This is my house that I was born. My mother was English. I was born out of wedlock".

Ms Pecorella greatly contributed to the community. She always put her nursing and midwifery caring attributes at the forefront before personal interest. She recollected an instance where she heroically saved a policeman from the police station when she helped him get out of the rubble after a bomb exploded. On the day she offered the necessary nursing care to the injured victims.

Respectable Midwife

Ms Pecorella shared her satisfaction of being so respected by the community and valued for her midwifery input. Although at such an advanced age, till this day, she is still approached by couples or their parents for advice and support. Proudly, she said, *"I haven't renounced midwifery as yet".*

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A Physiological Breech Birth

Recent evidence is highlighting that a breech presentation does not necessarily warrant an elective caesarean section (Bognor et al., 2015; Walker, 2015a; Louwen et al., 2017). A vaginal breech birth is considered an option for carefully selected women and under midwifery and obstetric guidelines, as it is considered to result in little difference in neonatal mortality and morbidity when compared to an elective caesarean section (Giuliani et al., 2002; Goffinet et al., 2006; Daviss et al., 2010; Toivonen et al., 2012; Vistad et al., 2013; Borbolla et al., 2014). Furthermore, the benefits of a physiological upright breech birth (Bognor et al., 2015; Walker, 2015a; Louwen et al., 2017) have been noted which warrants a review of current local guidelines for childbirth options for breech presentations. To ensure women have safe choices in places, it is important to ensure midwives and obstetricians are equipped with the required knowledge to facilitate a physiological breech birth. This short paper aims to present an overview of the mechanisms of breech birth.

Mechanisms of breech birth

The breech normally descends in a sacro-transverse position with the anterior buttock in the lead. Maternal movement encourages descent and, as such, active labour is encouraged (National Institute for Health and Care Excellence, NICE, 2014). The anterior buttock is born first (a process known as rumping), followed by

Image 1 - Sacro-anterior position (Kate Kennedy, 2017)

the baby's anus and posterior buttock. The sacrum then rotates into a sacro-anterior position (so that the baby's bum is facing the mum's tum). Note that whatever position the mother might be, the sacrum must always be in line with the mother's front. In an upright (or all-fours position) you will see the baby's legs facing you (see Image 1 - Sacro-anterior position (Kate Kennedy, 2017)). A 'hands off the breech' approach is still warranted as long as the baby assumes this optimal position, progress is noted and the baby is well perfused with a good tone (Walker, 2013). If rotation is moving towards a sacro-posterior position, this is an indication for gentle intervention such as supporting the woman into a deep asymmetrical lunge (lifting the leg on the side that the baby is facing) to encourage sacro-anterior rotation.

Image 2 - Birth of the legs (Indigo Birth Photography, 2016)

As the buttocks progress, the delivery of the legs may seem like they are taking forever, however, as long as the optimal position has been assumed and there is progress with each contraction and maternal effort, the legs will be born spontaneously and simultaneously (See Image 2). If the legs are not born at the same time, this indicates that full rotation to a sacro-anterior position has not occurred and help to deliver the arms may be needed (Walker, 2013). Continue to observe for descent and the colour and tone of the baby. Further descent, will fully expose the chest. A reassuring sign is the presence of a sternal crease (cleavage) which indicates that the birth of the arms will follow shortly. As the head engages, the baby will then rotate slightly to deliver one arm (See Image 3) and then rotates slightly in the opposite direction to release the other arm. However, sometimes no rotation occurs and the arms are born simultaneously (see Image 4).

Image 3 – Birth of the arms (Indigo Birth Photography, 2016)

Image 4 - Simultaneous birth of the arms (Kate Kennedy, 2017)

Whether rotation occurs or not to deliver the arms, the baby should spontaneously rotate back into sacro-anterior position to enable the birth of the head. Continue to encourage an active birth and a hands-off technique as long as signs of optimal mechanism and physiology is observed. Women will often experience an urge to lower their bottoms to the surface on which they are kneeling such at the bed or a mat and this natural process should not be interrupted as it encourages flexion of the foetal head (Walker, 2013). The baby is also often noted to do a 'tummy crunch' by pulling their knees towards their chest which also encourages flexion of the head and birth of the head (Walker, 2013). By directing women into lithotomy or semi-recumbent position, these natural physiological manoeuvres will be interrupted. If progress arrests following the birth of the arms, help to flex the head is indicated particularly if the colour and tone are not ideal.

Restoring the mechanism

When the mechanism is encouraged and respected, spontaneous birth often occurs, at times, even if the position of the baby is not optimal, simply by being in an upright position the combination of a roomy pelvis and the effects of gravity creates a situation in which the baby can quickly descend at once, and the mechanism remains unobserved or seemingly irrelevant to this baby and this mother (Walker, 2015). However, there will be occasions when the mechanism needs to be restored to encourage birth and avoid complications. Your signal to intervene is a variation in the normal mechanisms, accompanied by a delay which is unresponsive to maternal movements such as going into a lunge or any other occasion in which the baby appears compromised.

The physiological breech birth algorithm has been recently published to guide practitioners what may constitute a delay and enable them to understand when intervention is required to restore the mechanism (Figure 1; Reitter et al, 2020). For instance, while it is imperative to remember that the optimal position is 'tum to bum', it is also important to remember that rotation to a sacro-anterior position after rumping occurs after the birth of the pelvis and once the shoulder engage in the transverse diameter of the pelvis. As such, active rotation prior to this if not indicated can cause problems. This rotation often occurs spontaneously, however, if the baby is rotating into a sacro-posterior position it may be beneficial to intervene at this point by assisting rotation with your fingers on the bony prominences of the baby's pelvic girdle (Walker, 2016).

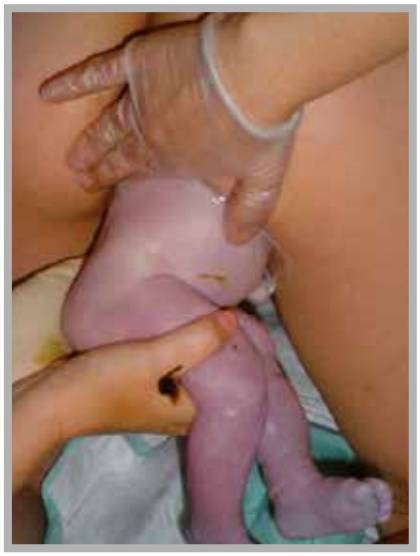

Image 5 - Sacro transverse position following no rotation (Birthing Way, 2017)

In the event of no rotation after the birth of the umbilicus despite spontaneous maternal movement, you can assume that rotation of the shoulders into the transverse diameter has not occurred (otherwise you would have noted external rotation). This often occurs because one or both arms are caught up in the pelvic inlet (see Image 5). In this case you need to restore the mechanism by encouraging rotation with your hands on the bony prominence - (much like Løvset's). If this is not easily effective, use 'prayer hands,' (see Image 6)

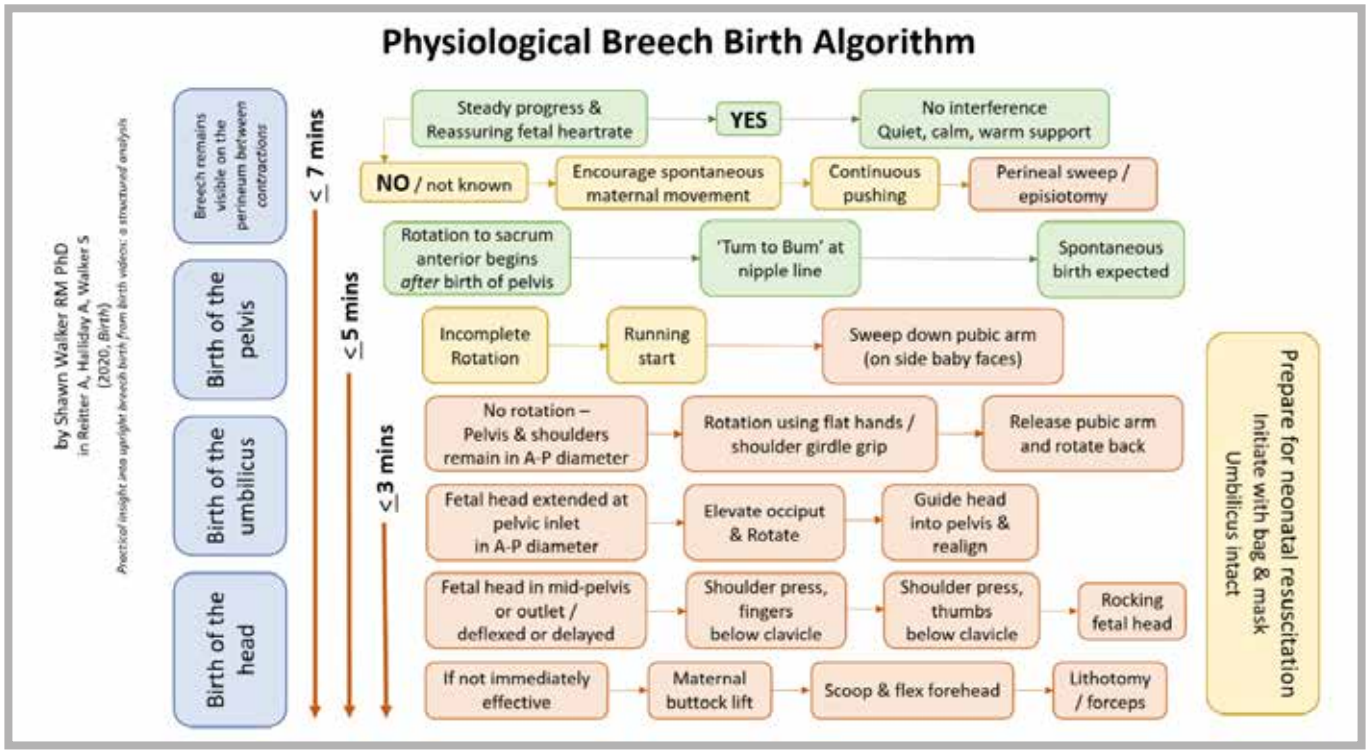

Figure 1 - Physiological Breech Birth Algorithm

Image 6 - Prayer hands (Walker, 2016)

with your fingertips against the bony prominences of the shoulder girdle, palms flat to avoid fetal organ damage. Elevate slightly to disimpact and rotate the fetal torso so that the shoulders are in the transverse diameter. Descent should resume following this rotation (Walker, 2016).

If the baby has rotated and one arm is born first followed by a delay of more than 30 seconds for the birth of the other arm, intervention is likely required due to a nuchal arm. In this case, insert your hand behind the fetal back on the side of the arm which needs to be released, grab the arm and sweep down, in front of the fetal face. This will restore the mechanism and enable the descent and birth of the head without delay. On the other hand, if no rotation has occurred and the posterior arm (closest to the attendant) is born first followed by a delay, it is often because the nuchal arm has become wedged tightly against the symphysis pubis, and it is not possible to sweep down in front of the fetal face (Walker, 2016). In this situation, often the shoulder of the posterior arm becomes tightly wedged against the mother and her anus will no longer be visible. This needs immediate intervention by using 'prayer hands' to rotate the baby into a sacro-posterior position (towards the direction that the baby is facing), which enables you to sweep the nuchal anterior arm down in front of the face and out under the pubic arch. Then you rotate back to sacro-anterior position to restore the mechanism and deliver the head without delay (Walker, 2016).

In the event that all mechanisms appear normal, yet there is still a delay of more than 30 seconds and there is no further descent, the arms may be right under the sacrum yet they have not been born yet. This is often due to an extended head that is trapped in the pelvic inlet with the forehead trapped against the sacral promontory and the occiput against the symphysis pubis. In this situation, even though you are able to sweep the arms, the problem will not be resolved due to the extended head. In this case you will need to use 'prayer hands' to elevate the baby back into the pelvis slightly to disimpact the extended head, rotate to one side if needed to enable the head to engage in the transverse position and then rotate back 'tum to bum' to restore the mechanism and aid delivery of the head without delay (Walker, 2016; Reitter et al., 2020).

In each situation when intervention was required, the head should be delivered quickly using a simple shoulder press. Using both hands, pressure should be applied to the baby's torso along the clavicular ridge, guiding the baby's body straight back through the mother's legs. This manoeuvre the head to flex and descend, following the curve of the birth canal (Walker, 2016). A buttock lift, in which the attendant lifts the buttocks upwards can also be used if the head is delivered up until the forehead. Additionally, when the baby is delivered up to the shoulders, the notion that women should wait for the next contraction to push should be reconsidered as the head is no longer stretching the uterus which changes the positive feedback cycle that stimulates physiological labor progress and initiates the third stage of labour. As such, maternal effort should be encouraged even in the absence of a contraction (Reitter et al., 2020).

Most importantly, it must be ensured that women who choose to have a vaginal breech birth are supported by experienced and well-trained midwives and obstetricians that have a full understanding of the mechanisms of labour and any deviation from the norm. It is imperative that they can work together to refrain from intervention when progress is noted and to restore the mechanism when needed. Keeping in mind the benefits of an upright vaginal breech birth and the risks associated with the exponential increase in elective caesarean sections as described in the previous issue (Fenech, 2019), it would seem like this is the right time to consider nationwide training for midwives and obstetricians in Malta to ensure that women have choices at hand alongside the required support during a vaginal breech birth.

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Caring For The Opioid Misusing Mother: The Vital Role of the Midwife

Pregnant women who are abusing opioids often present as a challenge to many working in the health care sector, but more over to midwives. Drug use tests the ideal image of a caring mother since society has enormous expectations of mothers. Mothers are supposed to be naturally caring, nurturing, self-sacrificing and wise. These social pressures do not allow for ambivalence which is present among most substance misusing mothers and there is often widespread feeling of guilt and inadequacy (Klee et al. 2002). Research has also shown that, even though a mother is a drug addict, she is still able to take care of her children if she is sustained and helped. Therefore it must be stressed with mothers that full cooperation is expected from them, in order to be able to approve that the child would be safe living with them (Fischer, 1997).

Depending upon the background of training one has acquired, a certain strand of theories is adhered to more than others. A broad understanding can help to clarify differences between professional groups and agencies, thereby enhancing multidisciplinary and multi agency working (Petersen & McBride 2002) The moral model which explained substance misuse problems with dependent individuals viewed as 'weak willed' or 'sinful' predominated the 19th century; although today we still hear its currents and undertones in different fora. The 'treatment' for such moral failing tends to concentrate on punishment or on 'saving' the person through religious conversion (Petersen & McBride 2002).

But who is the Substance Misusing Mother (SMM)? Is she a criminal, a junkie, an irresponsible person, a victim, a patient, or a problematic patient?

Is a pregnant woman who misuses substances different from any other pregnant woman? Does her pregnancy need special care? Should substance misusing women be treated in separate clinics from other pregnant women? Would letting substance misusing mothers mix with other mothers help them become 'normal' mothers? Do the substances they misuse make them bad mothers? Are these mothers able to consent or refuse treatment? Do drugs inhibit their cognitive functions? Do they have a free will? Can they really choose the best interest for themselves and their un\ born child? Have they the capacity to consent? Can they be good mothers? These are the many dilemmas that healthcare workers are often challenged with and they often do not find an answer to their questions.

At this point it is important to outline the profile of a Maltese SMM. She is younger than other mothers, more often single, weighs less, less qualified in education, unemployed and may be into prostitution. Often she is multiparous, a cigarette smoker, has multiple social problems and a late booker (Vella et al. 2016). And what is the profile of her newborn? It usually has decreased birth weight and Occipital-Frontal Circumference (OFC). It may be preterm and has lower Apgar scores. It usually has longer hospital stays because of Neonatal Abstinence Syndrome (NAS) and is often bottle fed (Vella et al. 2016).

Considering these profiles one has to admit that, yes, the SMM does present as a challenge and as not run of the mill case. Special care and attention is needed. Yet it often is a worthwhile effort. Pregnancy may be a turning point in her life (Klee et al. 2002; Llopis 2003) as it instils the desire to become a good mother. This must be done with much help and sustenance from others, both professionals as well as significant others.

How to engage with SMM:

In our system at Mater Dei hospital there are various opportunities that help the midwife to engage with the SMM.

- First and foremost the best opportunity is the booking day while the midwife is filling up the Antenatal sheet and 'Blue Card'. This is a golden opportunity for the midwife to encourage the SMM to open up and admit her substance misuse and ask for any relevant help. It should not be a rushed moment, or a 'tick the box' attitude. The midwife should not give in to pressures to skim through the questions and be happy with 'yes' or 'no' answers. She should make the mother feel that her presence in the room is the only thing that is important at that moment and the midwife is all ears to hear her out. Booking may be the opportunity to help the mother to engage to a service which will help her drug problem. It may be a turning point in her life if used well.
- Parental Craft classes are another very important moment to engage and help SMM. Mothers should be encouraged to attend the whole course at the most convenient time with other mothers so that they realise that their fears, their drawbacks and other difficulties are very similar to those of other expectant mothers. The midwife leading the lessons should make it a point to make everybody feel at ease to ask questions and discuss all their worries and doubts. Maybe after the course is finished the SMM can be offered a special session where the normal protocol followed for SMM and their neonates is explained and any queries are answered.
- Closely knit extended family: This is a very special characteristic of the Mediterranean family. In Malta we have still this very important feature that grandmothers, aunties and other relatives offer a helping hand to mothers with newborns. SMM need their relatives to help out and so the midwife should encourage the SMM to bring along close relatives to help out during their pregnancy and after.

There are then some disadvantages and hindrances that do not help in building up a good relationship with the midwife. The long lists of patients for booking and follow-up at the antenatal clinic can be seen as a threat

to a SMM who is fearsome that she will be judged to be an inadequate mother. Some members of society and some health care workers have been reported to have a disapproving attitude and behaviour towards pregnant substance misusing women (Royal College of Psychaitrists 2003; Carter 2002). Stigmatisation and fear of forced rehabilitation may be one cause why women using illicit substances do not seek help while pregnant (Royal College of Psychaitrists 2003; Carter 2002). Fear of losing parental rights or judgemental attitudes from different health care professionals were reasons why SMMs tended to hide their opioid use in pregnancy (Carter 1997, Lieb et al. 1995, Kearny et al. 1994). In the past, criminalisation used to be the solution to 'help' women to stop their illicit drug use. Today women are referred to treatment programmes (Keigher1999). Around thirty years ago, reprimanding attitudes and uncomfortable relationships with health professionals made women four times less likely to receive adequate care, thus, placing them and their unborn children at health risk (Cook et al. 1999; Carten et al. 1996). Hooks (2015) and Stone (2015) both argue that although some progress has been noted still a lot more needs to be achieved with regards to stigma of substance misusing pregnant women. Therefore fear that children will be taken away gossip and taboo misinformation and ignorance all work against the building of a good relationship between the SMM and the midwife.

If patient is suspicious she or her partner may become aggressive and abusive. The outcome of the pregnancy depends a lot on the first interview, the booking experience and on the way things are handled. If the mother feels safe she will cooperate and the baby will be safe. Therefore the midwife should make the mother feel as comfortable as possible. A midwife should not give in to pressures of waiting people outside or to telephone ringing! If the partner is present the midwife should make him part of the discussion. If the midwife notices that the mother is uneasy in his presence she should invent an excuse and try to find herself alone with her. (Eg: Accompany her to the toilet and ask her if there is something she would like to tell you.) When the midwife starts asking questions she should not be seen as inquisitive, intrusive or judgemental. Most mothers feel and understand hidden intentions. If the intentions aren't clear, the SMM will not open up. She may even start saying lies! Therefore the midwife should show care and not curiosity. All information gathered is not done for gossip's sake. Not even the midwife's relatives and loved ones should know who she met during the day. Malta is very small and everybody tends to know each other. Confidentiality should be respected ferociously. When asking questions, the midwife should double check the answer that is given by asking other questions which should give same answer. The midwife should use open ended questions and avoid questions where the answer would be a Yes or No. If the midwife feels that the patient is not saying the truth, or is hiding something, she must use great tact to get truth from her. She should not push too much! She can explain what will happen from this meeting onwards, and the usual itinerary that the mother will follow. That way the mother will be put at ease. She may have many questions to clear up. A mother maybe a SMM and admit it or deny it. She may have a history of substance misuse but not be using drugs at the moment. Her husband may be abusing of substances, and she may have many queries. If she admits substance abuse, the midwife should ask if she is being followed by any professional who works in the drug field. If she says yes, the midwife should then ask who her doctor is. She should also ask if she is using drugs or not, and for how long she has been that way. The job of the midwife is to support the mother and obtain from her clear information. She has a right to exact information, and where one is not sure one must refer to the experts. A new born has a right to live drug free and should not be left at the mercy of his mother's decisions.

The moral duties of a midwife:

Advice about contraception: Literature is very clear to indicate that SMM are offered poor advice with regards to contraception. SMM are expected not to have children as they lead chaotic lifestyles. Yet they are not advised on best practices. (Armstrong et al. 1999; Terplan et al. 2015; Cornford et al. 2015)

Cigarette Smoking: Cigarette smoking remains very high among SMM. Often we are happy to encourage women to stop using heroin but never pay attention to cigarette smoking. YET Nicotine is MORE teratogenic than heroin! Midwives are duty bound to give the right information to SMM. (Chisolm et al. 2013; Bailey et al. 2012.)

Late Bookers: Health Care services should not be daunting and threatening.

SMM should feel that they can access health services without any fears of being judged and criticised. Even though Child Protection Service should be referred in all cases where illicit drugs are being used, this does not entail stigmatisation or judgemental attitudes that make women go into hiding. (Chandler et al. 2013; Brandon 2012; McGlade et al. 2009).

Breast Feeding**:** All SMM should be encouraged to breast feed their children even if they are Hepatitis C positive. The only contraindication to breast feeding is HIV positive status and a chaotic lifestyle caused by heroin use. If a mother is on opioid substitution therapy, this will pass the breast milk to the child, helping the latter to suffer less Neonatal Abstinence Syndrome. Therefore besides the normal advantages of breast feeding, the child will be recovering from Neonatal Abstinence Syndrome more quickly. (Behnke et al. 2013; Gartner et al. 2005; American Academy of Paediatrics Committee on drugs 2001).

The experiences of SMM:

- SMM tell us of beautiful experiences before, during and after birth when they meet health care staff who not only empathise with their suffering but help and encourage them to move on.
- They tell us of nurses and midwives who were not judgemental but who walked the extra mile to support them during their journey.
- It is very encouraging from our side to hear that medical health care staff are growing and accepting harm reduction approaches that need to be adopted with SMM.

The way forward:

Definitely the priority is to help SMM become better mothers. This can be done by promoting a helping environment and not a punitive one. Also this can be achieved by improving the bio-psycho-social-educational environment in various ways; by providing an Outreach programme or a low threshold service for SMM. Food, vitamins, lodging should be accessible for them and their children. Training to all staff at ante-natal staff should be provided as how to deal with SMM. A better referral system between different professionals hailing from different fields should be enforced. Training of family doctors in this specialised field is an asset. Finally issues like safe Health Care, Communication and Confidentiality skills, consistent advice, respect of patient's rights and Postpartum care are all very important aspects of holistic care towards the SMM.

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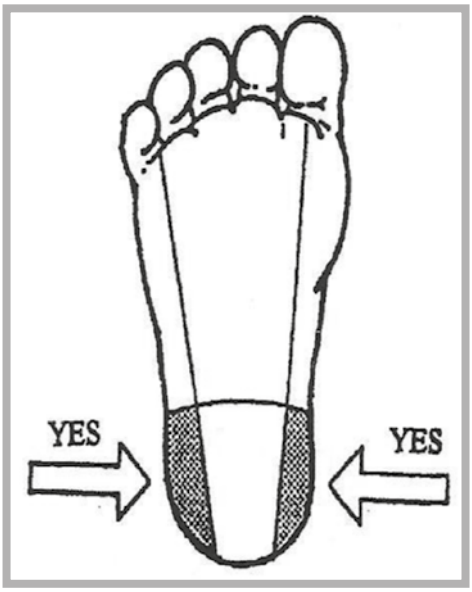
Hypoglycaemia In Neonates

At first glimpse of this title, us midwives will surely recall the recent hustle and bustle with regards to neonatal hypoglycaemia. This article will address this current matter and will highlight the very crucial role midwives have in this eventuality. Simple, practical measures may be adopted to minimise serious complications arising from low blood sugar levels. The midwives' role is critical in preventing a cascade of interventions and also possible admission to the neonatal and paediatric intensive care unit hence separating the mother/ father from their newborn in these early, most crucial days.

Locally, neonatal hypoglycaemia is defined as having a hemocue of less than 2.6mmol/L. Management differs between whether the hypoglycaemic newborn is symptomatic or asymptomatic (Guidelines for the Prevention & Management of Neonatal Hypoglycaemia in the Nursery). Symptoms include lethargy, poor feeding, seizures and jitteriness (Bates, 2011; Wardle, 2009). Management is beyond the scope of this article but an algorithm has been included at the end for your perusal. It is also worth pointing out that a copy of the above mentioned guideline is available on each obstetric ward.



Obtaining A Heel Prick

A hemocue may be taken in a few seconds by a heel prick. Although simple, this procedure carries its own risks especially for those babies requiring frequent hemocue checking. Correct site identification (as per figure below) and alternating heels/sites is pivotal to prevent complications. Needless to say, parents should be informed regarding the need of obtaining this test.

1. Obtain all necessary equipment and perform hand hygiene.
2. Ensure baby is in a safe position.
3. Inspect the foot to select a site free from previous punctures/bruising. With the foot dorsiflexed and held securely, prick the side of the heel with a disposable lancet. *It is very important to make sure that the lancet used is appropriate for neonates. Cleansing the skin with alcohol-impregnated wipes prior the intervention affects the accuracy of the results when testing for hypoglycaemia.*
4. Allow the foot to hang down to aid blood flow and squeeze the foot gently to allow the blood to pool, which can then be collected.
5. Apply pressure to the site and process the specimen promptly.

(Johnson & Taylor, 2016)

Preventing Neonatal Hypoglycaemia

The importance of the first hour after birth has been extensively researched (Widstrom, Brimdyr, Svensson, Cadwell & Nissen, 2019). Evidence strongly suggests that newborns placed skin to skin with their mothers immediately after birth make the transition from fetal to newborn life with greater physiologic stability including glucose homeostasis (Phillips, 2013; Safari, Saeed, Hasan & Moghaddam-Banaem, 2018). Moreover, skin-to-skin helps to regulate the newborn's body temperature (Phillips, 2013). Adequate temperature control is essential in preventing neonatal hypoglycaemia (Wardle, 2009). Hence, putting the infant skin to skin should be standard practice.

Skin to skin also paves the way for successful feeding (Phillips, 2013). Early and frequent feeding facilitates glycaemic stability (Wardle, 2009). Apart from glycogen stores, newborn blood glucose levels are reliant upon feeding (Bates, 2011) thus women should receive continuous feeding support. Babies born to diabetic woman, late preterms and small/large for gestational age babies are more prone to neonatal hypoglycaemia (Bates, 2011; Wardle, 2009) hence need special attention. A compelling finding that came out from a study by Azulay Chertok, Raz, Shoham, Haddad and Wiznitzer (2009) was that breastfed infants had a significantly higher mean blood glucose level compared to those who were formula fed for their first feed.

In conclusion, delaying an infant's first bath until 24 hours after birth seems to have a positive impact on glucose stability apart from other countless benefits (Smith & Shell, 2017; Chamberlain, McCarty, Sorce & Leesman, 2018). As one can notice this is a cycle, one thing leading to another. Thus, the importance of each and every measure aiming to prevent neonatal hypoglycemia is paramount. At this point I invite each and every one of us to reflect on our own practice.

In conclusion, as most of you are well aware, 2020 is special as it is the Year of the Nurse and Midwife. In commemoration, the WHO Director-General stated that 'Nurses and midwives are the backbone of every health system' (World Health Organization, 2020). Our role is definitely challenging but an equally important and significant one. Dear colleagues we make a difference!

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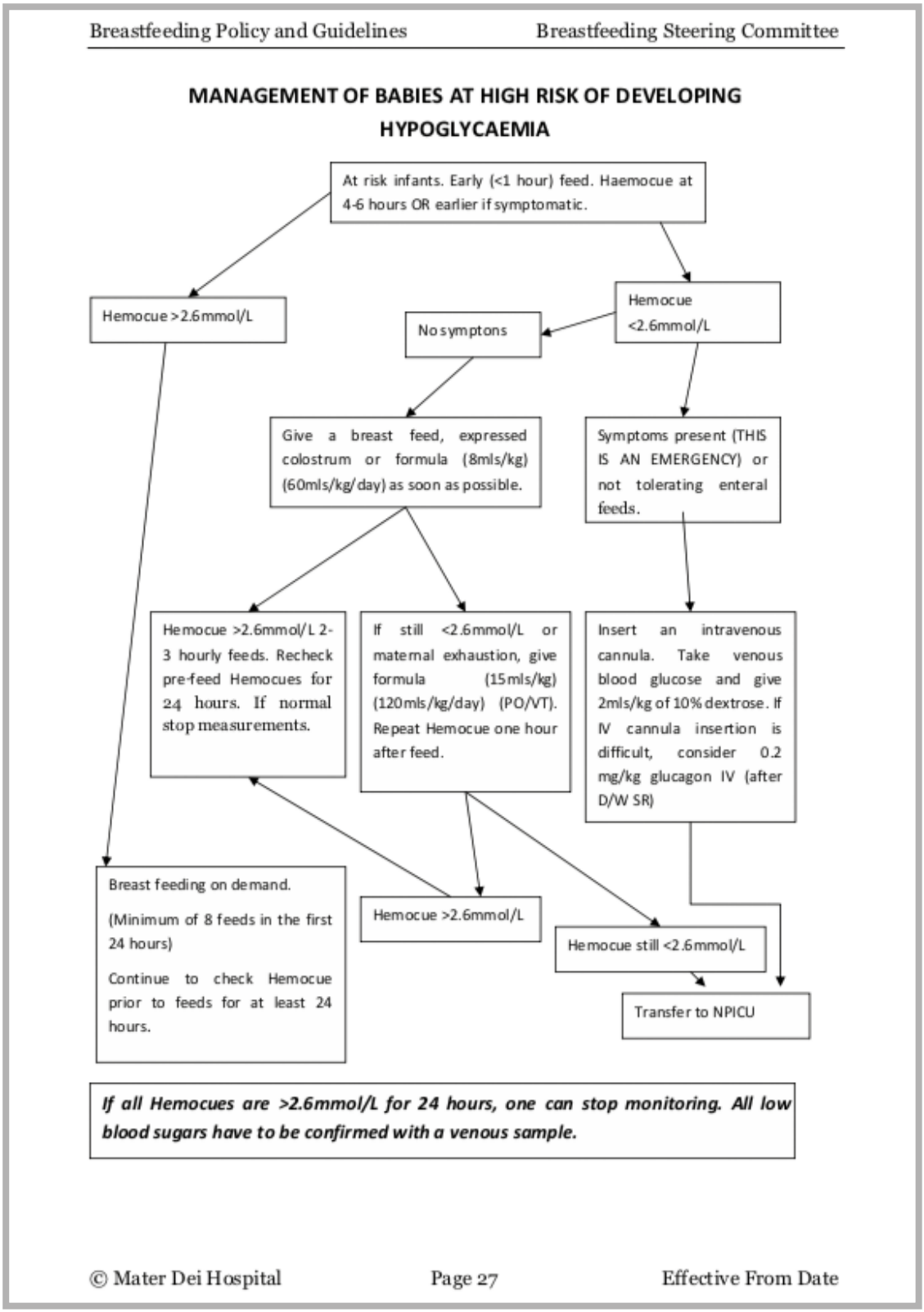

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Use of Codeine in Breastfeeding Mothers

Traditionally, codeine has been used extensively for antenatal and postnatal pain relief[1]. Codeine is an opioid analgesic metabolised in the liver to morphine, norcodeine and other metabolites. Both codeine and morphine are known to be present in breast milk[2].

Metabolism to morphine is mediated by the cytochrome P450 isoenzyme CYP2D6, which shows genetic polymorphism[3] and can result in decreased, absent, or increased enzyme activity with consequent wide inter-individual variations in drug clearance[4]. In women with normal CYPD2D6 metabolism, the amount detected in breast milk is expected to be dose-dependent[5]. However, some individuals may be ultra-rapid metabolizers of codeine. In these mothers, codeine is converted into morphine more rapidly than in other people. This rapid conversion may lead to higher than expected levels of morphine in breast milk, and potentially dangerously high serum morphine levels in their breastfed infants leading to serious adverse reactions[2]. The prevalence of this CYP2D6 phenotype varies widely and has been estimated at 0.5 to 1% in Chinese and Japanese, 0.5 to 1% in Hispanics, 1 to 10% in Caucasians, 3% in African Americans, and 16 to 28% in North Africans, Ethiopians, and Arabs (data not available for other ethnic groups)[2].

Neonates and young infants are at the highest risk of adverse effects because their hepatic enzyme function is immature[6]. Maternal use of codeine during breastfeeding can cause infant drowsiness, bradycardia, sedation, limpness, feeding difficulties, respiratory depression, cyanosis and even death[5,7]. In addition, withdrawal symptoms may occur in the breastfed infant exposed to codeine when maternal administration of an opioid analgesic is discontinued or when breastfeeding is discontinued[2].

In 2013 the Medicines and Healthcare products Regulatory Authority (MHRA) and the European Medicines Agency (EMA) issued advice on the use of codeine in pregnancy following the death of a breastfed infant in 2005 due to morphine toxicity following maternal use of codeine. Both organisations have advised that codeine is contraindicated in breastfeeding women[1,8]. In 2019, the U.S. Food and Drug Administration (FDA) reinforced the warning to mothers stating that breastfeeding is not recommended during treatment with codeine because most people do not know if they are ultra-rapid metabolizers and also because early signs of opioid overdose in an infant may be difficult to notice[9].

Whilst other agents are preferred over codeine during breastfeeding [1,2,5,7,10] we still need to keep in mind that other opioid alternatives have been studied less and may not be safer[10]. The UK Medicines Information (UKMi) consider dihydrocodeine (also an opioid analgesic) during breastfeeding[11]. However there is still little published experience[2,3,10] with dihydrocodine during breastfeeding especially while nursing a newborn or preterm infant[10]. Furthermore the information available regarding expected milk concentrations in ultrarapid metabolizers is also conflicting[1,11,12]. Until more evidence becomes available, consideration should be given to the potential for ultrarapid metabolism with dihydrocodeine use. If significant opioid adverse effects develop in the mother, this could suggest the possibility that she is an ultrarapid metaboliser and that the risk of adverse effects in the infant may be increased[1,11].

Use of any opioid by breastfeeding mothers, if necessary (and only as third line choice of medication after the use of regular paracetamol and non-steroidal anti-inflammatory drugs), should be at the lowest effective dose, for the shortest possible duration and under close medical supervision, regardless of the baby's age. Furthermore the mother should be made aware to stop the drug and seek medical advice, if she notices side effects in her baby such as breathing problems, constipation, lethargy, poor feeding, drowsiness and bradycardia[6,11,,13].

A breastfeeding mother should also be informed that some over-the-counter medications (e.g. cough preparations) may contain codeine. Mothers should be advised to check the label of all over-the-counter medicines for warnings about use while they are breastfeeding and seek appropriate medical advice[9].

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The Role of Hand Hygiene Towards Preventing Hospital Acquired Infections

According to the WHO (2013, 2016) in developed countries the incidence of acquiring a health care-associated infection (HAI) is 7%, potentially rising to 30% in intensive care settings. An HAI is defined by the WHO as 'An infection occurring in a patient during the process of care in a hospital or other health-care facility which was not present or incubating at the time of admission'. The most commonly acquired infections in adults are surgical site infections, urinary tract infections, pneumonias and blood stream infections (WHO). Bloodstream infections, pneumonia, conjunctivitis, skin and soft tissue infections, and central nervous system infections represent more than 80% of all the HAI's in neonates, with the incidence of Central Line associated blood stream infections (CLABSI) reported from NICU'S being consistently high in comparison to all other areas (De Angelis et al 2010, Hocevar et al 2014). HAI's are of considerable concern amongst premature neonates, who are dependent on vital intravenous lines such as umbilical lines and PICC lines for parenteral feeding due to their gut immaturity and initial inability to feed. HAI's can be caused by bacteria, fungi, viruses, or other, less common pathogens. The problems caused by these types of bacteria include prolonged hospital stays, disability, increased resistance of microorganisms to antimicrobials, increased financial costs for societies, healthcare systems, patients and their families and unnecessary deaths (De Angelis et al 2010, WHO 2016). These infections are often caused by multi drug-resistant bacteria which have resulted due to the inappropriate use of antibiotics and the use of broad spectrum antibiotics. Anti-biotic resistant bacteria are on the increase globally, causing grave concern, with the UK reporting more than 61,000 severe antibiotic-resistant infections in 2018 and a 32% increase in anti-biotic resistant bloodstream infections between 2014 and 2018 (Mitchell 2019). The most common multi drug-resistant bacteria causing HAI's are:

- MRSA Methicillin resistant *Staphyloccous aureus*
- VRE Vancomycin resistant *Enterococci spp*.
- ESBL Extended-spectrum beta (β)-lactamase gram-negative organisms
- CRE Carbapenems resistant *Enterobacteriaceae*
- MRAB Multi-resistant *Acinetobacter baumannii*

When transferred through health care providers' hands or through contaminated equipment or surfaces, these multi drug-resistant organisms can lead to outbreaks causing very significant infections and death, especially in critically ill patients (Hardwick et al 2018). Intensive care patients are particularly vulnerable to carbapenem-resistant *Acinetobacter*, which frequently contaminates surfaces and shared medical equipment (CDC 2019, Diamond 2020). Continuous adherence to standard precautions, in particular hand hygiene is vital to preventing the spread of such organisms (Truscott 2019).

Practicing good hand hygiene is a notoriously simple yet very effective way of preventing the transmission of HAI's which involves cleaning the hands either by washing with soap and water, or by using an antiseptic hand sanitizer such as an alcohol-based handrub. Alcohol-based handrubs are the preferred method for hand hygiene in most clinical situations due to their convenience and the effectiveness by which they reduce the number of micro organisms present on the hands (WHO, CDC). Washing the hands with soap and water however is indicated when the hands are visibly soiled, after using the toilet and when there is potential exposure to spore-forming microbes such as *C. difficile*, since spores are not destroyed by an alcohol-based handrub.

Whilst working in a patient setting there are 5 key moments when hand-hygiene should be carried out; before patient contact, before clean and aseptic procedures, after contact with body fluids, after patient contact and also after contact with a patients' surroundings (WHO, MDH Hand Hygiene policy 2009). Although the action of hand hygiene is simple, the lack of health care workers compliance still remains a worldwide problem. Looking further into factors that may influence hand hygiene compliance the WHO (2016) introduced a multimodal strategy consisting of 5 components which include;

1. **System change**: Having the necessary infrastructure in place to carry out hand hygiene and easily available alcohol-based hand rubs at the point of care, which is the meeting point where the healthcare provider, the patient and the interaction are meeting/ happening.
2. **Training and Education:** Offering regular training and continuous educational opportunities for orientation programs and also existing staff, regardless of level and position, including senior management and housekeeping staff, with regular evaluation.
3. **Evaluation and feedback:** Regular monitoring and evaluation of hand hygiene and HAI's and providing regular performance feedback to the staff
4. **Reminders in the workplace:** Having clear reminders and prompters in the work place.
5. **Institutional safety climate**: Creating an environment that facilitates raising awareness of patient safety and the value of hand hygiene improvement as a high priority at both individual and institutional levels.

Health care professionals are aware of the importance of hand hygiene when it comes to preventing the spread of infection, but also recognize that it is possible to forget or omit performing hand hygiene in an often rushed and busy clinical environment (Fashafsheh et al 2016). Hence handrubs need to be easily accessible and placed within arm's reach if possible, to where the bulk of patient treatment or care occurs. This is done so that health care workers do not need to leave the patient area, preferably by having dispensers affixed to the wall, patient's bed/ incubator/ cot, on the bedside table and on dressing/ treatment trolleys that are taken to the point of care. Diamond (2020) reports on a study where to improve awareness on hand hygiene, 'Hand Hygiene Ambassadors' where placed at the entrance to hospital lobbies with alcohol handrub and with permission, applied alcohol handrub to all those entering the lobby, be it visitors, patients and staff members. Using 'Hand Hygiene Ambassadors' targeted towards health care providers, along with clinical teaching could prove useful if adapted to specific clinical areas.

Auditory prompts, using signage and appointing a key member of staff to remain up to date on hand hygiene issues and initiatives have been advocated by the WHO in their Multimodal Hand Hygiene Improvement strategy,

along with initiatives that provide feedback and reward good hand hygiene compliance by specific staff members or wards. Using e-learning materials and establishing a buddy system to educate new staff on hand hygiene issues are also mentioned as part of the WHO strategy. Identifying a time when the majority of staff are gathered together such as after patient hand-over, or lull working times during the shift, may provide the ideal window to preview short videos on hand hygiene, or debate on how it could be improved in the ward.

Since research has shown that multiple techniques are needed to improve compliance with hand hygiene, another possible strategy is that of patient self advocacy, aided by distributing educational hand hygiene information leaflets to the patients themselves (WHO 2016). Also, in order to reduce the potential for exposure to infectious microbes, discharge protocols should advocate for the prompt discharge of mothers and newborns. Continuous education on the importance of breastfeeding in strengthening the newborns' immune systems and the judicious use of antibiotics are also imperative (Costello & Peterson 2016).

Integrated strategies from all stake holders, be it at a national, organizational, or ward level, involving infection prevention and control measures can contribute significantly towards ensuring patient safety and preventing the spread of HAI's (Ricardo et al 2015). Infection prevention and control measures such as hand hygiene are simple, low-cost and effective, however they do require staff accountability and some degree of behavioral change. Whilst support from the hospital management and the infection control team is essential, ownership for compliance with infection control practices such as hand hygiene ultimately needs to come from within clinical teams. As individual midwives and nurses, carrying out the simple evidence-based practice that is hand hygiene, prevents HAI's and ultimately advocates the patients right to safe quality health care.

Hand hygiene quick facts

- Alcohol based handrubs are a flammable liquid and although the incidence of fires is very low, store with caution.
- Use 2 pump actions of handrub for good hand hygiene.
- The areas between the fingers, the thumbs and the fingertips are the most commonly missed when using alcohol-based handrubs.
- Cleaning your hands with soap and water should take around 20 seconds.
- Avoid using hot water to prevent skin from drying.
- Keep natural nail tips less than 0.5cms long.
- Communal pots/jars of hand cream should be avoided.
- Cuts/ abrasions should be covered by a waterproof plaster for clinical work, which should be replaced if it becomes wet.
- Nail varnish and any type of nail technology must not be worn.
- No hand jewellery other than a plain wedding band should be worn.
- Wristwatches or any type of bracelet should not be worn.
- Avoid wearing any sleeves below the elbow.

(MDH Hand Hygiene Policy 2009 & CDC Guideline for Hand Hygiene in Healthcare Settings)

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CLEAN HANDS COUNT

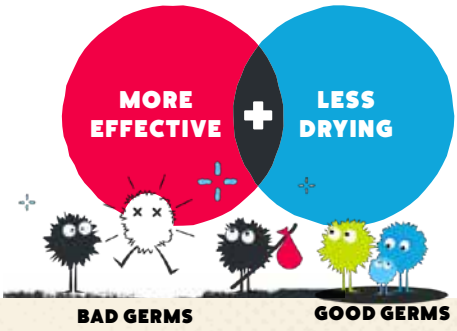
FOR HEALTHCARE PROVIDERS

KNOW THE TRUTH TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:
Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:
Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

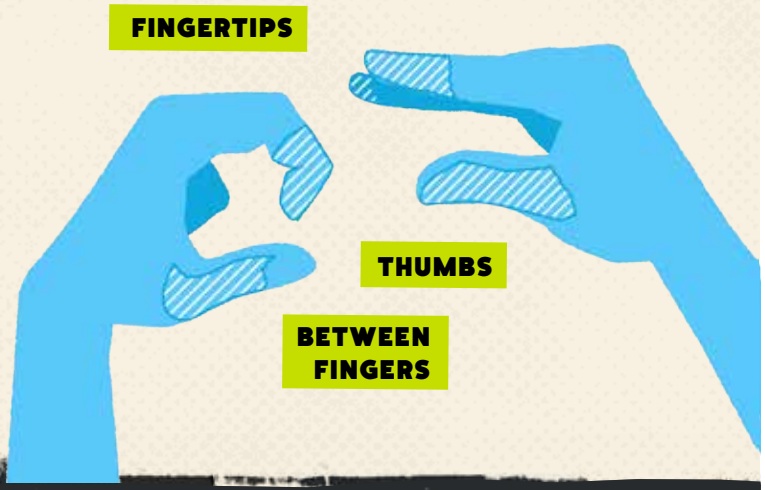
Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:
Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

THE NITTY GRITTY:
Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:



Clean Hands Count 100% of the Time

PROTECT YOURSELF AND PROTECT YOUR PATIENTS FROM POTENTIALLY DEADLY GERMS

TRUTH:

The amount of product you use matters.

THE NITTY GRITTY:
Use enough alcohol-based hand sanitizer to cover all surfaces of your hands. Rub your hands together until they are dry. Your hands should stay wet for around 20 seconds if you used the right amount.

TRUTH:

Glove use is not a substitute for cleaning your hands. Dirty gloves can soil your hands.

THE NITTY GRITTY:
Clean your hands after removing gloves to protect yourself and your patients from infection.

TRUTH:

On average, healthcare providers perform hand hygiene less than half of the times they should.

THE NITTY GRITTY:
When healthcare providers do not perform hand hygiene 100% of the times they should, they put themselves and their patients at risk for serious infections.

www.cdc.gov/HandHygiene

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.

The Role of the Midwife in Public Health

Public health plays a crucial role in the healthcare service (Biro, 2011). The widely used definition of Acheson (1988) gives a clear indication regarding what public health is really about. He defines it as the "science and art of preventing disease, prolonging life and promoting health, through the organised efforts and informed choices of society" (Acheson 1988, as quoted by the World Health Organization (WHO), 2020). In other words, public health strives to identify any risks that may impose on the health of populations, as well as find alternative ways to reduce these risks, for everyone to lead a healthy life. Generally, this is done through a:

1) health protection approach, whereby the population's health is protected from, for example, disease and infection,
2) health improvement approach, whereby people are encouraged to improve their health through health promotion schemes, and
3) healthcare approach, whereby the health services are effective, efficient and equally accessible to all (Royal College of Midwives (RCM, 2020).

So, what does public health have to do with midwifery and the maternity services? Midwives have an important, if not essential, public health role, which is rarely acknowledged (Biro, 2011). Midwives are the healthcare professionals who are present at a critical period in the mother, child and families' life. They are in a position to provide holistic care, especially during this era when the role of the midwife is expanding in all aspects of maternity care provision (Biro, 2011).

Health Promotion is one of the pillars of public health. As defined by the 1986 WHO Ottawa Charter for Health Promotion, Health Promotion is the process in which people are empowered to take control over their own health and improve on it. Consequently, health promotion does revolve around the day-to-day care of midwives, who promote health, rather than manage disease or ill-health (Beldon & Crozier, 2005).

A key factor in health promotion is identifying a way, unique to the patient's needs, to change their behaviour and adopt a healthy lifestyle (Green et al., 2015). This is easily accomplished when there is a good rapport between the midwife and the mother and her support system, under her care. For example, such a health promoting lifestyle change has been viewed when pregnant women give up smoking – midwives have been identified as the key healthcare professionals in providing smoking cessation education whilst also providing the necessary support needed for individual behavioural change for women to quit smoking (Beldon & Crozier, 2005). Thus, midwives are in a unique position at recognising the motivation in women at moving towards a healthy lifestyle, and hence building a supportive and enabling relationship to help them reach their goal (Beldon & Crozier, 2005). Such a positive outlook on health promotion can be incorporated to improve other public health issues related to midwifery. These may include breastfeeding, women's health and the upkeep of immunisations.

Immunisation

Immunisation has been labelled as the greatest success in public health (Andre et al., 2008). Yet it is widely known that there have been certain challenges in the acceptability of vaccination by certain groups of parents (Dub**é** et al., 2013). There has been great scepticism amongst certain parents about the risks and benefits of vaccination which has led to a decrease in immunisation and increase in outbreaks of infectious diseases, such as the measles outbreak (Gust et al, 2009). Midwives hold a unique position in supporting the decision making process of parents regarding immunisation, and this starts as early as the first antenatal visit (Dub**é** et al., 2013). The knowledge and attitudes midwives possess about immunisation must be up to date in order to aid parents to make informed decisions.

Apart from infant immunisation, the importance of influenza vaccination cannot go unnoticed. In view of the present issues the public health authorities are dealing with, because of the novel coronavirus (COVID-19), influenza and the importance of vaccination in pregnant women is worth mentioning. The risks of influenza infection in pregnancy can results in serious complications, both for the mother and fetus (RCM, 2020). Midwives should promote influenza vaccination so as to protect the mothers' immunity, as well as provide passive immunity to their baby (RCM, 2020). Such vaccination programmes are there to safeguard overall national, public health.

Breastfeeding

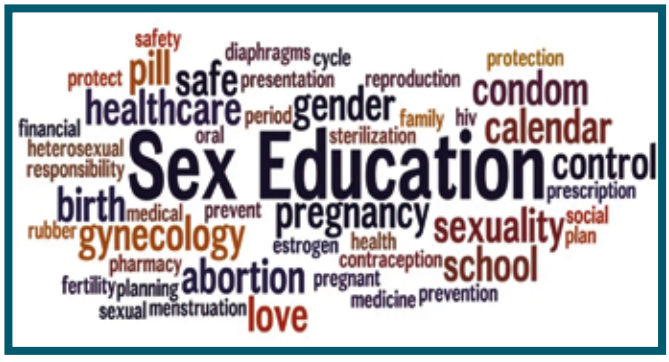
Breastfeeding is not only important for the health of the mother and her baby. It is also a public health priority (RCM, 2020). There is strong evidence which shows that breastfeeding is the ideal form of infant feeding resulting in public health benefits (WHO, 2020). These include:

- the reduction of childhood obesity, which has increased over the years, with its associated factors including cardiovascular disease and diabetes (Busuttil et al., 2012);
- the reduction in childhood health morbidity, such as asthma (Dieterich et al., 2013);
- long term immunity (Dieterich et al., 2013); and
- the reduction in health risks for mothers such as breast and ovarian cancer (Salone et al., 2013).

Improving the overall health of the population through breastfeeding will lead to an elevation of the burden of hospital admissions, which ultimately is also in the interest of national, public health (Ajetunmobi et al., 2015). Hence, midwives have a duty towards public health to promote breastfeeding as well as support mothers during their breastfeeding journey. Overall, being advocates and promoting breastfeeding has the potential to improve mother and child health on a global scale (Pérez-Escamilla et al., 2012).

Sexual Health

Traditionally, the role of the midwife in public health has centred round maternal and infant health during pregnancy, infant feeding and early parenting (Sanders et al., 2016). However, over the years public health has developed, expanding the role of the midwife (Sanders et al., 2016). Sexual health is another growing concern within public health, whereby promoting sexual health has been acknowledged as part of the midwife's role (Bennett et al., 2013). Pregnancy presents a unique opportunity to promote sexual health, and advice and support both the mother and father accordingly (Kelly & Edwards, 2007). These may include advice around family planning, contraception, sexual health screening and checks, as well as information around access to treatment (Kelly & Edwards, 2007). It is important that midwives are always up-to-date with the latest information and guidelines related to sexual health (Kelly & Edwards, 2007).



Obesity

The World Health Organization has identified Malta as one of the European countries with the highest obesity rate (Cuschieri et al., 2016). As healthcare professionals linked to promoting the well-being of patients, rather than managing ill-health, midwives have a distinctive role in educating mothers, as well as their families of the importance of a health balanced diet. Women have expressed the need for advice and guidance about healthy lifestyles, diet and exercise during pregnancy (Furness et al., 2011), and thus, midwives can fulfil this role. Such a contributory guidance can have an effect on the future choices women make towards leading healthy lifestyles.

The Social Determinants of Health

It is important to keep in mind the social determinants of health that are certain characteristics which make up a person. Public health is very much centred on the social determinants of health, which are the "conditions in which people are born, grow, live, work and age" (WHO, 2020). As midwives we must be aware of the impact these determinants have on the health of women we care for, and how we can contribute to improve health inequalities. An understanding of these social determinants of health – social status, income, employment, education, household conditions – will help midwives to put into perspective the mother's health behaviours and their ability towards making lifestyle choices (Biro, 2011).

Adopting a public health consciousness does not mean that midwives have to change their day-to-day role at work, or take on new tasks (Biro, 2011). As already discussed, midwives have an increasing range of public health duties which can be easily incorporated in their daily work schedules. Hence, it is important that public health administrators continue to support midwives in their practice and professional training, with regards to their public health responsibilities, and sustain this essential role of the midwife (Biro, 2011).

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Women's Perceptions of Midwifery Care During Labour and Birth

The small-scale quantitative study sought to examine women's perceptions of midwifery care during labour and birth through a structured, self-designed and self-completion questionnaire. In order to meet the aim of the study, the following objectives were formulated: to identify women's views of the key roles of midwives during the intrapartum period and to assess women's perceptions of important personal attributes of midwives providing intrapartum care. A sample of fifty postnatal mothers (N=50) within 24-48 hours of normal vaginal delivery of a healthy neonate at two Obstetrics Wards of a local public hospital was recruited. All questionnaires were completed, yielding a response rate of 100%. The results of the closed-ended questions were analysed manually by the use of simple descriptive statics. The open-ended questions were analysed by content analysis. The findings of the study showed how mothers gave importance to having a skilled midwife (n=44, 88%) as an important positive personal attribute whilst being a humorous midwife was considered to be the least important positive personal attribute (n=19, 38%) of midwives. On the other hand, the findings suggested that the mothers thought that most important absent negative personal attribute of the midwife was arrogance (n=46, 92%) whilst the least important was the negative personal attribute of being timid (n=18, 36%). In addition, the findings also suggested that the most important key role for mothers was that the midwife provides clear information about maternal options during labour (n=44, 88%) whilst the least important key role for mothers was that the midwife provides comforting physical measures e.g. touch and message during labour (n=17, 34%). It was, therefore, recommended that one-to-one care during the intrapartum period should be provided upon admission and throughout the entire childbirth experience. Respectful maternity care and good communication among healthcare professionals and with the women were also recommended. Continuous professional development and education course are recommended for midwives whilst student midwives are to be exposed to the latest evidence-based information related to the subject. In order to allow for generalisability of findings, future studies should incorporate a longitudinal large-scale random sample of women.

Daniela Buttigieg

Mothers' Knowledge on Neonatal Jaundice in the Postnatal Period

Neonatal jaundice (hyperbilirubinaemia), which is the yellow discolouration of the skin and sclera due to bilirubin deposits in the body, is a common clinical condition that occurs in neonates. The aim of this study was to explore mothers' knowledge on neonatal jaundice in the postnatal period. The objectives were to identify what mothers understand by neonatal jaundice, to assess their knowledge of recognizing neonatal jaundice in their neonates and to assess their knowledge of the causes and management of neonatal jaundice. A quantitative approach was used to fulfill this study's objectives. Data were collected by means of a self-designed, semi-structured questionnaire. The participants were recruited using the convenience sampling technique. They had to be 18 years or older, women who had given birth after 37 weeks of gestation to a healthy newborn by normal vaginal delivery with no maternal or neonatal complications and women who gave consent, were literate and able to participate in the study during time of data collection. The questionnaire was distributed to mothers (N=43) who were available at the time of data collection. The response rate achieved was 93% (n=40). The data collected were manually analysed, using descriptive statistics for the close-ended questions, and content analysis for the open-ended questions.

Results of this study revealed that many of the participants knew the definition of jaundice, where to check for the presence of jaundice in their babies and also the characteristics and symptoms of a jaundiced baby. However, inadequate knowledge of the causes of neonatal jaundice emerged amongst many of the participants. Furthermore, breastfeeding was not considered as a risk factor in neonatal jaundice; however, most of the participating mothers knew that prematurity was a risk factor. Most of the participants still believed in the efficacy of sunlight exposure as management of jaundice, even though evidence suggests otherwise. With regards to prevention of neonatal jaundice, many of the participating mothers were not aware of any measures, though the majority of participants showed readiness to resort to medical care if jaundice occurred. Information about neonatal jaundice was mainly sought from family and friends, but mothers mentioned health care professionals as their preferred source to increase their knowledge. Since convenience sampling was used to recruit the small sample size, the findings of this study cannot be generalised to the entire population. In view of the results, a number of recommendations were put forward. These include reinforcing the proficiency of health care professionals and exploring midwives' knowledge on neonatal jaundice. Other recommendations include educating mothers through verbal and written information as well as preventing conflicting advice.

Janice Bajada

Midwives' Experiences of Breastfeeding Challenges Encountered by Mothers Attending the Walk-in Breastfeeding Clinic

This retrospective qualitative study aimed to explore mothers' challenges encountered during breastfeeding reported by midwives at the walk in breastfeeding clinic. The objectives of this study sought to: identify difficulties encountered by breastfeeding mothers in the community, to explore midwives' competences (knowledge, skills and attitudes) in supporting mothers with the reality of breastfeeding and to explore support services provided by the walk-in breastfeeding clinic within the maternity unit.

A qualitative study using self-designed semi-structured interviews was carried out with a convenience sample of six midwives (N=6) who worked at the walk-in breastfeeding clinic at the local general hospital. An 85.7% response rate was obtained and the data was transcribed verbatim using Braun and Clarke (2006) thematic analysis.

The findings identified a range of difficulties in mothers during their breastfeeding journey. Mothers' expectations and lived experience of breastfeeding effected their perception about breastfeeding, often leading to feelings of failure when unable to overcome breastfeeding problems. The inability to cope with breastfeeding challenges may be due to mothers' lack of education and support. Inadequate preparation contributed to lack of confidence in the mother, leading to constant worrying that their infant's nutritional needs are not met. Other pressures such as not knowing the benefits of breastfeeding, the influence of family members and work place conditions lead mothers to resort to artificial feeding. Consequently, the findings demonstrated that mothers revert to the walk-in breastfeeding clinic for support and advice in resolving their breastfeeding problems. The clinic provided mothers with adequate feeding advice and techniques as inaccurate and conflicting advice provided by other health carers resulted in emotional distress and ultimately cessation of breastfeeding.

Recommendations for practice, education and future research are proposed, such as a 24/7 service to cater for problems at any time of day and week, particularly during the night when support for mothers during this time is minimal.

Hannah Debono

Midwives' Experiences of Promoting Maternal-Infant Attachment in the Neonatal Intensive Care Unit

Maternal-infant attachment is developed when natural behavioural systems within the infant are activated through his/her physical and emotional proximity and interaction with a principal secure attachment figure in his/her environment, namely the mother (Bowlby, 1969). The maternal-infant attachment process is often interrupted by the admission of the infant to the Neonatal Intensive Care Unit (NICU) (Franklin, 2006). Midwives are in a unique position to support mothers and facilitate this process (Hopwood, 2010). The aim of this study was to explore midwives' experiences of promoting maternal-infant attachment in the NICU. The study's objectives were to explore midwives' perceptions on maternal-infant attachment in the NICU, to identify what methods midwives use to promote maternal-infant attachment in the NICU, and to determine any challenges midwives encounter when promoting maternal-infant attachment in the NICU. A qualitative approach was adopted to fulfil the study's aim and objectives. Face-to-face, one-time, semi-structured interviews were conducted with a purposive sample of eight midwives who work in the local NICU. A 100% response rate was achieved. The interviews were audio-recorded and transcribed verbatim. The data was analysed using Braun and Clarke's (2006) thematic analysis.

The findings revealed that midwives view the process of maternal-infant attachment as important in the NICU. Midwives emphasised that they promoted maternal-infant attachment by enabling maternal-infant closeness in the NICU, through encouraging maternal participation in caring for the infant including physical contact and participation in infant caregiving activities. Additionally, the awareness of the midwife's attitudes and qualities was also considered as important to enable maternal-infant closeness, by being present, building a trustworthy relationship with mothers, having a positive attitude and keeping the mother informed on the infant's daily care. Furthermore, midwives discussed the possible restrictions and challenges to maternal-infant attachment in the NICU which included factors related to the mother's feelings and attitudes. Moreover, factors related to neonatal staff causing separation, conflicting staff beliefs, and the need for further education, were considered as possible restrictions. Finally, the intensive care environment, lack of space and privacy and ward policies were considered as challenges for midwives when promoting maternal-infant attachment. Based on the results several recommendations for practice, education and further research are suggested, such as implementing more Family-Centred Care practice, providing more emotional support interventions for parents and the need for staff education on maternal-infant attachment in the NICU.

Kristina Galea

Fathers' Awareness of Sudden Infant Death Syndrome in the Postnatal Period

Although the cause of sudden infant death syndrome (SIDS) remains unknown, it is still one of the leading causes of neonatal death. This study aimed to gain an insight into fathers' awareness of SIDS in the postpartum period, and their knowledge on how to reduce its associated risk. The main objectives were to explore fathers' understanding of the term SIDS, to determine fathers' awareness of how SIDS can occur, and to evaluate fathers' knowledge on how to reduce the risk of SIDS. In order to fulfil the aim and objectives of this study, a quantitative approach consisting of a one-time, self-administered questionnaire was used. A sample of fifty fathers (N=50) was selected by purposive sampling from postnatal wards at the local public hospital. All participants completed the questionnaire, thus obtaining a 100% response rate. Data was systematically analysed using simple descriptive statistics and content analysis. Findings suggest that many fathers were aware of the term SIDS, with parentcraft classes and the media being the most identified sources of information. Results further revealed that most of the participants were able to identify safe sleeping practices such as the back to sleep position, room-sharing, the use of a firm sleeping surface, no pillow use and no loose objects in the baby's cot. However, many participants still believed that the baby should be put to sleep in the middle of the bed when co-sleeping is practised. Moreover, the majority of the participants were still not aware that pacifier use and breastfeeding could help to reduce the risk of SIDS for their baby. Recommendations for clinical practice, future research and midwifery education were proposed, such as giving advice which is in accordance with the latest recommendations, introducing parentcraft sessions during the postnatal period which focus on the safety of the child, and one-to-one sessions between the midwife and the parents on safe infant sleeping practices.

Luana Gauci

Midwives' Awareness of Antenatal Depression in Childbearing Women

Depression in pregnancy, also known as Antenatal Depression is on the increase, affecting 10– 25% of childbearing women worldwide. Awareness of antenatal depression has proven to be a vital aspect in reducing the occurrence of postnatal depression after birth. However, only recently has antenatal depression been given the attention it needs, since over the past two decades, most research regarding maternal depression has focused on postnatal depression, thus time after childbirth (Brown, 2017).

This study aimed to explore the midwives' knowledge of antenatal depression in childbearing women. The objectives of this research were to assess midwives' knowledge of depression during the antenatal period, investigate the care practices provided by midwives to women experiencing antenatal depression and investigate midwives' learning needs with regards to antenatal depression. A quantitative approach was adopted, using a self-administered questionnaire as the research tool. A total of fifty midwives (83% response rate) working in six main maternity wards at the local general hospital were chosen by convenience sampling technique. Data was collected and analyzed manually using Word Excel Spreadsheet, which was then presented in pie charts and bar charts. The findings revealed that locally, midwives' were found to be knowledgeable about their role in Perinatal Mental Health (PMH), and felt comfortable discussing certain mental health issues concerning antenatal depression with pregnant women. However, lack of staff, privacy and time were still affecting the care provided by local midwives. Local care practices were revealed in which included active listening, referrals, provided support and empathy towards mothers suffering from AND. Although all these care practices are seen to follow The National Institute for Health and Care Excellence (NICE) Guidelines, other recommended care practices such as providing culturally relevant information, while also ensuring that the mother understands that depression is not uncommon during the antenatal period; may still not be practiced by the majority. Additionally, midwives felt that they required further training on identifying and managing AND.

Furthermore, recommendations for clinical practice, management, education and further research were proposed in the conclusion of this research study. Such recommendations include frequent conferences about latest research on AND and allocating more midwives to work at the antenatal clinic while also adding new booking rooms for appointments with mothers; initiating antenatal care in local health centers in every locality, thus providing more continuity of care and frequent follow up; and introducing a training programme for midwives focusing on AND awareness and management.

Keywords: Antenatal depression, perinatal mental health, midwives, healthcare professionals, survey, awareness, knowledge, childbearing, pregnancy, women, mothers, maternal depression

Karin Duff

Midwives Views on Spontaneous Versus Valsalva Pushing During the Second Stage of Labour

This small-scale quantitative study aimed to explore midwives' views on spontaneous versus Valsalva pushing during the second stage of labour. To meet the aim of the study the following objectives were set: to identify the way in which midwives instruct the women to push, the factors that influence the midwives' choice of pushing technique suggestion during the second stage of labour and midwives' views on the effects of the two techniques

on both the women and their infants. A self-designed, self-completion questionnaire was distributed amongst forty-five midwives (N=45) working at a Central Delivery Suite of a local public hospital, using the convenience sampling method. Forty questionnaires (n=40) were completed, yielding a response rate of 88.9%. The data obtained from the close-ended questions were analysed manually using simple descriptive statistics, whereas content analysis was used to analyse the open-ended questions. The findings showed that most midwives allowed women to push spontaneously because they believed in the beneficial effects of such an approach on women and their neonates. The most frequently reported factors that influenced the midwives' choices of pushing technique suggestion were the length of the second stage of labour, the foetal condition, women's preference and their general condition. Most midwives believed that spontaneous pushing had better maternal and neonatal effects when compared to the Valsalva pushing technique. Results also revealed how some participants were not aware of the negative effects that using the Valsalva pushing technique can have on women and their infants. Therefore, further information-giving opportunities need to be provided to midwives so that they can be helped to update their knowledge that can enhance the quality of care they can give to women. The implementation of locally prepared written guidelines on the best technique of pushing for the benefit of the mother and the neonate is recommended. Future studies should be conducted with a larger sample of midwives from all the maternity wards to allow for generalisability of these findings.

Christine Azzopardi

Midwives' Views on Obesity in Relation to Early Infant Feeding

The small-scale quantitative study, aimed to explore midwives' views on obesity in relation to early infant feeding. The objectives explored midwives' views of obesity in relation to the methods of early infant feeding, understanding of their role in shaping long-term health problems related to obesity and explored strategies in the prevention of obesity in maintaining healthy early infant feeding practices.

A self-designed questionnaire was distributed amongst 50 midwives using convenience sampling method, consisting of close- and open-ended questions. 80% (n=40) of midwives responded to the questionnaire. Measures of frequency were used to manually analyse the close-ended questions, whilst content analysis was used to analyse the open-ended questions.

The study's findings suggested that most midwives have an extensive knowledge about the impact of early infant feeding on obesity. Some midwives were not so knowledgeable on the impact of combination feeding and early weaning. Midwives were aware about the incidence of future detrimental effects of infant obesity and that midwives' advice is crucial for prevention. The findings pointed out that midwives provide various advice to mothers so as to prevent infant obesity, however, not all midwives provide consistent advice.

The present study presented several recommendations for research, practice and education. Midwives should have a strong knowledge base which is acquired through their pre-registration midwifery training and attending continuous professional development (CPD) courses, conferences and seminars, and participating in obesity prevention campaigns. Additionally, existing local, written, evidence-based guidelines on healthy early infant feeding practices should be easily accessible to all health-care professionals and parents. Future research should also be carried out including randomised controlled trials and longitudinal large sample studies amongst healthcare professionals.

Trudy Desira

The NICU Environment: Neonatal Staff Perspectives

The purpose of the study was to explore the perspectives of the neonatal staff about the physical facilities (i.e., ward layout- single family room and multiple bed rooms, equipment, educational facilities, ambience and rooming-in) at the NICU. The objectives were to determine the views of staff about the physical facilities on the neonatal unit which support family needs and to explore the midwives'/nurses' perceptions on how the physical facilities at the neonatal unit influence their relationship between parents and their newborns. A qualitative research design was adopted for this study and six (6) eligible participants were selected voluntarily through purposive sampling, which ensued in a 100% response rate. The generation of data was attained by utilising self-designed, semi-structured face-to-face interviews. Thereafter each interview was respectively audio-recorded, transcribed verbatim and analysed through thematic analysis as described by Braun and Clarke (2006). The study transpired three themes namely, the NICU environment, enhancing relationships and interactions and organisational change. The neonatal staff observed that the NICU physical facilities presented both advantages and disadvantages to meet families' needs. The neonatal staff's presence and modifications in the visiting hours based upon the family requirements were essential to build strong parent-to-staff relationships. The neonatal staff's proposal of implementing changes in the physical facilities at the NICU is deemed to better reflect the families' needs. However to perform such alterations, increased funding, staff complement and physical resources are required. Through data analysis it was observed that continuous education is an asset for the neonatal staff to enhance their professional role and knowledge.

Keywords: neonatal intensive care unit, perspectives, neonatal staff, physical facilities, room layouts, relationships, neonates, families

Amy Attard

Left to right: Dr Josephine Attard, Hannah Debono, Christine Azzopardi, Karin Duff, Trudy Desira, Janice Dorothy Bajada, Luana Gauci, Daniela Buttigieg, Amy Attard, Kristina Galea, Dr Rita Pace Parascandalo, Prof Rita Borg Xuereb.

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