The Stork

Malta Midwives Association

Issue 3 February 2013

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Editorial

Dear Member,

This is the 3rd edition of the magazine and the 1st issue of our magazine for 2014. One of the aims of this twice yearly publication is to provide a link between the Malta Midwives Association's (MMA) activities and its members. Forthcoming events include the Annual General Meeting to be held on the 28th February at the premises and the Public Speaking Course starting on the 4th of March. During Lent a morning spiritual activity will be held on 7th April at St Catherine's Monastery, Valletta, where midwives and their friends are encouraged to attend.

A key element of MMA activities is parent education. This is being achieved through the provision of several programs that are given routinely, such as: antenatal education programs, talks on how to deal with child emergencies, and recently the introduction of parental skills for parents who have children aged 0 to 5.

This issue features information on several midwifery aspects: importance of skin-to-skin in the first hour, the practice of delayed cord traction and whether it is time to evaluate our perceptions of normal progression in labour. The highlights of a midwife's experience during a two week Dutch midwifery tour is also included. Furthermore, this issue includes a copy of MMA's position paper on Female Genital Mutilation.

Finally the MMA would like to congratulate the newly qualified midwives who graduated last year from the University of Malta. Their dissertation abstracts are published in this issue.

Pauline Fenech

Letter to the Editor

Dear Editor,

It was a pleasure to read the article "Making Birth Safer" by Ms Gilson and Ms Xuereb. Indeed many were the topics discussed at the 1st European Congress on Intrapartum Care in Amsterdam last May. Various speakers presented clinical trials supported by evidence based medicine to improve intrapartum care as well as novel intrapartum fetal monitoring modalities.

The article quoted a 23% increase in diabetes in children delivered via caesarean section versus the ones via normal vaginal delivery. Bonifacio et al.[1] in the journal Diabetes in 2011 noted that there was a 20% increase risk for neonates to develop diabetes if genetically predisposed if delivered via caesarean section. Yet there is currently no mention or evidence regarding an overall neonatal increase in diabetes if not genetically predisposed. Neonates need to have genetic susceptibility mostly to anti-insulin antibodies, Insulinoma antigen 2, zinc transporter 8 and GAD production or inhibition.

Most of these conclusions came out of the BABYDIAB study[2] which followed up babies born to type 1 diabetic mothers via caesarean section. Other studies such as the TEDDY[3] (The Environmental Determinants of Diabetes in the Young) included only neonates born to families with a first degree relative with high-risk HLA genotypes for diabetes.

The proposed pathophysiology of such incidence is that in neonates delivered via caesarean section are exposed to different bacteria when compared to the ones via normal vaginal delivery thus altering the environmental factor for pre-disposition if genetically susceptible for type 1 diabetes. Also some studies have shown that neonates born to diabetic mothers are breastfed less, thus decreasing the possible initial immunity the mother would provide. The DAISY[4] (Diabetes Autoimmunity Study in the Young) has data supporting the idea that environmental factors can act on disease pathogenesis after autoimmunity has initiated, which is consistent with recent reports of an association of enterovirus infection with type 1 diabetes progression.

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Dr Karl Cutajar MD

President's Message

Being the President of an Assocation could be considered as a Privilege, being the President of the Midwives Association at this point in time is not only a privilege but a responsability. A responsibility that together with the dedicated, hardworking executive committee and members, will continue to work to maintain the momentum reached and persist to extend our positive contribution.

This year has been a busy and exciting one for our professional association. The success of this very productive year is incalculable, the richness and resources acquired were only possible due to the involvement of the always increasing number of enthusiastic members. Midwives, who with extra effort are offering their time in a number of different of activities to develop their personal and professional portfolio and share their knowledge with colleagues, prospective and new parents.

The Malta Midwives Association is heavily investing in midwives; we are doing all efforts to give each midwife the opportunity to be exposed and equipped with evidence base knowledge. Midwives whenever possible dedicate your time and effort to participate in learning opportunities; the Normalising Childbirth Training Module, Journal clubs, Case studies and Book reviews and share the knowledge to improve practice. Colleagues take actions to implement the learning acquired through scientific evidence and specialised personel, be empowered to use your expertise and skills to maximise maternal and fetal wellbeing such as the use complementary therapy in labour. Midwives are key providers in providing optimal care and are an essential tools in facilitating the necessary transformation of maternity care. Care that entitles all expectant couples in Malta to have the possibility to receive individualised care that meets their holistic needs according to the ICM Definition, the Royal College of Midwives, the Mother Friendly Hospital Initatives, EU directive 36/2005, the Midwifery 2020, NICE guidelines and the WHO recommendations.

Stating that all expectant couple / new parents:

- Should have a seamless maternity service which provides safe transition to parenthood with a postive and life enhancing experience.
- Midwife should have a visible place in the community setting were women can choose to access them as the first point of contact.
- Be the lead professional for women with no complications and the coordinator of care for all women.
- Each women and her partner need a midwife they know and trust to coordinate the physical and emotional care through pregnancy until the end of the postnatal period.

Investing in Midwives is an investment in the health of the mother, the child, the family; the health of the nation. All MMA activities are tailor made to empower you to work hard to create the necessary transformation of maternity care in Malta.

MMA thank the Minister of Health Dr Geodfrey Farrugia, the Minister of the Family, Elderly and Social Solidarity Dr Marie Louise Coleiro Preca, and the former Ministers Dr Joe Cassar and Dr Chris Said for their listening ear and consideration of our position statements and recommendations on different issues such as IVF, Female Genital Mutilation, Promoting Normal Birth forwarded during the 2013.

Pregnancy and birth are among the most powerful of all human experiences, yet it can also be one of the most disempowering and traumatic experience. Colleagues your valuable input will contribute to become one of the societies around the world that provides expectant mothers with true choice where their needs and the normal physiology of birth are honoured respected and trusted. We are doing all effort to attain this goal through models of care that create systems of knowledge, skills and practices that truly serve mothers babies and families.

Looking forward to meet you at the Annual General Meeting, the International day of the Midwife, the Public Speaking course, Normalising Childbirth Training Module and the study day by the Lecturing team of University of West England among many others.

Mary Buttigieg Said
President

Forthcoming Events

28th February 2014	Annual General Meeting. Malta Midwives Association premises
4th March 2014	Public Speaking Course. Malta Midwives Association premises
7th April 2014	Spiritual Reflections during Lent – morning activity for midwives and friends at St Catherine's Monastery, Valletta
9th & 10th April 2014	Optimising Childbirth Across Europe: an interdisciplinary maternity care conference, Brussels, Belgium. http://optimisebirth.com
23rd to 27th April 2014	Midwifery Today Conference. "Out of Many, One: Unity in Midwifery". Pennsylvania, USA
1st to 5th June 2014	ICM 30th Triennial Congress, Prague. www.midwives2014.org
4th to 7th June 2014	XXIV European Congress Perinatal Medicine. Florence, Italy. www.ecpm2014.org
2 weeks summer program	KNOV: The Dutch Midwifery Tour. fcadee@KNOV.NL

Secretary's Message

Dear colleagues

The past few months have been very busy for the Malta Midwives Association, we have just recently hosted Denise Tiran, midwife specialist for Complementary therapies, for two consecutive courses attended by 45 midwives. The social committee hosted the Christmas dinner at the Xara lodge.

Earlier in the year MMA issued a position paper on female genital mutilation (FGM). This position paper, copy of which can be found on page 6, was sent to the Minister Hons. Mr. G. Farrugia and Hons. Mr C. Fearne on the 5th of August, 2013.

The Association is also proud to have recently become affiliated with the Malta Health Network.

The Annual General Meeting will be held on the 28th February at 18.00hrs at the association premises. An election will be held. Nomination forms can be found in this issue of the stork and can be given to anyone on the committee by the 20th of February. Attendance by members entitles you to vote for who you want on the committee as well as the proposed changes for the association statute. Furthermore the AGM will keep you updated on all the association has done throughout the year.

On a final note I would like to thank and congratulate Pauline Fenech for all her work for The Stork, each issue seems to get thicker and more diverse!

Rebecca Gilson
Secretary

Treasurer's Message

Dear colleagues

It is with some satisfaction that I write this article to provide you with an update.

First of all allow me to thank all those midwives who support the MMA and its committee. It is extremely encouraging to note that the membership has increased by over 50% in the last two years, from 65 paid up members in 2011 to a current strength of 125.

The MMA will not however rest on its laurels and hence my appeal to all those who have not enrolled, to take the immediate plunge and do so today. I also appeal to members not to postpone paying their membership fee. Payments should be made by February before the General Assembly. A detailed financial report will, as usual, be provided during the AGM but I am pleased to inform you that the financial situation has, thanks to your contribution, improved over the past few years.

It is a known fact that the MMA, especially since it has moved into its new premises and enrolled as a duly registered NGO, has made a quality leap. The premises is well laid out and affords better possibilities for organising activities both for would-be parents as well as midwives. The Committee is committed to maintain this momentum of courses and activities. But the MMA is not simply the committee. You, the members are the actual backbone.

In this regard, allow me to make the following appeals:

(a) The association is now affording more possibilities (such as visits abroad) for paid up members. This is to be encouraged. However, as already stated, one should pay the fee regularly, and not ad hoc when the need arises. Your fees are the MMA's lifeline. Expenses are high and spread over the year: rent, W&E bills, maintenance etc. The premises is of a high standard and the association is keen to maintain these standards;

(b) We need more volunteers to help in the various activities. Allow me to thank more heartily all those, who are many, who donate some of their precious time in favour of the association. Without the support of these volunteers, the MMA cannot function properly;

(c) Please do come forward with suggestions – how can we improve? What other activities can be offered? Is there any other segment of society we can tap?

I am confident that with your active participation the Association can continue to foster and be benefit to its audience, namely parents and midwives themselves.

Doris Grima
Treasurer

Annual Membership €20

Annual General Meeting

28th February 2014 at 18.00 hrs

Annual Report and Election of Committee Members

Refreshments will be served

Malta Midwives Association

Position Statement on Female Genital Mutilation 2013

The procedure of female genital mutilation (FGM) constitutes a brutal form of gender-based violence against girls and women and a serious violation of fundamental human rights. Officially FGM is not practiced in Malta, certainly not amongst the Maltese population. However, midwives practicing in Malta are now being more frequently called upon to assist women who have undergone FGM.

In this developing scenario, the Malta Midwives Association (MMA) feels it should raise public awareness on the subject.

Furthermore the Association:

a) condemns unreservedly, the practice of FGM as a violation of human dignity; and

b) notes that no particular need ever arose to legislate on the subject; but in view of the changes that have taken place in Maltese society, the MMA now sees an urgent need to provide a legal framework whereby FGM is rendered illegal. FGM refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO 2007). These practices are carried out by many different societies for a number of traditional and cultural reasons. Girls and women who undergo this procedure are afflicted to immediate and long term complications that impact on their reproductive health and childbirth outcomes (WHO/UNICEF/UNFPA, 1997).

The MMA acknowledges the immense suffering that women who have undergone FGM experience when conceiving and giving birth. MMA urges midwives to be aware and be informed about the practice and its health consequences.

Midwives are encouraged to respect the dignity of the female body and refrain from supporting and participating in any way in genital mutilation.

Conscious of the societal changes that Malta has been experiencing over the years, the MMA, whilst respecting the diverse traditions that are enriching Maltese culture, can never accept to support FGM. The Association therefore wishes to put forward the following recommendations:

- Government should criminalise the performance of or the rendering of any form of assistance in FGM;

- The media is encouraged to give more prominence to the ill-effects of FGM. Even in the local context it is important that the media help in raise public awareness on the devastating impact FGM has on women's physical, emotional and psychological well-being. Education remains the main tool of persuasion. Those practicing FGM need to be persuaded to change their norms and behavior not least by obtaining more knowledge about the indelible and serious consequences the practice leaves on the person undergoing FGM.

- Appeals to Government to provide targeted services, including translation services and cultural mediation to those requiring such a service. Moreover Government is encouraged to offer specialized training for the local health professionals on FGM. This is also important as ultimately it is those involved in health care that are most likely to come across this phenomenon.

- Encourages the setting up of counseling sessions to women who have undergone an FGM procedure. These victims need to be helped to come to terms with their condition, otherwise they risk being ostracised.

The MMA publicly declares that it is also willing to team up with the Government and/or any other Organisation with the scope of holding seminars and public debates, targeting in particular, groups with high FGM prevalence.

Finally, the MMA further encourages anyone interested in the subject to consult:

- WHO (2007). Female Genital Mulitation – New knowledge spurts optimism. PROGRESS in sexual and reproductive health research; and

- WHO/UNICEF/UNFPA (1997). Joint Statement Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. Report of a WHO Technical Consulatation, Geneva amongst others.


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Should We Change Our Perceptions Of Normal Progress In Labour?

The first account of childbirth methodology and midwifery dates back to Soranus of Ephesus who described clearly cervical dilation in a cephalic fetus and methods how to monitor the dilation by the attending midwife. Friedman in 1954 depicted a labor curve and divided labor into several stages and phases[1,2].

The active phase was defined as >3-4cm dilatation. Velocimetry of cervical dilation was the established benchmark with abnormal labor progression being <1.2cm/hour in the nulliparous and <1.5cm/hour in the multiparous in the active stage[2]. No change in cervical dilation despite adequate strong contractions was regarded as labor arrest. Other contributors to the labor curve included studies by Peisner(1986), Rosen[3] (1986) as well as Rouse (2000).

In 1973 Studd graphed advanced labor with differing cervical dilations as starting points.[6] He demonstrated that dilation was around 1 cm/h in the normal, nulliparous and in the active phase of labor whether one was admitted at 2, 4, or 8 cm. For instance, if a patient was not dilating at a rate of 1 cm/h after admission, then either the patient was still in latent labor (ie, the wrong admission diagnosis was made or dystocia was present). The advent of increasing maternal age and maternal/fetal body weight as well as obstetric interventions such as epidural analgesia and oxytocin use have made labor a more challenging and evolving process[4].

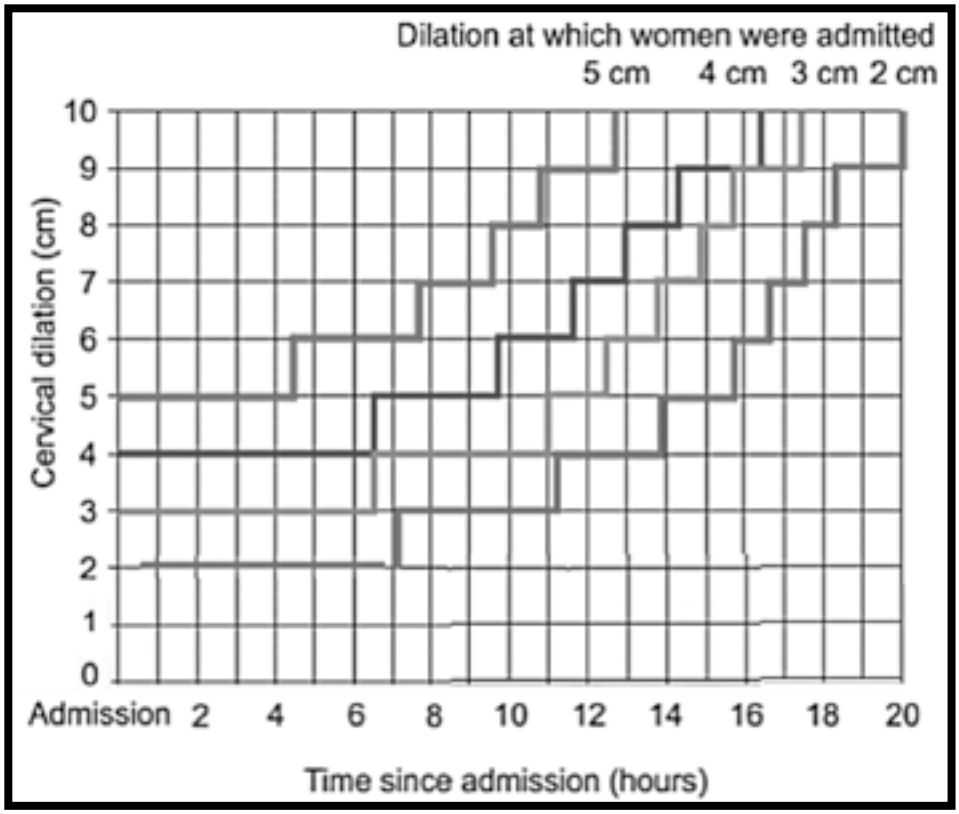

Figure 1

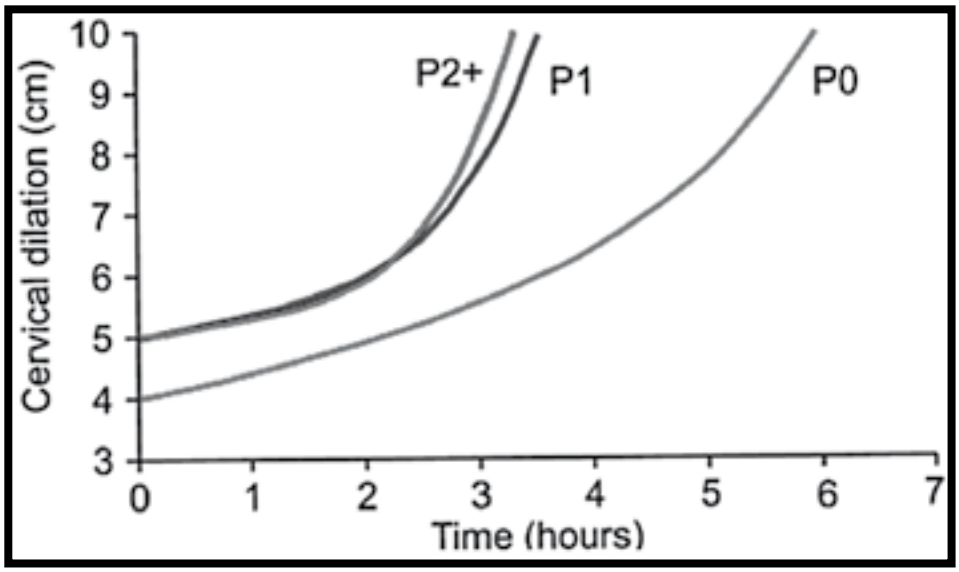

Figure 2

Jun Zhang in 2010 published a landmark paper describing current patterns of spontaneous labor with normal neonatal outcomes[5]. The Friedman curve was clearly challenged in a study of 62,415 patients across 12 clinical centers in 9 US districts. Various parities were considered and subdivided into nulliparous, secondagravida and multiparous (>2normal deliveries). All cases were singleton, vertex presentation, presented with spontaneous labor and delivered vaginally with normal outcome.

Initially, there was no difference in cervical dilatation between multiparas and nulliparous yet, when 6cm of dilatation was reached, multiparas showed faster labor than nulliparous women (The median and 95th percentiles were similar in nulliparous and multiparous women below 6cm). The study also showed that at the 95th percentile, 4cm of dilation could take 6hours to progress to 5cm, whilst 5cm dilatation would take 3hours to progress to

Cervical Dilation (cm)	Parity=0 Median (95th percentile) N=25624	Parity=1 Median (95th percentile) N=16755	Parity=2+ Median (95th percentile) N=16219
3-4	1.8 (8.1)	--	--
4-5	1.3 (6.4)	1.4 (7.3)	1.4 (7.0)
5-6	0.8 (3.2)	0.8 (3.4)	0.8 (3.4)
6-7	0.6 (2.2)	0.5 (1.9)	0.5 (1.8)
7-8	0.5 (1.6)	0.4 (1.3)	0.4 (1.2)
8-9	0.5 (1.4)	0.3 (1.0)	0.3 (0.9)
9-10	0.5 (1.8)	0.3 (0.9)	0.3 (0.8)
2nd stage with epidural analgesia	1.1 (3.6)	0.4 (2.0)	0.3 (1.6)
2nd stage without epidural analgesia	0.6 (2.8)	0.2 (1.3)	0.1 (1.1)

Figure 3

6cm thus shifting the active phase cut-off mark from 4cm to 6cm at any parity[5]. Interestingly, beyond 6cm the 95th percentile of the first stage was less than 2hours especially in the multiparas. The deceleration phase in the Friedman curve was not demonstrated to be present.

The 2nd stage of labor was also evaluated demonstrating 95th percentiles in nulliparous women to be 3.6hours and 2.8hours for patients with and without epidural analgesia. In multiparas the second stage was much shorter[5].

Figure 1 shows the newly proposed curves, which takes into consideration the cervical dilatation on admission of a nulliparous patient to the labour ward. The lines indicate the 95th percentiles, past that would indicate dysfunctional labor. Figure 2 indicated mean delivery times in nulliparous, secondogravidae and multiparous with Table 1 showing mean values in hours of labour[5].

These results indicate that our notion of normal progress based principally on 1cm/hr Friedman curve may be flawed especially based on the power of this recent study. It brings us to re-evaluate what we perceive as normal labour progression as well as "abnormal" or dysfunctional labour. 6cm of dilatation might be the "new" active phase alert line marker, as no change for 4hours may be normal in early labor but abnormal beyond 6cm. Should this be duplicated then we will have to re-evaluate our management guidelines with regards to augmentation of labour.

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[1] G. Hallsworth (Royal Glamorgan Hospital) et al. 'Iron absorption from Spatone for prevention of iron deficiency in pregnancy' in Clinical and Laboratory Haematology, 2003, 25 227-231.

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Skin To Skin Contact:
what is all the fuss about?

The routine separation of mother and infant at birth first appeared in the United States during the 20th century, when newborns were placed in a central nursery away from their mothers in an attempt to prevent infection. With time, research and gradual cultural changes with regards to birth and breastfeeding, we have witnessed a move towards encouraging skin-to-skin contact and rooming-in during the hospital stay. Locally we have implemented the above into our midwifery practice so as to move towards becoming a baby friendly hospital.

Breast crawl

Skin-to-skin care provides powerful sensory stimuli including; touch, warmth and odour. These sensory stimuli positively effect mother-infant interaction and breastfeeding. When allowed to move naturally on the mother's chest the infant uses the senses of sight, hearing, smell and taste to follow a sequential behavioural pattern called the breast crawl. The breast crawl is made up of nine steps (in italics); The ***birth cry***, is followed by a ***relaxation phase,*** during which the infant doesn't move for a short period, the infant then starts small movements such as thrusts with the head and small movements of the shoulders and arms, this is the ***awakening phase***, which is shortly followed by ***activity,*** the infant starts looking at the breast and the mothers face and starts rooting. This is where the ***crawling*** comes in as the infant starts approaching the areola. On reaching the areola the infant will start licking and touching the nipple to ***familiarize*** itself prior to ***suckling***. Suckling may be achieved without help during the breast crawl. A good feed is then followed by ***sleep.*** The infant will also often ***rest*** between the different phases.

We have all seen newborns go through various aspects, if not all of these nine phases, so then how come we often have to help babies with the first feed? When the baby is removed from the breast, even for a short period of time the infant must start the breast crawl from the beginning. Also research has shown that analgesia in labour may affect the infant's ability to complete the breast crawl, however these infants will still experience many or all the advantages skin-to-skin care has to offer.

Skin to skin care not just for breastfeeding

Skin to skin care has been mainly associated with breastfeeding; however, skin-to-skin contact immediately following birth has further positive effects for both mother and infant.

Oxytocin levels are elevated in the mother and infant when in skin-to-skin contact. Oxytocin will aid contraction of the uterus, prevent bleeding and enhance mother-infant bonding. High oxytocin levels in a mother during the first hour following childbirth and close contact from skin-to-skin care promote the development of the new relationship, enhancing the mother's bond with her baby. Oxytocin release in the infant during skin-to-skin contact may explain less crying and calmer infants. Extensive crying is related to the stress of being born which may be counteracted by skin-to-skin contact. Self-regulatory behaviour is seen in newborns placed in skin-to-skin contact with the mother at birth. At birth, infants experience a surge of cathecholamines for the adaptive processes in the transition from intrauterine to extrauterine life. Following these adaptive effects, the cathecholamine surge brings about the stress of birth. Skin-to-skin contact may exert an effect on somatosensory nerves, reducing the long-acting stress response from the cathecholamine surge. A further stress on the infant at birth is that of thermoregulation. Many studies have shown us that temperature regulation controlled by the mother's body increases infant body temperature if the infant's temperature drops. When compared to radiant heater care, skin to skin contact has the further advantage of warming the extremities of the infant as well as the core temperature. Furthermore, various studies have concluded that skin-to-skin contact helps preserve the infant's energy, protects against hypoglyacemia and aids metabolic adaptation, which may improve infant well-being. Aeration of the lungs, liquid absorption and cardiac performance are also improved.

Skin-to-skin contact ensures birth remains between mother and infant, which is where it belongs. Throughout pregnancy, mother and foetus are one entity. The foetus is protected, kept warm and fed. Following birth the infant still requires protection, warmth and feeding. Skin-to-skin contact between mother and newborn facilitates all the above, while at the same time enhancing the developing relationship between mother and infant.

Rebecca Gilson
B.Sc. (Hons) Midwifery

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Promoting Normality in Midwifery Normalising Childbirth

Bristol: 17th to 24th November 2013

This was my first experience in going abraod for a whole week as participant in the Vocational Educational and Training (VETRO) of the Leonardo da Vinci sectoral programme. The programme is responsible for vocational training. The scope of this experience was to support midwives promote normality in midwifery.

The lectures were held at the University of the West of England in Bristol from Monday 17th till Friday 24th of November, 2012. The group consisted of 9 midwives and as soon as we arrived at the Univeristy on Monday, we were greeted by Ms. Jenny Hall, the link organising midwife for the VETPRO programme. Ms Hall holds a PhD in midwifery. The focus of the lectures was on how midwives can support normal births. Ms Hall, who delivered most of the lectures, talked on the midwives' role in the provision of holistic care to mothers; on how to nurture attitudes of normality in midwifery; on exploring diverse approaches to midwifery care; on the value of time during labour; on the importance of spiritual care and emotional support; and on the importance of trustful relationships.

The group had the opportunity to discuss water births with a midwife who routinely assists mothers during waterbirths. This type of birth is becoming very common in midwifery led clinics and is considered a natural way of pain relief during labour. She described waterbirth as a peaceful event. We also discussed birth centres; these are centres which can either be next to a hospital or stand-alone. Only low-risk women can give birth in these centres. On Saturday, we were invited to visit a birth centre. My colleague and I visited the stand alone birth unit in Chaltenam Spa. This birth centre has a homely setting, which provides a very relaxing environment for the labouring woman. The room holds a big bath where waterbirths are possible. During a waterbirth, midwives do not use continuous Electronic Fetal monitoring but structured intermittent auscultation using a doptone. Technological instruments are all stored inside cupboards so as to minimize the appearance of a hospital environment and these are mostly used in case of emergencies.

One lecture was dedicated on the benefits of massage techniques to relief pain during labour. After listening to the recommendations of the benefits of massage, the lecturer, who is a midwife and holds a PhD on the benefits of touch and massage for women in labour, gave us a demonstration and later supervised the group as we practicesd on each other.

On another day, we were lectured by the Head of the University. Her lecture was focused on the effective use of communication, assertivity, autonomy and accountabilty. The lecturer stressed on the importance of research in midwifery to enhance midwives' knowledege which will facilitate change in midwifery practices. The lecturer highlighted the benefits in working hand in hand with other health care providers to promote normaility in childbirth and to provide woman-centred care.

Conclusion

Having the chance to discuss midwifery issues as a group helped me to reflect critically on midwifery practices. This experience gave me the opportunity to share and explore different prespectives. I highly recommend and encourage midwives to embrace such learning opportunities.

Daniela Bonnici
B.Sc (Hons) Midwifery

Bristol Group

Complimentary Therapy Course

Complimentary Therapy Course

Christmas activity at Xara Lodge

Public Speaking

Speaker:
Dr. JOSEPH AGIUS
B.A., M.Sc. (Dublin), EdD (Sheffield)

Duration: 20 hours (7 sessions)
Name Of Certification Body: The Malta University Consulting Ltd. (MUCL)

Tuesday 4 March • Tuesday 11 March
Tuesday 18 March • Tuesday 8 April
Tuesday 15 April • Tuesday 22 April • Tuesday 29 April

Time: 5.30pm – 8.30pm
Fee: Members 130 Euros
Non-Members 150 Euros
Workbooks will be provided

The course objective focuses on effective public speaking particularly dealing with the fear of speaking. It shows participants that public speaking is fun and easy. The course provides practice in both impromptu and prepared speeches and also addresses the important issue to 'wake 'em up!" during presentations! Participants are introduced to the principles of adult education.

Another area which is discussed in these sessions is stage fright. This is a phenomena that one must learn to control. Participants are encouraged to think of any presentation as a friendly conversation rather than a formal speech. Communication with confidence is the key.

Humour can be a useful tool in public speaking. So in these sessions participants are provided with guidelines on how to use humour in a presentation.

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The KNOV Dutch Midwifery Tour

Midwifery in the Netherlands

In contrast with the rest of Europe and most Western countries, the Netherlands have held fast to their traditional system of maternity care. By the end of the twentieth century the hospitalisation and consequent medicalisation of childbearing became the norm for most countries (Beech, 2006; Stewart, 2004). Nevertheless, the Dutch resisted, and though several changes have occurred over the years, their framework of maternity care has remained considerably integral (De Vries et al., 2013).

The Dutch system recognises midwives as the first point of contact for pregnant women. Most midwives work in groups of three/four thus each woman can choose a known group/team of midwives who will provide her with complete perinatal care. Subsequently, antenatal care continues to be provided in the community, led by midwives for all low-risk women and as shared care with obstetricians for the higher risk groups. Essentially, all low-risk women have the option of labouring at home in the first stage and/or having a home birth. Postnatal care is also community based with women being discharged from hospital within a few hours if all is well. Frequent midwifery visits and the service of a *kraamverzorgster* (trained maternity care assistant) see to the needs of the woman at home. In the Netherlands the culture is that postnatally, the woman, the newborn and the family are attended to and nurtured with great care during this transition.

The prevalence of homebirths in the Netherlands has received significant attention in both public and professional debate. In recent years controversial articles and equivocal data have marred the reputation of homebirths (de Jonge et al., 2013). However, extensive research of 529,688 low-risk births in the Netherlands indicated that there was no difference between perinatal morbidity and mortality between planned homebirths and planned hospital births (de Jonge et al., 2009). Certainly, further research is warranted. However, in a joint statement the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives recommend homebirth as a safe and essentially beneficial choice for low-risk women with uncomplicated pregnancies (RCOG/RCM, 2007).

The KNOV Dutch Midwifery Tour

The Dutch Midwifery tour was organised by the Royal Dutch Organisation of Midwives (KNOV) organisation for the first time in August 2013. This was inspired by several requests from midwives and professionals abroad for a direct experience of the Dutch midwifery system of care. The course commenced at the KNOV premises at the Domus Medica in Utrecht where an introduction and a series of lectures/discussions were held. These were designed and aimed to illustrate the theoretical and organisational framework behind the Dutch Midwifery system of care, including education, research, legislation, quality, legal, ethical and political issues.

The core component of the KNOV Dutch midwifery tour was focused on direct clinical experience. The placement consisted of two weeks, most of which were dedicated to shadowing the host midwife in her local practice. This was for the most part conducted in the community, that is in midwifery clinics and in the women's homes. In the Netherlands this is termed **primary care** and constitutes the care deemed appropriate for normal/straightforward pregnancies. When complications arise, women are referred to **secondary** and/or **tertiary** maternity care, which incorporates care led by obstetricians and specialised midwifery clinics, usually within the hospital setting.

This system of primary, secondary and tertiary professionals/care is integral to the maternity care set up in the Netherlands. This framework is steered by a comprehensive document - the Dutch Obstetric Indication List (VIL) which delineates which women should receive primary, secondary or tertiary care. On reflection, this system decreases the focus on the terminology of low or high RISK. Risk discourse gives weight to the potentiality of problems and complications rather than the normality of childbearing. In the Netherlands health professionals focus on the greater potential of all going well with a philosophy of a "… watchful and reactive rather than interventionist approach to birth" (DeVries et al., 2013, p.3).

Personal Reflection

The KNOV Dutch midwifery tour was in several ways a much welcomed culture shock for me. As a midwife from Malta, I had received my education and training in a fairly medicalised setting; in Malta basically all perinatal care is centralised in the tertiary acute hospital. Hence it was extremely refreshing to immerse myself into a society where both professionals and clients of maternity care held a physiological philosophy of childbearing. Unfortunately, this is also under treat in the Netherlands as influences of medicalisation permeate these sociocultural beliefs. Recent statistics reported a decline in homebirths. In effect, the KNOV organisation is seeing to strengthen and support midwifery practice. Ms Franka Cadee, KNOV international policy advisor & maternal health consultant, dedicated one of her initial lectures to explaining the foundations for the Dutch midwifery system of care. Ms Cadee explained that this is supported by three pillars; the university **education**, the KNOV **organisation** and the council **registration** system. Regular registration asks that midwives keep up-to-date by delineating a yearly number of clinical and educational hours.

As noted above, further into this experience I would opt to add **culture** as another pillar for the Dutch system. Even before I initiated the course I was fortuitous enough to meet a man on the train, a father of four children, all born at home. This man spoke with great ease and comfort of home birth, as if it were the norm rather than a special practice. Further on, as I met the women on a day to day basis in the midwifery practice I could see that this culture was ingrained in them and in their families. The midwives worked hand in hand with this sociocultural approach to childbearing; acting as the integral reference and professional to enable and support this practice and to empower the women and their families.

Working with my host midwife was an enticing experience. From a logistical perspective it was fascinating to see midwives acting as independent practitioners, running their own clinics and service as a business. Thus I learnt a completely new way of providing maternity care, where inadvertently health insurance guides women with straightforward pregnancies to the most suitable professional for them; the midwife. On the other hand it was a great learning experience for me to note the autonomy and subsequent responsibility of being an independent practitioner. Personally, I particularly enjoyed running the antenatal clinic with my host midwife, since this is something which is completely lacking in Malta.

In order to provide such a comprehensive service, midwives in the Netherlands are sometimes on call for 48 hours and I experienced this whilst on my placement. Waking up in the middle of the night to go for house calls may seem tiring initially. However, providing holistic midwifery care in the community to women who become personal clients, makes this work very gratifying. It was evident that the fact that women and midwives could build a trusting relationship through continuity of care from the antenatal to the postpartum period was a core strength of the Dutch system of care.

Conclusion

On completion of my experience in the KNOV Dutch Midwifery tour, I felt that this was a golden opportunity to see how midwives in the Netherlands work on a day to day basis and to meet the women and families who avail of this care. I noted that Dutch midwives exhibited great knowledge of the science and the evidence-base grounding their practice together with a great passion for the art of midwifery. I also realised that much can be acquired from seeing diverse sociocultural and professional approaches to childbearing. In connection with our local context, we may benefit from reflection, research and thinking outside the box in order to ameliorate our services to provide the best possible choices for the women and families who avail of our care.

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Pauline Borg
B.Sc. (Hons)(Melit.), M.Sc. (Melit.)

This midwifery Tour was attended and financed on a personal basis and not as a representatitve of the MMA.

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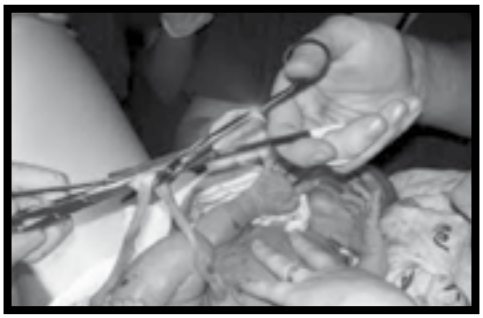
Delayed Cord Clamping

One of the components of active management in the third stage of labour is the timing of the cutting and the clamping of the umbilical cord. Before the 1950's, the term "early clamping" was defined as umbilical cord clamping within one minute of birth, and "late clamping," as umbilical cord clamping more than five minutes after birth. (American College of Gynaecologists, 2012) However at the time of writing no consensus regarding the definitions of 'early', 'late' or 'delayed has been standardized. In his article, Abalos (2009) discusses that trials evaluating active management of the third stage of labour have used a variety of definitions of early cord clamping and cutting, ranging from immediately after delivery of the baby to up to one minute after birth. The same confusion exists with regard to the definition of "late" or "delayed" cord clamping and cutting. These terms are generally understood to mean a delay of two to three minutes after birth, or when cord pulsation has ceased. However, their exact definition remains unclear.



The Royal College of Midwives issued their latest guidelines on the Third Stage of Labour in 2012. The update on the guidelines suggests that, although there is a possible risk that neonates require phototherapy post-partum due to delayed cord clamping, neonates are still at an advantage as they improve their iron status up to six months from birth. (Resuscitation Council 2010; McDonald and Middleton 2009; WHO 2007). However no differences have been reported in Apgar scores, umbilical cord pH, or respiratory distress caused by polycythaemia between neonates who had their cord clamped early and neonates with delayed cord clamping. (Rabe H, Jewison A, Alvarez RF, Crook D, Stilton D, Bradley R, et al, 2011).

Mercer and Skovgaard (2002) argue that a successful neonatal transition is dependent upon a newborn having both an adequate blood volume for respiratory function and red cell volume to provide enough oxygen for maintaining respiration. This transition should be performed unhurried, unlike the current practices of vigorous stimulation within one minute from birth. Mercer et al. (2002) argues that '*crying efforts are not effective in gaseous exchange within the lungs because blood flow has not had time to initiate capillary erection'.* Early cord clamping reduces the performance of this step as blood transfer is precipitously cut off. This is of paramount importance in preterms or compromised infants. Rabe H, Reynolds GJ, Diaz-Rosello JL (2006) performed randomized controlled trials comparing early with delayed (30 seconds or more) clamping of the umbilical cord for infants born before 37 completed weeks' gestation. 297 infants were eligible for their study. Their results concluded that delayed cord clamping was associated with fewer transfusions for anaemia (three trials, 111 infants; relative risk (RR) 2.01, 95% CI 1.24 to 3.27) or low blood pressure (two trials, 58 infants; RR 2.58, 95% CI 1.17 to 5.67) and less intraventricular haemorrhage (five trials, 225 infants; RR 1.74,95% CI 1.08 to 2.81) than early clamping. Furthermore, this paper instigates the practice of cutting the cord on a 'flat' baby should be challenged.

In 2009 Airey, Duley, Farrar and Tufnell carried out a postal survey in the United Kindgom analyzing care during the third stage of labour. A postal survey of 2230 members of the Royal College of Obstetricians and 2400 members of the Royal College of Midwives took part in this study. The respondents were asked regarding their care in the third stage of labour. 1189 (53%) fellows and members of the RCOG and 1702 (71%) midwives responded, of whom 926 (78%) and 1297 (76%) respectively had conducted or supervised births in the last year. For term births, 74% (682/926) of obstetricians and 41% (526/1297) of midwives clamp the cord within 20 seconds, as do 57% (523/926) and 55% (707/1297) for preterm births. This highlights the significant role that obstetricians and midwives have in delayed cord clamping.

In their Committee Opinion Paper, the ACOG (2012) also reviewed the maternal outcomes and consequences of delayed cord clamping. The latest studies show no increase in the incidence of postpartum haemorrhage with delayed cord clamping. This paper further highlights the fact that in obstetric emergencies such as antepartum haemorrhage and/or maternal resuscitation, the risk to the mother outweighs the benefits of delayed cord clamping, and thus one would need to reconsider the priorities at hand and ensure that the mother's condition is not jeopardized.

It is frequently argued that delayed cord clamping correlates positively with an increased incidence in the usage of phototherapy. Although this may be true, the benefits seen with delayed cord clamping, particularly the increased iron status in the neonate, far outweighs the usage of phototherapy. In conclusion, several randomized controlled trials have evaluated the benefits of delayed cord clamping in term and pre-term babies, however, the optimal time for delayed cord clamping remains to be established.

Jessica Dalli B.Sc (Hons) Midwifery

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Abstracts of Dissertations as partial fulfilment for the Degree of Bachelor of Science (Hons) in Midwifery University of Malta, 2013

First Time Mothers' Experience Of An Emergency Caesarean Birth

This study aimed to explore women's experiences of an emergency caesarean section birth. The objectives for this study were, to explore first time mothers' psychological responses to the emergency caesarean birth and to explore the benefit of interventions such as *debriefing,* to elevate negative feelings that may be caused by an emergency caesarean birth.

In order to achieve the objectives of this study, a qualitative research approach was chosen. Audio-recorded interviews were conducted in a private room at the general hospital. The interviews were guided by an interview schedule, which was designed for the purpose of this study. A total of ten women were recruited and consented to participate in this study. Ethical approval was sought and granted. Data analysis was carried out using thematic analysis as described by Braun and Clarke (2006). Four themes emerged, which included; maternal feelings before and after the emergency caesarean, recovery in the postnatal period and psychological support for the mother. The findings show that first time mothers experience a wide range of emotions. The predominant feelings before the emergency caesarean section were fear, anxiety and concern for their well being and that of their baby. These feelings were replaced with feelings of relief and joy when the caesarean birth was over and mothers saw their infant for the first time.

This study revealed that during the postnatal period, despite the caesarean birth, mothers still felt positive about their experience, as things had turned out well in the end. However, mothers felt guilty for not being able to care for the baby as much as they would have liked, due to their post-operative state. Moreover, this study found that most mothers did not feel the need for debriefing sessions, but suggested that debriefing sessions should be made available for mothers who feel psychologically affected by their birth experience. The findings obtained were discussed and recommendations for practice, education and research were noted.

Monique Abela

First Time Mothers' Views On Antenatal Breastfeeding Education

This study aimed to gain an insight on first-time mothers' views on antenatal breastfeeding education. The study's objectives were to identify and explore first-time mothers' sources of information provided during the antenatal period, to explore whether antenatal breastfeeding education provided at the antenatal classes met their needs and to identify factors that may improve antenatal breastfeeding education.

A quantitative approach was adopted using a questionnaire. Forty first-time, Maltese mothers were recruited for the purpose of this study using convenient sampling. These mothers had given birth to a healthy full term infant within one month and were all breastfeeding. All mothers who met the inclusion criteria were invited to participate. A 90% response rate was obtained. Data was analysed manually using percentages while the open-ended questions were analysed using content analysis. Ethical approval and all other permissions were sought and granted from all respective authorities.

Findings revealed that, the majority of the first-time mothers viewed antenatal breastfeeding education positively. In particular, mothers found antenatal classes to be a good source of information as a means of preparation for breastfeeding. However, a need for postnatal breastfeeding support was identified. In view of these findings, recommendations for education, practice and research were outlined such as: the provision of postnatal breastfeeding classes, including more hands-on practice as a means of breastfeeding support and making use of modern audio-visual aids. More breastfeeding publicity, breastfeeding promotion and further research on antenatal breastfeeding education is recommended.

Kylie Bezzina

Midwives' Views On The Implementation Of The Baby-Friendly Hospital Initiative In One Local Public Hospital

The Baby Friendly Hospital Initiative (BFHI) was commenced by the World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) to raise the breastfeeding rates by promoting worldwide adoption of the Ten Steps for Successful Breastfeeding. To date, in Malta there is still no hospital, governmental or private, accredited as Baby-Friendly. The aim of the study was to assess midwives' views on the implementation of the Baby Friendly Hospital Initiative in one local public hospital. The objectives of the study were to assess the midwives' knowledge on the BFHI practices, to explore their attitudes towards its implementation and to identify the barriers in implementing the BFHI.

To fulfil the study's aim, the data was collected using a self-designed questionnaire, consisting of closed and open ended questions. The sample consisted of 120 midwives working in all the maternity settings of the local public hospital and the sampling technique chosen was purposive sampling. Data was analysed manually using descriptive statistics and content analysis.

The study achieved a response rate of 59.2%, (n=71). Findings show that all the midwives who participated in this study are aware of the BFHI and in favour of implementing it. The majority of the participants are knowledgeable on the recommended BFHI practices. Some of the obstacles that emerged in the implementation of the BFHI included: implementation problems and mothers not receptive or impossible for them to breastfeed. Some benefits included: advantages of breastfeeding which increase the health care standards. One main limitation was the small scale study, which treated a sensitive issue in midwifery and neonatology care. It may have been influenced by time and financial constraints.

The main recommendation is to begin and strengthen awareness on the promotion of the Ten Steps to Successful Breastfeeding, amongst student midwives, by providing specific lectures and training in breastfeeding management so as to start practising early on the wards, during their practical placements.

Catriona Cassar

Front row from left: Alexandra Balsia, Marie Soler, Marla Saliba, Antonella Galea, Faye Marie Grima
Second row from left: Analise Ginell, Catriona Cassar, Joanna Farrugia, Stephanie Cutajar, Jeannine Cassar, Clara Spiteri, Kylie Bezzina, Monique Abela

Women's Knowledge On The Effects Of Smoking In Pregnancy

The aim of this study was to identify the knowledge women have on the effects of smoking in pregnancy. The study's objectives were to assess women's awareness on the immediate effects of smoking on the unborn child, to assess women's awareness on the long term effects of smoking on the infant, to identify women's knowledge on pregnancy complications associated with smoking and to identify women's knowledge about the risks associated with passive smoking. A quantitative study was carried out and a sample of 44 women was selected by convenience sample from those who attended the pre-marriage courses organised by Cana Movement.

The self-administered questionnaires were analysed and grouped manually through the use of simple descriptive statistics. The response rate was that of 100% (n=44). The results showed that Maltese women believed that both direct and passive smoking were harmful to the unborn child. The most common harmful effect identified by the participants was *'baby being born with breathing problems'* whilst the least common harmful effect identified was *'cot death'*. Participants identified *'asthma'* as the highly probable condition to be caused when children grow up due to smoking in pregnancy. The least identified was *'learning problems at school'*. The majority agreed that nicotine is the addictive substance in cigarettes. Participants gained information on the topic from the television, but, on the other hand, they viewed the midwife as the best source to obtain information. Moreover, participants viewed smoking as an unhealthy, selfish, irresponsible and egoistic act which harms the mother and baby, and thus should be avoided.

A number of recommendations were drawn up to serve as guidelines for clinical practice, education and future research. Pregnancy provides a golden opportunity for the pregnant woman to quit smoking. Therefore, healthcare professionals should make use of this time to encourage pregnant smokers to stop smoking and prevent relapse.

Jeannine Cassar

Mothers' Experience Of Perineal Trauma In The Early Postnatal Period

This study aimed to explore mothers' experience of perineal trauma in the early postnatal period. Moreover, the researcher sought to explore the methods of perineal pain relief used by mothers; identify the effects that perineal trauma has on the mother when performing everyday activities; and to explore the effects of perineal trauma on the woman's role as a mother.

The qualitative paradigm was used to conduct the study by means of a semi-structured interview schedule which was specifically designed for the purpose of the study. Ten women were chosen to participate in the study by purposive sampling. All participants took part in a face-to-face interview which was audio-recorded. Ethical issues were taken into account.

Data was transcribed verbatim and transcripts were analysed using interpretative phenomenological analysis (IPA) as described by Smith, Flowers and Larkin (2009). Findings revealed that mothers" experience of perineal trauma in the early postnatal period was „*A Time of Distress*", in which women „*Accepted and Pushed Through*" by „*Taking the Edge off Pain*" in an attempt to return to normality.

It was thus recommended that mothers should be better prepared for the reality of perineal trauma and be provided with adequate perineal pain relief postnatally to ensure better postnatal recovery. Further research on the effects of perineal trauma on the mother and its management is essential.

Stephanie Cutajar

Congratulations

to the newly qualified midwives

Mother's Experience Of Pain During Their Postnatal Period

Postnatal pain is a common problem many mothers may experience after childbirth. This study aimed to explore mothers' experiences of pain from four to six weeks postpartum. It sought to assess mothers' pain after childbirth; to measure the frequency and intensity of such pain; to explore if postnatal pain affected their routine activities and to determine if they were antenatally prepared for postnatal pain. A quantitative approach was utilized, where a self-designed questionnaire was distributed to a convenience sample of fifty mothers, at two Health Centres. A response rate of 100% was achieved (N=50). Data was analysed manually using descriptive statistics and content analysis. Ethical considerations were maintained throughout this study.

Findings revealed that most of the participants suffered from postnatal pain at four to six weeks postpartum (n=40; 80%). Several mothers reported lower back pain, followed by headaches, breast pain, pain at the caesarean section site and perineal pain. Postnatal pain was found to occur mostly with days intervals and to be mostly mild in nature. Such pain was found to be influenced by mothers' mode of delivery and parity. Mothers also reported mild pain with sudden change of body movement.

Most of the participants felt prepared for postnatal pain. The most commonly cited sources of information on postnatal pain were from the midwife and the internet. It is recommended that awareness on postnatal pain should be increased amongst mothers, midwives and other health care professionals. Other strategies may be to improve midwifery practice by avoiding episiotomy unless clinically indicated, improving midwifery community services and extending postpartum care beyond six weeks.

Keywords: mothers experiences, postnatal pain, women's health after childbirth, recovery after childbirth, postpartum physical symptoms and pain after childbirth.

Joanne Farrugia

Mothers' Experiences In The First Few Days After Giving Birth By A Planned Caesarean Section

This study aimed to explore mothers' experiences in the first few days following birth by a planned caesarean section at the local general hospital. The study's objectives were to discover mothers' physical well-being, feelings and interaction with the baby and the other family members in the early days. To fulfil these objectives, a qualitative approach was utilised. A self-designed, semi-structured interview guide was created to conduct face-to-face interviews with ten purposively selected mothers that agreed to participate in the study. These mothers were interviewed between their 3rd and 5th days following planned caesarean section. Ethical issues were considered throughout the study. Interviews were audio-recorded and then transcribed *verbatim.* Braun and Clarke's (2006) thematic analysis approach has been utilised to analyse the retrieved data. The findings demonstrate that mothers experienced various physical consequences in their early days following caesarean section, namely pain, anaesthetic effects and tiredness, provoking physical limitations in their daily tasks while in hospital. Additionally, the experienced physical consequences contributed to alterations in the maternal emotional well-being. The early maternal-infant separation created maternal concerns such as feeling of 'disconnection' from the baby. Experienced maternal physical and emotional consequences led to barriers and effects on mothers' interactions with others. However, the resulted consequences on the physical, emotional and interactions with others were managed by the support of midwives, nurses and family members. This study demonstrates mothers' ability to carry out certain daily tasks despite experiencing several consequences from their planned caesarean section with the essential support of others. In view of these findings, recommendations for practice, education and research were suggested including the provision of adequate early post caesarean care and evidence-based information to the mothers. Midwives and nurses should be encouraged to keep themselves up-to-date with recent evidence-based information on the area. It is also suggested to conduct the study on a larger scale and to explore partners' experiences in the early postpartum period.

Antonella Galea

Skin-To Skin Holding In The Npicu: Midwives' And Nurses' Perspectives

Skin-to-Skin Care (SSC) is based on skin-to-skin contact between the infant and the parent. This physical contact after birth enhances parent-infant attachment. However, infants born prematurely or at high risk of complications are deprived from such an attachment especially if they are admitted at the Neonatal Paediatric Intensive Care Unit (NPICU). The practices of neonatal nurses and midwives are influential to the parents and they are in a position to either promote or discourage the use of SSC in the NPICU.

In consideration of this, this quantitative study was carried out to explore the nurses' and midwives' views of SSC practice in the local NPICU. A sample of 40 Maltese midwives and nurses was selected by convenience sampling from the NPICU at the Local General Hospital. The objectives of this study are to identify the neonatal staff's awareness of the benefits of SSC, to identify the possible concerns with promoting SSC in the NPICU and to explore the attitudes and practices of the neonatal staff towards the use of SSC in the NPICU. A questionnaire was administered for the purpose of the study. The response rate was 100% (n = 40).

The findings of this study revealed that Maltese neonatal midwives and nurses were knowledgeable about the beneficial effects of SSC. Concerns with the infant's safety and resistance amongst the participants in assisting parents with LBW and intubated infants for SSC and in participating in educational sessions has emerged. More training and education to the staff were perceived as important in order to improve SSC practice in the NPICU. Recommendations for practice include the provision of written guidelines and more opportunities for supervised practice for the neonatal staff. Recommendations for regular educational programs to provide the neonatal staff with evidence-based research about effective SSC with vulnerable infants are also important. Longitudinal large scale studies which explore the views of neonatal staff on SSC, qualitative studies as well as studies which explore the mothers' or parent's views towards the practice and attitudes of the neonatal staff on SSC are also recommended to be carried out locally.

Analise Gingell

Midwives' Views Of Episiotomies And Perineal Lacerations During Normal Vaginal Births

Reducing genital tract trauma during labour is a prime concern. Questions remain unanswered as to how midwives may assist women to have a safe and positive experience. Should an episiotomy be done or should a tear be allowed instead? The aim of this study was to gain an insight on the midwives' views of episiotomies and perineal lacerations during normal vaginal births. The study objectives were to identify midwives' views on the risks and benefits of episiotomies, to identify midwives' views on perineal lacerations in a normal vaginal delivery and explore the midwives' views on the effects of perineal trauma on the mother after normal vaginal birth.

A quantitative approach was chosen for this study. Using a self-designed questionnaire, forty five midwives were recruited to participate in the research by means of convenience sampling where a response rate of 93.3% was obtained (n=42). Data was analyzed manually using descriptive statistics and content analysis.

Results showed that the majority of midwives are aware of the effects of episiotomies, including perineal trauma and the negative impact it may leave on the mother's lifestyle and furthermore her new family. Therefore, midwives do recognize that much of the morbidity following a normal birth arises from perineal trauma. The midwives questioned however, had different ideas as to why episiotomy is needed. No consensus appeared with regards to the increasing risk of third- and fourth-degree lacerations in relation to episiotomy. Inconsistencies also appeared with regards to their views on perineal trauma effecting perineal recovery. This reflects, that there is still conflicting evidence on the outcome. One of the main limitations of this research is that findings related to gentital trauma and midwives' views can't be generalized to the whole target population due to the small sample size and the convenience sample used. Recommendations proposed include: exploring the views of all the groups of midwives prevalent in the population, increasing services for midwives and other health professionals to learn from evidence based data in an attempt to increase their knowledge.

Faye Marie Grima

Mothers' Views On The Choice Of Pain Relief Used During Their Labour

The main aim of this descriptive study was to explore the mothers' views on the choice of pain relief used during their labour. The objectives were; to identify the mothers' views on intrapartum pain relief, to explore the factors that led to the choice of pain relief used and to identify the different sources from where the mothers gained their information. Self-designed structured questionnaires were distributed amongst 40 postnatal mothers who were receiving their care at a local general hospital. A response rate of 100% (n =40) was achieved.

Findings show that respondents preferred to use pharmacological pain relief as opposed to non-pharmacological types of pain relief. The main reason why participants opted to have pain relief was to alleviate pain. Furthermore, even though the majority of women believed that pain is a natural part of childbirth, a substantial number still preferred to make use of pharmacological pain relief. Women gained their information mostly from parentcraft classes. However, informal sources were still frequented by an equal number of participants, which revealed that women often make use of both informal and formal sources of information. Most of the participants (n=37, 92.5%) were satisfied with the level of information that they received prior to making their choice, thus women might not be open to receiving further information about non-pharmacological pain relief.

Nonetheless, choices of non-pharmacological pain relief may empower the laboring women and may promote normal birth, however such techniques are still greatly limited in the local midwifery setting. Providing more information with regards to alternative types of pain relief to women and having more equipment in the delivery suite may encourage midwives to promote such coping techniques. Further research is needed to explore women's views and needs with regards to pain relief and to identify possible barriers experienced by mothers when they express their wish to use alternative methods of pain relief.

Marie Soler

Mothers' Perceptions Of Breastfeeding In Public Places

Breastfeeding is known to be beneficial for both mother and baby, however some mothers still choose to bottle-feed their infants. Issues associated with breastfeeding in public might be restricting mothers to bottle-feed their infants. This quantitative study aimed to explore mothers' perceptions of breastfeeding in public places in Malta. The objectives of this study were to identify factors which help or hinder breastfeeding in public places and to identify in which places mothers find most comfortable to breastfeed when in public places. A self-administered questionnaire was distributed to a convenience sample of 45 Maltese breastfeeding mothers, during their visit at the breastfeeding walk-in clinic. These mothers were above eighteen years of age, and had no mental, drug or alcohol problems. The response rate of the questionnaire was 100% (n=48). Data collected was manually analysed using Microsoft Excel, and results were presented in graphs and tables. It resulted that the breastfeeding walk-in clinic was the main factor which encouraged mothers to breastfeed in public places, however public's attitude was regarded as a discouraging factor by most mothers. Mothers perceived, that breastfeeding in public is looked at as being healthy. Moreover, cinemas and aeroplanes were stated to be comfortable public places to breastfeed in.

The culture and environment mothers live in, affect their choice to breastfeed in public. Mothers living in a breastfeeding environment might be encouraged and supported to breastfeed in public, as it is seen as a natural activity. However those living in a bottle-feeding environment might be discouraged to breastfeed in public as it is seen as an immoral behaviour, since the breasts are given a lot of importance for their sexual function. Further research is required in this area, using larger samples of breastfeeding mothers, longitudinal studies which explore mothers' opinion at different stages postpartum, and qualitative studies to gain in depth responses. Recommendations for practice include the need for midwives to support mothers by helping them establish breastfeeding and involving their partners as much as possible as these are a good source of support. Breastfeeding education to the general public is recommended and midwives should be trained to help mothers establish breastfeeding wherever they are. Furthermore, the media should be used to portray breastfeeding as being normal, desirable and achievable.

Clara Spiteri

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