

The Stork



Malta Midwives Association

Issue 5 Feb 2015

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Editorial Board Pauline Fenech

Contribution to The Stork are welcome and should be addressed to the Editorial Board.

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

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Editorial

Dear Members,

This issue features on the events the committee members have attended as representatives of Malta Midwives Association in European meetings. Our aim is to keep you informed about the various midwifery policies and practices that are being discussed on an international level.

In this issue Dr Farrugia gives practical guidelines on the role of the midwife during resuscitation of the sick newborn. Furthermore, an informative overview of the Rh factor and its implications are discussed by Ms Astrid Zarb while Ms Annalisa Agius explores the different cultural rituals carried out on the placenta in different places.

Two junior midwives, Ms Marie Soler and Ms Annalise Gingell, interviewed Ms Margaret Abela. The interview shows how the midwifery practices in Malta evolved and developed over a period of 35 years. I am sure that for many junior midwives some of the things described in the interview may seem incredible. Nevertheless, in some other parts of the world women are still being deprived of basic necessities in health services as described by Ms Louise Bugeja who shares her missionary experiences during her visit in a remote area in Pakistan.

Nowadays, many midwives are seeking post graduate courses and MSc education after their BSc studies. Education is considered the key to success. Aiming for personal professional fulfilment gives a lot of satisfaction and academic maturity which may translate into better midwifery practices. Personally, I feel that the midwifery profession can be enriched if midwives seek higher education in different specialization areas. These include courses in mental health, counselling skills, diabetes, reproductive health and IVF, breastfeeding, clinical teaching, neonatology, management and HR, etc. The diversity of these courses will support best practices in midwifery.

On another note, few midwives has asked me to change the name of this publication. These midwives suggested to have a name which includes 'midwife' or 'midwifery magazine' in order to give the magazine a professional identity. Therefore, I would like you to put forward your likes and dislikes by sending an email to the association. The decision of the name will be taken during the AGM.

Furthermore, I would like to take this opportunity to congratulate the newly qualified midwives who graduated in 2014. Abstracts of their dissertations can be found in this publication.

For your diary, please take note on the upcoming events that are planned during the coming months. Coming up there is the Annual General Meeting during which Mr M. Ward will be giving a talk on empowerment and motivation. His presentations are always worth listening

Finally, I would like to thank all those who contributed to this publication because without their effort this magazine will not have been possible.

Thank you.

Pauline Fenech

ANNUAL GENERAL MEETING

27th February at 6pm

followed by a talk by Mr Martin Ward

Refreshments will be served

Nasal hygiene



An action that clears babies' noses

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President's Message

Midwives it is the time to **celebrate our achievement**. Our commitment to new knowledge in promoting normal birth, our determination to provide optimal care to each mother and family, our courage to stand and be counted to make our voice heard, have resulted in a positive outcome for the benefit of new mothers. Our assertiveness contributed to an encouraging drop of 2.5% in Caesarean Section Rate (equivalent to 102 new mothers). Most of us are taking the challenge to address one's long held beliefs and behaviour of the medicalisation of pregnancy and childbirth. We are doing all efforts to keep the basic skills of midwifery practice alive, to provide care that puts the mother at the centre of our care. Colleagues be proud, be glad while wisely securing our future investment. Our demanding challenge: **maintaining the improvement and building on the success**. Clinicians, currently working in services with low c-section rates, believe that maternity units applying best practices to the management of pregnancy, labour and delivery, can achieve consistent rates below 20% (NHS Institute 2006, Focus On: Caesarean Section).

We are now duty bound to utilize this effort and make good use of the public funds for the best interest of the society who contributes to these resources. It is crucial to share knowledge gained through educational opportunities provided with other midwives, members of the nursing and obstetrics team to create the necessary cultural transformation in maternity care towards humanizing childbirth. Collective efforts will support us to revolutionize statistics that are carved in stone "Malta has the highest caesarean section rate when compared to the EU27 figures WHO, 2013"

Colleagues, together every day we are writing the history of midwifery in Malta, we are reclaiming midwifery care, together; we can transform the culture, the philosophy of care during childbirth, the approach to childbirth. Good birth experiences can happen despite the challenges. Midwives, we need to re learn to respect nature, we are guardians of birth, helping, facilitating what is happening rather than what we think ought to be happening. Support the women to bridge the gap between being terrified and being submissive, being able, being in control – It is a big bridge to cross. The mind is a very powerful tool when it comes to childbirth, we midwives need to learn to use it wisely, empower women to trust their bodies, do not underestimate the capabilities of the woman's body that is designed to give birth. We've come to a point that women and midwives have handed over our personal power to the medicalisation of childbirth and gave way to unnecessary intervention that contradicts scientific evidence.

Colleagues, our contribution to influence and improve practice is much more than we ourselves believe. We need to be more attentive not to waste golden opportunities. We need to be empowered, be louder and make our voices heard, promote normality, educate expectant parents and inform policy makers with evidence. MMA will, in collaboration with the midwifery department and other relevant stakeholders, lead the way in the journey to transform the culture of Maternity Care towards humanizing birth and persisting for pathways based on the fundamental principles of safe women centred care. MMA is providing dynamic contributions by all means possible. Detailed

response was given in the National Health System Strategy for Malta 2014 – 2020, strategies for Maternity care reform based on scientific evidence were also recommended. Strategies that cover the midwifery input according to the ICM definition from preconception to puerperium.

Valuable input is guaranteed during 2015 through the awareness campaign of the WHO Regional Committee for Europe - Strengthening Nursing and Midwifery: European Strategy Direction towards Health 2020 and the Compendium of Good Practices in Nursing and Midwifery which identify Midwifery led care as efficient, evidence based, safe, and person centered care.

Success is in the able hands of Maltese & Gozitan midwives. It depends on our openness to continue the process of change, our determination to implement the vision and mission of our profession. The Malta Midwives Association wishes to express its appreciation to all Midwives for the big and small efforts you have done.

Never doubt that a small group of thoughtful committed citizens can change the world. Be the change you wish to see in the world. **It is possible, it is achievable.**

Listen to a few success stories by our counterparts.

The Western Sussex Hospital NHS has increased the rate of successful VBAC by more than 300% and will continue to reduce its overall Caesarean section rate through wide ranging programmes designed to normalise birth,

Blackpool, Fylde and Wyre Hospital

C-section rate drop from 28 to 22%, successful VBAC increased from 50% to 65%. They are offering aromatherapy to all low risk mums, with plans to roll out the service to all women.

Luton And Dunstable Hospital

80% of the women who attend the birth options clinic to discuss their birth choices went on to attempt a VBAC, around half were successful. Now the unit plans to open a pre-birth clinic, designed to advise women on the process of early labour and encourage self-care.

"Luton is a deprived area and we had lost our focus on normal birth due to the large numbers of high risk women coming onto the unit. Since 2009, we have succeeded in turning that around with a change in culture towards making birth a normal experience. Women now remain under the care of a midwife throughout their pregnancy unless there is a good reason to do otherwise."

This provides a positive impact on staff experience, more job satisfaction, less energy wastage in non midwifery roles, less burnout from excessive workload. Staff morale has improved as they become confident that they are providing a high quality service.

Colleagues we are in the right direction, let's get everyone on board and believe we Midwives are a small group – but we can make a difference. Today is the day, now is the time. You are the ideal person – act now. Do not fear going forward slowly, fear only to stand still as that means moving backwards, what do we live for, if it is not to make life less difficult for others.

Mary Buttigieg Said
President



Treasurer's Message

It is with pleasure that I put on record that last year was another bumper year for the MMA. In particular one should note that many more midwives have offered their services to the Association on a voluntary basis.

Thank you all.

Moreover I am also pleased to note that membership has doubled over the past year. The Association will continue striving to increase the membership base. The next step is to get even more members (and students) to participate in the various events that are organised by the Association. Meanwhile we thank all those of you who participate in these events. It is only thanks to your support that the MMA continues to plan such activities.

In this regard, please keep free the 27th February and the 5th May.

The Annual General Meeting is to be held on the first date whilst as we are all aware, 5th May is Midwives' Day. We do wish to see you ALL.

Finally I do hope that all of you have received the keychain which the MMA decided to distribute as a token to all members. Keep this key chain at hand. It's not just a key holder but can also come in handy should you need the MMA mobile and website address.

I augur we'll have a fruitful 2015.

Doris Grima

Treasurer

Letters to the Editor

Dear Editor,

Thank you so much for your note of 18th February in acknowledgement of my subscription, and the recent arrival of the magazine 'The Stork' to mark the 40th Anniversary of the Malta Midwives Association.

It was interesting to see details of the Association's beginning as well as a photograph of Miss Mary Vella Bondin in her younger days!

I do hope that the Association is enjoying its new premises. The former premises were cramped in many ways.

Reading through 'The Stork' the Association seems to be achieving much both for parents and their new children, and for midwifery. Mary Vella Bondin would have been so proud!

Please, give my congratulations to Dr Rita Borg Xuereb on her appointment with the ICM. I wish her well in her new work there.

With every good wish to you and to all who may remember me at the Malta Midwives Association.

Kind Regards,

Ruth Bird

Dear Midwives,

the sessions at the MMA were really informative and I really enjoyed meeting actual midwives and receiving knowledge from the professionals. I immediately felt like I was in good hands and getting up-to-date information. The midwives were all very helpful and always offered extra assistance where need be. I was really hoping that when I delivered my baby, I would meet one of the midwives that I met at the MMA classes. Very luckily for me, I had Carmen who I'd met at the classes to deliver my baby! I could not believe Carmen was working the night I went into labour let alone, that she delivered my baby! I was comforted that I had met her before and she was absolutely fantastic. She really helped calm me and Carmen really motivated me to carry on, when I was in the peak of labour.

I also enjoyed meeting other pregnant women at the classes and I have just contacted them to set-up a monthly meet up. It would be great to catch up with other mummies who are at very similar stages with our babies. The samples and gifts we received at the classes also came in very handy and it was nice to try some products before buying them. Overall the MMA antenatal classes were really positive and I would recommend them to any expectant mother (and father).

Tanya Renou

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² IRI HBA outlets, 52 w/e 27th October 2010.

³ D. McKenna (Royal Victoria Hospital) et al. 'a randomised trial investigating and iron-rich natural mineral water as a prophylaxis against iron deficiency in pregnancy' in Clinical and Laboratory Haematology, 2003, 25 99-103.

⁴ M. Worwood (University of Wales College of Medicine) et al. 'iron absorption from a natural mineral water' in Clinical and Laboratory Haematology, 1996, 18 23-27.

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Maternal Morbidity Measurement Stakeholders Meeting, 2-3 October 2014 Istanbul Turkey

The Millenium Developmental Goal 5 has called for a reduction of the maternity mortality ration (MMR) by 75% between 1990 and 2015. Significant progress has been recorded with a decrease in the estimated number of maternal deaths, yet the target will not be reached globally by 2015. Additionally for every woman who dies, 20 or 30 women more suffer from morbidity issues related to pregnancy and childbirth. According to the centre for Maternal and Newborn Health, 22% of the global disease burden is attributed to maternal reproductive ill health among childbearing women. The causes of maternal ill health however are highly complex and vary in duration and severity. Creanga et al, cited by Morton (2014) grouped maternal morbidities as disease-specific, as organ system dysfunction or in terms of management criteria. There is no one clear definition of maternal morbidity.

In 2012 a four year maternal morbidity project was set up, led by a technical working group of experts in maternal and women's health from all WHO regions. The Maternal Morbidity Working Group (MMWG) is made up of epidemiologists, obstetricians and gynaecologists, public health officers, researchers, clinicians, programme managers, midwives and consumer representatives. Participants represented WHO, UNDP, UNFPA, UNICEF, World Bank Special Programme of Research, AFRICSante, UN Women, ICF Macro, BRAC, International Confederation of Midwives, International Federation of Gynaecology and Obstetrics, International Confederation of Midwives, Maternal Health Task force, CCEMICAMP, USAID and WHO regional focal point which includes EMRO, SEARO, AFRO, EURO, AMRO,

WPRO, WHO Turkey together with several universities' representatives from all over the world. This project is supported by the Bill and Melinda Gates Foundation.

Dr Lale Say, Coordinator in the Department of Reproductive Health and Research at the World Health Organization (WHO), provided an introduction, as well as the historical context and steps leading up to the conceptualization of the Maternal Morbidity Measurement Project. The objectives of this meeting were: to share the results and progress so far; to achieve consensus of the definition of maternal morbidity; to gather feedback and support for the next phase of the MMWG work, which will be included in 11th revised ICD, piloting of the tool and its future use.

The 2 day meeting was a very intellectually stimulating experience which is directly linked to midwifery education and practice. I was the only midwife present at the meeting, as the representative of ICM, yet there were many Obstetricians, Epidemiologists, Public Health Officers, representatives of ministries and sponsors.

Concerning maternal morbidity, midwifery care involves the prevention, detection, treating and/or referring women for more specialised care. I think it is extremely important that midwives make their voices heard during such important meetings, as advocacy and supporting women and their families is a fundamental part of our role. Midwives can likewise play a central role in raising awareness about the possible long term effects of maternal morbidity, which, is still to date not given its due importance. As a consequence there will be an increase in attention to end preventable maternal deaths and to improve maternal health and child's health.

Morton, C.H. (2014) the problem of increasing maternal morbidity: integrating normality and risk in maternity care in the United States. *Birth*, 41, 2, 119-121.

Dr. Rita Borg Xuereb,
Head, Department of Midwifery,
ICM Board Member
(European representative).



World Health
Organization



Maternal Morbidity Measurement Stakeholders Meeting
2-3 October 2014, Istanbul-Turkey

European Midwives Association (EMA) Annual Meeting

26th & 27th October 2014 Tallinn, Estonia

The European Midwives Association (EMA) is a non-profit and non-governmental organization, representing midwifery organizations and associations from member states of the European Union (EU). The Annual General Meeting was held in Tallinn, Estonia and Ms Mary Buttigieg Said (President) and Ms Pauline Fenech (Vice-President) represented the Malta Midwives Association for this meeting.

Thirty midwifery associations from twenty five EU countries participated. This meeting gave the delegates the opportunity to meet, discuss and network with other organisations in areas of interest such as the promotion of women's general and reproductive health and the way forward for the midwifery profession across EU member states.

The first day of the meeting was dedicated to matters related to the official proceedings of EMA: reading the Annual General Report and strategic plan, Financial Report and election of the Treasurer, Secretary and Vice-President. MMA supported the nomination of Ms Maria Cutajar (MUMN). During this meeting Ms Maria Cutajar was elected as an Executive Board member. Congratulations!

The second day of the meeting, the Estonian Midwives presented an overview of how they managed to effectively disseminate midwifery information among their pregnant population by using social media. This association developed an innovative website for the expecting mothers which incorporated up-to-date information, relevant articles and gave pregnant women the opportunity to access professional advice from their home. A key element of this project was to provide pregnant women with the necessary information

and guidance to dispel myths and an opportunity to support women during pregnancy, birth and postpartum. Estonian midwives rated this project as very successful as was observed by the number of participants making use of the website.

Ms Ellen Bix, a Norwegian midwife, presented preliminary results from the Nordic Homebirth Study. This study was conducted in four Nordic countries (Norway, Denmark, Iceland and Sweden) with the aim of compiling data on outcomes of current homebirths. This is still work in progress.

Two midwives, one from Germany, Ms Miriam Wille and Ms Ute Wronn from Switzerland, gave insights on how to develop midwifery standards. While Ms Maria Cutajar from Malta and Ms Permantia Panani from Greece discussed the need of changing maternity policies to reflect today's practices. The presentation given by Maria was a joint effort by MUMN and MMA which reflected on midwifery practices in Malta.

The President, Ms Mervi Jokinen, described the different political stages of policy development at an EU level. She emphasised the challenges faced and the strategies required for a policy to be implemented and adopted. She also stressed the importance for midwives to represent the health of women on National Boards and at decision taking level as well as comprising the support of local MPs in the EU.

Workshops discussed issues of how to develop midwifery practice standards and how to change maternity policies. Both these workshops were attended by the delegates.

The meeting provided a golden opportunity to network and to strengthen links with other associations in Europe.



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The Role of the Midwife in the Resuscitation of the Sick Newborn

Approximately 10% of newborn babies require some form of assistance at birth, usually in the form of stimulation or airway opening manoeuvres. Less than 1% of newborns require more extensive resuscitation¹. In most cases the need for resuscitation may be anticipated prior to delivery if risk factors are taken into consideration. Unexpected emergencies will still be expected to arise in about 2 out of every 1000 low risk deliveries². Prompt initiation is critical to the success of any resuscitation. Midwives play a leading role in most deliveries. It is therefore of utmost importance that all midwives maintain a high level of competence in resuscitation.

Newborns differ from adults and children, not only in size but also in a number of very important physiological characteristics. Whilst most collapses in adults are primarily cardiac in origin, the neonatal heart is adapted to the hypoxic experience of childbirth and can withstand up to 20 minutes of severe hypoxia. In newborns collapse is almost always respiratory in origin. Adequate aeration of the collapsed, fluid-filled lungs of a newly delivered baby is usually all that is required for successful resuscitation at birth. Newborn resuscitation guidelines are a reflection of these priorities. Airway opening manoeuvres, such as jaw thrust and chin lift and correct technique for positive pressure ventilation feature prominently. For a newborn who fails to respond to these efforts, the guidelines recommend starting from scratch and re-assessing the airway before proceeding to give inflation breaths. This process needs to be repeated for as long as necessary until a good chest rise is seen. Only then can chest compressions be considered. Chest compressions in newborns are performed at a ratio of 1 inflation to 3 compressions as opposed to 2 inflations to 30 compressions in adults, yet again recognising that hypoxia is the main cause of collapse in the newborn³.

A decision on whether to commence resuscitation at birth frequently falls within the responsibility of the midwife and should be based on an assessment of tone, heart rate, breathing efforts and oxygenation. Heart rate is the most reliable of these assessments. A response in heart rate is a reliable sign of a successful resuscitation. Heart rate should be assessed by auscultation. Palpation of the umbilical cord pulse is unreliable as not all beats are transmitted and this could lead to unnecessary intervention. Colour has long been used to assess oxygenation. Colour is a subjective and unreliable sign with significant inter-observer variability⁴.

A decision on whether to initiate oxygen therapy and respiratory support should not be taken based on a newborn's colour. Pulse oximetry is the only standard that should be used to assess oxygenation and should be used for any baby requiring any form of resuscitation. It is important to keep in mind that it may take up to 10 minutes for healthy term infants to achieve oxygen saturations of 90%. Pulse oximetry has the added

advantage of providing real-time heart rate readings.

Newborns requiring resuscitation have traditionally been treated with 100% oxygen. Studies comparing air vs 100% oxygen for resuscitation have shown that newborns resuscitated in room air have a higher chance of survival⁵. There is a widespread consensus on the need to use oxygen judiciously. Oxygen therapy should only be administered under the guidance of continuous pulse oximetry. Oxygen should preferably be administered with the use of an air/oxygen blender (Figure 1). If such a blender is not available, it is recommendable to commence resuscitation in room air (Figure 1).

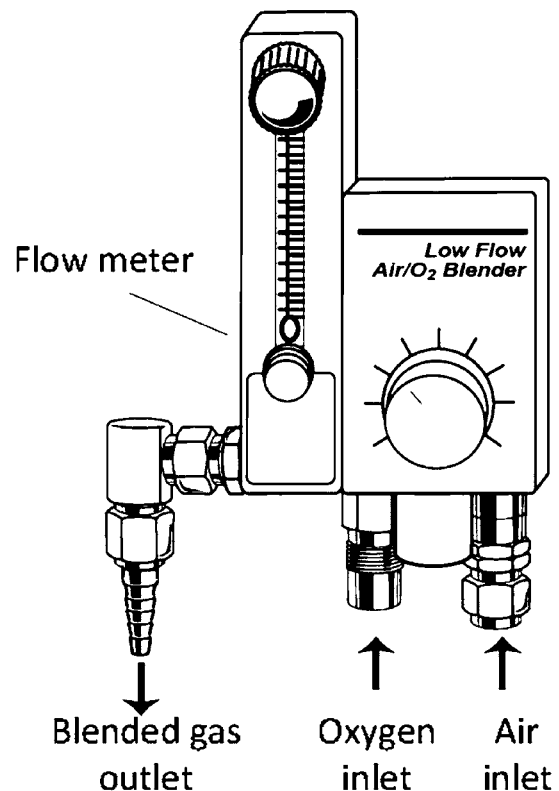


Figure 1 - Air-oxygen blender

Two devices are available for administering positive pressure ventilation to newborns with respiratory distress. Both can be used in conjunction with both facemasks and endotracheal tubes. Self-inflating bags (SIBs) (Ambu™ bags) have been around for a long time but are being replaced by T-piece systems such as Neopuff™ (Figure 2). T-piece systems have the advantage of delivering reliable pressures and are therefore safer and more effective. They may be used to deliver facemask Continuous Positive Airway Pressure (CPAP) and have been shown to be easier to use than SIBs⁷. We assessed the performance of several commonly used paediatric self-inflating bags using an infant lung simulator (D, B & M, Redlands, CA). If SIBs are to be used they should be of the 450-500ml variety (paediatric bags). Smaller bags

of 250ml volumes are inadequate to deliver effective ventilation even in preterms and have been phased out.

Newborns get cold very easily. Babies subjected to cold stress immediately after birth have lower oxygen saturations and increased metabolic requirements. Preterm babies are particularly vulnerable to hypothermia given their small size. Babies who are cold may fail to respond to resuscitation. It is often the role of the midwife to advocate for the baby to ensure that deliveries and resuscitations are carried out in the appropriate warm environment. A minimum temperature ambient temperature of 25°C should be guaranteed in accordance with World Health Organisation standards for delivery rooms⁸. These standards also apply for operating theatres that are used for caesarean sections. Heat losses should also be minimised with the appropriate use of radiant heaters and warmed towels. Preterm babies are placed in food-grade plastic bags at birth so as to minimise evaporative heat losses. Newborn babies should not be washed during the first 24 hours of life.

Induced hypothermia in newborns born at 36 weeks gestation or more who are at a high risk of brain injury, results in significantly reduced mortality and neurodisability⁹. Cooling prevents extension of damage caused by the initial hypoxic insult. Passive cooling for

these babies should commence in the delivery room aiming to achieve core body temperatures of 33.5-34.5°C. It is important to keep in mind that babies get cold very easily. Temperatures should be monitored very closely and the baby transferred to intensive care without delay.

Resuscitation of sick newborns requires considerable organisational and tactile skill that can only be attained through practice. It is beyond the scope of this article to attempt to provide a complete resuscitation manual. Attendance to courses such as the Neonatal Life Support (NLS) and Neonatal Resuscitation Program (NRP) is strongly recommended. Maintaining skills is also a challenge as resuscitation of sick newborns is thankfully a rare event. Continuous professional development through scenario teaching is therefore essential.

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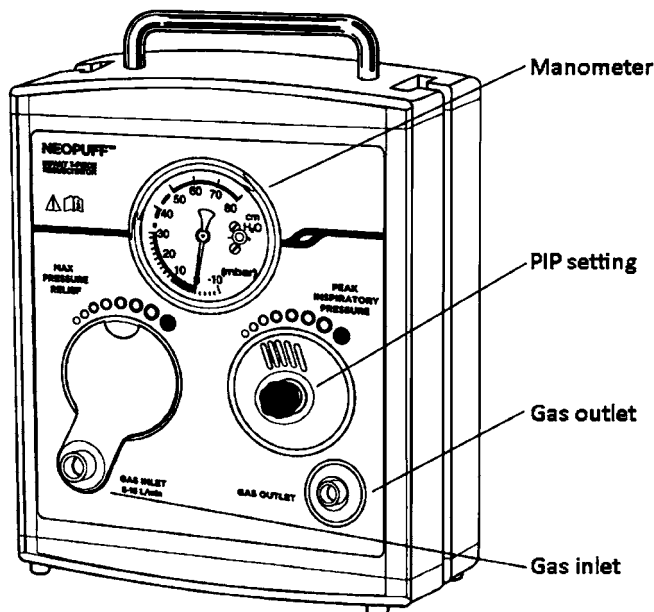


Figure 2 - Neopuff T-Piece system



Placenta Encapsulation

Many of you might have never heard of placental encapsulation. Some of you might start reading this article with an aptitude of disgust and who can blame you? The idea of eating one's own placenta in western culture is not only deemed revolting but also unnatural. However, by the end of this article you might be pleasantly surprised on what this custom has to offer. There are various rituals linked to the placenta across the world. Whereas we discard placentas, many cultures treat the placenta as sacred and believe in its' rich nutritional benefits and natural healing powers. There are many different ceremonial rituals involving the placenta that are practiced, but the burial of the placenta is common in various different cultures for very different reasons.

Placental Rituals around the World

In certain parts of Africa, the placenta is considered as the dead twin of the newborn child and is given a full burial ceremony. Indonesians also hold this belief, and the father is responsible for the washing and burial of the placenta. Many African cultures will bury the placenta in the dirt floor of their house to keep it safe. In some Arab cultures, it is thought that the mother's fertility depends on the sacred handling of the placenta and that any harm will result in infertility. In Thailand, the placenta is cured with salt and placed in a clay pot. For centuries families in Thailand have preserved the placenta tradition of burying the umbilical cord and placenta in front of the home after birth. It is believed that this will always guide the child to return home and it is a very important cultural practice. The tradition in Cambodia is to wrap the placenta in banana leaves and keep it close to the newly born child for three days, after which it is given a burial. Koreans cremate the placenta and save the ashes. The ashes will be used later in a liquid solution to help the child in times of illness. Some native Bolivians believe that the placenta is a spiritual force and that burial rituals, if performed improperly, will result in sickness or even the death of mother and child. Certain Aboriginal tribes practice the common burial under a tree, but some other tribes will bury the placenta under an anthill. They believe that when the ants eat the placenta, this will cause the mother to be temporarily infertile, or in other words, birth control. In Yemen the placenta is placed on the family's roof for the birds to eat, in the hope that it will guarantee the love between the parents.

Take a look around at all your beauty products. In France, placentas of all types have been widely used in beauty products, most notably skin care to reduce the

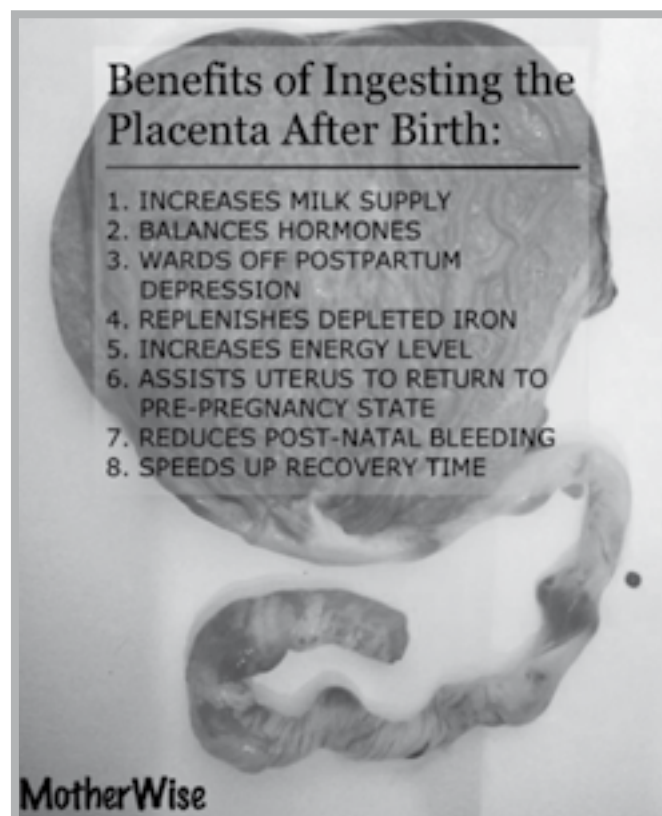


presence of wrinkles. In many Asian countries, especially in China the placenta is believed to have healing properties. The placenta is dried and taken as a supplement or added to food dishes for its health and healing benefits. Traditionally it is thought to strengthen fertility and prevent male impotence.

Placentophagy

The process of placentophagy or eating one's own placenta is undergoing a small revival in Western cultures. Placental encapsulation involves drying the placenta into a powder and placing in capsules for its easier ingestion. If you're thinking this is unnatural, think

again. Literature documenting mammalian behavior details how most mammals routinely consume their placenta or part of their placenta and/or their amniotic fluid (Lehrman, 1961; Kristal, 1980; Kristal et al., 2011). Most knowledge of placentophagy is drawn from animal research, particularly on rats. Kristal et al. (2011) have been involved in various experiments examining placentophagy. In fact, their studies have given the only two hypotheses for placentophagy that have been substantiated. Placental and amniotic fluid ingestion offers pain relief during labour and birth and





subsequent positive consequences on maternal care taking activities.

There have been many theories on the contents of the placenta, which if eaten, are thought to increase health and wellbeing. The placenta offers a bioavailable source of iron (Berwald, 2010; Selander, 2011e). Some maintain that boosting mothers' iron stores through placentophagy results in more energy, and consequently less postnatal depression (PND) (Berwald, 2010; Selander, 2011e), because low iron and fatigue are PND risk factors (Verdon et al, 2003; Beard et al, 2005; Bodnar et al, 2005; Corwin and Arbour, 2007).

A similar affirmation is that ingesting Vitamin B6 found in the placenta prevents PND and encourages postnatal wound healing (Graff, 2008; Higham, 2009; Selander, 2011e). B6 supplementation is indeed an established treatment for PND (Marmion, 2000), and has a proven role in regulating mental processes and mood (Expert Group on Vitamins and Minerals, 2003). It is also implicated in cellular replication and antibody production (Expert Group on Vitamins and Minerals, 2003). However, evidence of the effect of Vitamin B6 directly assimilated from placentophagy is lacking. Placentophagy is also thought to increase postnatal milk production and traditional Chinese medicine (TCM) prescribes placenta remedies for postpartum hypogalactia (Enning, 2007; Higham, 2009; Selander, 2011). However, evidence for this has not been further substantiated.

Placental encapsulation may be an acceptable sanitised method of consuming the placenta for those who could not face ingestion in other ways (Selander, 2011b). Concerns have been voiced regarding infection control; for example, that HIV or hepatitis could be spread through the preparation or eating of the placenta. Some placenta encapsulation specialists such as IPEN (2012) who require the use of only healthy placentas, address these concerns. These promote careful storage and preparation, and require their specialists to possess certificates relating to food hygiene and blood borne pathogens. It is also recommended that only the mother should consume her placenta (Weekley, 2007; Selander, 2011b).

There is the need for further research on human placentophagy and placental encapsulation. However, the absence of evidence does not mean that it is not beneficial and there are credible theories that could support placentophagy. It is a midwife's duty to use evidence-based practice, but also respectfully and sensitively discuss topics that may benefit women and promote informed choice (Nursing and Midwifery Council, 2008). Therefore, the next time a mother asks you if she can take her own placenta you may think again about completely rejecting it.

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Annalisa Agius

BSc Midwifery



Rhesus Factor in Pregnancy

Each person's blood is one of four major types: A, B, AB, or O. Blood types are determined by types of antigens on the blood cells. Antigens are proteins on the surface of blood cells that can cause a response from immune system. The Rhesus factor is a type of protein on the surface of red blood cells. Most people who have the Rhesus factor are Rh positive. Those who do not have the Rhesus are Rh negative.

Routinely as part of one's prenatal care, one will have a blood test to check the blood group. When the mother is Rhesus –negative and the father is Rhesus –positive, the fetus can inherit the Rh factor from the father, making the fetal blood as Rh –positive too. In this way, because the maternal Rhesus is negative, problems can arise if there is interchange of blood from the fetal circulation into the maternal circulation.

Prior to 1970 haemolytic disease of the newborn (HDN) due to unavailability of anti-D, was a significant cause of morbidity and mortality. By 1990, a reduction in mortality from 1.2 per 1000 births to 0.02 per 1000 births has been achieved in response to the introduction of immunoprophylaxis with anti-D immunoglobulin (Tovey, 1992). During that time the sensitisation rate dropped to about 1.2%. A further reduction to between 0.17 to 0.28% was achieved by introducing prophylaxis during the third trimester of pregnancy (Huchet et al, 1987; Mackenzie et al, 1999; Tovey et al, 1983). These findings contributed to the National Institute for Clinical Excellence (NICE) recommendation that all D-negative pregnant women who do not have anti-D should be offered anti-D immunoglobulin routinely during the third trimester of pregnancy (NICE, 2002).

Prevention of antibody formation:

Pregnant mothers who are D negative must be considered for prophylactic anti-D for the following potentially sensitising events:

- Amniocentesis
- Cordocentesis
- Other in-utero therapeutic intervention/surgery (e.g. intrauterine transfusion, shunting)
- Ante-partum haemorrhage (APH)
- Chronic villus sampling
- Ectopic pregnancy
- External cephalic version
- Fall/abdominal wall trauma
- Intrauterine death
- Miscarriage
- Termination of pregnancy.

Tests and treatment during pregnancy

Before 12 weeks of gestation, confirmed by scan, in uncomplicated miscarriages where uterus is not instrumented, or mild painless vaginal bleeding, prophylactic anti-D immunoglobulin is not necessary because the risk of fetal-maternal haemorrhage

(FMH) is negligible. However 250iu prophylactic anti-D immunoglobulin should be given in cases of therapeutic termination of pregnancy, whether by surgical or medical methods, to confirmed D negative women who are not known to be already sensitised to D (RCOG, 2002).

Between 12 weeks and 20 weeks gestation, for any potentially sensitising event listed above, blood sample should be tested to ensure the woman is D negative and that she is not already sensitised with anti-D. Anti-D immunoglobulin, 250 IU, should be administered (RCOG, 2002).

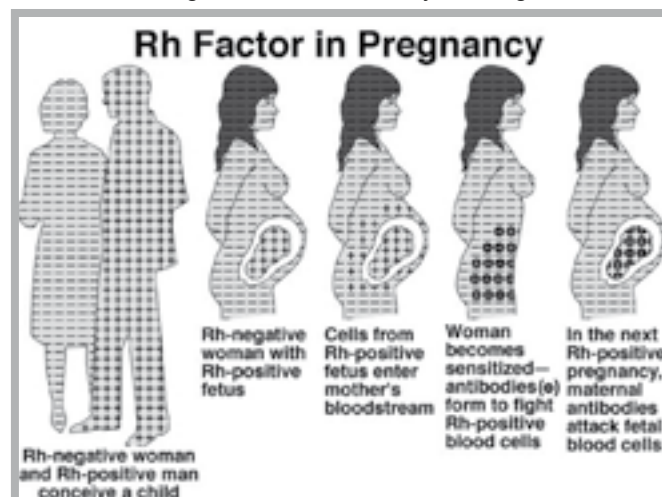
After 20 weeks gestation: There is an additional requirement to assess the volume of FMH. If the Acid elution (Kleihauer) technique is used and a FMH of >4mL is indicated, the test should be repeated using flow cytometry. At least 500 IU anti-D should be administered intramuscularly and additional anti-D given if the FMH is confirmed to be >4 mL (RCOG, 2002).

It should be noted that acid elution technique may give a false positive result if a woman has high level of fetal haemoglobin (HbF). This issue can be resolved by using flow cytometry technique.

Following birth. A cord blood sample should be tested to obtain the ABO and D type of the baby. If this is not collected for any reason, a heel prick sample should be obtained as soon as possible (BCSH, 2006).

Direct Antiglobulin Test (DAT) should not be performed on cord blood sample as a matter of routine since in a proportion of cases it may be positive because of antenatal prophylaxis with anti-D. However DAT should be performed if haemolytic disease of the new-born is suspected because of a low cord blood haemoglobin level and/ or the presence of maternal red cell antibodies.

Maternal samples for confirmatory ABO and D type and FMH testing should be collected after sufficient time has elapsed of any FMH to be dispersed in the maternal circulation. A period of 30-45 minutes is considered adequate (Mollison et al, 1997). Following birth of a D positive infant at least 500 iu anti-D must be administered to the woman if the FMH is \leq 4 mL. Additional dose of anti-D immunoglobulin is necessary for larger FMH and



the dose to be administered by intramuscular route should be calculated at 125 iu for each additional mL of FMH. In cases of very large FMH i.e. in excess of 80mLs, intravenous anti-D should be considered.

Recommendations

Documentation accompanying the injection must include a report containing the following details:

- Identity of the patient to include surname, forename, date of birth and ID number with the date when injection is given.
- Identity and address of the person/antenatal clinic administering the injection.
- Details of the injection will include batch number and strength of dose and route of administration.
- Anti-D should be stored in fridge at 2-5 degrees centigrade.

If the mother is sensitized, determine whether the fetus is at risk and monitor accordingly.

Once the presence of maternal anti-D has been confirmed, the next step is to determine whether the fetal RBCs are a target, i.e., confirm the RH status of the fetus. If the father is homozygous for the D allele (D/D), the fetus will be D positive. If however, the father is heterozygous (D/d), there is a 50:50 chance that the fetus is D positive, and the only way to know the blood type for sure is to test a sample of fetal cells taken from the amniotic fluid or umbilical cord.

If the fetus is Rh D-positive, the pregnancy is carefully monitored for signs of Haemolytic disease of the newborn (HDN). Monitoring includes regular ultrasound scans of the fetus and monitoring of the amount of anti-D in the mother's serum. Active haemolysis is indicated by a rise in anti-D. If a fetal blood test confirms fetal anaemia, depending upon its severity, a blood transfusion can be done in utero to replace the lysed fetal RBCs.

Blood transfusion may also be needed to correct anaemia in the newborn period. During this period there may be a sharp rise in the level of bilirubin in the neonate, which can be lowered by phototherapy and exchange transfusions.

Haemolytic Disease of the Newborn

Haemolytic disease of the Newborn (HDN), also

known as erythroblastosis fetalis, isoimmunisation, or bold group incompatibility, occurs when fetal red cells which possess an antigen that the mother lacks, cross the placenta into the maternal circulation, where they stimulate antibody production. The antibodies return to the fetal circulation and result in RBC destruction.

Clinical presentation of HDN varies from mild **jaundice** and **anaemia** to **hydrops fetalis** (with ascities, pleural and pericardial effusions). As the placenta clears bilirubin, the chief risk to the fetus is **anaemia**. Extramedullary hematopoiesis (due to anaemia) results in **hepatosplenomegaly**. Risks during labour and delivery include **asphyxia** and **splenic rupture**.

Postnatal problems include: Asphyxia

Pulmonary hypertension
Pallor (due to anaemia)
Oedema (hydrops, due to low serum albumin)
Respiratory distress
Coagulopathies (low platelets and clotting factors)
Jaundice
Kernicterus (from hyperbilirubinemia)
Hypoglycaemia (due to hyperinsulinemia from islet cell Hyperplasia).

Haemolytic disease of the newborn, used to be a major cause of fetal loss and death among newborns babies. It was not until the 1950s that the underlying cause of HDN was clarified; namely, the newborn's red blood cells (RBCs) are being attacked by antibodies from the mother. The attack begins while the baby is still in-utero and is caused by an incompatibility between the mother's and baby's blood.

By the 1960s, trials in the United States and the United Kingdom tested the use of therapeutic antibodies that could remove the antibodies that cause HDN from the mother's circulation. The trials showed that giving therapeutic antibodies to women during pregnancy largely prevented HDN from developing.

By the 1970s, routine antenatal care included screening of all expectant mothers to find those whose pregnancy may be at risk of HDN, and giving preventive treatment accordingly. This has led to a dramatic decrease in the incidence of HDN, particularly severe cases that were responsible for stillbirth and neonatal death.

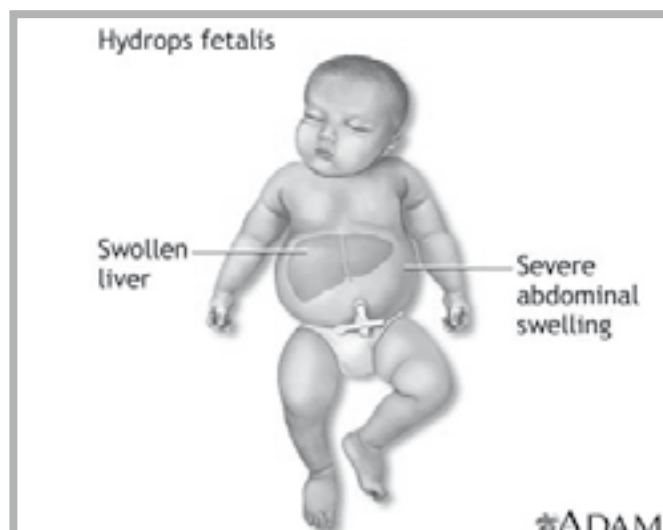
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Friday – Saturday ~ 6 – 7th March 2015

2nd European Congress on Intrapartum Care:

Making Birth Safer
21st – 23rd May 2015
ECIC 2015 Porto, Portugal
www.ecic2015.org

Dutch Summer Midwifery programme:

1st – 12th June 2015
2 weeks summer program KNOV: The Dutch Midwifery Tour.
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<http://www.knov.nl/samenwerken/tekstpagina/489/midwifery-in-the-netherlands/>

Innovation in Midwifery Education what works?

Bournemouth University – UK
3rd July 2015
<http://www.eventbrite.co.uk/e/innovation-in-midwifery-education-what-works-tickets-13962208341?aff=eorg>

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The Lahore Experience 2014

22nd July – 19th August 2014

On the 22nd August, we boarded a plane to travel over 12 hours to Lahore in Pakistan. The group consisted of Fr. Karm Debatista mssp and six other members, including my husband Tony (Bugeja) and myself.

We had been preparing for this experience for quite some time. We had met several times before, where we were briefed about the Pakistan culture, what was acceptable, and what was not tolerated. We also discussed the work involved, and our roles.

As expected, Tony and I were targeted for medical work, although it was not yet clear whether we would be working with the Medical Mission sisters, or on our own. During the preparatory meetings, Fr. Karm informed me that arrangements had been made for a Dominican sister to act as my interpreter.

Our Mission was to offer our help where and how needed. This was to be done mainly in the four Parishes in Lahore, run by the MSSP Fathers (Fr Pierre Bonnici, Fr Bernard Mangion, Fr Gerard Bonello).

The Parishes included Asif Town 1, Asif Town 2, Marcazar, and Karim Park, together with the surrounding villages and colonies. Our accommodation was at the mssp in Yuhannabad.

There, I met Sr. Surriya who had come all the way from Faisalabad to act as my interpreter. Sr Surriya herself is a nurse and a midwife, besides being in charge of a girl's school and hostel. This was her only vacation during the year, and yet she had chosen to spend it with us, and with me.

My first impression was that my companion was reserved, almost withdrawn. However, this perception evaporated over the weeks we worked together when

we became comrades and very good friends.

We shared many long hours in the stifling heat, and shared many experiences which will not be forgotten easily.

Our work consisted mainly of Clinics, Talks, and House Visits.

Clinics were held separately (women apart from men), but in the same room or area. We worked in all places and situations – in the church, outside the church, in the dark without electricity in extreme heat on the floor.

The most common ailments were back pain and joint pain (mostly knees), feeling weak and lethargic. High Blood Pressure and Diabetes was very common.

Initially, we were giving advice to eat fruits and vegetables, but soon we realised that even one fruit was an extravaganza to these people who had very little. So, we emphasised on avoiding salt and a healthy lifestyle.

We also realised that many would stop their treatment because they could not afford it. Others would go to quack doctors who would give them pills that we had no way of knowing what they were since they would be given in a small paper bag without names. Here, we worked with the medical mission sisters who distributed the correct treatment, funded mostly by the mssp missionaries. Other times, we had cases that we advised to go to a doctor since they needed medical advice.

Our work was becoming increasing more popular, with people already waiting for us when we arrived. We mostly had very little equipment to work with, although we did have bandages, dressings, and a blood pressure monitor, that belonged to Fr Bernard.





Other than that, we used basic nursing skills and techniques. This mostly included bandaging, massage, and EFT (emotional freedom technique) which both worked wonders.

The house visits were other occasions where we visited the sick in their homes. I was greatly surprised by the large amount of stroke patients, mostly middle aged, many with young children. The burden of the family is tremendous, with the wife having to find work or the husband caring for the wife after work, while the children caring for their mother or father in spite of being at a tender age. The situation is indeed tragic, considering that many times it could have been avoided with proper education and care.

In this regard, I also held a number of Women's talks, mostly in the church, again in all situations. As always, Sr Surriya would patiently translate the messages that I wanted to get across.

Occasionally, I also got to use my midwifery skills, and performed some antenatal examinations. Here, privacy was imperative. So, many times we sought how to provide a makeshift area where I could examine the mother.

The list is endless. I could go on and on, remembering all the experiences we went through.

One thing for sure, this experience humbled me. I went to Pakistan, with much pretension of wanting to make a change, a positive change. But for these people, our presence was enough. Just having foreigners interested in them meant so much to these Christians, who many times are persecuted because of their beliefs.

There are so many aspects that need urgent change, especially the complete lack of community midwifery or nursing service. The Caesarean rate is very high in Pakistan, yet these women have no visits when they go home while it is very far to go for a hospital visit.

So, they depend on their relatives. Care and advice is often full of myths and cultural rites.

Much more needs to be done. Our help was like a drop in the ocean. Yet I am extremely glad we managed to be that drop.

Louise Bugeja

SRN, SCM, PG DIP in
Systematic Family Psychotherapy



Experiences of a Veteran Midwife:

Ms Margaret Abela

Can you explain to us briefly the journey of your work experience?

My nursing career started when I enrolled in the nursing course in 1966. The 3 year course was intense and challenging, back then no computers were available and all the research had to be done manually. In the clinical area, there were no disposable items or availability of sterile packs, everything had to be prepared on the ward.

When I qualified, there was no immediate call for nurses, therefore I worked for three months as a private nurse, which I really enjoyed. This experience increased my enthusiasm to work in the community. When I started working as a hospital nurse, I met a foreign tutor who was in Malta to plan the first midwifery course. In 1971 qualified Maltese midwifery tutors did not exist and this tutor was appointed to provide a course with the aim to train health care staff as midwives to work in the community. Thus, since I enjoyed working in the community, I decided to enroll as a student midwife with the first group.

On completion of my midwifery studies in 1972, I was assigned to work in the Postnatal/Nursery Ward, where I worked for 2 years. Then I was transferred to Antenatal Ward and later on to the community. As a community midwife, I did postnatal visits of mothers who were discharged from SLH and a number of mothers discharged from the Mtarfa Hospital. During the visit I examined the mother and baby, gave a baby bath, gave advice on feeding and any further care that was deemed necessary.

In the community I was also responsible for antenatal care. The workload was allocated between myself and another midwife. Malta was divided into two areas; the Northern and the Southern area, and we used to do Antenatal Clinics in the village 'Berga'. I was responsible for the clinics in the Southern area; Birgu, Cospicua, Senglea, Kalkara, Valletta, Zurrieq, Zejtun, Hamrun and Marsaxlokk amongst others. I remember in Marsaxlokk, I used to see the mothers in a very old house which just had a low iron bed as a couch. During the first booking visit I would fill the Hospital Referral Ticket and refer the mother to the community doctor for a medical examination. The pregnant women used to continue the rest of the antenatal visits with the community midwives. Those women who had a medical or obstetric problem were referred to the Antenatal Clinic at SLH. On Monday morning I used to do the clinic in SLH where I used to schedule visits for the mothers for more investigations and to be assessed by the obstetrician.



During my years working as a community midwife, I encountered a small number of mothers who refused to give birth in hospital. Thus, I also had no assist homebirths during this period. We used to be two midwives present for the birth. Although in one instance I had an unbooked homebirth in Birgu and I had to go alone as the other midwife was not available and neither was the family doctor. After the birth, if sutures were needed, we would summon the doctor to do them, therefore for a homebirth we required a signed confirmation from a doctor that he would attend if the need arose.

After 2 years of community work, what was your next step?

In 1977, I was transferred to the labour ward. We were very busy at that time since few midwives worked at the labour ward (in a 12 hour shift, having approximately 10 births between 2 midwives was not unusual at that time). One of the shifts in Gozo was staffed by the Maltese midwives. Furthermore, we used to go to Gozo when any sick leave would crop up. Sometimes this meant working in Gozo for a whole month. The shift consisted only of one midwife and an enrolled nurse. There were instances when it was very quiet and other times when I had to deal with two or three births almost at the same time. It was very hard at times because the two of us had to cope with the antenatal and postnatal mothers, the nursery, babies in incubators and labouring mothers. I remember a time when we ran out of baby cots because all 12 were in use. I must say that the experience in Gozo taught me a lot because when you are working on your own one has to think fast, act quickly and efficiently in the best interest of mother and baby.

After 4 years at the Labour ward, in 1982, I decided to attend a one year course in Clinical Teaching. It was hard for me to leave the labour ward, as up to that time I believed that helping women to give birth was the most rewarding experience a midwife can have. However, I changed my attitude when I was in charge of the Postnatal ward in 1983. Working there for 9 years, I felt that postnatal midwifery care gave me much more satisfaction.

You have experienced a lot of changes, can you give us examples of some of the most important changes?

I like change; wherever I have worked I have implemented change. When I start working in a new



place, I look out for things that need to be improved or changed completely. I do not like the 'status quo' and once there is no need for further changes I get uneasy and have to move on to another challenge.

I worked for a long time on the Postnatal Ward as I considered that there was a lot of changes to be done. In winter there was water dripping from the roof and rain water coming into the bedrooms from the verandahs. This was definitely not safe for the mothers, babies and staff and this had to be remedied immediately.

I am a strong believer in staff development. When I started working at the Post Natal Ward, I realised that most of the staff had been transferred to other departments and were replaced by newly qualified Enrolled nurses. I wanted to ascertain that they were knowledgeable and skilled enough in maternity care. There were no post qualification courses available at that time. Consequently, together with the Midwifery School, I organised a course to train these nurses in maternity care.

The Postnatal Ward was divided between postnatal nurses and nursery nurses and I just could not understand why mother and baby were not cared for as one unit. This situation was imposed from the Head Office and any change had to be done by an official transfer. Therefore, since I could not change it officially, I initiated staff rotation between the two areas. Some of the staff were marveled at how interesting work in the other area was and they wanted to switch over periodically. Eventually all the staff learned to care well for both mother and baby.

Furthermore, I believed that every midwife should

be knowledgeable and skilled in all aspects of maternal care, being it antenatal, intranatal and post natal care as well as caring for the healthy and the critically ill new-born. Being knowledgeable and skilled in all these areas is beneficial for the staff because the overall experience makes employees more employable. It was also beneficial for the better management of the department since each midwife would be able to work in any area of the department. For this reason I introduced a system of rotation which each newly qualified midwife had to undergo during her first two years of employment. This system was further developed by subsequent management.

Before implementing any changes I used to do my homework and used to attend lots of conferences and visit other hospitals abroad to see their management before actually thinking of what I could implement. It is very important that change is always backed up with evidence-based research. This enables a person to speak up with assertiveness, to be consistent and persuasive.

To implement change, I believe that one needs to be proactive. I remember the staff showing the babies to the husband and relatives from behind two large glass windows in the nursery. This made me very uneasy because apart from the fact that the father had no chance to cuddle or even touch his baby, there was the chance of cross infection and the possibility of returning the baby to the wrong cot. I used to go outside the ward and observe the comments of the public when a baby was shown. I realised that there was also complete lack





of privacy. So I decided to stop this practice and let the parents show their baby to whom they wanted to at any time during the visiting hours.

I also believe in implementing small, gradual changes rather than a sudden change. For example when I implemented the 'rooming-in' practice, in 1988, the majority of the staff were against it initially, as they thought that baby care was being taken away from them. Therefore, each morning all the babies were taken out from the nursery and taken next to their mothers and the staff would go and care for the baby at the mothers' bedside. However, during the night the mother would decide whether to keep the baby next to her or to take him/her in the nursery. Thus, initially only partial rooming-in was introduced. Full rooming-in was implemented later on when the large nursery was taken over by the Ophthalmic Ward. I foresaw that the staff would resist rooming-in and possibly a parliamentary question would be asked to question the new practice. This actually materialised, however I had done my research and prepared an adequate response.

What further changes did you implement?

It was the norm to use triple dye, (brilliant green, crystal violet, and proflavine hemisulfate) to help the cord to dry. When this practice was stopped, we used alcohol swabbing and sterzac powder with every nappy change. As part of my BSc studies, I did an experimental research study on umbilical cord care. My hypothesis was that nature could do its own work very well and the study supported this hypothesis. Following my study, the practice of swabbing the cord was stopped, thus reducing the stress on the mother of having to handle the cord. Furthermore, the use of the caustic pencil on the umbilical stump when there was an over growth of the blood vessels was no longer necessary. This overgrowth apparently occurred because alcohol swabbing disrupted the natural process of cord separation.

I strongly believe in the family as a unit as well as in the early bonding of the parents with the newborn baby. Hence, I allowed longer visiting time even though I had lots of objections from different departments. Moreover, in order to reduce the overcrowding and shortage of beds I reduced the hospital stay from 3 days to 2 days. Mothers who had a normal vaginal birth were examined by a senior midwife and if all was well were discharged. We used to discharge mothers of three consultants. This procedure was agreed between the three consultants and a protocol was written to guide this practice. Unfortunately, this practice was stopped after I left the postnatal ward.

I also stopped the practice of femoral blood taking in newborns. I knew about its possible complications. I was in charge and I didn't know how to do it and was not interested in doing it because I knew there were safer methods of blood sampling in newborns. Similar to rooming-in, there was a lot of resistance from the staff as they thought that I was taking away a skill and lowering

their status. After an intense discussion with the paediatric team, it was determined that the nurses and midwives were not legally protected for this procedure and thus it was stopped and done only by the doctors. This practice continued for a short period because the paediatricians also changed to peripheral blood sampling. Furthermore, during my years the paediatricians started to examine the babies by the mother's bedside in the presence of the mother.

What further education did you complete and where else did you work?

In 1990 I finished my degree in Religious Studies and in 1992 I graduated with a BSc in Nursing. I furthered my studies and finished my Masters in Human Resource Development in 1997. Personally, coming from a family of 12 other siblings, all brought up with love and affection, I feel quite honoured to have reached such a good level of education.

In 1996, I was appointed Manager of Midwifery Services where I was later replaced by Ms. Nathalie Zammit in 2001. Following this appointment, in 2001, I was asked by the Health Department to join the FMS as a Health Planner.

From 2004 to 2006, I worked as an acting Manager in Nursing Services at SLH. I had the responsibility of the nursing services of the whole hospital except maternity. Obviously it was a challenge for me but I was always up to new challenges. In the 16 months in this position, I tried to introduce rotation of the nursing staff between the medical and surgical wards. By the time I returned to FMS, the rotation was only done by a very limited number of staff, however they saw the experience as a very positive one.

I worked with FMS on the New Hospital Project (MDH), from January 2001 until I retired in 2008. During this time I worked as a Health Planner and towards the end as a Migration Facilitator. The work was very interesting, challenging and stressful. One of my roles was to liaise between the architects, engineers and other workers and the SLH hospital staff. I worked with a number of departments amongst them the Outpatient, Dental, Radiology, Pathology, Paediatrics, NPICU and Maternity which was later taken over by Ms Mary Buttigieg Said.

In conclusion I feel that midwifery is a profession that needs to be promoted more for the interest of the midwife and the well-being of the family. Midwives need to work with couples to provide continuity of care. I used to meet couples during the Natural Family Planning courses which I used to do with the Cana Movement and during the Prenatal classes at the Midwives' Association premises at Pieta. Finally, I urge midwives to find the time to participate in voluntary work because this gives them a lot of satisfaction and personal fulfilment.

Interview conducted by
Marie Soler and Analise Gingell



Abstracts of Dissertations as Partial Fulfilment for the Degree of Bachelor of Science (Hons) in Midwifery University of Malta, 2014

Mothers' Experiences of Gastrointestinal Discomforts during Pregnancy

Pregnancy is associated with considerable physiological, anatomical, biochemical, and immunological changes, which affect virtually every system of the body, and which give rise to uncomfortable sensations, referred to as minor discomforts of pregnancy. Hence, these hormonal and physiological changes affect every organ of the gastrointestinal system, thus, bringing about a multitude of common discomforts, such as nausea, vomiting, heartburn and constipation. The study aimed to explore pregnant mothers' experiences of gastrointestinal discomforts during pregnancy. The objectives sought to explore their experiences and knowledge; to identify the predisposing factors and to explore mothers' ways of relieving themselves from such discomforts. A quantitative design was selected with a sample of 51 pregnant mothers, who were chosen through convenience sampling, from an antenatal clinic. A self-designed questionnaire was utilized which yielded a 100% response rate, and data was analysed using simple statistical analysis and primary categorisation.

Nausea and heartburn seemed to be the most common discomforts

that participants faced during pregnancy. Multiparae mothers reported more discomforts than primigravidae mothers. Nausea and vomiting were common during the first 12 weeks of pregnancy, while heartburn was common in the second and third trimester. Constipation was common in the first 27 weeks of pregnancy. Lack of exercise, sleep and water consumption seemed to affect these discomforts. Spicy, fried, and acidic foods caused more nausea, vomiting, and heartburn; while lack of fibre-rich foods caused constipation. The majority of the participants used non-pharmacological pain relief to ease such discomforts. More than half of the participants seemed to be knowledgeable on such discomforts, and 70.6% obtained information from the Internet and other medical professionals. Recommendations for practice include: antenatal classes which will provide mothers and their partners with high-quality advice on how to cope with such discomforts. Qualitative studies are also recommended to better explore mothers' experiences in the local setting.

Cheryl Agius

Women's and Men's Awareness of the Effects of Alcohol during and after Pregnancy

Alcohol consumption during pregnancy and breastfeeding has been associated with various adverse effects for the unborn child and the newborn. The present study explored the awareness of Maltese women and men of the use and effects of alcohol during pregnancy and breastfeeding. The study also explored whether the participants had acquired any information on such a health hazard. The present quantitative study included a convenience sample of 40 females and 40 males attending the marriage preparation courses of Cana Movement as couples. The total sample consisted of 80 participants and a 100% response rate was obtained. A self-designated questionnaire was provided to each female and male participant, who answered the questionnaire separately.

Men seemed to be slightly more knowledgeable about the facts that there is no safe amount and type of alcohol during pregnancy, and that alcohol can lead to life-long disabilities in the baby. A slightly greater number of women agreed that

alcohol is harmful at any time during pregnancy and that the baby will benefit if prenatal alcohol use is discontinued. Thirty-one women and 21 men listed at least one correct harmful effect of prenatal alcohol use, while 12 women and 6 men listed at least one harmful effect of alcohol consumption during breastfeeding. Overall, women seemed to be more aware of the potential risks of alcohol consumption during pregnancy and breastfeeding. Coherently, a greater number of women acquired information about the adverse effects of maternal alcohol use. Generalizability is limited in this small-scale study. A national study can be conducted to explore the awareness of the Maltese population about the effects of maternal alcohol use. Widespread promotion can be done through the media to increase awareness and thus promote maternal alcohol abstinence.

Leanne Attard

Experiences of Teenage motherhood

This small-scale study aimed to explore the experiences of teenage motherhood. The objectives of the study were to explore the challenges and rewards mothers experience during the pregnancy, during the early postnatal period, and to explore the support systems which are available to teenage mothers. A qualitative approach was chosen, and a self-designed interview schedule was used to collect data from mothers who had their first child when they were aged between 15 and 19. All ethical approvals and permissions were collected from respective authorities and all ethical considerations were adhered to. The study was conducted on adult participants who divulged their experiences in retrospect. Nine participants who met the inclusion criteria were recruited by purposive sampling from unit 'Ghozza'. Each participant voluntarily accepted to partake in the study. The interviews were audio-taped and transcribed verbatim using thematic analysis as described by Braun and Clarke (2006). Findings demonstrate how the teenage mothers experienced changes in their lives, while highlighting the difficulties experienced throughout the pregnancy and during early motherhood. Despite the challenges, the teenage mothers viewed their

experience positively and commented that in spite of the situation they felt they changed for the better, having more amiable qualities. Furthermore, the teenage mothers expressed the need for support from others especially their mothers and partners. The findings establish that the teenage mothers experienced stresses, stigma, feelings of isolation and loss of liberty. Moreover, the teenage mothers identified a plethora of changes which occurred, including relationship, education and lifestyle changes. Finally, it was concluded that teenage mothers looked for support from their mother, partner, peers and social services such as unit 'Ghozza'. Recommendations include organizing and enhancing educational classes aimed towards teenagers regarding family planning and contraceptive use. It is also recommended that antenatal and postnatal classes are available to the teenage mother and her family. Suggestions also include the implementation of educational classes for midwives and midwifery students to enhance their knowledge of the implications of teenage motherhood. Finally, it is recommended to replicate the study on a national level, using mixed methodology in order to enforce the findings and allow them to be more generalized.

Emma Beck

Fathers' Experiences of an Emergency Caesarean Section

The aim of this study was to explore the experiences of fathers with regards to their partners' emergency caesarean section. In order to fulfill this aim, the objectives of the study were to explore the thoughts and feelings of the father throughout the emergency caesarean section and to explore the relationship between the father, mother and the baby following the emergency caesarean section. To best accomplish these objectives, a qualitative research design was chosen. A self-designed, semi-structured, face-to-face interview schedule was used to collect data from a purposively chosen sample of eight fathers two or three days after the caesarean section. The target population consisted of Maltese fathers whose partner experienced an emergency caesarean section at 37 weeks gestation or more. The interviews were carried out in a private room at one of the obstetric wards at the local, general hospital and were audiorecorded. These were then transcribed verbatim and the transcripts were analysed using thematic content analysis as explained by Newell and Burnard (2006). Ethical issues were

strictly adhered to throughout the whole study. The findings showed that fathers experience of an emergency caesarean section is filled with an array of thoughts and feelings. This implies that they too are affected by these emergency events. Fathers discussed their concern about their partner and child and also the fact of reality not meeting their expectations. Feelings of panic, anxiety, frustration and helplessness were also highlighted when fathers felt they lost control upon the decisions taken. Different levels of involvement were also felt by the fathers and this had an effect on their overall experience. The subsequent relationships between the father, partner and child were identified to be unique for the different situations encountered. It is recommended that fathers are better prepared for the possibility of their partner requiring an emergency caesarean section as it decreases the chances of him feeling lost. Being allowed to stay with their partner and child during the postnatal period was also recommended.

Danica Camilleri

Fathers' views on smoking during pregnancy

This study aimed to gain insight on fathers' views of smoking during pregnancy. The objectives of this study were to identify fathers' knowledge on the side effects of smoking during pregnancy, to explore fathers' views on smoking cessation and to find out from where fathers obtained information on smoking during pregnancy.

A self-administered structured questionnaire that was specifically designed for the purpose of this quantitative study was utilised to collect data. The sample included 42 Maltese fathers recruited by purposive sampling. The participants' wives/partners had just given birth and were receiving care at one of the maternity wards within a local general hospital. A 93% response rate was obtained. Data was analysed manually using descriptive statistics and content analysis. Ethical approval and other necessary permissions were obtained from all the respective authorities.

Results revealed that overall both smoking and non-smoking participants were knowledgeable about the effects of smoking during pregnancy and viewed both active and passive smoking as harmful to the unborn child. However,

none of the fathers recognized all complications as possible risks of smoking during pregnancy. Fathers believed that both the pregnant women as well as their husbands/partners should stop smoking once a pregnancy is confirmed. Moreover, stress and addiction were the most common mentioned reasons that the fathers gave for continued smoking during their partner/wife's pregnancy. Many of the fathers expressed the need to enhance the information available on the subject. Twenty-six percent of the fathers stated that they had received no information during their partner/wife's pregnancy, portraying the lack of information being provided. These results cannot be generalised due to the small nature of the study.

Recommendations include assessing fathers smoking status while dedicating time to discuss issues related to smoking and its cessation during pregnancy with them; repeating the study on a larger scale to make it generalisable and providing adequate training for midwives in order to provide the appropriate support.

Justine Casha

Exploring Woman-Centred Care: Mothers' Experiences

Woman-centred care is a distinct concept of midwifery, that focuses on the woman's individual physical, psychological, spiritual, cultural, social and emotional needs, her baby's and those of her family, whilst recognizing the need for the woman to have choice, control and continuity from a known caregiver or caregivers (Leap, 2009). The aim of this study was to explore mothers' experiences of woman-centred care, during labour and birth. The study's objectives were to explore mothers' experiences of continuity of care and carer during childbirth, and to explore mothers' experiences of informed choices during labour and delivery of their child. To accomplish these objectives, a qualitative approach was adopted and semi-structured, face-to-face interviews were conducted with a purposive sample of ten Maltese mothers. All the mothers had gone through the experience of a normal vaginal delivery and gave birth to a healthy term infant. Mothers who met the inclusion criteria for participation were approached, and voluntarily accepted to participate. The interviews were audiotaped and transcribed verbatim. The transcripts were analysed using thematic analysis as described by Braun and Clarke (2006). Three themes were identified from the mothers' accounts of their experiences; 'Informed Choice

during Labour', 'Continuity of Care and Caregiver during Labour' and 'Presence of the Midwife during Labour'. The findings revealed that, although mothers stated that they had the opportunity to make choices in labour, the researcher noted that information given prior to decision-making was lacking. Continuity of carer was favoured over continuity of care, since mothers argued that having the same midwife in labour enabled them to form trusting relationships. Mothers also indicated that the constant presence of a supportive midwife during labour is beneficial due to the encouragement provided. In view of these findings, recommendations for practice and management, education and further research were proposed, including the need to provide mothers with information to enable informed decision-making; the requirement for midwives to be aware of the advantages of woman-centred care, and to start practicing it; to conduct further studies exploring mothers' experiences of woman-centred care with regards to the antenatal or postnatal period; as well as to explore woman-centred care from the midwives' perspectives.

Alice Cassar

First time mothers' experiences whilst taking care of their infants' umbilical cord

In developed countries, although rare, umbilical cord infections continue to occur in hospitals. For this reason, umbilical cord care is an important issue that needs to be discussed with the mothers. Keeping the umbilical cord stump clean and dry is an important factor if infection is to be prevented. Antenatal education is one of the most important sources of education that mothers have during their pregnancy. It is important that mothers know how to take care of the umbilical cord so they will gain more confidence thus, they will have a better experience. The study aimed to explore the mothers' experiences while caring for their infants' umbilical cord. The objectives sought to explore how mothers have cared for their infants' umbilical cord, to identify any concerns mothers' experienced when caring for their infants' umbilical cord and to determine the information mothers received about umbilical cord care. A quantitative design was adopted to reach these objectives. A sample of 45 mothers was selected by convenience

sampling from the well-baby clinic. A self-administered questionnaire yielded a 100% response rate. Data was analysed manually. Descriptive statistics were utilised for close-ended questions while content analysis was used for open-ended questions.

Mothers knew how to take care of their infants' umbilical cord. Most of the participants did not encounter any difficulties whilst taking care of their infants' umbilical cord, while some participants in the study experienced some type of difficulty. However, on the other hand even though mothers had concerns, most of the participants felt confident in taking care of their infants' umbilical cord. Mothers' expressed the need for more information about umbilical cord care. Recommendations for practice include; Promotion of umbilical cord care by means of more educational programs and leaflets in the hospital maternity wards, Parentcraft classes should continue to discuss the importance of umbilical cord care and give more importance to the appropriate method of umbilical cord care and its benefits. Qualitative studies are recommended to better explore the mothers' experiences whilst taking care of their infants' umbilical cord.

Jessica M. Camilleri

Congratulations to the Newly Qualified Midwives



Back row left to right: Tiziana Gauci, Alice Cassar, Anne Marie Muscat, Justine Casha, Danica Camilleri, Emily Garnisi.
front row left to right: Cheryl Agius, Yanika Vella, Mariella Saliba, Jessica Camilleri, Emma Beck, Leanne Attard.

Midwives' Views on Delayed Cord Clamping

The optimal time to clamp the cord after birth has been a controversial issue for several years. Cord clamping can either be done immediately following birth or else after some time. The study aimed to gain an understanding on the midwives' views regarding delayed cord clamping. The objectives sought to identify the midwives' views of the advantages of delayed cord clamping, to identify the midwives' views of the disadvantages of delayed cord clamping and to explore the factors that influence the timing of cord clamping. In order to reach these objectives, a quantitative approach was adopted. A sample of 40 midwives was selected by convenience sampling from the Central Delivery Suite of one local general hospital. A self-administered questionnaire which yielded a 75% (n=30) response rate was used. Data was analysed manually where, descriptive statistics were utilised for close-ended questions whilst for open-ended questions content analysis was employed. Currently, there is no set definition of the term 'delayed cord clamping' and in the current study, it was referred by several midwives as clamping of the cord once it stops pulsating. Many midwives who participated in the present study believe that when cord clamping is delayed the baby will benefit a lot. In fact, more than half of the midwives expressed that they often practice delayed cord clamping and many agreed that it should become a routine practice. In view of these findings, recommendations for practice, education and research were proposed, including promotion of the benefits of delayed cord clamping, local seminars for midwives to promote more awareness



about the effects of delayed cord clamping, replicating the same study with a larger sampling, involving parents in decision making with regards to timing of

cord clamping and education on delayed cord clamping as part of antenatal education to pregnant women and their partners.

Emily Garnisi

Women's Awareness of their Fertility

Fertility awareness is important in helping women to understand and make informed decisions about their reproductive and sexual health. The aim of this study was to gain an understanding of the women's awareness of their fertility. The objectives were to explore women's awareness of the factors that may affect their fertility; to identify their awareness of the indicators used to check their fertility; and the sources from where they may gain information on their fertility. A quantitative approach using a self-administered questionnaire as a data collection tool was adopted. The sample included 60 women, recruited through convenience sampling. They were attending the Cana Movement course in preparation for their marriage. A 100% response rate was obtained. Data was analysed manually using descriptive statistics. Ethical approval and other permissions were acquired from all respective authorities.

The findings showed that all participants were aware of some or all of the factors that can affect their fertility. Many of the participants were knowledgeable about the signs of ovulation. They were mostly aware of 'thin, transparent, stretchy mucus' (n=43, 72%), followed by 'breast tenderness' (n=39, 65%) and

'increase in basal body temperature' (n=30, 50%). However, 31 women (52%) incorrectly chose 'thick, white, sticky mucus' as a sign of ovulation. Participants were mostly familiar with the temperature method (n=49, 82%), followed by the cervical mucus method (n=44, N=59, 75%). Few participants were aware that examination of the cervix is a method that could help them determine their fertility (n=20, N=58, 34%). There appears to be lack of awareness regarding the menstrual cycle (n=49, 82%) and the time of ovulation (n=41, 68%). Thirty-three (55%) of the participants had never received information on fertility. Participants believed that they could receive information on fertility most commonly from the internet (n=38, N=51, 75%) and the gynaecologist (n=33, N=51, 65%). The midwife was chosen by 16 participants (N=51, 31%).

The main limitation of the study is a lack of representation of the target population due to the small sample size. It is recommended that midwives maintain and continue to develop their professional responsibilities to increase fertility awareness among the general public.

Tiziana Gauci

Mothers' Experiences of Introducing solid food to their babies

The introduction of solid food, also known as weaning, is a transitional period where the infant is introduced to food other than breast or formula milk. For parents, who strive to ensure their baby's well-being, this can be a challenge. Some infants are introduced to solid food by being spoon-fed pureed foods which is known as the traditional method. Others are allowed to follow their instincts and are given finger foods from the beginning. This is known as Baby-led weaning. Local published guidelines are sparse and advice is mainly given by word of mouth from health professionals or family members. In view of this, a quantitative study was carried out using a self-designed questionnaire to explore mothers' experiences when introducing solid food to their babies. A sample of fifty mothers was selected through convenience sampling from the local Well Baby Clinics.

The objectives of the study were to explore mothers' choices of different sources of food given to their babies; to determine mothers' awareness of signs which indicate baby's readiness for solid foods; to identify any concerns mothers had when introducing solid food to their baby and to determine the sources of information utilised by mothers when weaning their babies. The findings revealed

that Maltese are still introducing solid food using the traditional approach. Moreover, the population under study follows the ESPGHAN recommendation (European Society for Paediatric Gastroenterology, Herpetology and Nutrition, 2008) of starting solid food after 4 months of age. Mothers are aware of the developmental milestones that indicate their baby's readiness for introducing solid food. Maternal concerns focus mainly on providing their infant with a healthy diet.

The study demonstrated the importance of providing mothers with more professional advice as this would make weaning less confusing for mothers. The provision of guidelines both in Maltese and English would be of a great benefit for mothers during the weaning period. Also, continuous developmental courses for healthcare professionals would ensure that the latest information is given to mothers. Qualitative studies as well as studies which explore health professionals' knowledge, attitudes and advice given to parents on the introduction of solid food are also recommended to be carried out locally.

Anne Marie Muscat

Expectations of first-time Fatherhood

This study aimed to explore the expectations of first-time fatherhood amongst men, who were attending parentcraft classes at the local general hospital, while their partner was in the last trimester of pregnancy. The study's objectives were to explore fathers' thoughts and feelings regarding fatherhood and to gain insight into how fathers prepare themselves for this new phase in their life. Moreover, the researcher was also interested in exploring first-time fathers' intentions about postnatal involvement with infant care and how they develop knowledge regarding fatherhood. A qualitative approach was used to conduct the study, using a self-designed, semi-structured interview schedule. The study's sample was selected by purposive sampling and ten men were chosen to participate on a voluntary basis. The interviews were audiotaped and later transcribed verbatim for analysis using Braun and Clarke (2006) thematic analysis. All ethical considerations

were adhered to throughout the duration of the study. Findings revealed that expectant men often associate the initiation of fatherhood with the moment of birth. A change in lifestyle and priorities was expected by all participants in the study. The anticipated advantages of becoming a father were linked to becoming more united as a family and having a sense of fulfillment and achievement in life. Findings also showed that most of the participants expected an improvement in the couple's relationship after the birth of the child. The participants' accounts also revealed that the mother was still positioned as the primary carer of the child. Recommendations included the need to discuss more frequently and openly issues such as parental leave. Moreover, male-focused sessions in antenatal classes with more of a realistic preparation on what to expect during the postnatal period was also recommended.

Mariella Saliba

Mothers' awareness of nutrition and weight gain in pregnancy

A woman's diet in pregnancy has essential implications for her fetus, both in the immediate health outcomes and also, for the child's future (Crozier et al., 2009). The aim of the study was to explore pregnant women's awareness of nutrition and weight gain. The objectives sought to determine the quantity of food mothers eat and drink during their pregnancy, and to explore pregnant women's awareness of their weight gain or weight loss during their pregnancy. A sample of 42 pregnant women was chosen by convenience sampling from the antenatal clinic of a general state hospital. A quantitative approach was used and data was collected by means of a self-designed questionnaire, which yielded a 100% response rate. Simple descriptive statistics and content analysis were used to analyse data.

Mothers described a healthy diet as eating a little of everything in moderation,

eating healthy foods which are not processed, and eating from all the seven main nutrients. Nearly all pregnant women followed a healthy diet and they were quite aware of what foods and drinks they should eat or avoid in pregnancy. Most mothers increased their daily intake of food and drinks during pregnancy. Mothers' weight gain in pregnancy affected their body image. Parentcraft classes were the main source for knowledge to mothers about nutrition and weight gain in pregnancy.

The main limitation of the study was the small sample size. Also, the tool with the close-ended questions limited the respondents' answers. The main recommendation of the study includes continuous promotion and education based on healthy lifestyles, not only for the mothers, but also within the family and the community.

Yanika Vella



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* 10-day clinical test on 47 women during breast-feeding, under the control of midwives and paediatric nurses

** for 81% of subjects