THE SOCIETY OF MIDWIVES OF SOUTH AFRICA

13TH CONGRESS

23 - 26 August 2016

Elangeni Hotel, Durban

“Midwives taking the lead in achieving the sustainable development goals”
Welcome Message from SOMSA President

Welcome dear midwives to our annual congress. Moving the congress to August came after many requests over the years and carries the significance of being in women’s month. In all times the role of women in society was what kept a society growing and prosperous. As midwives we have the privilege (some) of being a woman, mother and more, but all of us are part of the process where mothers are created. At that crucial time in a family’s life we are there and can empower each mother we touch to be the best mother possible to her baby and in her family.

We saw the end of the millennium development goals in 2015, and are now working to meet the Sustainable Development Goals. We will discuss this in a number of forums during congress, but take time to look at this and see yourself as key members in your community where we all have a role to play to meet these targets.

We are also taking this time to say to the world that we, as the midwives of South Africa, see ourselves as key to eliminating preventable maternal deaths by 2030. We can achieve this if we empower women, girls, families and communities. By integrating maternal and newborn care and protecting the mother–baby relationship we would form partnerships with the families we serve. As the professional association for midwives we want to prioritise country ownership, leadership and supportive legal, regulatory and financial mechanisms to enable our work. Lastly we need to apply a human rights framework to ensure that high-quality sexual, reproductive, maternal and newborn health-care is available, accessible and acceptable to all who need it.

This is why we have the opportunity to pledge our commitment to respectful care during this congress.

May you be rejuvenated in the knowledge of new evidence, skills and professional matters, so that indeed midwives in South Africa would be compassionate and competent.

Elgonda Bekker
SOMSA President
Welcome Speech KZN Chairperson
SOMSA 2016

Dear Colleagues

It is our pleasure to welcome all the midwives of Southern Africa and our supporters/
partners to the 13th SOMSA National Annual Midwifery Congress in Durban in the KZN
Province.

The KZN chairperson of the KZN Society of Midwives and the executive team are
delighted to have you all here to participate and share in this Congress. Many of you
have travelled long distances and this serves to remind us all just how important our
work is. Thanking you for coming!

The theme for the SOMSA 2016 Congress is “Midwives taking the lead in achieving the sustainable development goals” which resonates from the UN Sustainable Developmental goals launched 25 – 27 September 2015 (SDG 3, 4, 5,17) to
be achieved by 2030. As Midwives we have an obligation to implement, support, fulfill and commit towards the attainment
of these goals. (Sure!!)

Over the period 23 – 26 August 2016 we will share best practices, learn from one another’s experience and develop new
strategies and collaborations. This Midwifery Congress is made possible through strong partnership between civil society,
research, partners and governmental structures.

Thanking you again for trusting and choosing KZN, as it is challenged with the quadruple burden of disease including
HIV, AIDS and TB which has a negative bearing in our MATERNAL Health outcomes. A big thank you goes to our KZN
Department of Health, for the full support and recognition of the midwives contribution to Maternal neonatal and child
health programmes or to saving mothers and babies in our country.

We wish you a safe and a productive stay in the 3rd largest city in South Africa “Durban” - a coastal port with calm
sub-tropical climate and large golden beaches which makes it a paradise for visitors around the world. We hope that this
will be a breath-taking moment.

Kholeka Makhathini
SOMSA KZN Chairperson

The National Anthem

Nkosi sikelel’ iAfrika
Matshakhanyise’ uphondo lwayo,
Yizwa imithandazo yethu,
Nkosi sikelela, thina lusapho lwayo.

Morena boloka setjhaba sa heso,
O fedise dintwa le matshwenyeho,
O se boloke, O se boloke Setjhaba sa heso
Setjhaba sa South Africa – South Africa.

Uit die blou van onse hemel,
Uit die diepe van ons see,
Oor ons ewige gebergtes,
Waar die kranse antwoord gee,

Sound the call to come together,
And united we shall stand,
Let us live and strive for freedom,
In South Africa our land.

Midwives Anthem

UNTIL I REACH MY GOAL (solo)
Until I reach my goal
I REACH MY GOAL (solo)
Until I reach my goal
I REACH MY GOAL (solo)
I will never depart from the GOLDEN RULE
Until I reach my goal
Until I reach my goal

UNTIL HE SAYS WELL DONE (solo)
Until HE says well done
HE SAYS WELL DONE (solo)
Until HE says well done
UNTIL HE SHAKES MY HAND (solo)
Until HE shakes my hand
HE SHAKES MY HAND (solo)
Until HE shakes my hand
He will never depart from the GOLDEN RULE
Until HE shakes my hand
Until HE shakes my hand

South Africa – South Africa.
# TUESDAY 23 August 2016

## DAY 1

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<td>Welcome to the Congress by SOMSA President</td>
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<td>13h00 - 13h45</td>
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## SESSION 1: GLOBAL, REGIONAL AND NATIONAL PARTNERSHIP FOR SUSTAINABLE DEVELOPMENT GOALS (SDGs)

**CHAIRPERSONS**

- Nokuzola Mzolo
- Elgonda Bekker

**VENUE** Great Ilanga (Congress Hall)

### DAY 1

- **07h00 - 08h00** Registration
  - **VENUE**: Great Ilanga (Congress Hall)
  - **CHAIRPERSONS**: Nokuzola Mzolo and Elgonda Bekker

### VENUE

- **Great Ilanga (Congress Hall)**
- **Suites 4 and 5**
- **Suites 1 & 2**
- **Suite 3**

### FACILITATORS & NOTE TAKERS

- **Brenda Ngwabeni and Hlengiwe Myeza**
- **Rebecca Motete and Sthandwa Mnyapi**
- **Sisana Majekke and Peggy Dasi**
- **Ayanda Ngema and Mookho Kumpi**

### Activities

- **08h00 - 08h15** Midwives anthem
- **08h15 - 08h30** General issues: Logistics, Introduction of KZN Congress Team
- **08h30 - 08h50** Welcome to the Congress by SOMSA President
- **08h50 - 09h10** Introductions of the National Minister of Health
- **10h00 - 10h30** Introductions of the National Minister of Health
- **10h30 - 11h10** Midwifery 2030 Pathways towards the SDGs
- **11h10 - 11h30** Ministerial Committee: Saving Mothers report and recommendations
- **11h30 - 12h10** Ministerial Committee: Saving Babies report and recommendations
- **12h10 - 12h40** SOMSA Position Statement and Ceremony Pledge: Respectful Care
- **12h40 - 13h00** Midwives discussion on respectful care
- **13h00 - 13h45** LUNCH – Lingela and Ocean Breeze

### Resolutions

- Recognition, representation and involvement at National, Provincial and District Level.

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# SESSION 3: BREAKAWAY SESSIONS

### DAY 1

**VENUE**: Great Ilanga (Congress Hall)

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<td>Midwives discussion on respectful care</td>
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# WEDNESDAY 24 August 2016

## DAY 2

### SESSION 4: INNOVATIONS FOR IMPLEMENTING THE SUSTAINABLE DEVELOPMENT GOALS

**CHAIRPERSONS**

- Busiswe Kunene
- Thobekile Mpembe

- **VENUE**: Great Ilanga (Congress Hall)

### Activities

- **07h00 - 08h00** Registration
  - **VENUE**: Great Ilanga (Congress Hall)
  - **CHAIRPERSONS**: Nokuzola Mzolo and Elgonda Bekker

### RESOLUTIONS

- Recognition, representation and involvement at National, Provincial and District Level.

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**VENUE**: Great Ilanga (Congress Hall)

### DAY 2

**SESSION 4: INNOVATIONS FOR IMPLEMENTING THE SUSTAINABLE DEVELOPMENT GOALS**

- **CHAIRPERSONS**: Busiswe Kunene and Thobekile Mpembe

- **VENUE**: Great Ilanga (Congress Hall)

### Activities

- **08h00 - 08h10** Morning devotions
- **08h10 - 08h20** Midwives discussion on respectful care
SESSION 5: BREAKAWAY SESSIONS

ORDER OF VENUES

Great Ilanga (Congress Hall) 400

Suites 4 & 5

Suites 1 & 2

Suite 3

CHAIRPERSONS

Francina Boer and Zodwa Dladla

Lulu Nompmandela and Nokuzola Mzolo

Thandi Magingxa and Otty Mhlongo

Fanny Nyalunga and Lindiwe Ngwenya

11h00 - 11h20 Effective Family Planning Interventions in Preventing Pregnancy in Adolescents

Cindy O’Connor

11h20 - 11h40 Factors associated with TB screening for pregnant women living with HIV in uThungulu District in 2012

Shandwa Mnqayi

11h40 - 12h00 Perceptions of the pregnant women regarding the Basic Antenatal care approach in eThekwini District, KwaZulu-Natal

Thembelihle Nxzongo

12h00 - 12h20 Improving the quality of Antenatal Care at the Primary Health Care (PHC) Clinics in the Free State (FS) through implementation of the Advanced Antenatal Care (AANC) programme.

Winnie Motlolometsi

12h20 - 12h40 Discussion

12h40 - 13h00 Discussion

13h00 – 14h00 LUNCH – Lingela and Ocean Breeze

SESSION 6: BREAKAWAY SESSIONS

ORDER OF VENUES

Great Ilanga

Suites 4 and 5

Suites 1 and 2

Suite 3

CHAIRPERSONS

Sisana Majeke and Brenda Ngwabeni

Jabu Tobo and Francinah Boer

Pinky Phungula and Winnie Motlolometsi

14h00 - 14h30 Facilitated empowerment of midwives to enhance utilisation of antenatal care services by pregnant women in Mnquma sub-district in the Eastern Cape

Thandi Rosemary Ngwanya

14h30 - 15h00 Pregnancy Testing at House Holds by Community Care Givers (CCGs)

Vanessa Boysen

15h00 – 16h00 LUNCH – Lingela and Ocean Breeze
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<tr>
<th>Time</th>
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| 15h00 - 16h30 | EMTCT Satellite Session UNICEF  
  1. Real-Time Monitoring of Paediatric HIV Programme: Digital and Gaps projects:  
    Faith Moyo  
  2. Safer Conception / Preconception:  
    Nokuthula Makhoba  
  3. Role of Mothers to Mothers in eMTCT:  
    Zinhle Zulu  
  4. Safe Infant feeding in the context of HIV:  
    UNICEF Representative  
  5. EMTCT Last Mile Network for SA: Live Demonstration:  
    UNICEF Representative |
| 16h30 - 17h00 | TEA BREAK |

**THURSDAY 25 August 2016**

**VENUE:** Great Ilanga (Congress Hall)  
**SESSION 7:** INTEGRATING THE SDGs TARGETS INTO MIDWIFERY EDUCATION, REGULATION AND PRACTICE  
**CHAIRPERSON:** Rebecca Motete and Jabu Tobo

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<th>Time</th>
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| 08h00 - 08h10 | Morning devotions  
    Pastoral Devotions  
    Pastor B. T. Mnguni  
    DOKSA Family Church |
| 08h10 - 08h20 | Daily logistics  
    Congress Chairperson  
    Kholeka Makhathini |
| 08h20 - 08h50 | Clinical Leadership in the Labour Ward  
    Solange Mianda |
| 08h50 - 09h20 | Improving Quality of Perinatal Audit Process  
    Sthandwa Mpayi |
| 09h20 - 09h40 | UMOJA – Midwife-led basic ultrasound in rural areas  
    Technical and organisational development  
    Sturla H. Eik-Nes and Eva Tegnander |
| 09h40 - 10h00 | Midwife-led basic ultrasound in rural areas  
    Applying evidence-based knowledge  
    Eva Tegnander and  
    Sturla H. Eik-Nes |

**Friday 26 August 2016**

**SESSION 9:**  
**EDUCATIONAL VISITS:**  
*Conference Co and Educational Visits Team Co-ordinators and Facilitators*

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<tr>
<th>Time</th>
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| 08h00 - 09h00 | EDUCATIONAL VISITS:  
    MEETING and  
    PREPARATION FOR DEPARTURE |
| 09h00 - 09h10 | EDUCATIONAL VISITS: Coaches to depart the Elangeni Hotel for educational visit sites  
    Educational visit site: Siyanda Ward 11,  
    Educational visit site: Prince Mshiyeni Memorial Hospital  
    Educational visit site: R. K Khan Hospital  
    Educational visit site: Clairwood Hospital  
    Educational visit site: UKZN George Campbell  
    Educational visit site: Women Empowerment |
| 12h00 | Coaches to return to Elangeni Hotel |
Abstracts

The abstracts on the following pages are listed and printed alphabetically by presentation title. The presenters’ names have been underlined.

The abstracts are produced as they were submitted by the authors/presenters. The content is the responsibility of the presenter.

A simulation learning package on postpartum haemorrhage for undergraduate midwifery students

Hafaza Bibi Amod

1 University of KwaZulu-Natal, Durban, South Africa

Background:
The training of undergraduate midwifery students to identify and manage post-partum haemorrhage is an essential skill in midwifery.

Problem statement:
The lack of clinical sites and opportunities for nursing students to gain clinical experience is a growing concern for nurse educators. Therefore it is imperative to integrate innovative and creative teaching approaches.

Aim:
The aim was to develop an innovative method of teaching undergraduate midwifery students how to manage post-partum haemorrhage, using high fidelity simulation.

Methods:
A sequential mixed methodology was used. This study was made up of three phases namely; development of the learning package, implementation and then evaluation. The research participants were 4th year baccalaureate of nursing midwifery students as well as midwifery experts involved in teaching midwifery to nurses. Data was collected using an evaluation checklist for experts, a student satisfaction survey and focus group sessions. Data were analyzed using SPSS Version 23.0 and content analysis.

Results:
The evaluation checklist for experts revealed that the developed SLP was considered to be suitable for undergraduate students. It encouraged active learning, teamwork and accommodated diverse learning styles. The package was easy to use and offered opportunities for student feedback. The student satisfaction survey revealed that the pre-simulation support received was adequate and helpful and the post simulation outcomes showed that using high fidelity simulation improved clinical skills, knowledge, critical thinking, self-confidence and satisfaction. The focus group sessions revealed that using SLP was an innovative and interactive method of learning; it improved the student’s perception of their clinical competence, stimulated critical thinking; empowered students and allowed for them to practice in a safe learning environment.

Conclusion:
A simulation learning package, that uses high fidelity simulation, can be an innovative and interactive method to teach midwifery emergencies within the undergraduate programme.

Keywords:
High fidelity, simulation.

Abstract writing workshop

Busisiwe Kunene

1 Independent Midwife Consultant

Most of the time midwife who do very effective interventions in their place of work struggle to share this information with other and empower them. One of the reasons is that, in order for one to be able to present one needs to have good abstract that can make her or him to be accepted as presenter.

The goal of this workshop is to assist participants to prepare for submitting their projects or interventions developed and implemented to the congresses or conferences for presentations to conference panels.

The presenter does not promise or guarantee that the workshop exposure will get into conferences but the facilitate has been involved in many abstract reviews and she has presented in many international conferences over and above that she was exposed to such workshop at certain stage. Therefore guarantees that if you follow some basic principles you will have a much better chance of having your paper accepted.

Content of the workshop include inter alia, basic principles of writing an abstract, the practical uses of abstract writing, how to write an effective abstract and what the effective writing will allow you to accomplish with your professional and academic pursuits.

Procedure:
• This will a practical work shop, therefore participants should bring their own computer, own information
• Number of participants: about 35 people in order to allow enough attention for the individual
• This should take about 45-60 minutes. It is requested that this be allocated towards the end of the day so that participants can be able to use their time even after hours if they need more attention.
Acceptability of midwife obstetric units in five districts in KwaZulu-Natal

Ayanda Ngema1, Anna Voce1
1University of Kwazulu-Natal, Durban, South Africa

Introduction:
Increasing the proportion of deliveries with skilled birth care in an enabling environment contributes to lowering maternal mortality ratios. Increasing the proportion of midwife-led deliveries contributes to increasing the proportion of deliveries with skilled birth care. The promotion of midwife-led deliveries is in line with evidence that supports midwife-led care as a safe, cost-efficient option of choice for the management of low-risk pregnancies and deliveries. In order to increase the proportion of midwife-led deliveries, and to improve access to skilled birth care and to life saving interventions closer to where women live, the KwaZulu-Natal Department of Health implemented a policy in 2012.

Methods:
A mixed method study, comprising both quantitative and qualitative data collection was implemented

Results:
The respect and care granted to pregnant women reportedly differed according to the perceived status of the woman, whether by the community generally, the family or health workers. While 75% pregnant women reported knowing they could deliver in an MOU, 38% reported an intention to deliver in an MOU, and 42% reported a preference for midwife-led care. A majority of pregnant women (76%) reported they themselves, alone or with their partner, were the final decision makers with regard to where they would deliver. 9% pregnant women reported no relationship, 73% reported a stable relationship but living apart,19% reported a stable relationship and living together. Challenges reportedly deterring the decision to deliver in MOUs included: previous experience when delivering in an MOU; 24-hour staff coverage not always available in the MOU; midwife attitudes; delayed emergency response-time; lack of provision of food; location of relatives.

Discussion:
Reasons provided for preferring midwife-led care to doctor-led care were similar and point to the need for a whole-system reorientation to client-centred care, engendering trust between pregnant women and health care providers through relationships that are caring and compassionate, respectful and responsive to individual questions and needs.

Addressing gender-based violence at community level

Sthandwa Mnqayi1
1Department of Health, Empangeni, South Africa

Background:
There seems to be a lack of knowledge of women and girls’ rights sometimes how to demand these and inability of health and social services to meet their obligation with regards to ensuring those women and girls’ rights are upheld. The impact of gender-based violence (GBV) on HIV and AIDS among women is two-folded: first, it increases the risk of HIV infection by placing women and girls in coercive situations in which they may be unable to exercise any authority over their bodies or sexual interactions. Secondly, it acts as an impediment to accessing the information, testing, treatment, care and support that women who are vulnerable to or affected by HIV may require. GBV affects the ability of abused women to exercise their reproductive right in terms of contraceptive and fertility regulation, choice on termination of pregnancy and looking for antenatal care.

In the context of high HIV prevalence in South Africa, Gender-based violence (GBV) is increasingly recognized as a public health problem and a violation of human rights.

The project aimed to increase women and girls’ access to quality services provided by public sector and community providers.

Methods:
Project implementation approach was used to partner with community, train and mobilize community to support and protect vulnerable groups, capacity building and advocacy.

Results / Lessons learned:
Capacity building, partnerships, advocacy and health service strengthening were identified as focus areas for improving reporting and access to sexual assault services.

Conclusions:
Community partnering, capacity building and health strengthening such as establishing Thuthuzela care centres in hospitals can improve women and girls’ health outcomes.
Clinical leadership in the labour ward

Solange Mianda¹, Anna Voce¹
¹University of KwaZulu-Natal, Durban, South Africa

Background:
Poor patient care and adverse events have been reported in health facilities around the world prompting the call for strong clinical leadership in health systems at the point of care. With regard to birth care, poor admission assessment, delays in referral, and not following standard protocols of management were the most common health care provider avoidable factors leading to maternal deaths in district hospitals in South Africa, indicating inappropriately trained doctors and midwives. These findings resulted in the 5Hs recommendations with an emphasis on improving health care providers’ competencies. Strengthening clinical leadership at the point of care, in labour wards and delivery rooms, is recommended for its potential to impact on the quality of patient care, and affecting decisions regarding resource allocation at the ward level. However, the clinical leadership required in the labour ward is not fully described. The study was design to explore conceptualizations of clinical leadership in labour wards in KwaZulu-Natal.

Overall study design:
Qualitative, participatory enquiry approach.

Data collection and analysis:
Data collection comprised (1) in-depth interviews with advanced midwife members of the District Clinical Specialist Team (DCST); and (2) mini Delphi technique with DCSTs, operational managers of labour wards, district and provincial MNCWH representatives, and academics involved in midwifery training. Both inductive and deductive approaches were used to thematically analyze the data. Each transcript was read and re-read to identify themes and patterns; similar themes were grouped and given a label, then summarized.

Results:
In conceptualizing clinical leadership five major domains emerged from the data. For each domain a description of what comprises clinical leadership was identified.

Conclusion:
Conceptualizing clinical leadership provides a foundation for further research on clinical leadership, towards identifying clinical leadership activities, measurement and development.

Keywords:
Clinical leadership, frontline nurses

Effective family planning interventions in preventing pregnancy in adolescents

Cindy O’Connor¹
¹Stellenbosch University: Advanced Midwifery Student, Wynberg, Cape Town, South Africa

Background:
WHO 2016, identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. According to WHO 2016, approximately 16 million adolescents aged between 15-19 years old give birth annually. This accounts for 11% of all births worldwide.

95% of these births occur in low and middle income countries. The average adolescent birth rate in middle income countries is more than double to that of high income countries, and the rate in low income countries five times as high.

The average births to adolescent mothers are approximately 2% in China, 18% in Latin America and the Caribbean and more than 50% in Sub Saharan Africa.

According to WHO 2016, unintended pregnancies to unmarried adolescents are more likely to end in induced abortions. 10% of adolescents who had coerced sex before the age of 15 years old, contributes to unwanted pregnancies. Adolescents account for 23% of the overall burden of disease (disability adjusted life years) due to pregnancy and childbirth. 14% of unsafe abortions in low and middle income countries are from adolescents between the ages of 15 to 19 years old. Approximately 2.5 million adolescents have unsafe abortions annually.

In the above incidences there is a definite decrease in the amount of births to adolescents in most countries and regions, not specific to race or creed. Yet, the statistics remain high for adolescent pregnancies.

Method:
The types of studies included will be systematic reviews.

The eligibility criteria will be for 12 to 18-year-old sexually active female adolescents.

The interventions will include sexual education, promoting abstinence, risks and consequences explained regarding sex. Other interventions include contraception use, including dual contraception with condom use.

Primary outcomes include decreasing pregnancy or unintended pregnancy rates.

Secondary outcomes include changes in knowledge, initiation of sex, use of family planning methods, childbirth.

Findings:
Reviews done are often limited to measuring the success of one form of contraception over the other. It appears there is a lack of evaluations of teenage prevention programs and the effect on positive sexual health. (Blank L, et al, 2012).

To bridge this gap, I will conduct a scoping review that focuses on effective family planning interventions in preventing pregnancy in adolescents. These interventions include different types of contraception and where to get it, emergency contraception, and abstinence educational programs.

Conclusion:
Adolescent pregnancy is dangerous for the mother, dangerous for the neonate and it adversely affects the communities.

The purpose of this study is to identify effective family planning interventions in preventing pregnancy in adolescents.

The objectives of the study are to map existing systematic reviews on interventions in preventing pregnancy in adolescents and; to identify the gaps in the literature regarding teenage pregnancy and effective family planning interventions.
Enhancing clinical preparedness of basic midwifery students: Perceptions of midwifery educators

Zanyise Vuso
*Lilitha Nursing College, East London, South Africa

Background:
In the Department of health in South Africa every year most litigations are from midwifery practice. Furthermore, these litigations involve newly qualified midwives. The drop in performance and quality of midwifery practice, thus suggesting a link with competency levels. There are concerns regarding the nature and quality of midwifery clinical preparation for students in the college.

Problem Statement:
The need to conduct research was influenced by increased failure rate of students in midwifery clinical practice, at the nursing college where the researcher is working. This resulted in students repeating the year whilst some exited the programme. Therefore the researcher saw a need to enhance clinical teaching to prepare the newly qualified midwives to be competent practitioners.

Objectives:
The objectives of the study were – To explore and describe the perceptions of midwifery educators regarding the need for additional measures to enhance clinical preparedness of basic midwifery students before they are allocated in the clinical areas. Secondly to make recommendations that will further assist midwifery educators to clinically prepare their students before they are allocated to the clinical areas.

Method:
A qualitative, exploratory, descriptive and contextual research design was used. Population for the study consisted of midwifery educators in the Eastern Cape Province. Purposive sampling was used to select suitable candidates according to the set criteria. Focus groups were used to collect data and seventeen educators participated in the study. Tesch’s method of eight steps was used to analyse the data.

Findings/Results:
The results revealed factors that hinder clinical preparedness of their students, related to increased workload, lack of support from the management, students lacking commitment towards their work, inconsistencies in clinical practices and insufficient timeframes for both theory and clinical placement.

Recommendations / Conclusions:
Based on the findings recommendations for clinical midwifery practice, nursing education and research were made.

Facilitated empowerment of midwives to enhance utilisation of antenatal care services by pregnant women in Mnquma sub-district in the Eastern Cape Province

Thanisi Rosemary Ngwanya
*Lilitha Nursing College, Butterworth, South Africa

Background:
Antenatal care is essential care that assists in maintaining a state of good health for the woman and her unborn baby. Globally the use of antenatal care services remains a challenge and this tendency is closely associated with the increased rate of maternal and neonatal mortalities and morbidities. South Africa like the other countries devised means to avert to challenge and has adopted a free service policy for pregnant women, their infants and for children up to the age of six. Furthermore primary healthcare services are to be within a 5km radius and distance from each community being served.

Despite these policies, the problem of limited utilisation of antenatal care services by pregnant women is still observed in this country. The purpose of the currently reported study was to explore and describe the reasons for limited utilisation of antenatal care services in the Mnquma sub-district, and depending on the findings of the study, develop guidelines to assist the midwives to encourage the use of antenatal care services by pregnant women.

Objectives:
• To explore and describe the reasons for the limited utilisation of antenatal care services by pregnant women at Mnquma sub-district.
• To explore and describe the knowledge of antenatal care services by the pregnant women.
• To develop guidelines to facilitate empowerment of midwives to enhance utilisation of antenatal care services by pregnant women in the Mnquma sub-district in Eastern Cape Province.

Methods:
A qualitative, exploratory, descriptive and contextual research design. The research population were post-delivery women and the purposive sampling was used to identify women who met the stated criteria. One-on-one audio-taped semi-structured interviews were conducted and field notes were kept to justify some of the themes identified. Data for the study were collected in Mnquma sub-district during the months of June to July 2015 and study completed in January in 2016. Thirteen participants were interviewed using a digital voice-recorder with permission from Nelson Mandela Metropolitan University and participants. Interviews were transcribed verbatim and data was analysed using Tesch’s data analysis method. Trustworthiness was maintained through the standards of truth value, credibility, transferability, dependability and conformability. The ethical considerations of beneficence, justice, autonomy, non-maleficence and veracity were maintained.

Results:
From the findings three main themes emerged, namely, participants raised various concerns with regard to barriers influencing limited utilization of antenatal care services. The participants demonstrated limited knowledge of antenatal care services with regard to maternal and fetal screening. Furthermore, participants recommended some solutions to enhance utilization of antenatal care services. Recommendations were made with regard to clinical practice, nursing education and nursing research. For the purposes of the presentation only the main themes of the study will be discussed. Furthermore, based on the barriers and limited knowledge of participants regarding antenatal care services guidelines were developed, namely, to provide midwives with assistance to create a socio-economically sensitive clinical environment that will accommodate easier access to antenatal care services and secondly to provide a calm well-managed ANC environment for midwives and pregnant women.

Conclusion:
The conclusion is that the barriers associated with the utilization of antenatal care services are mainly related to socio-economic matters, limited communication between the women and midwives hence limited knowledge of the antenatal care services by the women. A few of the barriers relate to the health care system. Midwives have to be assisted to deal with these matters in their efforts to increase ANC attendance.

Keywords:
Pregnancy, Antenatal care, Women, Limitation, Utilisation, Service, Empowerment
Factors associated with TB screening for pregnant women living with HIV in uThungulu District in 2012

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**Background:** Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) in pregnancy are risk factors for both maternal and perinatal outcomes. TB is both preventable and treatable in pregnancy. TB is preventable in pregnancy by initiating Isoniazid (INH) prophylactic therapy (IPT) after TB has been excluded. Prevention and treatment of TB in pregnancy is dependent on early detection through screening.

This study explored factors associated with TB screening in the antenatal care services in the province of KwaZulu-Natal in uThungulu District in 2011/2012.

**Problem statement:** Pregnant women living with HIV should be screened for TB and if there is any symptom suggestive of TB, appropriate investigation using sputum/Gene-Xpert and TB culture should be used. However, inadequate screening for TB during antenatal care in pregnant women living with HIV has been identified as one of the contributory factors to adverse maternal and perinatal outcome.

**Aim:** To describe factors associated with TB screening during antenatal care for pregnant women living with HIV in uThungulu District.

**Methods:** An observational study design with descriptive and analytic cross-sectional components was carried out in uThungulu District health facilities for pregnant women living with HIV at first antenatal care visit. Multi-stage sampling was used. A structured interview and data extraction tools were used to collect data. Data was analysed using descriptive and doer/non-doer analytic statistics.

**Results:** The study found that there were more Clinics that were visited by PHC supervisor, with personnel training on TB management, leadership and governance were associated with higher TB screening coverage at clinics.

**Recommendations:**

Based on the findings, recommendations were made for PHC supervisors to provide leadership in BANC service and that all midwives rendering antenatal care should be trained in TB management, in ART for pregnant women and in PMTCT.

**Keywords:** HIV, isoniazid preventative therapy, pregnant women, screening, tuberculosis

Harmonization between Emergency Medical Services and Health Facilities for better Maternal and Perinatal outcomes

Mervin Naidoo1, Sthandwa Mnqayi2
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**Focus:** Delays in transferring Obstetric Emergency patients between Primary Health Care and District/Regional/Tertiary Hospitals pose a serious risk to both Mother and Baby. EMS Call Centres are inundated with numerous cases which often exceed the resources available to attend to all Calls timeously. Harmonization of Ambulance Teams together with designated Hospitals and Clinics was introduced to improve on Ambulance Responses to Obstetric Emergency Patients.

**Target Population:** All patients assessed and classified as Obstetric Emergencies for Referral from Lower Levels of Care to Higher Levels of Care.

**Intervention:** Consultation was conducted in September 2013 between various Stakeholders and EMS uThungulu to determine placement of Ambulances and staff at Strategic Points and to outline working arrangements for harmonization. In November 2013 harmonization commenced with a paradigm shift from EMS Call Center Dispatching to Dispatching by Clinicians/Professional Nurses. EMS Teams integrated with Labour Ward teams and participate in Doctors Audit meetings, Ward Rounds and Perinatal Meetings.

**Significance:** Prior to Harmonization Ambulance Responses were measured at an average of 37% < 60 mins to Obstetric Cases in uThungulu District. With the focus being directed at Obstetric Emergencies between Health Facilities the Response Times have improved to an average of 81% < 60 mins. This has translated into no maternal deaths that can be directly attributed to a delay in Ambulance Response to Obstetric Emergencies between Health facilities.

**Recommendations:** Challenges are long distances between health facilities, harsh terrain, limitation in availability of Advanced Life Support Practitioners and limited resources. However Harmonization in uThungulu has yielded positive results, not only in improving Maternal and Perinatal outcomes, but also strengthening the integration between Health Care Workers and EMS. This has resulted in EMS uThungulu winning an award for Service Excellence through Innovation and Best Practice at the MEC’s Annual Service Excellence Awards in 2015.
Helping babies breathe…The “WHY” behind the HBB action plan…

Vanessa Booysen

Possible Themes:
- Evidence–based Midwifery practice, education and leadership
- Strengthening midwifery practice through monitoring and evaluation processes
- Strengthen midwifery education and other maternal neonatal, child and women’s health (MNCWH) workers’ education.

Significance for education, practice, research, policy and or service user:
- Evidence–based Midwifery practice, education and leadership
- Strengthening midwifery practice through monitoring and evaluation processes
- Strengthen midwifery education and other maternal neonatal, child and women’s health (MNCWH) workers’ education.

Focus:
- In 2010, the AAP launched Helping Babies Breathe (HBB), a simplified evidence-based resuscitation training program to address lack of neonatal resuscitation skills in resource-limited areas. The curriculum was developed in response to the need for an evidence-based and harmonized training program in neonatal resuscitation designed to be easily incorporated along with other ongoing maternal and newborn care initiatives and strategies. HBB Role training and roll-out has been done in many districts throughout SA. But are midwives convinced that HBB is better?

Recommendations and future actions:
- For new skills and practices to be implemented midwives need to understand the REASON behind the change of essential newborn care practices. “Don’t tell me I must do it..... Explain WHY”
- For new skills and practices to be implemented midwives working in labour wards need frequent fire drills, support visits and follow ups from HBB Master trainers, and DCST’s is imperative. How do we monitor the implementation of HBB post training?

HIV PCR testing at birth in KwaZulu-Natal, South Africa – One year post introduction of the largest neonatal HIV testing programme

Otty Mhlongo

Background:
- South Africa’s guidelines for early infant diagnosis (EID) of HIV have undergone a series of revisions since inception of the prevention of mother to child transmission (PMTCT) programme in 2002. Whereas implementation of routine HIV PCR testing at 6-weeks of age for all HIV-exposed infants has proven to be successful there remained concerns regarding delayed diagnosis and access to treatment for in utero infected infants. For this reason routine birth testing of all HIV-exposed infants was introduced into national guidelines in June 2015 in addition to testing at 10-weeks of age to identify intra-partum infection. KwaZulu-Natal (KZN) officially implemented the new testing guidelines from April 2015. We describe uptake of birth testing and 10-week testing in KZN one year post implementation of the new guidelines and compare programmatic outcomes of current and preceding guidelines.

Materials and Methods:
- HIV PCR data was extracted from the National Health Laboratory Service Corporate Data Warehouse from April 2012 to March 2016. HIV PCR tests were categorized as follows: Birth test at age <7days, 6-week test at 7days-<2months of age and 10-week test at 7days-3months of age. Programmatic outcomes evaluated included % positivity rates (number of positive PCR results as a proportion of total number of PCR tests) and EID coverage calculated as number of PCR tests done over estimated number of HIV-exposed infants in KZN (calculated by multiplying provincial live births registered from Statistics South Africa by provincial maternal HIV seroprevalence) per fiscal year.

Results:
- The number of HIV-exposed infants born in KZN is estimated to be 6000 per month. During the fiscal year April 2014 to March 2015, an average of 5900 PCR tests were performed monthly at age 6-weeks amounting to a testing coverage of 80%. The positivity rate for this time period was 1.3%, a 0.2% decrease from the previous fiscal year when coverage was 85%. For the first year since the implementation of the new testing guidelines (fiscal year April 2015 to March 2016), an average of 4800 birth tests were performed per month, amounting to a birth testing coverage of 81% and intrapartum transmission rate of 0.8%. During this same time period, average of 4675 10-week tests was performed per month amounting to 10-week coverage of 79%. The percentage positivity at 10-weeks could not be determined due to repeat testing being performed for confirmation of HIV status.

In DHIS there is high 10 weeks PCR positivity (1.6%) compared to Birth PCR testing (0.8%) and even higher at 14 weeks at 3.2 % with 354 positive infants versus 10 949 tested; confirmatory PCR cannot be segregated.

Conclusions:
- Findings suggest successful uptake of birth testing in KZN, scaling up to over 80% coverage in a matter of one year. Efforts should be directed at linkage to care of the PCR positive babies and working closely with NHLS to segregate confirmatory tests. As KZN’s intrauterine transmission rate accounts for 60% of early infant transmission, the introduction of the new testing guidelines provide the opportunity for earlier initiation of ART in infected infants. However, the association between the introduction of birth testing and ART initiation and infant mortality rates remains to be determined.
Implementing inter facility ambulance KMC. Changing attitudes, saving lives

Vanessa Booysen
1UFS, SABR, Estherea Women’s Wellness Clinic, Bloemfontein, South Africa

Introduction:
The transport of a neonate is always a very stressful situation because of a Neonate’s Physiological Instability. The mode of transport by ambulance has always been in a Transport Incubator.

Despite being in a pre warmed transport incubator…neonates often complicate on route, and especially HYPOTHERMIA is life threatening for a neonate.

Method:
The Saving Babies Report and NaPeMMCo Triennial Reports recommend and insist that the Bogota Declaration of 1989 be adopted.

“Kangaroo Mother Care is a Basic Right of the newborn, and should be an integral part of the management of low birth weight and full term newborns, in all settings and at all levels of care, in all Countries.”

KMC has been widely accepted and adopted in hospitals… but very little has been researched or documented on implementing KMC during a Neonatal Transfer by Ambulance.

This presentation will discuss the importance of skin to skin transport and transfer as well as explaining the process and “how to implement skin to skin” as well as sharing EMS data on temperature monitoring on route.

Conclusion:
KMC not only humanizes neonatology, it makes better use of the human resources available, even in an ambulance. Resulting in less stressed staff, mothers and babies, improving the outcome for all.

Improving quality of perinatal audit process

Sthandwa Mnqayi
1Department of Health, Empangeni, South Africa

Aim / Rationale:
To reduce overall perinatal and maternal mortality by 20% in KwaZulu-Natal through improved audit process by 2017.

Objectives:
• Reduce avoidable perinatal and maternal mortality
• Increase number of facilities where deliveries are conducted that implemented the complete audit process
• To introduce quality checklist for perinatal audit process

Description of workshop:
The workshop is designed for midwives and doctors involved in maternal cares that are then expected to conduct perinatal audit for quality improvement.

A maximum of 20 participants will be ideal for the workshop.

The workshop will provide background information on perinatal audit process and discuss how it can be implemented.

Intervention:
A PowerPoint presentation will be prepared on how perinatal audit checklist has been used to improve quality, where participants will be able to actively engage in discussion, share experiences and give further input.

Significance:
Perinatal audit has a potential to improve quality and reduce preventable perinatal and maternal deaths, however individual within maternity teams including Primary Health care need to identify whether the audit process has been optimally implemented to effect change. The optimal implementation includes who participate in the process depending on their accountability and responsibility to effect necessary actions.

Recommendations and future actions:
All health care workers involved in reproductive and neonatal care should have a process to identify gabs in the care provided leading to a particular outcome so that those actions that contributed to undesirable outcomes can be identified and actioned.

The implementation of a checklist could help identify gabs in the audit process itself which might lead to it less effective.
Improving quality of perinatal audit process for better perinatal care outcomes

Sthandwa Mnqayi

1Department of Health, Empangeni, South Africa

Focus:
The audit process enables individuals and teams to measure the quality of their work on a regular basis in order to obtain and maintain maternal and perinatal outcomes. If audit is not done regularly and thoroughly it is inevitable that performance may decline. It is recommended that the quality of the perinatal audit process itself be monitored. There are many approaches to conducting audits and the presentation will focus on how uThungulu facilities conducting deliveries have been implementing the perinatal audit cycle from 2014 to date.

Target population:
Obstetric teams that are midwives and doctors involved in perinatal care at all levels.

Intervention:
The perinatal audit checklist was used from 2014 in uThungulu District to determine whether the perinatal audit process/cycle is adhered to in improving quality of obstetric care. During the perinatal meeting the facility would receive feedback on how audit process/cycle was followed during the review period. This intervention has improved the audit process thus improving not only perinatal/maternal outcomes but also caesarean section (C/S) rate.

Significance:
Perinatal audit has a potential to improve quality and reduce preventable perinatal and maternal deaths, however individual within maternity teams including Primary Health care need to identify whether the audit process has been optimally implemented to effect change. The optimal implementation includes who participate in the process depending on their accountability and responsibility to effect necessary actions.

Recommendations and future actions:
All health care workers involved in reproductive and neonatal care should have a process to identify gaps in the care provided leading to a particular outcome so that those actions that contributed to undesirable outcomes can be identified and actioned. The implementation of a checklist will help to identify gaps in the audit process itself which might lead to audits less effective.

Improving the quality of Antenatal Care at the Primary Health Care (PHC) Clinics in the Free State (FS) through implementation of the Advanced Antenatal Care (AANC) programme

Winnie Motlolometsi

1University of the Free State, Free State, South Africa

Focus:
In South Africa, 4452 maternal deaths were recorded in the 2011-2013 triannual report. The FS province contributed to 6% of the deaths. Even through there is a significant decline in the mortality rates, FS has had to implement improvement strategies based on the disturbing outcomes outlined in the Saving Mothers report (2008 – 2010) where the province contributed to compared to 8, 8% of the maternal deaths. Moreover, 4/5 districts of the province was amongst the 10 worst performing in terms of the maternal mortality rates.

Similarly, the province had the highest perinatal mortality rate and the highest number of early neonatal deaths in the 2008 – 2010 report.

With the assumption that there is a perceived competency gap at the PHC clinics, the Free State Department of Health (FSDoH) designed and implemented a programme referred to as AANC.

Target Population:
Midwives in practice.

Intervention:
A group of advanced and / experienced midwives identified and trained as advanced antenatal care practitioners. The expectation is for them to, on outreach basis, (1) visit the identified PHC clinics, (2) Screen and Identify pregnant women at risk during the 2nd antenatal visit consultation, (3) evaluate the" potential risk pregnancies" identified through BANC screening, (4) develop and implement a midwifery management plan as well as to (5) make a clinical decision regarding the proper place of delivery for the pregnant women assessed (6) act as mentors and do corrective training.

Significance for education, practice and research:
It is expected that the implementation of the Programme will improve the pregnancy outcomes.

Recommendations and future actions:
Implementation of the AANC programme will be evaluated. The findings will be used to develop a framework to justify / nullify the implementation of the AANC model country wide.
KZN strategies in implementing recommendations of saving mothers

Neil Moran

1Department of Health, KZN.

Focus:
The presentation will highlight some trends and targets for the incidence of different causes of maternal mortality in KZN, and discuss some of the key interventions that are needed to reduce maternal mortality in KZN.

Target population:
The interventions involve all health workers, but the talk will focus particularly on the role of midwives.

Interventions:
These include;
- A more effective maternal mortality audit process, ensuring that solutions for prevention of recurrence are implemented;
- Integrating ESMOE training, particularly team training with fire drills, into the routine weekly activities of maternity units;
- Improving supportive supervision for antenatal care providers at PHC level;
- Reducing mortality from complications of caesarean section by avoiding unnecessary caesarean sections, for example through use of vacuum deliveries.

Significance for education, research, policy and service users:
- The inclusion of ESMOE into midwifery training programmes;
- Focus on audit including maternal mortality audit in training programmes;
- Documentation of success stories and sharing these through presentation and publication.

Recommendations for future actions:
Midwives must;
- Familiarise themselves with Saving Mothers recommendations and provincial and district implementation plans;
- Work as a team with doctors and other role players to effectively implement them.

Low tech high impact of multi sensory stimulation on infant brain development – Focus skin to skin touch and massage

Karen Hansen

1Johnson's, Cape Town, South Africa

Objectives:
• To demonstrate the impact of the Science of Senses on Brain and infant Development;
• To understand the senses and how they affect development;
• To identify how multi-sensory stimulation can be incorporated in everyday Baby Care Routines;
• Skills training on skin to skin touch and massage.

Implication for practice and future actions:
Midwives to implement Mother Baby Friendly high quality care.

Intervention:
Research demonstrates the importance of multi sensorial stimulation on child’s physical, emotional and cognitive development giving them the opportunity to grow and develop to their full potential.
Therefore skills will be taught on Skin to Skin Massage and Touch.
Educational DVD will be given to all workshop participants, to ensure implementation.

Outcomes:
Implementation of human care for mothers and babies.
Improve Quality of Midwifery Care, ensuring infants are given best opportunity to grow and develop.

Mode of presentation:
Two hour workshop, with skill training and DVD usage.
Utilization of PP slides, Video clips, Demos and Hand on skills work stations.
Participants would be 50 to 60 Midwives, working in pregnancy, labour and post-partum.
Work stations and equipment will be supplied by facilitator 5/6 people at 10 work stations.
Myself and x1 other facilitator to assist.
Midwife-led basic ultrasound in rural areas

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2Department of Laboratory Medicine, Children’s and Women’s Health, Norwegian University of Science and Technology

Keywords:
Pregnancy care, obstetric ultrasound, midwives

Focus:
Evidence based knowledge shows that ultrasound in pregnancy optimizes pregnancy care by improving the estimated date of delivery, detection of twins, location of placenta and detection of gross fetal anomalies. Ultrasound knowledge empowers midwives in their daily work.

Target population:
All pregnant women.

Intervention:
Performing ultrasound in pregnancy requires a solid base of knowledge and experience. A one-year post-qualification education in obstetric ultrasound, with three on site teaching modules (4+2+2 weeks) with intermittent ultrasound practice at the home site, is introduced to give midwives the necessary skills to master the technology and the interpretation of the ultrasound information from a Level 1 ultrasound examination.

Significance for education, practice, research and policy:
The Sustainable Developmental Goal 3 aims to improve the child and maternal mortality rate. Proper ultrasound examinations applied to a pregnancy population have shown: a decrease in pregnancy inductions due to post dates; early detection of twins; detection of IUGR; detection of placenta praevia. Doppler ultrasound allows monitoring of fetal growth and selection of women at high risk of developing preeclampsia. Ultrasound in pregnancy has shown to strengthen the bonding between the pregnant women and the fetus.

The quality of the diagnostic ultrasound performed in South Africa varies widely. As “first-hand” providers of pregnancy care, midwives are the obvious profession to perform the ultrasound examinations. Data from the Scandinavian countries show high quality performance by midwives that have completed a one-year ultrasound education. The information collected from Level 1 ultrasound is sufficient to improve the monitoring of the pregnancy, and is within the legal issues stated by Health Professions Council of South Africa.

Recommendations and future actions:
The presented model to teach South-African midwives obstetric ultrasound skill may be used at midwife-led institutions in rural areas. The model needs to be accredited.

Monitoring HIV diagnosis and linkage to care in Umkhanyakude, KwaZulu-Natal

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1KZN Department of Health
2Umkhanyakude Health District

Background:
Whereas coverage of early infant diagnosis of HIV in South Africa exceeds 80% and is well documented, the number of confirmatory HIV tests and HIV-infected infants initiating antiretroviral therapy is not at 100%. KZN implemented Birth PCR testing for all HIV exposed infants from April 2016 whilst National implemented later in quarter 2.

Methods:
HIV-1 qualitative PCR results from the Umkhanyakude district of Kwazulu-Natal were extracted from the National Health Laboratory Services (NHLS) Corporate Data Warehouse (CDW) from 1 June – 10 October 2015. Infants with a positive or indeterminate result were followed up by the district PMTCT coordinator at facility level and by searching the NHLS CDW for additional HIV PCR or viral load results. Descriptive analysis was performed on the collated clinical and laboratory data to determine repeat PCR testing and ART initiation rates for infants with positive and indeterminate HIV PCR results.

Results:
Over 14 weeks, 4259 HIV PCR tests were performed with 4153 (97.5%) negative, 78 (1.8%) positive and 28 (0.7%) indeterminate results. A total of 57 infants tested positive and 25 tested indeterminate on initial testing, therefore 82 infants required confirmatory testing according to national guidelines but only 37 (45.1%) had a traceable follow-up test. Thirty (50%) infants with an initial positive PCR all had confirmatory positive PCR tests but only 7 (28%) infants with an initial indeterminate PCR received confirmatory testing. Antiretroviral therapy was initiated in 40 (70%) of the 57 infants who tested positive, despite 14 (35%) having no confirmatory test result.

Conclusions:
A potential model for monitoring paediatric HIV testing and linkage to care is described. The results suggest that confirmatory testing is performed in 45.1% of infants who require such testing and that antiretrovirals were initiated in 70% of infants with HIV positive results in Umkhanyakude. Improvements in the rate of confirmatory testing for HIV PCR positive and indeterminate results is required to prevent delay in initiating infants that might have initially had a discordant result and are positive when confirmatory test is done.
Perceptions of the pregnant women regarding the basic antenatal care approach in eThekwini District, KwaZulu-Natal

Thembelihle Ngxongo¹, Nomthandazo Gwele¹, Nokuthula Sibiya¹
¹Durban University Of Technology, Durban, South Africa

Background:
The Basic Antenatal Care (BANC) approach is listed as one of the priority interventions for reducing maternal and child mortality in South Africa and is used in the public health institutions to provide health care services to the pregnant women.

Problem statement:
More than 90% of women in South Africa have access to antenatal care (ANC) services and more that 83.5% of the women who die during pregnancy or childbirth had attended ANC. The question is ‘Why do women continue to die despite ANC attendance?’

Aim:
The aim of the study was to describe the perceptions of pregnant women regarding the ANC services received in the Primary Health Care (PHC) clinics as a means to assess how the BANC approach was being implemented.

Methods:
A descriptive qualitative design was used to conduct the study in eThekwini district, KwaZulu-Natal. Data were collected from 12 PHC clinics using semi-structured interviews conducted with 54 pregnant and analysed using Tech’s method of data analysis.

Results:
The BANC approach was being implemented successfully. Some participants were aware of the change to the BANC approach to ANC while others were not. Some participants highlighted how the BANC approach had brought about improvement in the quality of care. Others were concerned regarding the waiting times, the intervals between ANC visits, integration of ANC with other PHC services, limited space at the clinics and attitudes and performance of clinic staff.

Recommendations/Conclusion:
Recommendations were made with special emphasis on compliance to service delivery guidelines and protocols, availability of the clinic staff members who had been trained and oriented towards the implementation of the BANC approach, integration of services and reviewing human and material resources for adequacy when new programmes are introduced.

Keywords:
Antenatal care, approach, basic antenatal care.

Pregnancy testing at households by Community Care Givers (CCGs)

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Background:
The initiation of antenatal care is universally recommended in the first trimester. It is regarded as the cornerstone of maternal and neonatal health. However, existing evidence from developing countries indicate that majority of pregnant women begin Ante Natal Care very late in pregnancy, KwaZulu- Natal is no different. While ANC coverage for KwaZulu- Natal is a little under 90% (87.9%), ANC before 20 weeks is only 57.2% (DHIS FY 14/15).

Rationale:
World Health Organization, with fifth MDG had planned to reduce maternal deaths by three-quarters by the year 2015. Antenatal care is widely used for prevention; early diagnosis; treatment of medical and pregnancy-related complications, the opportunity which is mostly missed because of late booking.

According to NCCEMD (KZN) non-pregnancy related infections still accounts for the largest number of maternal deaths in KwaZulu- Natal, 42% in the last triennium (2011-2013). Some contributory factors are patient behaviour related and avoidable; the three most common in the 2011-2013 triennial periods:
- Delay in accessing medical help - 286 cases (32.9%)
- No antenatal care - 152 cases (17.5%)
- Infrequent antenatal care - 74 cases (8.5%)

Objectives:
- To identify early all pregnant women, who were not aware of their pregnancy status to start ANC early.
- To educate women to go to clinics if they miss 1 or 2 menstrual periods.

Goal:
This is to improve maternal and neonatal health and reduce morbidity and mortality.

Intervention:
While doing their usual visits, CCGs also target women of child bearing age to identify, those who have missed menstrual period, conduct pregnancy test, and refer to the local clinic those with a positive pregnancy test. It is imperative that they obtain consent to carry out the activity.

Results:
Some improvement in ANC before 20 weeks has been seen in Q1 16/17 FY from 57.2% – 64.9%.
Provision, utilisation and functionality of midwife obstetric units in five districts in KwaZulu-Natal

Jabu Tobo1, Anna Voce1
1University of Kwazulu-Natal, Durban, South Africa

Introduction:
Increasing the proportion of deliveries with skilled birth care in an enabling environment contributes to lowering maternal mortality ratios. Increasing the proportion of midwife-led deliveries contributes to increasing the proportion of deliveries with skilled birth care. Three years post-inception of the policy, an assessment of the utilisation of the MOUs in five districts was commissioned by the KwaZulu-Natal Department of Health, with a view to informing further policy implementation. The assessment had the objectives of: (1) Establishing the availability and geographic distribution of MOUs; (2) Ascertaining the utilisation of MOUs; and (3) Determining the functionality of MOUs.

Methods:
An observational, descriptive, cross-sectional survey, utilising both primary and secondary data, was implemented.

Results:
Overall, there appears to be an oversupply of delivery sites per population in each district. MOUs are generally underutilised, with only 4 of the 25 MOUs (16%) conducting an average of > 50 deliveries per month. With regard to functionality: the 25 MOUs in the five districts under investigation are stand-alone delivery facilities, providing a full range of maternal health services, from antenatal to postnatal care. None of the MOUs had back up for interruptions in water and electricity supply. Generally there were unsafe staffing allocations, when assessing ADM coverage, midwife allocation to labour wards, rotation practices, and day/night staffing distributions. None of the MOUs could perform six of the assessed BEOC signal functions.

Discussion:
The number and distribution of delivery sites requires a district-by-district analysis, taking into consideration population distribution, population density, and terrain and transport routes. In the determination of the required number and distribution of MOUs per district, a hybrid approach to the establishment of MOUs may need to be implemented (both stand-alone and alongside). The number and distribution of delivery sites per district has implications for staffing and equipping of, and the provision of emergency referral support, to MOUs.

Respectful and safe childbirth

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2Department of Health, Ixopo, South Africa

Background:
Disrespectful care has been reported in many maternity facilities throughout the world including South Africa. It is a worrying factor that its consequences are detrimental to maternal and perinatal outcomes. The Essential Steps in the Management of Obstetric Emergencies (ESMOE) team then developed and additional module for health care workers in maternity units to be aware and do something about abuse during childbirth.

Objectives:
- To recognise disrespect and abuse of women in maternity facilities.
- To understand some of the causes of disrespect and abuse.
- To become aware of attitudes which can influence respectful maternity care.
- To practise the skills needed to provide respectful maternity care.

Target population:
Obstetric teams: midwives, doctors and support staff in maternity.

Description of workshop:
Plan (Duration 90 minutes)
A maximum of 2 facilitators: 20 participants will be ideal per workshop session

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<tr>
<th>Slides 1 to 6 presentation</th>
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<tbody>
<tr>
<td>Skills 1. Adolescent in early labour</td>
<td>25 minutes</td>
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<td>Slides 8 to 11 presentation</td>
<td>6 minutes</td>
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<tr>
<td>Video presentation</td>
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<td>Slides 13-20 presentation</td>
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<td>Skills 2. &quot;Uncooperative&quot; women in second stage of labour</td>
<td>25 minutes</td>
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<td>Slides 22-26</td>
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<td>Questions</td>
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Resources required: Data projector, computer, 2 flip charts and marker pens, Loud Speakers, Bed/couch if available.

Intervention:
Participants will be able to actively engage in discussion, share experiences and volunteer to participate in role plays.

Significance:
Participants will identify disrespectful and abusive actions and its consequences in maternity facilities and why they occur. They also discuss respectful communication skills during childbirth. Respectful care in maternity and childbirth has been associated with good maternal and perinatal outcomes.

Recommendations and future actions:
All health care workers involved in reproductive and neonatal care to conduct regular fire-drills on this module so that they always reflect on how respectful communication can contribute to better outcomes.
Responsible Reproductive Health Education Project (RRHEP)

Nozimanga Lesia

1University of the Free State

Teenage pregnancy is a concern to both parents, learners and educators worldwide. According to Sipho Masondo (City Press, 2016: Online); in South Africa more than 99 000 schoolgirls fell pregnant in 2013-a rate of about 271 for every day that year. As a result, learners become parents in early ages even before reaching matric/ grade 12.

This project was implemented to all grade 8s learners from the two identified High Schools in Mangaung Metro.

The aim of this project is to educate/ teach learners about responsible reproductive health so as to reduce the number of teenage pregnancy in the region. The project is implemented after informed consent and accent is obtained/signed by both parents and learners.

The first leg of a four year project with these learners that is focused on learning how to make responsible reproductive healthcare choices is a doll- parenting project. Some learners of these schools are given cell phones and dolls for a period of a week to take care of. Others (learners) are given a task of acting as police and social workers to ensure that the babies/dolls are being well cared for by parents/learners; and if not a report is being written and handed over for punishment.

Discussion:

The results of this project would be discussed during the session. The effect of this project was captured amongst others in a journal and on the last day with a debate session. Content of this would be shared as well as how the project was combined into the curriculum of the learners with tasks in mathematics, life-orientation and English. Further steps as the project evolves over the years as well as possible escalations would be discussed.

Strengthening World Health Organisation (WHO) signal functions in Lejweleputswa Health District, Free State province

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3Netcare Kroon Hospital

Purpose:

A quality improvement project from a leadership development initiative in the Sigma Theta Tau International(STTI) Maternal Child Health Nurse Leadership Academy. The purpose of this leadership project was to strengthen World Health Organization( WHO) signal functions in all the seven delivery sites in Lejweleputswa Health District to improve responsiveness to routine and emergency care, both maternal and neonatal.

Discussion:

Facilities were classified as Basic Emergency Obstetric Care (BeMOC) and Comprehensive Emergency Obstetric Care(CeMoC). Delivery sites were assessed using a designed tool, initial results analysed and shared with stakeholders. A task team was established consisting of Provincial Specialist unit , District Clinical Specialist Team, maternity unit managers and clinical managers. Action plans were drawn using the Logic Model. Facilities were empowered with outreach, in reach and benchmarking. Resources were shared and diverted to needy areas. Process matters were addressed with regard to acquisition plans and budgets. Post implementation of corrective strategies facilities improved their performance remarkably , one facility reached 100% on both maternal and neonatal signal functions.

Outcome/ Application to midwifery practice, education or regulation/ policy and leadership:

The project influenced the district  Strategic Plan. The worst performing facility was merged with a regional hospital to strengthen it. Campaign on Accelerated Reduction of Maternal Mortality in Africa(CARMMA) implementation improved. Provincial bulletin issued n the use of steroids. Project gave birth to a reproductive health clinic in one of the district hospital. The project was presented at the Free State Province Millennium Development Goal (MDG) countdown Summit. Signal functions are now monitored in the Member of Executive Council (MEC) of Health office as one of his injunctions and has been incorporated in the provincial maternity accreditation tool for maternity services. Mentee spearheaded some of the project at facility while the mentor is facilitating some of the provincial projects.
The experience of HIV infected mothers regarding exclusive breast feeding in the first six months of the infant’s life

Selloane Phakisi
1Free State School of Nursing, Bloemfontein, South Africa

Background:
The South African and WHO guidelines for PMTCT recommend exclusive breast feeding by all mothers in the first six months of life, including those who are HIV infected as the risk of HIV transmission is minimised by avoiding mixed feeding. Little is known about how HIV infected mothers experience this since most of them claim that free formula was provided in public facilities for PMTCT and now they are encouraged to breastfeed.

Problem statement:
Mothers were first oriented to the fact that HIV can be transmitted from the mother to the baby through breast feeding and there was free supply of formula in public health facilities for HIV infected mothers. This was followed by the promulgation of the Tshwane declaration for the promotion of breastfeeding for all mothers irrespective of the HIV status and this led to confusion among some of these mothers.

Aims:
The aim of this study was to explore and describe the experiences of HIV infected mothers regarding exclusive breastfeeding in the first six months of the infant’s life.

Method:
A qualitative exploratory study was undertaken in Managing, Free State in 2014. Purposive sampling was done. Data were collected through individual interviews of mothers who met the inclusion criteria. Data saturation was reached with the fifteenth participant. Thematic analysis was done through coding. Ethical clearance was granted by UNISA Higher Degree Research Committee and permission to conduct the study was sought from the Head of Free State Department of health.

Results:
The study revealed both negative, positive experiences and challenges. Some of the subthemes that emerged were satisfaction, motivation, well informed, support, anxiety, guilt, incongruence and family pressure and conflict.

Recommendations:
Regular in-service training for health care workers on infant feeding in the context of HIV is required as well as massive community mobilisation to all members of society regarding exclusive breastfeeding.

The role of assessments in enhancing midwifery programme outcomes in a public nursing institution in the Eastern Cape Province

Vuyelwa Njikija
1Lilitha Nursing College, Bizana, South Africa

Background:
Quality assessments could assist in preparing the students for the needed midwifery programme outcomes. The midwifery curriculum in South Africa is currently under scrutiny as it is seen as producing midwives who are not sufficiently competent to meet the expectations of pregnant, delivering and postnatal women and their babies.

Problem statement:
The increased mortality rates in the Eastern Cape Province have been associated with substandard care noted and reported on in midwifery practice at level one institutions. The concern is mainly directed at the clinical performance of newly qualified professional nurses / midwives.

Objectives:
The objectives of this study were to:
- Explore and describe the role of assessments in enhancing midwifery programme outcomes at a public nursing education institution, and
- Use the results of the study to recommend guidelines that could assist in enhancing midwifery programme outcomes at a public nursing education institution through well – founded assessment strategies.

Methods:
Quantitative descriptive correlational and contextual design was utilised with a self - administered questionnaire as a data collection instrument. The population consisted of 170 community service practitioners and first year professional nurses utilising non random sampling to complete the questionnaire during low – peak hospital routine times or per appointment. Research ethics were observed, n=134 questionnaires were completed. Coded data was analysed with the assistance of a statistician using Cronbach’s alpha computer software.

Results:
The findings revealed that participants had positive perceptions of assessments in enhancing midwifery programme outcomes. The participants rated the statements at agree rating in response to the question about positive contributions towards development of competencies and enhancement of midwifery programme outcomes. They also agreed and strongly agreed that there were factors majorly preventing achievement of midwifery programme outcomes.

Conclusion:
Theoretical and clinical assessments are designed to deliver balance between the theoretical and clinical components.
The role of the neonatal nursing specialist in the PHC re-engineering process

Vanessa Booysen

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Focus:
MDG 2015…….SA has successfully reduced the Under 5 mortality rate…..but sadly the NMR Neonatal Mortality rate has remained stagnant.

For many years the “mother” and “baby” have been familiar concepts in the field of midwifery.

It is acceptable practice that the Midwife cares for the mother……and the Paediatric Nurse cares for the baby. But what about the NEWBORN BABY….THE NEONATE??? Defined as a child under 28 days of age. During these first 28 days of life, the child is at highest risk of dying. (WHO) Who is responsible for this fragile and vulnerable person? The midwife? The paediatric nurse or the Neonatal Nursing Specialist?

What is the role of the Neonatal Nursing Specialist in reducing the NMR in South Africa?

Should she be part of the Provincial and District Specialist team?

Target population:
DCST’s, MNCWH directors and Managers

Intervention:
This presentation will explain the role of the Neonatal Nursing Specialist to lay critically needed foundations for life beyond the first 28 days. Sharing experience as being the only Provincial Neonatal Nursing Specialist in the country appointed as part of the Provincial Specialist team. Success stories and lessons to learn from.

Significance for education, practice, research, policy and or service user:
When other Provincial Specialist teams interacted with our team, some provinces created posts for this critical gap in the Specialist team with success stories and data to support this.

Recommendations and future actions:
The baby is not a small part in the spectrum from conception to surviving childhood. It’s a huge part that needs focussed, specialised attention. Only then will we reduce the chance of the baby being passed on from one side to the other…and actually falling through.

UMOJA – Midwife-led basic ultrasound in rural areas

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2 Department of Laboratory Medicine, Children’s and Women’s Health, Norwegian University of Science and Technology

Keywords:
Obstetric ultrasound, midwives, ultrasound development

Background:
In Scandinavia most routine obstetric ultrasound is done by nurse-midwives. Since 1997, NCFM has functioned as a WHO Teaching and Training Center for Diagnostic Ultrasound in Obstetrics and Gynaecology. In 2004 we became involved in training midwives to use ultrasound in KZN. Over time we realized that the ultrasound equipment developed in industrialized countries was not suitable for Africa to address the challenges indicated in the Sustainable Development Goals.

Objectives:
Develop a functional and extremely low-cost, robust and portable ultrasound instrument to be used by midwives in clinical practice.

Technical and clinical methods:
Primarily a simple, portable, traditional ultrasound prototype was developed in 2008 by Aurotech Ultrasound AS, Trondheim, and presented to our clinical colleagues and midwife ultrasound students in KZN. Through the ongoing teaching activity in the rural setting we continuously evaluated the users’ response and gained knowledge about how to make an instrument that would make a clinical impact. Since 2012, a joint development between NCFM, NTNU, University of KwaZulu-Natal and GE Ultrasound, Horten, Norway, produced a second prototype to be evaluated clinically.

At various clinics and CHCs in KZN the clinical routines have been considered with respect to future inclusion of ultrasound technology.

Results:
A tablet based robust ultrasound machine has been developed for future use in the rural setting with extensive automatic processing and a user friendly interface. Clinically, a practical model has been developed where the midwives at a CHC use ultrasound in their daily work to collect information about the fetal age, term, multiple pregnancy, growth development and basis for referral to higher levels if needed.

Conclusion:
A robust, easy to use ultrasound instrument has been developed for rural areas. It is possible to incorporate ultrasound at a midwife led CHC for assessment of local pregnancies and to accept referrals from surrounding clinics.
‘What happens when we separate a mother and baby? Maternal Infant Separation – The neuroscience of neonatal care. The importance of the presence of the mother for the first three years in a child’s life – Building an emotional solid society

Vanessa Booysen

Possible Themes

• Saving mothers, newborns and children: Strategies towards achieving recommendations.
• Evidence-based Midwifery practice, education and leadership.
• Strengthen midwifery education and other maternal neonatal, child and women’s health (MNCWH) workers’ education.

Headings for non-research abstracts:

Focus:
KMC, skin to skin of a mother and a baby, has been widely accepted and adopted as an interim practice, directly after birth…but this practice needs to be prolonged and implemented even in our affluent societies.

The newborn is emotionally, physically, nutritionally and security/ safety wise 100% dependant on the mother’s presence 24hrs a day for the first 3 years of life.

Maternal separation (nurseries in hospitals, caesarean section separation, babies sleeping away from their mothers, own bed, own bedroom) is a major stress factor for the vulnerable newborn, which increases cortisol and disrupts the development of new neural pathways.

THE MOTHER is the key to neurodevelopment …… because she is the RIGHT PLACE!!

It matters how we are born! It influences our emotional and social development, our future Emotional Quvalance and our life long emotional wellbeing.

Target population:
Educators, doctors, midwives, mothers

Intervention:
“Kangaroo Mother Care is a Basic Right of the newborn, and should be an integral part of the management of low birth weight and full term newborns, in all settings and at all levels of care, in all Countries.” – Bogota Declaration 1989.

Significance for education, practice, research, policy and or service user:
Extremely significant and relevant as we as midwives have been used to removing the baby in labour ward, putting him on the meco until the mother has birthed the placenta and the perineum is checked. Especially the caesarean section baby is then sent to a nursery until the mother is back from theatre. This has profound disruptive neurological impact on the baby’s brain. Health professionals and mothers need to be aware of this as the lifelong effects of maternal infant separation are seen during puberty and thereafter.

Recommendations and future actions:
“It is easier to build strong children than to repair broken men.”
- Frederick Douglass (1817–1895)

WHO MEC Wheel: 2015

Manala Makua

Possible Themes

• Evidence-based Midwifery practice, education and leadership.
• Strengthen midwifery education and other maternal neonatal, child and women’s health (MNCWH) workers’ education.

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