42nd Conference on Priorities in Perinatal Care in Southern Africa,

12-15 March 2024,

Western Cape,

ATKV Goudini Spa

SCIENTIFIC PROGRAM AND ABSTRACT BOOK

PRIORITIES IN PERINATAL CARE ASSOCIATION

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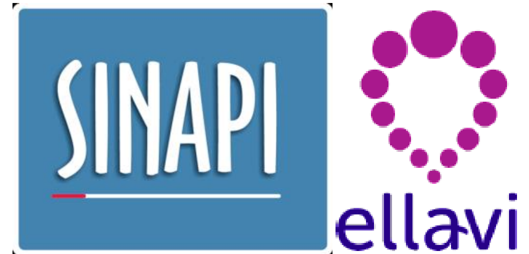
The 42nd Conference on Priorities in Perinatal Care in Southern Africa is convened by the Priorities in Perinatal Care Association

THANK YOU



Conference organiser and administrator
Cathy Bezuidenhout
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INVITED SPEAKERS

Professor Joy Lawn, BMedSci, MB BS, MPH, PhD, FRCPCH, FMedSci; Professor of Maternal Reproductive and Child Health Epidemiology, Twitter or X: @joylawn
Wikipedia profile

Joy is an African-born, British-trained paediatrician and perinatal epidemiologist with 30 years' experience notably in sub-Saharan Africa including trials, complex evaluation of newborn and child health services, and epidemiological burden estimates for WHO and UNICEF. Her paediatric and neonatal training were in the UK, followed by teaching, clinical care, implementation, and research, mainly in Africa. Her MPH was from Emory, Atlanta, USA, whilst at CDC, and her PhD at Institute of Child Health, London. For 10 years, she was based in Africa as the Director of Evidence and Policy for Saving Newborn Lives/Save the Children. She has been a professor at London School of Hygiene & Tropical Medicine for 10 years.

Her main contributions to global health have been developing the evidence-base to measure and reduce the global burden of 2.3 million neonatal deaths, 2 million stillbirths, and 15 million preterm births, including informing Sustainable Development Goal targets. She and her research team work on multi-country studies regarding newborn health, stillbirths, and child development worldwide, including implementation research on small and sick newborn care with NEST360 network at large scale across five African countries. She led novel estimates work on Group B Streptococcus (GBS) burden with WHO and others that has helped to accelerate progress towards more action including maternal immunisation. She has published >350 peer-reviewed papers with a H-index of >110, including leading several Lancet series and UN reports, with wide media and policy uptake. She was the co-editor and data scientist for both editions of the Born Too Soon report. She has served on WHO's STAGE, Global Statistics and GBS committees. She is a champion for equitable and diverse research leadership, and one of the few women nominated to membership of both UK Academy of Medical Sciences and USA National Academy of Medicine.

Professor Dilly ANUMBA

Dr Dilly Anumba (MBBS, FWACS, MD, FRCOG, LLM Medical Law) is Professor of Obstetrics & Gynaecology at the University of Sheffield, Honorary Consultant Obstetrician Gynaecologist and Subspecialist in Maternal and Fetal Medicine, Sheffield Teaching Hospitals NHS Trust. He is Faculty Director for Clinical Academic Training. He is Honorary Professor of Obstetrics and Gynaecology at the University of Cape Town South Africa.
Professor Anumba runs specialist clinics in Maternal and Fetal Medicine focusing on pregnancy screening, prenatal diagnosis and fetal therapy and prematurity prevention. His research focusses on the physiology of human birth, reproductive immunology, placental function disorders and preterm birth, and improving health equity for women/families. These are variously funded by the Department of Health and Social Care, DHSC (the National Institute for Health Research, NIHR), the Medical Research Council (DPFS and Knowledge Exchange Schemes) and the Engineering and Physical Sciences Research Council (EPSRC) amongst others. His UK research has "rippled out" into Global Health as Principal Investigator on the NIHR-funded Global Health Research Group on Preterm Birth Prevention and Management in LMICs (PRIME - involving researchers in South Africa, India, Bangladesh, Nigeria, and Ghana) and several studies funded by Research England's QF-GCRF scheme. Dilly serves on the Preterm Birth Committee of the International Federation for Obstetrics and Gynaecology (FIGO), the NIHR Advisory Group for Clinical Academic Training, and is Chair of four Selection Committees of the NIHR Academy including the Short Placement Award for Research Collaboration (SPARC) and the Global Health Research SPARC. He is one of the leaders of the Tommy's Centre for Maternity Improvement at the RCOG and served on the committee for the Saving Babies Lives Care Bundle version 3 of NHS England and NHS Improvement. He is a member of the RCOG Council representing Sub-Sahara Africa. He served two terms on the NICE Medical Technologies Evaluation Programme.

Dr Helen Payne

MBChB, BSc International Health, MRCPCH, PhD

I am a Clinical Lecturer at Imperial College London, dividing my time between research, teaching and working clinically as a registrar in Paediatric Infectious Diseases and Immunology at St Mary's Hospital in London. I am also an honorary Clinical Lecturer at Stellenbosch University.
My research interests are in congenital infection, co-infections and understanding the role of immune activation in driving or inhibiting infections. The theme of my current work is exploring the host-immune response to cytomegalovirus (CMV) in infants and immunosuppressed children and young people, and I am running several studies within this theme.
TINI-CC is a national observational study in the UK which aims to identify biomarkers or algorithms that are predictive of long-term and late-onset disease in congenital CMV using transcriptomic, immunological and radiological features associated with neurodevelopmental and hearing outcomes. The CHERI study examines both congenital and postnatal CMV infection in very low birth weight and premature infants at Tygerberg Hospital. Finally, a study called CHECKPOINT examines how co-

infection with HIV and EBV or CMV may be associated immune activation and dysregulation, and subsequent increased risk of lymphoma, cardiovascular and respiratory disease.

Professor Mushi Matjila

Mushi Matjila is Professor and Head of the Department of Obstetrics and Gynaecology Groote Schuur Hospital, University of Cape Town, Cape Town, South Africa. His clinical interests are embedded in High-Risk Obstetrics, Reproductive Medicine and Recurrent Pregnancy Loss.
Professor Matjila's research focuses on the molecular aspects of aberrant placentation, as well as maternal- fetal dialogue in placental-based disorders such as Preeclampsia, Recurrent Pregnancy Loss, Gestational Diabetes Mellitus and Assisted Reproduction. In particular, his research focuses on the reproductive roles of kisspeptin and angiogenic factors on trophoblast invasion and maternal immune tolerance.
He is Director and Principal Investigator of **H**uman **A**frican **M**olecular P**L**acental R**E**search Pla**T**form (HAMLET), housed in the Department of Obstetrics and Gynaecology at Groote Schuur Hospital. HAMLET aims to harness modern approaches and technologies to understand human placental development and function. Through HAMLET, we aim to forge a transdisciplinary intra-African network by training African basic science and clinical postgraduate students with the with the intent of improving maternal and perinatal health in South Africa and on the continent.
Prof Matjila is current Chair of the Faculty Research Equipment Committee (FEC), member of University Equipment Committee (UEC) and Senate member of the University of Cape Town.
Prof Matjila has a Ministerial appointment as Chair of the National Health Research Committee (NHRC)- the Ministerial Advisory Committee on Research for Health. He is serving a second term as Chair of the Academic Liaison Committee of the South African Society of Obstetricians and Gynaecologists (SASOG).
He has been involved in the organization of local and international conferences, including serving as Chair of the Abstract Committee for the World Congress of the Royal College of Obstetricians and Gynaecologists (RCOG) hosted in Cape Town. He has served as Section Editor for *BMC Women's Health* and is Reviewer for numerous journals, including the *European Journal of Obstetrics and Gynaecology and Reproductive Biology (EJOGRB)*, *Biology of Reproduction (BOR)* and *Neuroendocrinology (NEN)*. Prof Matjila serves on the Editorial Board of the *American Journal of Obstetrics and Gynaecology Global Reports* (*AJOG Global Reports*).

Ms Thobekile J. Mpembe

Deputy District Director: Uthukela District KZN & NaPeMMCo Chairperson
Thobekile holds a Bachelor of Nursing Science Degree from the University of North West and Post Graduate Diploma in advanced Midwifery and Neonatal Care from Kwa-Zulu Natal College of Nursing, Post graduate Diploma in Nursing Education and Nursing Management from University of South Africa and Post graduate diploma in advanced HIV Management with University of Kwa-Zulu Natal (UKZN). She holds a Masters Degree in Public Health obtained at the UKZN. Currently a Doctoral candidate in Public Health UKZN.
She has been a Professional Nurse Midwife since 1999 at GJ Crookes hospital and an Advanced Midwife who has been an MNCWH Programme Manager At Harry Gwala Health District in KZN and has served as an Assistant Manager Obstetrics, Gynae and child health. Currently serving as a KZN Society of midwives secretariat and was nominated to represent the DOH in the UNFPA as member of the reference group. She has served as a member of District Clinical Specialist Teams as an advanced midwife where her responsibility were mainly clinical governance ensuring mentorship and support for the midwives in the entire Uthukela health district.
Currently a Chairperson for a Ministerial advisory committee (National Perinatal Morbidity & Mortality Committee) & a Deputy Director Clinical & Programs – Uthukela (KZN)

Joyce Mahuntsi

Joyce Mahuntsi completed her Diploma in Nursing Science majors: General, Midwifery, Community and Psychiatry nursing in 1993 at the former Baragwanath Nursing College. Her Nursing career started in 1994 in Mpumalanga province, Themba Hospital. She moved back to Chris Hani Bara Hospital to spent almost 14 years of clinical experience in the Maternity and neonatal services. She went ahead to do her Diploma in Advanced Midwifery and Neonatal Nursing Science from Baragwanath Nursing College Nursing College in 2001.
Still in the Clinical setting Started her postgraduate B Cur degree at the University of Pretoria part time in 2010, continued to do her Master's Degree in Nursing9 Clinical fields and graduated in 2013. She moved from the clinical experience and moved to the Ministry of Health, National department of Health as Assistant Director for Neonatal Health and later got senior position, where she is currently Deputy Director For Maternal and

Neonatal Services with key focus areas of policy and guidelines development, program management of the maternal and neonatal services for the country to improve the health services to mothers and babies.

Dr Sylvia Cebekhulu is a Specialist Obstetrician and Gynaecologist.
Presently the head of Obstetrics and Gynaecology in Brits hospital, an associate lecturer at Sefako Makgatho Health Sciences University.
She is the Chairperson of the NCCEMD, member of the SA-Society of Obstetricians and Gynaecologist (SASOG), Critical Care Society of SA (CCSSA) and the College of Medicine of SA (CMSA),
She's a researcher, author and editor of the International Journal of Obstetrics and Gynaecology (IJGO)
She has special interest in critical care and infectious disease with special focus on maternal sepsis.

SCIENTIFIC PROGRAM

Scientific program

DAY 1 – TUESDAY, 12 March 2024

12h00 – 17h00	Registration desk open – Delegates to check in and collect their keys from reception
12h00	Packed lunch available at registration desk

16h00-18h00	**Session 1: Pregnancy outcomes, Monitoring and Postnatal Care of Neonates** Chairperson: Neil Moran

Keynote	**Stillbirths and Small Vulnerable Newborns: Priorities in Action and Research to Change Flatlines in South Africa and Across the World**	**Joy Lawn**

Paper 1	THE PREVALENCE AND PREGNANCY-RELATED OUTCOMES OF SMALL FOR GESTATIONAL AGE NEWBORNS DELIVERED AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL 2020 - 2021	Sylvia Ubeh
Paper 2	COMMUNITY-BASED POSTNATAL CARE MODEL: A CATALYST FOR POSTNATAL WOMEN ON THE MANAGEMENT OF NEONATES	Joyce Shirindza
Paper 3	DEVELOPMENT OF A RESOURCE DOCUMENT FOR THE FEEDING OF PRETERM AND LOW-BIRTHWEIGHT NEWBORNS	Elise van Rooyen

Paper 4	A QUALITY IMPROVEMENT INITIATIVE TO INCREASE THE NUMBER OF MOTHERS WHO INITIATE BREASTFEEDING WITHIN THE FIRST HOUR POST CEASARIAN SECTION IN HUMANSDORP HOSPITAL	Joyce Makgatho
Paper 5	HOW IS TSHWANE DISTRICT FARING WITH KANGAROO MOTHER CARE PRACTICE AND SERVICES?	Elise van Rooyen

18h00 – 19h00	Exco Meeting
19h00 – 20h00	Dinner – Restaurant

DAY 2 – WEDNESDAY, 13 March 2024

07h00	Breakfast – Restaurant
07h00	Registration desk opens

07h30-10h00	**Session 2: Outcomes in Maternal Care and Quality Improvement** Chairperson: Stefan Gebhardt

Keynote	**Saving Mothers 2020-2022 Triennial Report on Confidential Enquiries into Maternal Deaths in South Africa**	**Sylvia Cebukhulu**

Paper 1	RANDOMIZED TRIAL OF EARLY DETECTION AND TREATMENT OF POSTPARTUM HAEMORRHAGE: RESULTS OF THE E-MOTIVE TRIAL	Sue Fawcus
Paper 2	RAPID RESPONSE, E-MOTIVE AND SUCTION TAMPONADE FOR POSTPARTUM HAEMORRHAGE (ARREST PPH): A QUALITY IMPROVEMENT PROJECT	Justus Hofmeyr
Paper 3	USE OF THE ELLAVI UTERINE BALLOON TAMPONADE IN MALI, IN THE MANAGEMENT OF IMMEDIATE POST-PARTUM HAEMORRHAGE IN FIVE CASES	Felix Sanogo
Paper 4	IMPLEMENTING RESEARCH EVIDENCE TO REDUCE SEVERE POST-PARTUM HAEMORRHAGE (PPH): BEYOND THE EMOTIVE TRIAL	Neil Moran

Paper 5	AN AUDIT OF THE INDICATIONS FOR PERIPARTUM HYSTERECTOMIES PERFORMED AT A TERTIARY FACILITY	Nakedi Mmabatswa
Paper 6	AN AUDIT OF MATERNAL MORTALITY AND NEAR-MISS CASES AT NELSON MANDELA ACADEMIC HOSPITAL	Akona Kama
Paper 7	CONTINUITY FOR EFFECTIVE CARE COORDINATION: A MIXED METHODS STUDY BASED ON THE OBSTETRIC NEAR MISS APPROACH	Samuel Mulongo

10h00 – 10h30	Morning tea

10h30 - 13h00	**Session 3: Antenatal Care and Contraceptives** Chairperson: Sthandwa Mnqayi

Keynote	Prevention of Preterm Labour	Dilly Anumba

Paper 1	TEENAGERS' PERCEPTIONS OF CONTRACEPTION USE AND SUPPORT REQUIREMENTS TO PREVENT TEENAGE PREGNANCIES: A SOUTH AFRICAN STUDY	Kathleen Froneman
Paper 2	CAREGIVERS' PERCEPTION ON ADOLESCENTS' ACCESS ON, USE OF AND SUPPORT NEEDED TO PREVENT UNWANTED PREGNANCIES	Tinda Rabie

Paper 3	NESTED QUALITY IMPROVEMENT INTERVENTIONS TO PROMOTE SUB-DERMAL IMPLANTS UPTAKE, SAFE ABORTION USAGE AND UPTAKE AT EHLANZENI DISTRICT	Themba Chauke
Paper 4	INFORMATIONAL CONYINUITY BY CONTINUTY BY SKILLED BIRTH ATTENDANTS DURING ANTENATAL CARE IN LESOTHO	Angelina Zhangasha
Paper 5	PROFESSIONAL NURSES' PERCEPTIONS OF PROVIDING CONTRACEPTIVES TO ADOLESCENTS AT PRIMARY HEALTH CARE FACILITIES.	Tinda Rabie
Paper 6	THE PERFORMANCE OF ADVANCED ANTENATAL CARE -TRAINED MIDWIVES AND BIRTH OUTCOMES IN A PRIMARY HEALTHCARE SETTING	Winnie Motlolometsi
Paper 7	ENHANCING PERINATAL CARE IN RESOURCE-LIMITED SETTINGS: IMPLEMENTING AN ONLINE TRAINING SYSTEM FOR CARDIOTOCOGRAPHY AND OBSTETRIC CRISIS TRAINING IN THE WESTERN CAPE DEPARTMENT OF HEALTH AND WELLNESS, SOUTH AFRICA	Abigail Blumenthal & Maria Lagrimas-Botha

13h00 – 14h00	Lunch – Restaurant

14h00 – 16h00	**Session 4: Maternal Diseases and Perinatal Outcomes** Chairperson: Sibongile Mandondo

Keynote	Placenta Mediated Disorders: Contrivution to Preterm Birth and Adverse Perinatal Outcomes	Mushi Matjila

Paper 1	GLYCAEMIC CONTROL IN PREGNANCY DIABETES: BIOPSYCHOSOCIAL CHALLENGES AND SUBOPTIMAL CONTROL	Pumza Mjuleka
Paper 2	MIDWIVES' SKILLS OF DIAGNOSING HYPERTENSIVE DISORDERS DURING PREGNANCY IN VHEMBE DISTRICT, SOUTH AFRICA	Sonto Maputle
Paper 3	COMPARATIVE ANALYSIS OF PRE-ECLAMPSIA RATES IN WOMEN WITH AND WITHOUT HIV IN THE MODERN ART ERA IN BOTSWANA: RETROSPECTIVE COHORT	Bridgette Wamakima
Paper 4	PERINATAL OUTCOMES IN WOMEN WITH HYPERTENSIVE DISORDERS OF PREGNANCY AT A TERTIARY HOSPITAL IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.	Luvuyo Madikizela

Paper 5	EXTENDED BALLOON LABOUR INDUCTION: A SINGLE ARM PROOF OF CONCEPT TRIAL	Justus Hofmeyr
Paper 6	STEPS OF A SAFE CAESAREAN SECTION: A DELPHI STUDY OF SOUTH AFRICAN EXPERTS AS A BASIS FOR SURGICAL TRAINING	Liesl de Waard

16h00 – 16h30	Afternoon Tea

16h30 – 18h30	**Session 5: Histopathology in Still Births and Perinatal Infections** Chairperson: Firdose Nakwa

Keynote	**Prevention, Diagnosis and Management of Congenital Cytomegalovirus Infection**	**Hellen Payne**

Paper 1	STILLBIRTHS AND INTRAUTERINE FETAL DEATH: ROLE OF ROUTINE HISTOPATHOLOGICAL FINDINGS TO DETERMINE CAUSE OF DEATHS AND IMPROVE ANTENATAL CARE	Sibongile Mandondo
Paper 2	THE UGLY FACE OF PERINATAL SYPHILIS IN A RURAL REGIONAL HOSPITAL IN NORTHERN KZN.	Ingrid Gasarasi
Paper 3	SYPHILIS IN PREGNANCY IN THE CAPE TOWN METROPOLITAN DISTRICT: LABORATORY TESTING PATTERNS, MANAGEMENT, AND OUTCOMES OF GESTATIONAL SYPHILIS BETWEEN 2017 AND 2022 USING ROUTINELY COLLECTED ELECTRONIC HEALTH DATA.	Jessica Gammon
Paper 4	EFFECTS OF THE COVID-19 PANDEMIC ON EARLY INFANT TESTING AND DIAGNOSIS OF HIV, IN CAPE TOWN SOUTH AFRICA	Hendrike van Vollenhoven

18h30 – 19h00	Priorities In Perinatal Care Association Annual General Meeting All conference attendees: your inputs are important! A very short meeting where you, as part of the conference, can give your input on conference matters. Please join us for 15 minutes.

19h00 – 20h00	Dinner – Restaurant

DAY 3 – THURSDAY, 14 March 2022

07h00	Breakfast – Restaurant
07h00	Registration desk opens

07h30-09h30	**Session 6: Complications and monitoring outcomes in neonatal care** Chairperson: Natasha Rhoda

Keynote	**Small and Sick Newborns: Implementing for Faster Impact and Gentler Care in South Africa and Across the Continent**	**Joy Lawn**

Paper 1	PLACENTAL PATHOLOGY OF NEONATES DIAGNOSED WITH ENCEPHALOPATHY SOON AFTER BIRTH: A RETROSPECTIVE ANALYTIC STUDY	Lorraine Sebolai
Paper 2	BLOOD CULTURE AND TIME TO POSITVITY RATES, PATHOGENS AND THEIR ANTIMICROBIAL SUSCEPTIBILITY, IN NEONATES WITH POSSIBLE SERIOUS BACTERIAL INFECTION ADMITTED AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL	Kelly Wong
Paper 3	A DESCRIPTION OF HYDROCORTISONE USE AND OUTCOMES IN INOTROPE RESISTANT HYPOTENSIVE PRETERM NEONATES AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL	Raymond Tsakila
Paper 4	INCIDENCE, CHARACTERISTICS, MANAGEMENT AND OUTCOMES OF NEONATES WITH PATENT DUCTUS ARTERIOSUS (PDA) AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL	Delisha Naidoo
Paper 5	CAUSES AND OBSTETRIC FACTORS ASSOCIATED WITH TIMING OF NEONATAL DEATHS IN SOWETO, SOUTH AFRICA	Admire Chikandiwa
Paper 6	FROM PRE-IMPLEMENTATION TO INSTITUTIONALIZATION: LESSONS FROM SUSTAINING A PERINATAL AUDIT PROGRAM IN SOUTH AFRICA	Natasha Rhoda

09h30 – 11h30	**Room 1 09:30-11:30**	**Room 2 09:30-11:30**	**Room 3 09:30-11:30**	**Room 4 09:30-11:30**
	Workshop on Research Methodology and Scientific Writing **Joy Lawn and Sithembiso Velaphi**	Panel Discussion: Is Neonatal Nursing training a Dead Baby in SA? Panel discussion with leading academia , clinical staff, SANC **NNASA Neonatal Nurses Association of SA**	Perinatal Palliative Care, Ensuring a continuum of Care in the face of uncertainty. **Tracy Rawlins, Sue Boucher, Samantha Govender**	Respectful Maternity Care, Maternal Mental Health, and Intimate Partner/Domestic Violence: Three new chapters in the upcoming National Integrated Maternal and Perinatal Care Guideline for SA **Simone Honikman**
	Room 1 09:30-11:30	**Room 2 09:30-11:30**	**Room 3 09:30-11:30**	
	Workshop on Research Methodology and Scientific Writing **Joy Lawn and Sithembiso Velaphi**	Panel Discussion: Is Neonatal Nursing training a Dead Baby in SA? Panel discussion with leading academia , clinical staff, SANC **NNASA Neonatal Nurses Association of SA**	Perinatal Palliative Care, Ensuring a continuum of Care in the face of uncertainty. **Tracy Rawlins, Sue Boucher, Samantha Govender**	

11h30 – 12h00	Tea

12h00 – 14h00	**Room 1 12h00-14h00**	**Room 2 12h00-14h00**	**Room 3 12h00-14h00**

	Workshop on Artificial intelligence in Neonatology: The Pros, The Cons, The Unknown **Marianna Kruger, Lizelle van Wyk**	Workshop on Evidence-based Prevention and Management of Post-Partum Haemorrhage **Justus Hofmeyr, Neil Moran, Sue Fawcus**	Workshop on Birthing positions **Margreet Wibbelink** **Room 3** **12h00-14h00** Workshop on Birthing Positions **Margreet Wibbelink**

14h00	Lunch – Restaurant

	Free afternoon, no tea

19h00 – 20h00	Dinner – Restaurant

DAY 4 – FRIDAY, 11 March 2022

	Check out and hand keys in at registration desk during breakfast before session commences
07h00	Breakfast – Restaurant
07h30	Registration desk opens

08h00 – 09h30	**Session 7: Maternal and Neonatal Guidelines, Adverse Outcomes and Compassionate Care** Chairperson: Spencer Nkosi

Keynote	**National Perinatal Morbidity and Mortality Committee (NaPeMMCo) Triennial Report: 2020-2022**	**Thobekile Mpembe**

Paper 1	NATIONAL INTEGRATED MATERNAL AND NEONATAL CARE GUIDELINES IN SOUTH AFRICA	Ellence Mokaba
Paper 2	EXPLORING DISSEMINATION AND IMPLEMENTATION OF MATERNAL CLINICAL GUIDELINES FOR USE IN PRIMARY HEALTH CARE FACILITIES – A QUALITATIVE STUDY FROM TWO COUNTIES IN KENYA	Eunice Atsali

Paper 3	COMPASSION IN MATERNITY SETTINGS: A DISCUSSION	Petronella Lunda
Paper 4	BEREAVEMENT AND SPIRITUAL SUPPORT IN PERINATAL CARE	Tracey Brand

09h30 – 10h00	Morning tea

10h00 – 12h00	**Session 8: Training & Mentoring in Maternal and Neonatal Care** Chairperson: Vanessa Booysen

Keynote	**Partnerships for Maternal and Neonatal Implementation and Research: How Can We Go Faster Together?**	**Joy Lawn**

Paper 1	MIDWIVES SELF-PERCEIVED CONFIDENCE IN THEIR KNOWLEDGE AND SKILLS IN KENYA: AN OBSERVATIONAL CROSS-SECTIONAL STUDY	Edna Tallam
Paper 2	EMPOWERING TOMORROW'S DOCTORS: NURTURING CRITICAL THINKING PROFICIENCY IN OBSTETRICS AND GYNAECOLOGY	Balandeli Sonti
Paper 3	NURSES' PERCEPTIONS REGARDING THEIR OWN PROFESSIONALISM ATTRIBUTES TO QUALITY NEONATAL, INFANT AND UNDER-5 CHILDCARE	Dibolelo Lesao
Paper 4	REGISTERED MIDWIVES'NEEDS FOR SUCCESSFUL MENTORSHIP OF STUDENT MIDWIVES IN LABOUR ROOMS IN THE NORTH WEST PROVINCE	Antoinette du Preez
Paper 5	MENTORSHIP NEEDS IN AN INTRAPARTUM SETTING- A MENTOR-CENTRED APPROACH- A QUALITATIVE DESCRIPTIVE STUDY	Kgomotso Mathope

12h00	Lunch
13h00	Airport busses depart

THE PREVALENCE AND PREGNANCY-RELATED OUTCOMES OF SMALL FOR GESTATIONAL AGE NEWBORNS DELIVERED AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL. 2020 - 2021

Ubeh Silvia, Odell Natalie, Georgiou Chrisanthi, Frank Nadiya
Department of Obstetrics and Gynaecology, Chris Hani Baragwanath Academic Hospital, University of Witwatersrand, Johannesburg, South Africa

ubehchidimma@yahoo.com

Abstract (including introduction, method, results, conclusions)

Small for gestational age (SGA) newborns refers to newborns whose birth weight are less than the 10th percentile for gestational age and gender for a specific population. SGA newborns are not only at risk of perinatal morbidity and mortality, but also have potential for morbidity later in life. There is lack of literature on the prevalence and perinatal outcomes associated with SGA newborns in South Africa

The study was a hospital-based retrospective, descriptive study done at the Department of Obstetrics and Gynaecology at Chris Hani Baragwanath Academic Hospital (CHBAH) in Johannesburg, from 1 October 2020 to 31 March 2021. SGA newborns were identified from the birth register. Data on the perinatal outcomes of the SGA newborns were collected from the maternity files of the mothers who delivered SGA babies. The prevalence of SGA was calculated as the number of SGA newborns per total number of newborns within the study period. Frequencies with percentages, median with interquartile ranges, and Box and Whisker plots were used for data analysis.

There were total of 7837 births at CHBAH from 1 October 2020 to 31 March 2021, out of which 834 were small for gestational age (SGA). Therefore, the prevalence of SGA from this study is 10.6%. Using non-probability sampling technique, 291 out of the 834 SGA newborns were included in the analysis. Among the mothers who delivered the SGA newborns, 77.7% were single and 71.5% unemployed. Overweight and obese mothers were 32.65% and 38.8% respectively. One-third of the mothers were multiparous (67.7%). 71.5% of mothers delivered by caesarean section. Among SGA babies, majority were male (56.0%) and about half of the SGA population were low birth weight (50.2%). Most of the SGA newborns (96.6%) had APGAR scores of ≥7 at five minutes. One out of the 291 SGA newborns demised within seven days of life (Early neonatal death). 29.5% were admitted to nursery/NICU.

Small for gestational age births is highly prevalent in South Africa. There is higher operative delivery and NICU admissions among SGA newborns.

Keywords: Small for gestational age, prevalence, perinatal outcomes, newborns

Dr Silvia Ubeh is an Obstetrics & Gynaecology Registrar at University of Witwatersrand. Obtained master’s degree in clinical epidemiology from University of Stellenbosch and postgraduate diploma in family medicine from University of Pretoria, South Africa. She obtained MBCHB from Nnamdi Azikiwe University Nigeria where she won several awards and graduated as the best graduating student. Passionate about Women’s and Child health, with interest in Maternal & Foetal Medicine.

COMMUNITY-BASED POSTNATAL CARE MODEL: A CATALYST FOR POSTNATAL WOMEN ON THE MANAGEMENT OF NEONATES

Katekani Joyce Shirindza, Thivhulawi Malwela, Sonto Maria Maputle. University of Venda, Thohoyandou

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Introduction

Early postnatal discharge is perceived as a factor that contributes to possible maternal, and neonatal complications and deaths. The implementation of postnatal care model is crucial to mitigate the morbidity and mortality of postnatal women and neonates during the first weeks of delivery. A postnatal care model was developed for use by primary caregivers in the management of neonates during the postnatal care period at the community.

Method

A mixed methods approach was used to develop the community-based postnatal care model. An inductive research approach was used to develop a model through four phases. The phases included phase 1 collection of empirical data; qualitative approach with 20 primary caregivers and quantitative approach with 100 attending midwives followed by data analysis and core concept emerged. Unstructured phenomenological individual interviews and checklists were used to collect data. Reflective field notes were documented. The collected and transcribed data were analysed using thematic coding and Statistical Package for the Social Sciences (SPSS) version 25. Phase 2 was concept analysis of core concept; community-based postnatal care. Phase 3, which is the focus of this paper was development of community based postnatal care model. The study was done in Limpopo district, South Africa.

Results

The findings indicated that postnatal women did not have a community-based model to manage neonates in the rural areas. A community-based postnatal care model that serves as a catalyst to assist postnatal women on the management of neonates was developed. The model followed a dynamic interactive process which consisted of agents, recipients, context, relationship phase, working phase and termination phase.

Conclusions

The participants compromised the provision of community-based postnatal care at home utilizing the traditional postnatal care skills. The developed model could contribute to the reduction in maternal and neonatal deaths within the communities.

Katekani Joyce Shirindza is a lecturer at the University of Venda within the Department of Advanced Nursing Sciences

DEVELOPMENT OF A RESOURCE DOCUMENT FOR THE FEEDING OF PRETERM AND LOW-BIRTHWEIGHT NEWBORNS

Elise van Rooyen[1], Fatima Gohar[2], Anne-Marie Bergh[1]
[1]University of Pretoria; [2] UNICEF ESARO
Email: elise.vanrooyen@up.ac.za

Abstract Background. A mapping exercise in 2021 of newborn care documents developed by governments and development partners in UNICEF's Eastern and Southern Africa region revealed critical gaps in the content of the feeding of preterm and low-birthweight (LBW) newborns. These included a lack of quality feeding information, outdated information, and little standardisation of appropriate feeding practices. Based on a need for the latest appropriate global feeding evidence and practical feeding experience in newborn care and kangaroo mother care (KMC), a living resource document for use by health care providers and health systems was developed and will be updated regularly.

Aim. To introduce conference delegates to the content of this document.

Methods. A review was conducted of systematic reviews, trials and guideline articles, guidelines by the WHO and other development agencies, and country guidelines related to the feeding of preterm and LBW infants.

Results The content of the document is organised into three focus areas: complexities of feeding small newborns, breastfeeding and breastmilk feeding, and alternative feeding methods. In addition, the document and several annexes contain a number of flow diagrams, tables, charts, tools for recording feeding practices, handouts, and job aids. The document has been distributed widely in the Eastern and Southern African countries, but also beyond. It has been used in training workshops for small and sick newborns in Somalia and South Africa. Clinicians use relevant sections for drafting standard operating procedures (SOPs) and protocols and select specific topics for individual in-facility training sessions. Individual health facilities reproduce the job aids and charts for clinical use.

Conclusion. The information in this resource document has many applications and sections of the documents can be individualised and contextualised according to the needs of a health facility or an administrative in a health system.
The document is available in electronic format at:
https://www.up.ac.za/media/shared/717/KMC/feeding-for-preterm-lbw-infants_technical-resource-doc_-v1.2-2023-10-23.zp243054.pdf

Elise van Rooyen was the head of the kangaroo mother care (KMC) unit at Kalafong hospital from July 1999 till December 2021 when she retired. She has been involved in KMC clinical care for 24 years and has taken part in KMC implementation research under the auspices of the MRC unit for Maternal and Infant health care strategies at Kalafong hospital. As part of the MRC unit team, she was involved in implementation projects in Africa. Currently she is a consultant for UNICEF ESARO office as technical advisor and extra-ordinary member of the Department of Paediatrics, Kalafong Hospital.

A QUALITY IMPROVEMENT INITIATIVE TO INCREASE THE NUMBER OF MOTHERS WHO INITIATE BREASTFEEDING WITHIN THE FIRST HOUR POST CEASARIAN

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Introduction

The South African National Guidelines encourages initiating breastfeeding within the first hour for optimal newborn's physiological adaptation, bonding and breastfeeding irrespective of the mode of delivery. In Humansdorp Hospital, the newborn babies born via Caesarean Section were not exposed to breastfeeding during the first hour of delivery.

Method

10 Healthcare workers in Humansdorp Hospital were trained on Quality Improvement Methodology. A team was developed to do root cause analysis and to use the Plan-Do-Study-Act process to test the following change ideas: (1) Buy-in and involvement of all staff including theatre staff through continuous encouragement (2) Allocation of the lower category of staff to relieve clinicians after delivery of a stable baby (3) Moving the screen to create more space on the theatre table to allow for breastfeeding (4) Re-introduction of birth companions to assist with skin-to-skin (5) Patient education on what to expect in theatre after the baby is delivered. The project was monitored on a monthly basis and staff motivated to sustain the improvement.

Results

Through continuous mentoring and coaching of the team, the project saw and improvement from 0% in August 2022 to an average of 70% in December 2023. There is improved communication and willingness to ensure that all the babies, except the ones who are sick, are initiated within 1 hour post C-Section. The team wanted to standardize allocation of a lower category nurse to theatre for C-Section, but due to shortage of staff this is sometimes not possible.

Conclusion

The project demonstrates that the quality improvement approach can analyse practices and make efforts to improve performance. New practices become the norm and revised policies and procedures are put in place to support this improvement and sustain the improvement.

Joyce is a Quality Improvement Advisor from Clinton Health Access Initiative with 20 years of experience working with healthcare facilities in SA and neighbouring countries. She obtained a bachelor's degree in nursing, Honour's Degree in Midwifery and Neonatal Nursing and Master's Degree in Public health. She is passionate about improving quality in health care settings.

HOW IS TSHWANE DISTRICT FARING WITH KANGAROO MOTHER CARE PRACTICE AND SERVICES?

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Abstract Background. Tshwane District has a history of KMC implementation since 1999. The District Clinical Specialist Team (DCST) has supported the KMC programme in the district since 2012. This included a quality improvement initiative to strengthen and implement KMC services in all hospitals in 2013/4. A need was identified to further strengthen KMC services in the 9 hospitals in the district, namely 2 central, academic hospitals, 1 provincial tertiary hospital, 1 regional hospital and 5 district hospitals.

Aim. To assess the state of KMC services and to conduct a series of refresher workshops in the district.

Methods. Two health-systems strengthening processes ran simultaneously in July 2023. All 9 hospitals in the district had to complete a survey regarding their KMC services and had to report on the current state of KMC in their respective hospitals as part of a series of 4 identical KMC refresher workshops organised by the DCST. The survey elicited information on the following: current status of KMC services and available space in the district; staffing; clinical care practices; achievements; strengths; and challenges.

Results *Workshops:* The hospitals were clustered into 4 subgroups, each to receive a KMC workshop. The workshop training content included an overview on the immediate and long-term benefits of KMC, the latest research on immediate KMC and demonstration on how to secure the infant safely in the KMC position. An extensive amount of time was spent on the theory and practice of feeding small and sick newborns which included an intervention stimulation technique to accelerate the transition from gastric tube to cup to breastfeeding and a feeding readiness assessment tool that evaluates the feeding ability of the infant and tracks the mother and baby's progress towards breastfeeding. A total of 105 delegates attended the workshops, with attendance per hospital ranging between 4 and 35.

Survey: One district hospital had no KMC services and one of the central hospitals only provided intermittent KMC. There were 84 continuous KMC beds in the district. Four hospitals had their KMC unit inside the neonatal unit, 1 has it adjacent to the neonatal unit and two had it in separate buildings, with their own staff complement. The annual rotations of nurses take place mainly in the district hospitals. Neonatal care in the KMC units varies between low care only and the addition of some high-care components (e.g. oxygen, IV fluids and antibiotics). Most of KMC newborns are followed up after discharge from hospital, with one hospital having a dedicated KMC follow-up clinic.

One achievement was the continuation of KMC and the integration of KMC practice in the neonatal services in all the hospitals that had implemented and strengthened their KMC during the previous outreach. Lessons emanating from the current outreach was the importance of having supportive supervision embedded in the functions of the DCST, working in multidisciplinary teams, having district-wide KMC refreshers every 2-3 years and improving on current gaps in KMC data collection.

Conclusion. Tshwane District was able to sustain KMC services during the past 10 years. However, despite great strides in KMC implementation, the road to continued sustainability remains challenging. This outreach initiative demonstrated the value of the DCST as a formal operational unit for the improvement of the quality of KMC services.

RANDOMIZED TRIAL OF EARLY DETECTION AND TREATMENT OF POSTPARTUM HAEMORRHAGE: RESULTS OF THE E-MOTIVE TRIAL

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INTRODUCTION
Delays in the detection or treatment of postpartum haemorrhage (PPH) can result in complications
or death. A blood-collection drape can help provide objective, accurate,
and early diagnosis of PPH, and delayed or inconsistent use of
effective interventions may be able to be addressed by a treatment bundle.
OBJECTIVES
Evaluate the effect of implementation of the E-MOTIVE intervention (blood collection drape and WHO treatment bundle) compared with usual care on PPH-related outcomes as well as on detection and management of PPH.
METHODS
We conducted an international, cluster-randomized trial to assess a multicomponent
clinical intervention for PPH in patients having vaginal delivery.
The intervention included a calibrated blood-collection drape for early detection of
PPH and a bundle of first-response treatments (uterine massage,
oxytocic drugs, tranexamic acid, intravenous fluids, examination, and escalation),
supported by an implementation strategy (intervention group). Hospitals in the control
group provided usual care. The primary outcome was a composite of severe
PPH (blood loss, ≥1000 ml), laparotomy for bleeding, or maternal
death from bleeding. Key secondary implementation outcomes were the detection
of PPH and adherence to the treatment bundle.
RESULTS
A total of 80 secondary-level hospitals across Kenya, Nigeria, South Africa, and Tanzania,
in which 210,132 patients underwent vaginal delivery, were randomly assigned
to the intervention group or the usual-care group. Among hospitals and patients with
data, a primary-outcome event occurred in 1.6% of the patients in the intervention
group, as compared with 4.3% of those in the usual-care group (risk ratio, 0.40;
95% confidence interval [CI], 0.32 to 0.50; P<0.001). PPH was
detected in 93.1% of the patients in the intervention group and in 51.1% of those in
the usual-care group (rate ratio, 1.58; 95% CI, 1.41 to 1.76), and the treatment bundle
was used in 91.2% and 19.4%, respectively (rate ratio, 4.94; 95% CI, 3.88 to 6.28).There were 28 maternal deaths in the usual-care group and 17 in the intervention arm.
DISCUSSION AND CONCLUSIONS
Early detection of PPH and use of bundled treatment led to a lower risk of the primary outcome, a composite of severe PPH, laparotomy for bleeding, or death from bleeding, than usual care among
patients having vaginal delivery. There is a need to scale up the intervention at global and country level beyond the research sites.

Obstetrician and Senior research scholar Dep Obs/Gyn UCT. Member of NCCEMD, Co PI for E Motive trial

RAPID RESPONSE, E-MOTIVE AND SUCTION TAMPONADE FOR POSTPARTUM HAEMORRHAGE (ARREST PPH): A QUALITY IMPROVEMENT PROJECT

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Introduction: The E-MOTIVE Study showed that in a research setting routine monitoring of blood loss and early bundled first response treatment reduces severe postpartum haemorrhage (PPH) by 60%.[1] For refractory PPH, a large observational study showed better outcomes with Jada suction uterine tamponade than with balloon tamponade, the current WHO recommendation.[2] We aimed to implement the principles of these recent advances in a setting without access to disposable blood loss monitoring drapes and Jada devices.

Methods: We conducted a quality-of-care improvement project at Princess Marina Hospital, Gaborone, Botswana. We held meetings with labour ward staff to reach consensus. We developed an implementation package including: (1) a PowerPoint presentation explaining the rationale of recent advances in PPH treatment, use of the reusable Maternawell tray for blood loss monitoring after birth, early implementation of the MOTIVE bundle for PPH, and early use of the improvised FG24 Levin tube for Suction Tube Uterine Tamponade (STUT) for refractory PPH; (2) We placed posters in the labour ward to reinforce the details of the project; (3) We provided mentorship by senior staff to encourage adherence to the intervention.

Results: Unstructured observations indicate good uptake of the E-MOTIVE bundle for first line treatment of PPH and early use of the STUT catheter for refractory PPH. Use of the Maternawell tray for blood loss monitoring has not yet become routine.

Conclusion: Recent innovations in the first-line and second-line management of PPH are well accepted by medical and midwifery staff. Institutionalizing the routine measurement of blood loss after birth requires further intervention.

Training materials are available on the 'Obstetric Skills Library' (Youtube).

References: 1 Gallos Iet al. Randomized Trial of Early Detection and Treatment of Postpartum Hemorrhage. N Engl J Med. 2023 Jul 6;389(1):11-21

2 Gulersen M, et al. Vacuum-Induced Hemorrhage Control versus Uterine Balloon Tamponade for Postpartum Hemorrhage. J Obstet Gynaecol Can. 2023 Apr;45(4):267-272

Conflict of interest: GJH has an interest as inventor of the Maternawell tray

Justus Hofmeyr works part-time at University of Botswana and at Walter Sisulu University, Eastern Cape. Our research focus is on novel innovations and clinical trials to improve childbirth outcomes in low-resource settings

USE OF THE ELLAVI UTERINE BALLOON TAMPONADE IN MALI, IN THE MANAGEMENT OF IMMEDIATE POST-PARTUM HAEMORRHAGE IN FIVE CASES

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Abstract

Introduction: Postpartum haemorrhage (PPH) is the leading cause of maternal deaths in low-to-medium income countries (LMICs), such as Mali.

Objective: The aim of this study was to determine the effectiveness and efficiency of the Ellavi UBT in the management of refractory immediate postpartum haemorrhage (IPPH).

Methodology: This is a case series, reporting on the success or failure of using a pre-assembled, free-flow uterine balloon system with free flow and controlled pressure in the management of IPPH, in the *Luxembourg Mother and Child University Hospital in Bamako, Mali*.

Results: *The sample consisted of five young women, aged 20 - 29 years, whom had parity greater than or equal to 3, who presented IPPH due to uterine atony. In all cases, the use of the Ellavi UBT completely stopped hemorrhaging, of which 60% was within 3 hours after inserting the free-flow UBT. In 1 case, the cervix was sutured due to a cervical tear before the Ellavi UBT was placed. It is the uterine retraction which is the insurance after the use of the free-flow UBT in all five patients. The free-flow UBT was proven to be 100% effective in stopping bleeding during PPH. Health professionals, of which 40% was midwives, reported that it was easy to use the device.*

Conclusion :
A pre-assembled, free-flow UBT is an innovative, easy to use solution to support IPPH due to uterine atony. It is effective and efficient, simple, minimally priced and very acceptable for LMICs. The free-flow and controlled pressure system, is considered one of the most effective weapons in the face of IPPH due to uterine atony.

Keywords : Effectiveness, Efficiency, HPPI by uterine atony, UBT - Ellavi.

Dr Sanogo**, **Felix, is a Specialist Doctor in Gynecology and Obstetrics in Bamako, Koulikoro, Mali. He is a monitoring-evaluator of health programs and projects as well as an expert in International Public Health and Humanitarian Action. In 2023, he has been appointed the vice-President of the National Counsil of the Order of Physicians of Mali and is seen as a powerful voice for maternal health.

IMPLEMENTING RESEARCH EVIDENCE TO REDUCE SEVERE POST-PARTUM HAEMORRHAGE (PPH): BEYOND THE EMOTIVE TRIAL

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Introduction

The EMOTIVE trial, which concluded in February 2023, demonstrated a 60% reduction in PPH-related complications in hospitals randomised to the EMOTIVE intervention. This study follows up the South African hospitals in the EMOTIVE trial, to evaluate the implementation of the EMOTIVE intervention a year after the end of the trial. Can EMOTIVE be integrated into birthing unit practices outside the trial setting, in order to make childbirth safer?

Methods

Seventeen South African hospitals were included in the EMOTIVE trial; of these, 7 were randomised to the EMOTIVE intervention, 7 to control (usual care) and there were 3 pilot site hospitals. Post-trial, all 17 hospitals have been given a year's supply of plastic calibrated drapes for measuring blood loss after vaginal delivery. All on-site research staff were withdrawn from the hospitals at the end of the trial. Intermittent telephonic follow-up and occasional on-site visits have been conducted by the local trial investigators to evaluate ongoing implementation of the EMOTIVE intervention in the year following the trial

Results

One year after the end of the trial, all 17 hospitals have an on-site midwife and doctor EMOTIVE champion. These champions, including at the control sites, have all been through a train-the-trainer course and are able to train the nurses and doctors at their site in the EMOTIVE protocol. Not all staff have yet been formally trained, but they also learn by participating in the management of PPH cases. All sites currently have access to calibrated drapes and are routinely using them to collect blood following vaginal deliveries. It has become normal practice even at the control sites and allows objective measurement of blood loss and early detection of PPH. Documentation of blood loss in observation charts and in the birth register remains inconsistent, but is improving. All the hospitals give positive feedback about EMOTIVE and are committed to sustaining the intervention

Conclusions

Early follow up suggests that it will be feasible to scale-up EMOTIVE to become the standard of care at all birthing units in South Africa. For this to happen, there must be reliable access to calibrated drapes or alternative equipment for measuring blood loss (eg trays), and regional Master trainers who can train and mentor facility-based champions

Neil Moran, Head of Clinical Department: Obstetrics and Gynaecology, KZN Department of Health, NCCEMD member and principal investigator for KZN for the EMOTIVE trial

AN AUDIT OF THE INDICATIONS FOR PERIPARTUM HYSTERECTOMIES PERFORMED AT A TERTIARY INSTITUTION IN JOHANNESBURG, SOUTH AFRICA: A RETROSPECTIVE STUDY

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ABSTRACT

Background: Peripartum hysterectomy (PH), the surgical removal of the uterus during or shortly after childbirth, is a critical procedure in maternal healthcare. Definitions of PH vary globally leading to challenges in understanding its occurrence. Our study aimed to provide comprehensive insights into PH in a South African context, investigating indications, demographic characteristics, clinical and histopathological diagnoses, complications, and outcomes.
Methods: A retrospective record review study design was used, focusing on PH cases at a tertiary facility in Johannesburg, South Africa. The study ran between January 2018 and December 2020. Medical records were systematically examined to identify trends, indications, and outcomes associated with PH. Data collection encompassed demographic characteristics, obstetric history, clinical indications, clinical and histopathological diagnoses, and complications. Data analysis used descriptive statistics, interrater reliability tests and comparative findings with previous South African studies.
Results: The study included 56 pregnant women who underwent PH, reflecting a diverse demographic spectrum. Pregnancy-related sepsis emerged as the most common indication, with an 88.8% histopathological confirmation rate. Abnormal placentation and uterine rupture were also common indications. Clinical and histopathological diagnoses exhibited a strong level of agreement (70.9%), emphasising the importance of accurate diagnostics. We found an evolving landscape of PH indications in our clinical setting, with pregnancy-related sepsis surpassing historical indications. Complications of PH included haemorrhage and bowel injury, with 26.8% of patients requiring intensive care. The study reported a maternal mortality rate of 21.4%, higher than in developed countries.

Conclusion: Our study found a shift in the primary historical indications such as uterine atony and uterine rupture in South Africa, with pregnancy-related sepsis emerging as the primary indication in recent years. Clinical assessment complemented by histopathological findings remains critical for improved obstetric complication management.

DR NR Mmabatswa, originally from Bochum, Limpopo, currently a fourth-year registrar at Wits department of obstetrics and Gynaecology.

AN AUDIT OF MATERNAL MORTALITY AND NEAR-MISS CASES AT NELSON MANDELA ACADEMIC HOSPITAL

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Background
Maternal near miss is a significant entity in the assessment of the quality of obstetric care, particularly at institutional level. It renders possible the assessment of events surrounding a woman surviving what would have been otherwise a fatal outcome during childbirth or within 42 days post termination of pregnancy. The World Health Organization introduced a tool that eases the identification of these cases and the interventions that were offered during their care. There have been several assessments of maternal deaths within South Africa but no such audit of maternal near miss cases has been carried out within the Eastern Cape Province, particularly in the rural regions.

Objectives
To establish the period prevalence of maternal near miss and maternal mortality cases and to identify their common causes and other associated factors.

Methods
A prospective cross-sectional audit was carried out at Nelson Mandela Academic Hospital over a six months period between January 2019 and June 2019 identifying all cases that met the WHO criteria for maternal near miss, together with maternal mortality cases.

Results
There were a total of 1706 live births, 228 maternal near miss cases and 24 maternal death cases. The institutional severe maternal outcome ratio was 147/1000 live births with an overall mortality index of 9.5%. The maternal near-miss ratio was 133.6/1000 live births, the maternal mortality ratio was 1406.8/1000 live births and the maternal near-miss/maternal mortality ratio was 9.5:1. The stillbirth rate was found to be 95.0/1000 births.

The leading causes of maternal near miss were found to be eclampsia (47.8%), abruptio placentae (19.7%), and post-partum haemorrhage (8.3%) and the leading causes of maternal death were eclampsia (29.2%), puerperal sepsis (25%), and post-partum haemorrhage (12.5%). All the maternal mortality cases were referred from lower levels of care, the vast majority of whom were from district hospitals (95.8% n=23), and only one from a community health centre (4.2% n=1). Interventions included blood transfusion (48.4%), laparotomy (20.6%) and admission to ICU (9.9%).

Conclusion
In this audit the MNMR and the MMR were comparable to other LMICs within sub-Saharan Africa, although these ratios were notably higher than the more urban areas within South Africa. The conditions that resulted in the highest fatality rate were potentially preventable conditions, namely eclampsia and puerperal sepsis. The majority of patients with life-threatening conditions were low risk patients and this emphasizes the need for a more vigilant surveillance of patients during the antenatal, intrapartum, and postpartum periods.

I am a specialist in Obstetrics and Gynaecology with a subspeciality in Urogynaecology and pelvic reconstructive surgery. I have experience in both public and private sector. I was born in Mthatha in the Eastern Cape graduated from Walter Sisulu University with a MBchB in 2009. I obtained my FCOG via the Colleges of medicine of South Africa in 2019 and my MMed in Obs and Gynae from Walter Sisulu University in 2020. I recently qualified as a Urogynaecologist in 2023, having trained at Groote Schuur Hospital/ UCT.

CONTINUITY FOR EFFECTIVE CARE COORDINATION: A MIXED METHODS STUDY BASED ON THE OBSTETRIC NEAR MISS APPROACH

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Abstract

Background:
The near-miss approach assumes that mothers facing life-threatening conditions like severe pre-eclampsia and postpartum hemorrhage share common risk factors. Among these women, those who survive (near-miss cases) can offer insights into the determinants of the near miss phenomenon.
Aims: To investigate elements of continuity and coordination leading to obstetric near misses.
Setting: A major referral hospital and its catchment population in *Kenya.*
Methods: Explanatory sequential mixed-methods design.
Results: Quantitatively, near miss survivors had lower continuity and coordination of care indices during antenatal visits (COCI=0.80, p=0.0026), (MCCI=0.62, p=0.034), and those with non-life-threatening morbidity in the first trimester were more likely to experience a near miss (aOR = 4.34, p=0.001). Facilities in the western region had a higher burden of near misses compared to the Eastern region. Qualitatively, three deductive themes were identified: *sequential coordination, parallel coordination and continuity*, along with factors classified as *access.* In mixed integration, poor continuity indices were explained by quality of interpersonal relationships and lack of woman centredness. Poor coordination among near misses was explained by inadequate teamwork between providers. Higher near-miss rates in the western region resulted from differences in human and physical resources.
Conclusion: Promoting woman-centered care, improving communication, teamwork and introducing innovative coordination roles like case and care managers can enhance continuity and coordination of maternal health care.
Contributions: This study contributes to our understanding of the challenges of continuity and coordination in maternal healthcare in resource-poor settings by applying the WHO operationalization of continuity and coordination using mixed methodology.

Dr. Sam Mulongo hold a PHD in Maternal and reproductive health Nursing from Stellenbosch University, a masters in clinical and Psychosocial Epidemiology from the University of Groningen, Netherlands. He is currently a post-doctoral fellow in the Faculty of Medicine and Health Science at Stellenbosch University. Dr. Mulongo has interest in advancing scholarship in person centred care in maternal health and is specifically interested in antenatal care models, coordination of care between levels of care and management of obstetric emergencies.

TEENAGERS' PERCEPTIONS OF CONTRACEPTION USE AND SUPPORT REQUIREMENTS TO PREVENT TEENAGE PREGNANCIES: A SOUTH AFRICAN STUDY

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Abstract (including introduction, method, results, conclusions)

Background: Teenage pregnancy continues to be a concern that affects high, middle, and low-income countries. Complications during pregnancy and childbirth are the leading causes of death between 17-19-year-old teenagers. The use of contraception and support to prevent teenage pregnancies is of utmost importance to help address this concern.

Objectives: To explore and describe teenagers' perceptions of the use of contraception and of the support they need to prevent teenage pregnancies in the Limpopo Province, South Africa.

Methods: A qualitative research strategy with exploratory and descriptive approaches was used in this study. Teenagers in the public secondary school with the highest pregnancy rate in its district in the Limpopo Province were purposively sampled. Data were collected from 23 participants using naïve sketch booklets with 12 questions. Data were analysed using content analysis.

Results: Three categories emerged, namely (1) opinion of contraception, (2) factors preventing the use of contraception and (3) help and support, each with respective themes.

Conclusion: Teenagers are knowledgeable about contraception methods, including condoms, oral contraceptives and injectables and their use. Participants also know the advantages, disadvantages, and areas to access contraception. However, there were different opinions on contraception, factors preventing the use and help, and the support needed.

Dr Kathleen Froneman is currently a senior lecturer at the School of Nursing Science, North-West University. She is passionate about presence, and about nursing education.

CAREGIVERS' PERCEPTION ON ADOLESCENTS' ACCESS ON, USE OF AND SUPPORT NEEDED TO PREVENT UNWANTED PREGNANCIES.

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Introduction: Hormonal or barrier contraception to prevent teenage pregnancy by adolescents is still a challenge in the 21 century, teenage pregnancies is concerning across the globe. This is even a greater concern in low- and-middle income countries, where the poverty, unemployment, education, and social challenges are higher.

Objectives: To explore and describe caregivers' perceptions of access (1) and the use of (2) contraception for adolescents in Lesotho and to explore and describe caregivers' perception of types of support needed for adolescents to prevent unwanted pregnancies (3).

Methods: A qualitative explorative, descriptive, and contextual design. Caregivers of adolescents were purposively sampled from public primary health care facility with the highest outpatient number in Maseru district, Lesotho. A total of (N=30) participants were included and data was collected through five focus groups with six participants each. Data were analysed using Creswell's six steps of data analysis with the assistance of a co-coder.

Results Three categories with their respective themes emerged. The categories included (1) access to contraception by adolescents, (2) use of contraception by adolescents, (3) and support to prevent unwanted pregnancies.

Conclusion: Contraception use among adolescents is a challenge. There is a need for supportive service providers with a positive attitude and user-friendly health services that is not rigid and discouraging for adolescents to access to receive contraception. Caregivers must also be accommodative with specific reference to cultural and religious practices and be knowledgeable on contraceptive types and use. School also needs to give age appropriate reproductive and sexual education to promote independent decision-making and prevent unwanted pregnancies.

Tinda Rabie is an Associate Professor at the North-West University, School of Nursing Science, Potchefstroom Campus, South Africa. She has National Research Foundation rating of C2. Her expertise is in community nursing science and primary health care, with specific focus on child, adolescent health, and reproductive health.

NESTED QUALITY IMPROVEMENT INTERVENTIONS TO PROMOTE SUB-DERMAL IMPLANTS UPTAKE, SAFE ABORTION USAGE AND UPTAKE AT EHLANZENI DISTRICT

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Abstract

Introduction: This is a case study of quality improvement (QI) interventions. The QI interventions implemented were based on the model of improvement, which aims to answer three fundamental questions to address gaps, what are we trying to accomplish? How will we know whether a change is an improvement? What changes can we make that will result in improvement? (1). The use of family planning promotes desired spacing in pregnancies and prevents unwanted pregnancies (2). Ehlanzeni district started QI interventions to promote the use of long-term acting reversible contraceptives (LARCs) and safe legal termination of pregnancy in public health facilities. These interventions were initiated to address health care providers' training gaps, insufficient skills and poor mentoring on insertion of LARCs.

Method: Ehlanzeni district implemented quality improvement interventions using the model of improvement to: 1. provide training of health care providers (HWCs) on the insertion of sub-dermal implants, 2. strengthen mentorship and support of HCWs after the training to ensure quality provision of family planning services, 3. Link family planning services with youth friendly services to address the gap of poor provision of contraceptives and safe abortion services to youth, and 4. Conduct community campaigns targeted at educating communities about safe abortions, awareness of available contraceptives in public health facilities and insertion of subdermal implants during campaigns.

Results: Training of 117 HCWs on the insertion of sub-dermal implants across the district, followed by intensive mentoring, improved youth friendly services in 45 primary health care facilities, overall subdermal implants insertion for Ehlanzeni district increased from 839 in year 2019 to 21 610 between 2021 – 2023. In the financial years 2019/20 and 2021/22, the district also experienced an increase in the use of legal termination of pregnancy from 3 751 to 10 603 respectively.

Conclusions: As observed from Ehlanzeni district QI interventions, it is evident that quality improvement interventions, facility support, and healthcare worker mentoring led to an increase in contraceptive usage, and sexual reproductive health services rendered in health facilities within the district.

Short Biography Themba Chauke is an Epidemiologist and a public health clinician working at Clinton health Access Initiative as a Quality improvement advisor for the sexual, reproductive, maternal, and neonatal health program.

INFORMATIONAL CONYINUITY BY CONTINUTY BY SKILLED BIRTH ATTENDANTS DURING ANTENATAL CARE IN LESOTHO

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Introduction: Informational continuity (IC) is one of the four approaches that enables integrated people-centred health services as described by the World Health Organisation (WHO). IC enables the availability of all health and psychosocial information of the pregnant women at all encounters with healthcare providers. WHO recognised that ineffective IC results in pregnant women receiving fragmented health care and duplication of services. Hence, IC is one of the measures that may assist in the reduction of maternal morbidity and mortality. The aim was to explore and describe the experiences of skilled birth attendants (SBAs) with IC during the antenatal period within three primary health care (PHC) settings in Maseru, Lesotho.

Research Methods and result

A qualitative approach with a descriptive phenomenological design was used with purposive sampling to choose nine participants from three PHC centres within Maseru district. Individual semi-structured interviews were conducted, transcribed and analysed using Colaizzi's framework. Four themes emerged; Theme one: SBAs and pregnant women information communication, theme two: information communication between the SBAs, theme three: information collection during ANC and theme four guidelines used during ANC to standardise care. Several challenges regarding information communication from the sources of information, transition of information, information between caregivers and women which demonstrated the frustration between the women during antenatal care and the SBAs leading to ineffective care coordination.

Conclusion: Enabling IC during ANC enables effective data collection from the sources of information, transition of information during care giving and within and between health facilities.

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PROFESSIONAL NURSES' PERCEPTIONS OF PROVIDING CONTRACEPTIVES TO ADOLESCENTS AT PRIMARY HEALTH CARE FACILITIES.

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Introduction**:**
Globally adolescent pregnancy is a concern, especially in low- and middle-income countries. The unmet need for contraception remains high among adolescents despite strides made within health systems to improve the availability and accessibility of contraceptives. Contraception do not only not only prevent pregnancy but also have added benefits such as alleviating menstrual pains, excessive blood flow, and acne which is also challenges to many adolescents. Professional nurses are on the forefront of all primary healthcare services. Adolescent pregnancy rates are alarming despite the availability of contraceptives in public primary health care facilities at no cost.

Objective:
To understand professional nurses' perceptions of providing contraceptives to adolescents at primary health care facilities in Lesotho.

Research design and method:
A qualitative research strategy with exploratory and descriptive approaches.
Primary health care facilities were purposively sampled in Lesotho (N=7; n=4); these facilities had the nearest proximity to schools and therefore the shortest walking distance for adolescents. All-inclusive sampling of professional nurses (N=22), of which (n=12) was willing to participate, resulting in a 55% response rate. Data collection was done through semi-structured open-ended interviews with the use of an interview schedule. Audio recordings were transcribed verbatim. Data were analysed using qualitative content analysis, with the assistance of an independent co-coder who was fluent in Sesotho.

Results:
Six categories with their respective themes were extracted from the data. The categories included: (1) perceptions of contraception use; (2) perceptions of consulting adolescents at primary healthcare facilities; (3) perceptions of adolescent pregnancy; (4) advice to adolescents using contraception; (5) challenges to effective service provision; and (6) improvement of service provision. The study's findings revealed that, in general, professional nurses perceive the provision of contraceptive services to adolescents as an essential primary healthcare service, although faced with various challenges. They are concerned with the current adolescent pregnancy statistics in their communities and the detrimental effects it has brought to both the adolescents and their families, as well as its relativity to poverty.

Tinda Rabie is an Associate Professor at the North-West University, School of Nursing Science, Potchefstroom Campus, South Africa. She has National Research Foundation rating of C2. Her expertise is in community nursing science and primary health care, with specific focus on child, adolescent health, and reproductive health.

THE PERFORMANCE OF ADVANCED ANTENATAL CARE -TRAINED MIDWIVES AND BIRTH OUTCOMES IN A PRIMARY HEALTHCARE SETTING

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Abstract

Introduction
The transfer of learning depends on various factors, such as the programme design, transfer climate, and environment. Individual and organisational performance are indicators of learning transfer. The aim of the study was to describe the performance of the Advanced Antenatal Care (AANC) trained midwives and the birth outcomes in primary healthcare settings.

Method
A cross-sectional, quantitative study was conducted in two purposely selected districts of a South African province. All AANC midwives operating in the selected districts were included in the study. Document analyses were done using the National Department of Health Ideal Clinic dashboard and the standardised Quality Check for Antenatal Records tool. Statistical Analysis Software version 9.4 was used for descriptive statistical data analysis.

Results
Seventeen (68%) clinics in TM, and six (22%) in LJ achieved Ideal Clinic status. The scores for management of low- and high-risk pregnancies ranged between 86-89% and 87% respectively. Babies of mothers with high-risk pregnancies had Apgar scores of between 7 and 9 (in 1 minute) and 8 and 10 (in 5 minutes) in both districts. The performance of the midwives was good, although they were working in less-than-Ideal primary health care (PHC) clinics. Despite poor clinical data interpretation, women were generally well managed. The babies had good Apgar scores.

Conclusions
An AANC programme is recommended for upscaling of midwives to strengthen antenatal care services. Furthermore, strengthening curriculum design of the AANC programme is suggested, based on midwives' poor interpretation of assessment.

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Provincial midwife specialist, Free State province (2011 – 2015).
Co- Pioneer of the AANC programme in the Free State province.
Member and vice-president of the Society of the Midwives of the Free State (SOMSA).
Member of the Council - International Confederation of Midwives (ICM)

ENHANCING PERINATAL CARE IN RESOURCE-LIMITED SETTINGS: IMPLEMENTING AN ONLINE TRAINING SYSTEM FOR CARDIOTOCOGRAPHY AND OBSTETRIC CRISIS TRAINING IN THE WESTERN CAPE DEPARTMENT OF HEALTH AND WELLNESS, SOUTH AFRICA

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In resource-limited settings, access to comprehensive training in perinatal care is often challenging both to provide and to attend, leading to gaps in addressing critical maternal and fetal care needs. To bridge this gap, the Western Cape Department of Health and Wellness has introduced improved access and flexibility to skills development by adopting an online training system for cardiotocography (CTG) and obstetric crises for staff in provincial health facilities. This initiative aims to empower obstetric and midwifery professionals by providing accessible and interactive educational resources, thereby improving their proficiency in interpreting fetal heart rate patterns and management of obstetric emergencies crucial for effective perinatal care.
Through this conference presentation, we will share our experiences, challenges, and successes in rolling out the online perinatal training system. We will highlight the impact on skills development which leads ultimately to improving perinatal outcomes in resource-limited settings. We will present staff feedback on their experiences using the system and how barriers to access were overcome.
We will also discuss the potential benefit of this initiative in reducing obstetric litigation costs by improving clinical decision-making and reducing adverse perinatal outcomes. By optimizing the online training platform to meet evolving user needs, this project demonstrates promise in enhancing perinatal care and mitigating the financial burden associated with obstetric litigation.

Dr Abigail Blumenthal, Obstetrician and Gynaecologist in the Maternity Centre at Groote Schuur Hospital, completed FCOG (SA) in 2021, completed Medicine at the University of Cambridge, UK in 2009.
Maria Lagrimas-Botha, Programme Coordinator: Clinical Training at the People Development Centre, Western Cape Department of Health and Wellness. Completed B.CUR (2010), M.CUR - Nursing Education (2015), PGD in Public Health (2022).

GLYCAEMIC CONTROL IN PREGNANCY DIABETES: BIOPSYCHOSOCIAL CHALLENGES AND SUBOPTIMAL CONTROL

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INTRODUCTION

Diabetes is commonly encountered in pregnancy and the burden of disease **is high in low-income countries and continues to increase rapidly. Women of low-income countries experience numerous biopsychosocial challenges that impact treatment adherence. They also experience higher rates of complications resulting in significant adverse obstetric and perinatal outcomes.** Long-term cardiometabolic risks also exist for both mother and infant.

Treatment guidelines for diabetes in pregnancy are largely derived from high-income countries. Modifications to treatment guidelines may be required to meet the unique challenges faced by pregnant women with diabetes from low-income countries. **We aimed to** identify and describe the biopsychosocial factors that are associated with poor glycaemic control in women with diabetes in pregnancy attending Tygerberg Hospital's high risk antenatal clinic.

METHODS

The study is a descriptive, cross-sectional survey conducted in the Obstetric Department of Tygerberg Hospital from May 2023 to November 2023. A total number of 111 patients were enrolled into the study. We recruited participants that were admitted to the antenatal wards for suboptimal glycaemic control.

Data was collected using two instruments: a biological data sheet and a newly developed and validated questionnaire. The biological data sheet was used to collect information contained in the patient's maternity case record. The questionnaire assessed five domains: diet and physical activity, diabetes in pregnancy knowledge and glucose control, biological factors (bothersome pregnancy-related symptoms, symptoms of hyperglycaemia, medication-related factors), psychological factors (cognitive load, information retention, mood symptoms), and social factors (poor social support, life chaos, and poverty).

RESULTS

Data is available on 109 women. The mean age was 33 years with a range of 19-44 years. Median gravidity 3 (1-8) and median parity 2 (0-4). A mental health screen at booking was done on 78 (71%) and 4 were referred for further counselling. A family history of diabetes was present in 66 (60%). Alcohol and/or tobacco use was reported by 22 (20%). Of the 109 women, 10 had gestation diabetes (9%), and 24 (22%) met criteria for overt diabetes first diagnosed in pregnancy. A further 30 (27%) had pregestational diabetes type 1 and the rest 45 (41%) had pre-gestational type 2 diabetes.

37 women admitted to snacking on high-sugar food in between prescribed meals 2-4 times per week, a further 11 does this 5-6 times a week and 14 does this daily. The rest only once a week or less often. 21 Women (19%) said it was difficult to follow lifestyle advice due to cost and lack of income. 63 (58%) women exercise at least once a week or more. 58 (53%) women needed insulin in addition to oral drugs to control blood sugar. Yet 52 of the total group admit to forgetting to take their medication from time to time (32 of this 52 are using insulin). 15 women admitted to going without food for 24 hours sometimes because there is not enough money to buy food. 21 admitted to going to sleep hungry due to a food shortage. 59 women (54%) were unemployed. On average, a household consists of the patient plus 4.5 other people (range 1-11). Only 34 women (31%) have regular meals three times a day.

CONCLUSION

A high number of women admitted for blood sugar control during pregnancy have food insecurity or dietary related challenges that could contribute to the poor control. The biggest challenge they experience in a healthy diet are hunger, cost and income, time constraints and social issues. This study highlights various challenges that must be taken into consideration and addressed when managing women from low-income areas with pregnancies complicated by diabetes. Practical treatment strategies tailored to meet these challenges are needed and may result in improved glycaemic control; however, more robust studies must be performed to prove this concept.

MBChB (Stellenbosch University), Obstetrics and Gynaecology Registrar; Work history: Helen Joseph and Rahima Moosa Mother and Child Hospital (Internship); Cecilia Makiwane Hospital (Community Service); Cecilia Makiwane and Frere Hospital (MO); Groote Schuur Hospital (MO); Worcester Hospital (Registrar); Tygerberg Hospital (currently); Qhakaza Kukhanye Foundation (Founding member of a youth development programme, focus area: teen sexual reproductive health and wellbeing)

MIDWIVES' SKILLS OF DIAGNOSING HYPERTENSIVE DISORDERS DURING PREGNANCY IN VHEMBE DISTRICT, SOUTH AFRICA

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Background: The district profiles of Limpopo Province indicate that hypertensive disorders during pregnancy contribute to 11.5% of maternal mortality, which is usually noticed post-delivery. Blood pressure monitoring, urinalysis, and accurate interpretation of blood investigations remain important in managing hypertensive disorders. The purpose was to assess the skills of midwives of diagnosing hypertensive disorders during pregnancy.
Method: The study was conducted at all eight facilities in three municipalities of Vhembe district; Collins Chabane, Makhado, and Thulamela. A quantitative research method with a cross-sectional descriptive survey was used. Purposive sampling of all eight hospitals which were providing maternal health care services in the district were included. The population comprised all midwives and advanced midwives working in maternity wards with the following inclusion criteria; two years of experience working in the maternity ward. Sampling of respondents included a total population of a total of 100 midwives who were available during the time of data collection participated. Structured questionnaires were used to collect data from 77 midwives. The Statistical Software Package (SPSS) version 26 was used to analyse data. Ethical standards were ensured by obtaining the ethical clearance (Ref: SHS/19/PDC/29/2708), from the university Ethics Committee.
Results: The diagnosing of hypertension focussed on history taking, blood pressure measurement, urinalysis, blood tests to be taken and interpretation, and the classification of hypertension. The midwives demonstrated the variable skills of blood pressure measurement, this ranged between 63.6% to 76,6 %. At the same time, knowledge of hypertensive classification was 81.8% to 96.1% and for history taking was 75%. The skill of interpreting the normal and abnormal investigation was above 70%.
Conclusion: Hypertensive disorders of pregnancy complicate up to 10% of pregnancies and remain the major cause of maternal and neonatal morbidity and mortality. Midwives showed reasonable knowledge and skills of diagnosing hypertensive disorders in pregnancy. Early and accurate diagnosis is essential to appropriately manage hypertension and reduce the risks. The correlation of theory and practice related hypertensive disorders should be enhance during the training of student midwives. In-service training by conducting drill practice regularly to support a quality and safe midwifery practice.

Keywords: Diagnosis, hypertensive disorders, pregnancy, midwives' skills

Short Biography

I am a Professor in the Faculty of Health Sciences at the University of Venda. Hold DCur Degree in Midwifery and Neonatal Nursing Science, an NRF C3 Rated researcher have successfully supervised/mentored 22 PhDs and 15 as a co-promoter, 30 master's and 13 as a co-supervisor and 66 honours students. I have authored 125 peer-reviewed articles in accredited Journals and 6 book chapters.

COMPARATIVE ANALYSIS OF PRE-ECLAMPSIA RATES IN WOMEN WITH AND WITHOUT HIV IN THE MODERN ART ERA IN BOTSWANA: RETROSPECTIVE COHORT

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Introduction: Pre-eclampsia is a major contributor to maternal mortality[1]. In women with HIV not on anti-retroviral therapy (ART), lower rates of pre-eclampsia were documented, likely related to HIV's impact on the maternal immune system. However, as ART usage increased, rates and severity of pre-eclampsia in pregnant women with HIV appeared to approximate and even surpass those in women without HIV.[2],[3] This study evaluated pre-eclampsia rates in a large cohort with high HIV prevalence where 95-95-95 targets to eliminate HIV have been achieved.

Study design: This analysis uses a convenience sample of data from the *Tsepamo Birth Outcomes Surveillance (*R01HD080471-01*)* and *Safe Birth* studies, which collected information from medical records on maternal and perinatal outcomes among women at 24+ weeks gestation with one or more infants/stillbirth at Princess Marina Hospital, Botswana's main tertiary referral hospital, from November 2021 to July 2023. Pre-eclampsia was defined using the American College of Obstetricians and Gynecologists guidelines.

Results: This analysis included 6982 delivering women. 1,336 (19%) were living with HIV, of whom 95% were on ART at conception, 93% of which were dolutegravir-based regimens and 93% were virally suppressed. There was no statistically significant difference in the rates of elevated blood pressures in pregnancy between women with and without HIV (36.2% v. 33.7%; p=0.07). There were no significant differences between those living with and without HIV observed for pre-eclampsia (9.1% versus 9.7%; p=0.49), eclampsia (0% versus 0.2%; p=1.0), HELLP syndrome (5.8% versus 4%, p=0.39), and superimposed pre-eclampsia (16.5% versus 19.8%; p=0.37). There was no difference in presence of severe features between the two groups.

Conclusions: Women with HIV may have similar risk of pre-eclampsia, eclampsia, and HELLP compared with women without HIV in a population where roughly 95% with HIV are on ART and virally suppressed.

Bridgette Wamakima, MD is an obstetrician/gynaecologist who completed her training at Beth Israel Deaconess Medical Center, a Harvard Teaching Hospital. She is currently a global health fellow at Brigham and Women's Hospital where she is focused on improving outcomes in maternal care in low-resource settings.

PERINATAL OUTCOMES IN WOMEN WITH HYPERTENSIVE DISORDERS OF PREGNANCY AT A TERTIARY HOSPITAL IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.

Authors, Institutions. Indicate presenter by underlining only the presenters name
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Background
Hypertensive disorders of pregnancy (HDP) significantly impact maternal and perinatal health globally.
Materials and Methods
A prospective cross-sectional study of perinatal outcomes of women admitted with HDP at NMAH from November 2022 to December 2022. Received ethical approval and written informed consent from participants. Data was extracted from maternal and neonatal hospital records.
Results
230 women with HDP contributed 38.4% of the burden of high-risk patients delivered at NMAH. Median age was 24.0 years (IQR 20.0-31.0). Median BMI was 28 (IQR 24-32) kg/m^2. Risk factors for HDP included previous history of eclampsia, (7.4%) chronic hypertension (4.3%), diabetes (3%) and antiphospholipid syndrome (0.4%). The overall admission gestational age was 35.0 (IQR 31.0-37.0) weeks. Preeclampsia patients booked at median gestational age of 22 (IQR 18-26) weeks. Patients with preeclampsia, eclampsia, chronic hypertension with superimposed preeclampsia, chronic hypertension, and gestational hypertension were admitted at 30 (IQR 28-32), 35.5 (IQR 32.8-37), 35.5 (IQR 32.75-37), 37 (IQR 35-37.5) and 35 (IQR 32-36) weeks of pregnancy, respectively. 77.4% (N=178) had preeclampsia, 15.2% (N=35) eclampsia, 0.9% (N=2) gestational hypertension, 3.9% (N=9) chronic hypertension with superimpose preeclampsia and 2.6% (N=6) chronic hypertension.Overall median SBP 158 (IQR 150-169) mmHg and median DBP 101 (IQR 95-110) mmHg at admission. Preeclampsia patients had the highest median SBP and SDP measurements, with median SBP 159 (IQR 150-171) mmHg and median DBP 101 (IQR 95-111) mmHg. There was a statistically significance difference in BP of preeclampsia patients with stillbirths and those with livebirths (SBP 160 (IQR 150-174)/ DBP 103 (IQR 95-113) versus SBP 157 (IQR 150-166) / DBP 98 (95-100) mmHg ($p < .001$). 76.1% (N=175) of patients were delivered by C/S. HDP-related complications occurred in 67.4% of patients. Median neonatal birthweight was 2310.0 (IQR 1682.5- 2900.0) g. Median 1 minute Apgar score was 8.0 (IQR 7.0-9.0), 5 minutes was 9.0 (IQR 8.0-10.0). 62 newborns needed respiratory support. Preeclampsia at 30 weeks had a higher perinatal mortality rate than at 36 weeks. HELLP syndrome and placenta abruptio were associated with poor outcomes. Newborns with high/normal Apgar scores 1.14 times more likely to live.
Conclusion
There is a high prevalence of preeclampsia, maternal and foetal complications among women referred to NMAH.

Dr Luvuyo Madikizela working in Obstetrics and gynaecology Department at Nelson Mandela Academic Hospital, Mthatha.

SESSION: 4 PAPER: 5

EXTENDED BALLOON LABOUR INDUCTION: A SINGLE ARM PROOF OF CONCEPT TRIAL

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Introduction: Mechanical labour induction with a transcervical balloon is as effective as pharmacological methods, with fewer adverse effects. We have developed an innovative approach using 2-3 balloons side-by-side to enable mechanical labour induction/augmentation with a cervix too dilated to retain a single balloon, rather than amniotomy or uterotonics.
Methods: We conducted a single arm proof of concept trial at Princess Marina Hospital in Gaborone, Botswana. Three Foley catheters taped symmetrically side by side were passed through the cervix and inflated with 60mls each. Clinical outcomes were recorded. Participants' satisfaction was assessed using a descriptive scale.
Results: We enrolled 20 participants of whom two were nulliparous. Indications for labour induction were mainly late term (70%) and hypertensive disorders of pregnancy (25%). The mean cervical score was 7.2. Overall, 17 (85%) of the participants achieved a vaginal birth, of whom 5 required oxytocin for labour augmentation. Four of these had requested removal of the balloons, one due to discomfort and three felt the process was taking too long. Three participants underwent caesarean birth. The mean time from initiation of labour induction to vaginal birth was 16 hours (standard deviation (SD) 504) and 20 hours for caesarean birth (SD 632). There were no 5-minute Apgar scores below 7 nor neonatal admissions. One baby required brief resuscitation. There were no adverse maternal outcomes. The procedure was described as acceptable (9) or bearable (11 participants).
Conclusion: This study suggests that use of side-by-side balloons is effective in achieving vaginal birth in most participants without uterotonics or amniotomy. This offers a novel option for labour induction/augmentation, particularly where uterotonics or amniotomy are best avoided such as prior caesarean birth, vertical infection transmission risk and in settings with limited capacity for fetal surveillance. We are developing a purpose-designed balloon for extended balloon labour induction/augmentation.
Reference: Matshitsa L, Mercy-Nkuba N, Hofmeyr GJ. Extended balloon labour induction: A single arm proof of concept trial. Eur J Obstet Gynecol Reprod Biol X. 2023;19:100226

Short Biography Justus Hofmeyr works part-time at University of Botswana and at Walter Sisulu University, Eastern Cape. Our research focus is on novel innovations and clinical trials to improve childbirth outcomes in low-resource settings

STEPS OF A SAFE CAESAREAN SECTION: A DELPHI STUDY OF SOUTH AFRICAN EXPERTS AS A BASIS FOR SURGICAL TRAINING

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Caesarean section is the most common surgery globally. In low- and middle-income countries, including South Africa, caesarean section-associated maternal and perinatal complications are of concern, some of which are attributed to lack of clinical skill and training. There is no standard technique for performing or teaching caesarean sections in South Africa. This study aimed to determine the essential and comprehensive steps of a safe caesarean section, according to South African experts.
Methods
A modified three-round Delphi survey method was used. The steps were divided into pre-operative, intra-operative and post-operative steps. Email invitations were sent to a panel of South African obstetric experts. These were defined as obstetric medical specialists currently or previously actively involved in caesarean section training in the South African public sector identified by the research team or suggested by institutional heads. Aimed sample size was 15, and a consensus was reached according to the confidence intervals (CIs). The final list was reviewed by stakeholders, who are clinicians frequently performing caesarean sections.
Results
Invitations were sent to 44 experts: 28 (64%) completed round one, 20 (45%) round two and 19 (43%) round three. Twenty-five (92%) experts had >11 years of professional experience, and 22 (82%) had performed more than 1000 caesarean sections each. There were 30 steps deemed essential after three rounds: 11 essential/12 sub-steps preoperatively, 14 essential/15 sub-steps intraoperatively and 5 essential/9 sub-steps postoperatively. Stakeholders agreed with most and had some additional suggestions.
Conclusion
This panel and stakeholders suggested 34 essential and 40 sub- or considered steps for a safe caesarean section. A defined task list can standardise the procedure and training. This may be an important step toward increasing the safety and quality of caesarean sections, especially in low- and middle-income settings where junior doctors perform most caesarean sections, often without supervision.

I am Liesl de Waard, an Obstetrician and Gynaecologist working at Tygerberg Hospital and Stellenbosch University. My interests include intrapartum care, maternal mortality, teaching or surgical skills and especially caesarean sections. I am currently working toward my PhD in the Educational practices of Caesarean Sections.

Stillbirths and intrauterine fetal death: role of routine histopathological findings to determine cause of deaths and improve antenatal care .

Dr SD Mandondo DCST O&G Amathole EC

Background
Placental abnormalities are a common cause of death in stillbirth following unexplained .There is a wide variation of the proportion attributed to placental disease . In clinical practice interpretation of the significance of placental findings is difficult .Finding a cause of death can bring healing to families
There are no first- or second-trimester tests of placental function in routine clinical use which can predict stillbirth reliably, although uterine artery Doppler indices show promise.

In 2022 the province approved and disseminated a policy where facilities could send specimens for placental histology .Amathole district has a stillbirth rate of 13.9 in 2022-23 which is rising .Also the syphilis positivity rates were high at 4,3 %.

Aim
The aim was to examine role of placental histology examination findings from stillbirths This would also assist to design interventions for improvement plan .
Method
Placental histology was sent for all stillbirths that occurred in Amathole district hospitals in 2023 to determine causes of deaths which was often unexplained .

Results
Among the stillbirths, 89 cases had placenta submitted for histological evaluation .
The cause of death was ascending infection with choreo -amninitis Grade 1 to 3 in 34/89 (38%) cases, a majority occuring at less than 28 weeks' gestation. There were 25/89 (28%) cases of retroplacental haemorrhage . Maternal vascular malperfusin 18/89 (20 %) was the largest category of placental abnormalities in stillbirth, with higher prevalence in the early third trimester. There were 10/89 (11%) cases with hyper -coiled umbilical chord .Syphillis was confirmed in 2 cases ,villous oedema in 2 cases and 3 with no remarkable findings .There was no association with HIV infection.

Recommendations
At PHC midwives need to examine patients for infection and screen and treat them appropriately. High risk patients need to have antenatal CTG and education on foetal movements to triage them for Doppler ultrasound or umbiflow. Stillbirth follow up clinics need to be established to provide feedback on the cause of the stillbirth .

Dr SD Mandondo DCST O&G Amathole EC and represents province in NCCEMD. Her role is supportive supervision and clinical governance

SESSION: 5 PAPER: 2

THE UGLY FACE OF PERINATAL SYPHILIS IN A RURAL REGIONAL HOSPITAL IN NORTHERN KZN.

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Abstract
Introduction: Maternal syphilis infection is on the rise and despite being a treatable infection to prevent devastating consequences in the foetus, an increased number of adverse pregnancy outcome continue to be seen. We call this poor outcome "the ugly face" of perinatal syphilis as it represents the result of untreated maternal syphilis.

Method: A retrospective analysis of maternal perinatal syphilis was conducted using the Perinatal Problem identification Program (PPIP) for still births audit and Epi info for audit of neonatal outcomes. The number of maternal syphilis seen from 2018 to 2023 was reviewed and the pregnancy outcome was determined.
Results: The number of maternal syphilis infection has increased exponentially from 57 to 371 maternal infections from 2018 to 2023 respectively as reported in PPIP which is equivalent to a 550% increase in maternal syphilis over a 5-year period. In the same period, 5% of all still births were due to syphilis. During the same period, the Epi info which records all the neonatal cases reported an increase in syphilis exposure from 79 to 360 syphilis exposed neonates reflecting an increase of 350% over the 5-year period. Of the exposed babies, 7% had congenital syphilis with a case fatality of 26.6%.
In one hand there were two peaks in the number of maternal syphilis diagnosed in 2020 and in 2023 and in the other, a steady increase in the number of maternal syphilis related poor outcomes.
Conclusion: Syphilis is a treatable infection however an increasing number of maternal syphilis with an equally increasing number of poor outcomes continue to be seen despite availability of effective treatment for pregnant women. More investigations is needed to determine the driving forces behind the re-emerging of maternal syphilis.

I am a medical practitioner graduate from the University of Zambia with interest in neonatal and perinatal medicine. I have more than 15 years experience in neonatal medicine. I have diplomas in child health and HIV management and I am currently pursuing a master's degree in Public Health.

SYPHILIS IN PREGNANCY IN THE CAPE TOWN METROPOLITAN DISTRICT: LABORATORY TESTING PATTERNS, MANAGEMENT, AND OUTCOMES OF GESTATIONAL SYPHILIS BETWEEN 2017 AND 2022 USING ROUTINELY COLLECTED ELECTRONIC HEALTH DATA.

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Introduction Congenital Syphilis (CS), an important cause of perinatal morbidity and mortality, is notifiable in South Africa. CS results from vertical transmission of inadequately treated syphilis in pregnancy, a treatable sexually transmitted infection caused by *Treponema pallidum*. Gaps in our understanding of syphilis epidemiology exist amidst concerns of penicillin stockouts increasing CS cases. We evaluated current management and outcomes of syphilis in pregnancy in Cape Town.

Methods
We retrospectively reviewed routinely collected electronic health data on a pregnant cohort and their infants from the Western Cape Provincial Health Datacentre. Clinical administration data, pharmacy and laboratory data were collated for patients identified as pregnant between January 2017 and December 2022. Pregnant women with a positive TPAb (Treponema pallidum antibody) and RPR (rapid plasma reagin) were considered seropositive for syphilis.

Results
419 312 pregnancies were identified, resulting in 425 138 outcomes. 47.1% of pregnancies had a documented laboratory syphilis test, with 6355 (1.5%) of total pregnancies testing TPAb and RPR positive. The proportion of seropositive pregnancies increased over time from 1.14% in 2017 to 1.82% in 2022. Testing practices differed between geographic service areas with some doing laboratory tests for syphilis for all pregnancies and others doing confirmatory laboratory tests only after positive point-of-care treponemal tests
Of the syphilis seropositive pregnancies, 66.9% had no electronic evidence of appropriate treatment. 27% had recorded benzathine benzylpenicillin; 4.3% received amoxicillin with enzyme inhibitor; 0.7% received ceftriaxone. Only 23% of syphilis-positive women had a follow-up RPR titre. Adverse pregnancy outcomes were higher among syphilis seropositive compared to seronegative women: neonatal deaths 1.49% vs. 0.75%, stillbirths 4.36% vs. 1.53%.

Conclusion
Routine electronic health data can provide oversight of CS prevention. Electronic capturing of pharmacy data is suspected to be incomplete and requires independent verification. Increasing syphilis prevalence requires a public health response to ensure adequate treatment and repeat RPR titres to monitor response. Cases treated with an alternative regimen should be audited to assess outcomes.

Dr Jessica Gammon is currently a Public Health Medicine Registrar at UCT, working in the Provincial Department of Health & Wellness in the Western Cape. After completing her undergraduate (MBChB) training at UCT and internship in Durban, she has worked as a doctor in rural hospitals in KZN and paediatric & neonatal departments in Cape Town and is passionate about maternal and child health for all. She holds a Dip Man HIV (CMSA), Pg Dip Community and General Paediatrics (UCT) and Diploma in Health Economics (UCT).

EFFECTS OF THE COVID-19 PANDEMIC ON EARLY INFANT TESTING AND DIAGNOSIS OF HIV, IN CAPE TOWN SOUTH AFRICA.

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Background: In South Africa, infants who are HIV-exposed are tested for HIV at birth and 10 weeks of age. The coronavirus disease 2019 (COVID-19) pandemic lockdown restrictions resulted in reduced access to healthcare services and uncertain impact on early infant HIV testing.
Objectives: To describe the effects of the COVID-19 pandemic lockdown restrictions on early infant HIV testing and diagnosis in Cape Town, South Africa.
Method: This retrospective cohort study compares HIV-exposed infants born during the first COVID-19 pandemic lockdown (2020) to those born in the same period the year before (2019). Laboratory and other data were abstracted from the Provincial Health Data Centre.
Results: A total of 2888 infants were included: 1474 born in 2020 and 1413 in 2019. Compared to 2019, there was an increase in the 10-week HIV polymerase chain reaction (HIV PCR) uptake in 2020 (71% vs. 60%, $P < 0.001$). There was also an increase in the proportion of infants who demised without 10-week testing or were lost to follow up in 2020 compared to 2019 (8% vs. 5%, P 0.017). Differences detected in birth HIV-PCR positivity rates between the two groups (1.1% vs. 0.5%, P 0.17) did not reach statistical significance, however, a significant increase in vertical transmission of HIV by 10 weeks old was found in the 2020 cohort (1.2% vs. 0.5%. P 0.046).
Conclusion: Vertical transmission of HIV at 10 weeks increased in the Cape Town Metro during the initial COVID-19 lockdown. There was also an increase in the proportion of deaths without testing by 10 weeks in the 2020 group.

Hendrike van Vollenhoven is a newly minted paediatrician from the University of Cape Town currently working with the neurodevelopmental research group in the Department of Paediatrics and Child Health at UCT and Red Cross War Memorial Children's Hospital.

PLACENTAL PATHOLOGY OF NEONATES DIAGNOSED WITH ENCEPHALOPATHY SOON AFTER BIRTH: A RETROSPECTIVE ANALYTIC STUDY

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Introduction: Placental pathology has been associated with neonatal encephalopathy (NE). Despite the high prevalence of NE in low-and-middle income countries (LMICs), there are few published studies on this association. In this study, we describe the placental histopathology in term infants with NE from Klerksdorp hospital.

Methods: This was a retrospective analytic study in neonates diagnosed with encephalopathy after delivery at Klerksdorp hospital between December 2019 and October 2022. Inclusion criteria were neonates born with birth weight of ≥2000g and had placentas sent for histopathology. Patients were grouped into those with NE suspected to be hypoxic ischaemic encephalopathy (NESHIE) and non-NESHIE and into mild and moderate-to-severe for each group according to Thompson score or Sarnat staging. NESHIE was defined as NE who required resuscitation and had an arterial pH of <7 and/or a base deficit of ≥12.

Results: There were 16336 live births, of which 271 were diagnosed with NE (16.6/1000 livebirths), and of which 193 had NESHIE (11.8/1000 livebirths). Placental histopathology was available in 239 (88.2%) cases. Most placentas (98.2%) showed at least one lesion. The common placental lesions were maternal vascular malperfusion (55.6%), foetal vascular malperfusion (53.1%), chorioamnionitis (41.2%) and villitis of unknown origin (28.9%). There were more placentas with ≥2 lesions in neonates with NESHIE (69.9%) compared to non-NESHIE (51.6%), p=0.042. There were no differences in proportion of placentas with ≥2 lesions in mild versus moderate-to-severe NE (69.7% vs 62.0%, p=0.07) or NESHIE (71.7% vs 65.4%, p=0.231).

Conclusion: In this study we demonstrated that almost all neonates with encephalopathy had at least one placental abnormality. Neonates with NESHIE were more likely to have ≥2 lesions than non-NESHIE. Previous studies have shown that placental lesions have a synergistic effect, independent of type, and multiple lesions may contribute to NESHIE or even death. Future studies should include controls (well neonates) to further elucidate the association of placental pathology and encephalopathy.

Lorraine Sebolai is a third year paediatric registrar at the University of the Witwatersrand.

BLOOD CULTURE AND TIME TO POSITVITY RATES, PATHOGENS AND THEIR ANTIMICROBIAL SUSCEPTIBILITY, IN NEONATES WITH POSSIBLE SERIOUS BACTERIAL INFECTION ADMITTED AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

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Introduction: Neonatal sepsis is a leading cause of neonatal mortality globally. This highlights the importance of timely antibiotic treatment while cautioning against antimicrobial overuse, which exacerbates resistance. Identifying culture positivity rates, the time to culture positivity, identifying causative organisms and antimicrobial susceptibility assists in antibiotic stewardship and improving outcomes.

Method: Retrospective review of culture positivity rates, organisms isolated, antimicrobial susceptibilities and time-to-positivity (TTP) from neonates with possible serious bacterial infection (pSBI) admitted to the neonatal unit at Chris Hani Baragwanath Academic Hospital, between 1st January to 31st December 2021. Positive cultures from the same patient that were within 14 days of each other were considered as one episode of sepsis.

Results: There was a total of 7486 episodes of PSBI with blood cultures taken, of which 1302 were positive (17.4%). There were 1712 organisms isolated, of which 527 (30.8%) were considered contaminants and 1185 (69.2%) pathogens. Pathogens types were gram-negative bacteria (GNB) (845/1185; 71.3%), gram-positive bacteria (GPB) (211/1185; 17.8%) and yeasts (129/1185; 10.9%). Common GNB were *Acinetobacter baumannii* (315/845; 37.2%) and *Klebsiella pneumoniae* (252/845; 29.8%), while common GPB were *Enterococcus species* (127/211; 60.2%). Amongst the Enterobacterales, 96.4% and 10.5% were extended-spectrum beta-lactamase producers and carbapenem resistant, respectively. A high proportion of *Acinetobacter baumannii* were meropenem (95.2%) and cephalosporin (92.7%) resistant. Average TTP (in hours) was shorter in bacterial pathogens, GNB (8.5±9) and GPB (11.8±13.3) versus contaminants (17.8±7.6) and yeasts (23.9±12.2).

Conclusions: There was low yield in blood cultures from neonates with PSBI, therefore diagnosis of sepsis in neonates should include clinical assessment and laboratory biomarkers. Common pathogens isolated were GNB and were mostly carbapenem resistant. This highlights a greater need to adhere to strict infection prevention and control measures and having a good antimicrobial stewardship (AMS) program. Knowing TTP of different pathogens will assist in the implementation of AMS program

I am a third year Paediatric Registrar, Faculty of Health Sciences, University of Witwatersrand.

A DESCRIPTION OF HYDROCORTISONE USE AND OUTCOMES IN INOTROPE RESISTANT HYPOTENSIVE PRETERM NEONATES AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

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Introduction
Hypotension in preterm infants remains a major cause of mortality. Hydrocortisone has been documented to improve blood pressures in inotrope resistant preterm infants though there is limited information about its efficacy and outcomes.

Aim:
The aim of the study was to investigate the characteristics and outcomes of preterm neonates admitted to the neonatal intensive care unit (NICU) with hypotension and got administered hydrocortisone.

Method:
This was a retrospective descriptive study of hypotensive preterm neonates admitted at the NICU in Chris Hani Baragwanath Academic Hospital (CHBAH) between January and December 2020. A neonatal Sequential Organ Failure Assessment (nSOFA) score was used as a standardized tool to describe illness severity. Data was retrieved from a REDCap database and medical files. Moreover, data was analyzed using Statistica (version 13).

Results:
183(95.8%) of the 191 hypotensive preterm infants received inotropes with 115 (60.2%) administered hydrocortisone. Mean gestational age and birthweight were 32(30-34) weeks and 1340 (1115-1765) g respectively. More females were admitted to males (54% vs 44%). Dobutamine (52%) was the most common inotrope used. The mean hydrocortisone dose was 3mg/kg±1.0 and the average time from the first inotrope to the first hydrocortisone dose was 9.3(2-12) hrs. The commonest dosing frequency was 8hourly 107(87.7%) and hydrocortisone administration improved both systolic and diastolic blood pressures(p-0,001) in participants. Among the demised 86(75%) metabolic acidosis (p-0,01), sepsis (p-0.0035), nSOFA score (p-0.001) and length of stay (p-0.001) were the significant predictors of mortality. Sepsis (OR 3.8586, 95% CI 1.5570 to 9.5624) and a high nSOFA score (OR 3,972, 95% CI 1.5858 to 9.896) were strongly associated with mortality.

Conclusion:
Hydrocortisone was prescribed according to hospital guidelines though more studies should be undertaken to improve current protocols and outcomes.

Raymond Tsakila MMed Pediatrics student, Supervisor Dr Firdose Nakwa, Head of Neonatology Chris Hani Baragwanath Academic Hospital.

INCIDENCE, CHARACTERISTICS, MANAGEMENT AND OUTCOMES OF NEONATES WITH PATENT DUCTUS ARTERIOSUS (PDA) AT CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

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Introduction and objectives:
Patent Ductus arteriosus (PDA) accounts for 10-15% of all congenital heart disease and is associated with significant morbidity and mortality. Therefore, it remains imperative that neonates with PDA are diagnosed and managed timeously. This study aims to determine the incidence, clinical course, treatment, and outcomes of very low birth weight (VLBW) neonates diagnosed with PDA in a public, tertiary neonatal unit in South Africa

Methods:
This was a retrospective, descriptive study on VLBW neonates, admitted to the neonatal unit between January 2017 and December 2017, and diagnosed with a PDA. All VLBW neonates admitted to the neonatal unit during the study period were identified using the neonatal unit Redcap database. Patients' files were then retrieved for data collection and analysis.

Results:
There were 859 very low birth weight neonates born during the study period. Fifty-four (6%) VLBW neonates were diagnosed with a PDA clinically and/or on echocardiography, giving an incidence of 64/1000 live births. Neonates with PDA had a median gestational age of 29 weeks and median birth weight of 1114g. Lower gestational age was a significant risk factor for PDA (p=0.04). The most common presenting sign was an ejection systolic murmur (n=22; 41%), followed by increased oxygen requirements (n=14; 26%). Pharmacologic therapy was prescribed in 43% of neonates, with ibuprofen being the most frequent agent used. PDA was significantly associated with the need for invasive ventilation (0,6 -, CI-0,34 and 0,58 and p-value- 0,009), and the development of BPD (OR- 0,7, CI -0,2- 0,23 and p-value-0,001) and IVH (0R-1,4, CI 1,2- 1,7 and p-value- 0,001). All-cause mortality in VLBW neonates with PDA was 28%, with no significant difference among those with and without PDA.

Conclusion:
VLBW infants with PDA are at increased risk of morbidity those without PDA. However, there was no increased risk of mortality for mortality.

SESSION: 6 PAPER: 5

CAUSES AND OBSTETRIC FACTORS ASSOCIATED WITH TIMING OF NEONATAL DEATHS IN SOWETO, SOUTH AFRICA

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Objective: Describe the obstetric characteristics of women whose decedents died during the neonatal period and to explore factors associated with postnatal age at time of death.

Methods: A secondary analysis of data collected by the Child Health and Mortality Prevention Surveillance (CHAMPS) South Africa (SA) study site. CHAMPS is a network that generates cause of death data in children across nine sites in low- and middle-income countries. Postnatal age at time of neonatal death was evaluated by Kaplan-Meier methods. Factors associated with time to neonatal death were evaluated using Cox proportional hazards regression models. Analyses were conducted in Stata 15.0®. P-value < 0.05 was considered statistically significant.

Results: There were 225 neonatal deaths during the study period, of which 184 (81.7%) had complete data for mother-neonate pairs. The median (IQR) maternal age at booking was 27 (23-34) years. Most of the deaths were early neonatal deaths (ENND; 79.4%, 146/184) and remainder (20.6%, 38/184) were late neonatal deaths (LNND). The main underlying causes of death were prematurity (60.3%, 111/184), intra-partum hypoxia (17.4%, 32/184), neonatal sepsis (10.3%, 19/184), and congenital anomalies (9.2%, 17/184). Prematurity remains the leading cause of death even after categorizing deaths to ENND and LNND accounting for 56.9% and 73.7% of deaths respectively. Intrapartum hypoxia was the second common cause in ENND, while sepsis was the second common cause in LNND. Intra-partum hypoxia (Adjusted Hazard Ratio [aHR]=2.01, 95% CI: 1.23-3.27, p=0.01), assisted-vaginal delivery compared to normal vaginal delivery (aHR=1.96, 95% CI: 1.03-3.71, p=0.04), preterm delivery (aHR=1.62, 95% CI: 1.03-2, p=0.04), Apgar score <7 at 5 minutes (aHR=1.59, 95% CI: 1.01-2.31, p=0.02) and a previous neonatal death ([aHR] = 1.33; 95% CI: 1.10-1.89, p=0.04) were associated with time to neonatal death.

Conclusion: Intra-partum complications were associated with earlier time to neonatal death. Improvements in intrapartum care can reduce neonatal deaths.

Dr Admire Chikandiwa **(MBChB, MPH, MBA, PhD, Dip in HIV Man)** is a National Research Foundation rated clinician-researcher with an interest in evidence-based women's health. He has experience in designing and implementing a wide range of study designs in sexual reproductive health. He is currently a third-year registrar in Obstetrics and Gynaecology at the University of the Witwatersrand.

SESSION: 6 PAPER: 6

FROM PRE-IMPLEMENTATION TO INSTITUTIONALIZATION: LESSONS FROM SUSTAINING A PERINATAL AUDIT PROGRAM IN SOUTH AFRICA

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Introduction: Maternal and perinatal death surveillance and response (MPDSR), or related forms of maternal and perinatal death audits, has the potential to strengthen health systems. This study explored the history of initiating, scaling up and institutionalizing a perinatal audit program in South Africa.
Methods: Data collection involved 56 individual interviews, a systematic document review, administration of a semi-structured questionnaire; and 10 non-participant observations of meetings related to the perinatal audit program. This study drew on case study research applied to five sub-districts in the Western Cape Province with long histories of implementation. Data analysis included thematic content analysis and application of a tool to measure implementation at sub-district level.
Results: While established in the early 1990s, the perinatal audit program was only integrated into national policy and guidelines in 2012 but then excluded from policy in 2021. Multiple national and subnational structures evolved and interacted to support uptake and implementation. These structures benefited from a continuity of actors, who were able to expand and nurture the network. Intentional efforts to demonstrate impact and enable local adaption allowed for more ownership and buy-in. Implementation requires continuous efforts, and even in five sub-districts with long histories of practice, we found operational gaps, such as incomplete meeting minutes, signalling the need for strengthening. Nonetheless, the tool used to measure implementation may require revisions particularly in settings with institutionalized practice.
Conclusion: This study provides rich lessons on how to initiate, expand, and strengthen perinatal audit. Despite a long history of implementation, the perinatal audit program in South Africa cannot be assumed to be indefinitely sustainable or final in its current form. To monitor uptake and sustainability of MPDSR including perinatal audit, we need research approaches that allow exploration of context, local adaption and underlying issues that support sustainability, such as relationships, leadership, and trust.

Natasha Rhoda has been a neonatologist for two decades and is the current head of neonatology at Mowbray Maternity Hospital. She previously served as the chair for NaPeMMCo. She coordinates the neonatal fellowship training for Sub-Saharan Africa. She is also a mom, wife, gardener and bird watcher.

EXPLORING DISSEMINATION AND IMPLEMENTATION OF MATERNAL CLINICALGUIDELINES FOR USE IN PRIMARY HEALTH CARE FACILITIES - A QUALITATIVE STUDY FROM TWO COUNTIES IN KENYA

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Introduction: Maternal clinical guidelines (MCGs) dissemination and use is one strategy to improve quality of care for women. Often, guidelines do not reach the intended users at a primary health care level and sometimes they are disseminated but not utilized. This study aims to explore key stakeholder´s experienced of the dissemination and implementation of MCGs at primary health care facilities.

Method: Qualitative interviews were conducted with six key stakeholders (2 county nursing officers, two Reproductive health coordinators and two county clinical officers) in two Kenyan counties. Individual in-depth interviews were conducted on each of the stakeholders.

Results: The findings of this study were summarized in four overarching themes 1) dissemination strategies, 2) facilitators for dissemination, 3) barriers for dissemination and, 4) monitoring and evaluation of MCGs.

Conclusion: The findings of this study support the need for use of multiple strategies in dissemination and use of maternal clinical guidelines. There is a need to develop a strategy that will incorporate both active and passive dissemination method. The is a need to identifying strategies to address the barriers inhibiting effective dissemination and use of MCGs to improve the uptake at Primary Health Care facilities (PHC).

Eunice is a PhD student at Stellenbosch University, She works as a lecturer at Kenyatta University.

COMPASSION IN MATERNITY SETTINGS: A DISCUSSION

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Abstract

Objectives: To explore literature on compassion within maternity settings, the different models of care and the implication of compassion during the perinatal period.

Method: To identify relevant literature on compassion in maternity settings, a search was done on Academic Search Premier, CINAHL full text, Medline, PubMed, and Science Direct. The search string included "compassion" together with other terms: "maternity care", "midwifery care", "midwife", "model of care", "woman-centered", "patient-centered."

Results: Literature reiterates that compassion is central to midwifery practice. The success of compassion is influenced by aspects such as healthcare professional attributes, the model of care and institutional culture. Evidently, although women are at the centre of maternity care, sometimes the care is sometimes discriminatory, disrespectful, and abusive. Thus, perceptions of women are shaped by experiences of the care received.

Conclusion: In the interests of women and the midwifery profession there is a need to align practice with evidence-based practice to promote compassion in maternity settings. Thus, all stakeholders should acknowledge the importance of compassion and consequently practice it.

Petronella is a Midwifery lecturer at the North-West University. Passionate about respectful care in maternity settings.

BEREAVEMENT & SPIRITUAL SUPPORT IN PERINATAL CARE

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The loss of a child at any stage is devastating. Helping families prepare for this is a crucial part of palliative care. This is even more so in the perinatal palliative care when parents are facing this news even before their child is born. The news of a life-threatening condition before a child is born can lead to many grief and bereavement responses that are similar to "normal" grief and bereavement but are also more complicated given all that has been prepared for the new baby. Parents may choose to terminate the pregnancy – which brings its own grief & bereavement and spiritual issues – or may choose to go through to term and meet their new-born. This too has a myriad of grief & bereavement and spiritual nuances.

This presentation will explore how to assist families during a perinatal diagnosis, ante-natally and into bereavement. Cases presented will be from work done by the author in various State Hospitals within KwaZulu-Natal. It will also explore addressing spiritual needs and crises during this time.

Practical examples will be given to assist practitioners in addressing grief, bereavement and spiritual needs of their families. Insight into bereaved families' experiences will be discussed to assist in participants understanding.

Tracey has been involved in providing palliative care to children since 2009. She has also been involved in teaching and training of medical professionals, the development of numerous training materials (the most recent being the BetterCare Books on Children's Palliative Care and Perinatal Palliative Care in conjunction with PATCHSA), and was a co-developer for the KZN Provincial Plan for Paediatric Palliative Care. She is currently assisting in the training and implementation across the province.

TITLE IN CAPITAL LETTERS

MIDWIVES' SELF-PERCEIVED CONFIDENCE IN THEIR KNOWLEDGE AND SKILLS IN KENYA: AN OBSERVATIONAL CROSS-SECTIONAL STUDY.

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Abstract

Background: Midwives' confidence in the requisite knowledge, skills and behavior acquired during training is essential for high-quality pregnancy and childbirth care and positive experiences by women and newborns.

Purpose: Assess the midwives' self-perceived confidence in their knowledge and skills based on ICM competencies in Kenya.

Methods: An observational cross-sectional study among 576 midwives from 31 public hospitals using a self-administered questionnaire. Confidence categorized as low, moderate or high and relationships between confidence and midwives' characteristics tested by Kruskal-Wallis tests.

Findings: A total of 495 (85.9%) midwives participated in the study with a median age of 37.0 (32.0-43.0). Most of the midwives were diploma nurse/midwives (295, 59.6%) followed by degree nurse/midwives (156, 31.5%) and diploma midwives (44, 8.9%). Majority of the midwives had high confidence in knowledge (57.2%) and skills (62.0%) in the labor and birth domain while the general competency domain had the least confidence in knowledge (30.5%) and skills (36.6%). Male midwives reported high confidence in skills compared to females (57.7% vs 45.0%, P=0.036) with no differences in knowledge (P=0.148). Midwives in tertiary hospitals reported higher confidence in knowledge and skills compared to those at county/sub-county hospitals (P<0.001). There were significant differences between midwives' qualifications and confidence in knowledge on the general competency domain (P=0.02) and skills in the labor and birth domain (P=0.017).

Conclusions: Labour and childbirth domain and working in tertiary facilities were associated with high confidence in knowledge and skills. In-service capacity building opportunities for midwives to build their confidence in obstetric care is needed.

Keywords: *Confidence,-Midwives, Midwifery education, knowledge, skills and behaviour*

Dr. Tallam holds a Ph.D. In Nursing Education from the University of Stellenbosch. Currently, she is a doctoral fellow at the same university. Additionally, she has a Master's degree in Public Health and a Bachelor of Science in Nursing. She is honoured to be a Fellow of the Afyabora Global Health Leadership program and an alumnus of the Global Nursing Leadership Institute (GNLI)™ Program. Furthermore, Dr. Tallam is proud to be a Certified Global Nurse Consultant specializing in Policy and Leadership

EMPOWERING TOMORROW'S DOCTORS: NURTURING CRITICAL THINKING PROFICIENCY IN OBSTETRICS AND GYNAECOLOGY

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Background: Critical thinking is crucial for achieving positive perinatal outcomes. The absence of the ability to engage in critical thinking and make sound decisions based on clinical assessments significantly compromises positive perinatal outcomes. This poses a challenge for undergraduate students and junior doctors undergoing obstetric training, highlighting the inadequacies of education programs in meeting the demands of the 21st century. Medical students often encounter difficulties in integrating theoretical knowledge with practical experience in obstetrics due to the fast-paced nature of the obstetric environment, which limits opportunities for the development of critical thinking abilities and impedes problem-solving skills. Globally, and particularly in the South African context, there are obstacles in fostering critical thinking skills and knowledge within medical training institutions, which fail to address the pressing issue.
Purpose: This paper aims to critically evaluate the necessity and significance of nurturing thinking proficiency in the field of Obstetrics and Gynaecology with the intention of refining local research methodologies on current practices.
Methods: A comprehensive search was conducted in academic publications, encompassing international and local scientific and academic journal, to explore the subject matter. These publications encompassed both clinical and non-clinical aspects. The review encompassed definitions, assessment methods, and educational processes within general academic and health-related fields.
Conclusion: Despite the presence of literature dating back to the 1990s, little progress has been made in meeting the demands of the 21st century. The concept of critical thinking is multifactorial, and therefore, it is anticipated to be approached from various perspectives. Obstetric-related publications predominantly originate from European and American research. Critical thinking in an integral component of fostering a sustainable society in higher education, particularly within the field of medicine. Given the high prevalence of litigation in South Africa, there is an urgent need to prioritize critical thinking in order to mitigate professional risks.
Keywords: Empower, Doctor, Critical Thinking, Proficiency, Obstetrics and Gynaecology

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NURSES' PERCEPTIONS REGARDING THEIR OWN PROFESSIONALISM ATTRIBUTES TO QUALITY NEONATAL, INFANT AND UNDER-5 CHILDCARE

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Introduction: Professional nurses are trained to provide quality of care. Despite their skills, neonates, infants, and under-5 children mortality rates remains acceptably high, and the healthcare is challenged towards reaching the Sustainable Development Goal number 3, of healthy lives for all and reducing the mortality rates of the bunder-5 child.

Methods: This study employed a qualitative exploratory, descriptive design to explore and describe professional nurses' professionalism attributes to provide quality of care to neonates, infants, and under-5 children in the North West Province. Eight naïve sketches of an all-inclusive sample of invited professional nurses (N=25; n=8) were received. The naïve sketch questions were based on the Registered Nurses Association of Ontario's professionalism attributes. Tesch's eight data analysis steps were used with an independent coder's assistance.

Results: The categories included (1) knowledge, (2) spirit of inquiry, (3) accountability, (4) autonomy, (5) advocacy, (6) collegiality and collaboration, (7) ethics and values) and (8) professional reputation with their respective themes and sub-themes.

Conclusion: Professional nurses are aware of their nursing professionalism attributes in providing quality of care for the neonates, infants and under-5 children, 'innovation and visionary' attribute did not emerge, which should receive more attention to strengthen the quality of care. However, the attribute 'professional reputation' newly emerged in the South African context.

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REGISTERED MIDWIVES'NEEDS FOR SUCCESSFUL MENTORSHIP OF STUDENT MIDWIVES IN LABOUR ROOMS IN THE NORTH WEST PROVINCE

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Introduction

The South African healthcare system is overburdened by numerous problems, particularly in maternity services. It has been reported that nurses are not skilled enough to provide quality care to pregnant women, leading to several litigations against the department. This is more evident in maternity services. The onus is on nursing education institutions to produce competent midwives to improve the quality of care provided. Mentorship has been proven to improve competence among mentees, and this strategy can be improved to address this health problem in the Republic of South Africa.

Method

The study aimed to explore and describe the needs of registered midwives in labour rooms in the North-West Province regarding clinical mentorship of student midwives. A qualitative descriptive design, using purposive sampling was used to select the participants from the level 2 hospitals in South Africa's North-West province. Data were collected using individual telephonic interviews. Fourteen participants from level 2 hospitals in the province participated in the study.

Results

Three main themes emerged. Theme 1, A positive environment for teaching, learning and mentorship, are patience, teamwork, mutual respect and human and material resources. Theme 2, A collaborative relationship between the nursing education institutions and the health facilities, had three sub-themes, namely, presence, effective communication on students' objectives, activities and progress, and opportunities for self-development and empowerment. Commitment to learning (presence, patience and pre-knowledge) is the sub-theme that emerged from the theme of positive student conduct.

Conclusion

Mentorship is a valuable strategy for improving quality maternity care and should be implemented in all practical settings.

Antoinette is a midwifery lecturer at the North-West University with a special interest in quality midwifery care.

MENTORSHIP NEEDS IN AN INTRAPARTUM SETTING- A MENTOR-CENTRED APPROACH- A QUALITATIVE DESCRIPTIVE STUDY.

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Aim: The study aimed to explore and describe the needs of registered midwives in labour rooms in the North-West Province of South Africa with regards to clinical mentorship of student midwives so as to identify the strengths and gaps within the clinical mentorship programme and make recommendations to optimise clinical mentorship for student midwives in this setting.
Background: The South African healthcare system is overburdened by numerous problems, particularly in maternity services. It has been reported that nurses are not skilled enough to provide quality care to pregnant women. The onus is on nursing education institutions to produce competent midwives to improve the quality of care. Mentorship has been proven to improve competence among mentees, and this strategy can be utilised to address this health problem in South Africa.
Design: The study employed a qualitative descriptive design, and purposive sampling was used to select the participants from the level 2 hospitals within the North-West province in South Africa.
Methods: Data were collected using individual telephonic interviews, and 14 participants from three level 2 hospitals within the North-West province participated in the data collection process.
Results: Three main themes emerged from interviews conducted with the participants. Their needs to successfully mentor student midwives in an intrapartum setting are a positive environment for learning, teaching and mentorship; a collaborative relationship between the nursing education institutions and the health facilities where they are employed as well as positive student conduct. The sub-themes under theme 1, a positive environment for teaching, learning and mentorship, are patience, teamwork, mutual respect, and human and material resources. Theme 2, a collaborative relationship between the nursing education institutions and the health facilities, had three sub-themes, namely, presence, effective communication on students' objectives, activities and progress, and opportunities for self-development and empowerment. Commitment to learning (presence, patience and pre-knowledge) is the sub-theme that emerged from the theme of positive student conduct.
Conclusions: For successful mentorship in the clinical setting, the focus should not just be on the mentees themselves and creating an environment where they can learn. There is a need to investigate how the mentors, who provide learning opportunities and teach, guide, and support mentees in order for them to be competent, can be assisted to enjoy mentorship.

My name is Kgomotso Mathope from the North West Province in Mahikeng. I started my nursing career in 2005 when I enrolled for a Bachelor of Nursing Science degree. Thereafter I obtained an Advanced Midwifery diploma, a postgraduate diploma in nursing education and a Masters degree. I am currently a lecturer at the NWU, teaching midwifery theory and practical modules.