

FGD with DCST's UGu- UThukela and Harry Gwala

FGD transcript

Duration 1h44'

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Introduction

DCST's have been commissioned with the mandate to provide clinical leadership and governance in district hospitals. In my study we are focusing on the labour ward because of high maternal and perinatal mortality in the province. The literature suggests that it is because of the lack of clinical leadership. The people called to provide clinical leadership are not clear of their roles as clinical leaders, they don't know what to do, and they cannot define clinical leadership so they find themselves as clinical leaders but don't know how to provide it.

That's why we thought of including DCST's in this study so that you can help us provide a definition for clinical leadership since you are responsible of providing it in district hospitals.

Q1. In the labour ward it is the OM who is responsible for clinical leadership, how would you define clinical leadership

Respondent 1

Clinical leadership, I think I will take it from your study, it is ensuring that you understand clinical governance as a manager; to ensure that you improve the quality of patient care.

So when you are saying labour ward, it means saving the mother and the baby, so whatever you are providing, the care that you are providing to the mother and the baby the minute they enter the labour ward you need them to go home with everything.

You need to ensure that the quality of care that you are providing ANC, intra-partum care or postnatal care there are steps that you should be doing to ensure effectiveness of providing that.

1st you need resources to provide clinical leadership, you need staff, proper equipment; you need an environment conducive. And then when you've got these resources you need to be able to measure and say the community that I am serving what level of care I will be providing is PHC, level 1, regional.

But you said DSCT is district level, our focus which is level 1, once you identify that you cannot work without policies, protocols, principles and guidelines. So you need to bring in your policies, protocols, principles and guidelines and say for me to be providing services I will be providing normal labour, normal deliveries, high risk clinics, C/S, have neonatal nursery, post-natal all those services need to be documented and then you are going to need guidelines, policies and protocol.

And then when you are employing your staff, you need a proper plan on what you are going to be doing, your orientation, monthly induction for all your new staff that are coming; you have a planned in-service training, as a manager as well, **that how I will be defining** and then continued education also, send the staff for basic courses available. You also need to have clinical audit, because whatever you are providing you need to look at yourself, viewing yourself, put a mirror before yourself, they always say data is looking at yourself, this is what I am doing, how are we doing, what results are out there.

Clinical audit is one thing, but having the tools to do clinical audit and ensuring it is giving you the result you are asking for, so that is clinical audit that is supposed to be also there. You need also to have information meetings, be able to understand the data that is needed by the outside world, I am saying outside world, our principals, national and provincial department of health that is looking at us as the labour ward 1st, as a district, as your hospital, as your province, as your country. Then this is the result that is coming from that labor ward so we need to understand those also as a manager and say when we are in this labour ward it is because we are aiming at reducing mortality and morbidity and improving so much health and saving mothers and babies.

So there roles additional roles as clinical leader you need also to be doing, I am saying additional because under nursing I am so lazy for those ones, like your research and sometimes it is not that we are lazy, it is just that because of funding and the time and also going for workshops, seminars to network to see, oh! Even the look the type of labour ward you think you've done well when you go to another area it is a different case.

I am saying additional because it is one of the roles, sometimes you will find because of the finance/funding we don't get that and it is not being offered.

That what I do understand by clinical leadership; and now as DCST that what I will be supporting the OM to be leading/ looking that it is in place.

My colleague will add.

Respondent 2

I thank you really for a good background of defining it. But also for a clinical leader to be quite effective it is for the clinical leader to have certain expertise, or certain qualities, my colleague talked about there must be resources, but then you must have a way of how to manage the resources, your staff, how do you manage your staff in terms of how do they function as a team and also team work is very important communication, all those things how would they happen so that everybody feels that we are providing quality of care.

And also some of the qualities that are needed, you need to be able to stand up and stand out for what is right and bringing the team together in dealing with different categories; that leading with midwives, doctors, dealing with lower categories, how you make them function so that we will ultimately provide this quality of care.

So I think she mentioned a lot of things, creating a good environment, an enabling environment I one of the key thing for anyone to work in the labour ward must be created and I think the OM must be the key person. As we add all those things as the key/ pillars to make sure that clinical leadership happens

R1

One critical area that is also critical when talking of clinical leadership is that as a clinical leader on a day to day is the clinical managing of the clinical department. Like doctors do doctor's rounds where they teach each other and midwives are supposed to be joining; but as midwives, ADM we should be doing midwives rounds where as an OM by midday I take a round with my midwives we go patient to patient we give report how far, we advise each other, please call the doctor for this one, do this.

I Think the role that has been lacking when we talk about clinical leadership we don't give report like on shortage of staff, we only report problematic cases while even if the outcome is good you find that there gaps in the outcome.

I think we are lacking the initiative of saying midday as an OM I am leading these people that why I have got advanced midwifery, I come we go from patient to patient, read the file, midwives present the case, give feedback, we advise each other. I think that it's an area I feel we need to really to put more emphasis on. Because we end up now being reactive leaders only when there are negative incidences, only then we act, we are able to pick these people are not able to plot a partogram, because of these negativity and they are not monitoring women during induction, they are not doing this. So we need to come up with initiatives that will pick up all those gaps before there are negative incidences.

R2

Also in picking up the gaps you must after identifying them, be able to know what sort of interventions are needed, if staff are unable to deal with emergencies you know that we have ESMOE drills. We must be able to deal with those things. We must be able to provide ESMOE drills in all units and all is important.

I think for the OM she doesn't function by herself, if there are other ADM, they need to help at a delegated authority in terms of leading now the team, having team leaders. Being an OM under her must have team leaders for the day and for the night as well.

From the discussion we've just had, what I got from both of you in terms of clinical leadership, you've spoken of the role of clinical leadership/leader in the labour ward and then you colleague touched on the leader. In other word all combined clinical leadership is

about the role that the clinical leader plays in the labour ward and the qualities or attributes that a clinical leader need to achieve clinical leadership.

Is there anything else you would like to add on the attributes or characteristics of clinical leadership?

R1

As a clinical leader you also as well managerial skills, although you are a clinical leader, there are also managerial issues that you need to pick, because you are managing the labour ward you need to have those managerial skills to be able to supervise people and be consistent in whatever you are doing to be able to see professional educated also, to be updated with the knowledge because you are going to be developing policies, so you are also responsible to update yourself by bringing people from the outside to assist your department, to say I need help in 1,2,3 so that is also for you as a person to say.

Also the community around you, it does have an influence on the type of leader that you are because of the negative incidences we are having in the labour ward. You know a leader or a manager in a rural or urban area you need to understand the community around you. Because we are communicating with outside world, so the way you address the community will determine the community response to your need.

Let say you are in a rural area where people are still reporting to their mother in law who is at home, when you have a case of a woman who have reported late in the labour ward.

As a manager, you need to have that situational analysis/understanding of the community around you, because this will have an impact on how you are performing as well. So you need a good understanding of the community around you, analyze them, introduce yourself to them, talk to them and if you have open days address other areas that are needed to improve the care provided.

So I think those are some of the things we are not looking at, because ANC < 20 weeks they stay at home and hide fearing that they will be bewitched so come only when the belly is showing.

So your knowledge of the community as a leader is also important. It will have an impact on the outcome of whatever services that you are providing.

On that same note if you can in a summary what are the main attributes of a clinical leader. What would you mention as key attributes or skills that a clinical leader need to possess.

R2

Clinical competence, good communication skills, bring the team together, team approach in many things, she must not do things on her own because when she is not there nobody is able to that. If she knows that we function as a team, she will know how to bring the team together.

Be a team builder, she mustn't separate doctors from midwives/nurses, bring the team together under one unit. Whatever she is doing plan with doctors, therapists and others, she must be assertive and able to advocate for patients.

As we stand now, from your point of view, do you agree with the literature that clinical leadership is not provided or not. Is clinical leadership provided in our labour ward in KZN?

R2

It is constrained, in some places it is provided, remember when we have OM it is this 80/20. She must be 80% managing and 20% maybe clinical but it is the other way round, because of staff shortage she find herself unable to perform the other duties, she must do everything herself. It is constrained, it is really delays provision, because clinical leader must look forward to change, she must be a change agent. We have been doing things this way, let us turn the other way round, it is constrained by lack of resource.

R1

What I am realizing is that the roles are not clearly defined/ clarified; in some facilities you will find there are an OM and an assistant nursing manager (ANM). You find the OM act more like a

matron and the matron goes more on a relaxed mode. They even verbalize < I didn't know that it was very nice to be an ANM>, the OM are doing more of managerial duties than clinical duties. There are more managers than leaders. As DCST, I go to facilities and work with OM, I find them doing more of managerial than clinical tasks. Like strategic planning, change/ take over, she is not in the department and when I understand those duties are supposed to be the ANM's so we have discovered that they are moving more towards managerial issues instead of being in the department.

When you ask about managers they say there is a team leader in the labour ward, so you end up working with team leaders than OM. I think there are some roles that are not clear between the ANM and the OM. I even asked a colleague why they ask for advanced midwifery from ANM. Since she has got post-basic she must also be able to provide clinical leadership. The minute they want post-basic, they should also provide clinical leadership. Instead of pulling the one in the ward to office, that is the role that I am seeing missing in other areas.

R2

Yes it's differ from place to place, because what confuses the ANM while she is the assistant manager for the whole of maternity she also becomes assistant manager for pediatrics which takes her away from maternity and the load of work rest on the OM who is also counted as a staff member who is hands on that where difficulties come from.

We are moving to the second question. After we've discussed all this, it is clear that there is a problem of role clarification; I think that what makes it difficult for clinical leaders to provide clinical leadership. Because at times as you mentioned they do not know exactly where to stand or what to do.

Question 2

If you have to talk of a framework, a structure that can be designed, what do you have in mind, so that clinical leaders are supported, mentored to provide clinical leadership?

R1

We need to look at the workload as an OM, facilities are not the same but the provincial guidelines speaks only of maternities,

We find some facilities as busy as 400 deliveries per month. The OM is looking after the labour ward, postnatal and nursery, obviously the workload is too much. I think we should maybe having more of OM in charge of nursery as an independent structure, because there are so many programmes, in nursery so have one in the labour ward and one for postnatal or maybe combine nursery and postnatal, that one thing even though they want to assist in the labour ward but the workload is much and they are pulled in every direction, so you will find that she will tell you she want to focus on nursery, the minute you have somebody like that is also a problem.

R2

I think this role clarification issue between ANM and OM brings them confusion, other think she should not come in, I don't see the ANM doing the rounds, they are called upon in times of crisis, where there is crisis which is managerial , the need to be dealing with those. But in terms of the quality of care to be done, the way it is supposed to be it does follow the OM who does really have a wide scope to be able to see nursery functioning well or postnatal functioning well.

So it is mainly in the structure that things need to be changed

R1

It is one of those but not the main one because you cannot group all facilities, that one coupled to workload, we need to look at the workload as well, one that is sorted as she was saying also the role clarification I think also the standardization of the same clinical governance. The tools that we are using are not the same but it is our role I think as DCST that we need to have clinical leadership evidence, to say based on what we are providing that will be documented and look the same.

R2

We need to look at the job description, it will help us in terms of role clarification and because that will take from the job description, your PKs, your work plan as an OM and we are well focused. Best performance agreement all of them coming to play. Bring the performance agreement and the work plan, what each brings, do they say the same thing, are they targeted towards providing quality of care.

Which is now talking as DCST when we go into facilities we don't look into that, to say now is the triennial report let look at the job description, what are we going to be doing for the year 2015/2016 and when we do our own work plan it must be the same as the OM; we are putting things into our mind as well.

Because it must be in line, if I put something in my work plan, the OM must be in line so we must work as a team. We don't share work plans so that we all know we are all targeting reducing maternal mortality.

Because whatever you put in your department must be in your performance agreement to say this year this is what I need to work on as a facility.

Although mine is district wide but facility will look at the data and say for me according to our facility maternal death or we've got intrapartum related asphyxia to work on, so this will make my priority as clinical leader,

I think we need to strengthen more work plan.

Currently as DCST do you have any tool or guide line that you use to mentor or support clinical leaders in the labour ward?

We've got programs, saving mothers and babies reports, partogram audit tool, ANC audit tools, policies, provincial guidelines, referral guidelines and then adapted at district and level of care, PHC whether MOU, level 1, so we also guide them into those policies and guidelines and conducting meetings like the perinatal review meeting both labour ward and so on because it helps us look into the PIP program to look at avoidable factors correcting actions, we've got those things to guide us so that we can do the right thing, intervention and follow those up.

And then your reviews, like PMTCT will be reviewed so we are responsible so that it will be implemented. Guidelines coming from national, we have saving mothers/ babies reports showing how maternal deaths should be conducted so we've got programs that come with direct policies as DCST we come with those programs as we train people, orientate, audit if they have been implemented, whether HIV initiated on ART, so whatever comes management of hypertension; So all those protocols, policies, protocols coming from national. We use them for implementation and updating whatever the midwives need in the labour ward.

From everything we've just said, this is what you are using to support clinical leaders, what do you think is lacking, what do you feel is missing maybe at organizational level or hospital or district to ensure that clinical leadership is provided.

R1

I am missing a doctor because clinical leadership is not only for nursing, it is doctors, midwives, there's friction you know when you bring something as a nurse and I don't have a specialization, doctors sometimes you have to phone the provincial office for somebody to support you. It such that sometimes you hit a wall when implementing policies but coming out with negative outcomes so although it is a policy but it is not working for us because we are losing mothers and babies, so that sometimes we feel like DCST's we meant to be a diet I am feeling that so much.

R2

You know also having mentioned the doctor who is a specialist/ obstetrician I am talking about clinical manager. Not having a clinical manager, somebody who is allocated there permanently who is part of the doctor category, they are also coming in and going out maybe each 3 months, all our district hospital need a clinical manager for maternity somebody who's going to be there whatever you set as the standard this person comes in as confused, not sure, needing orientation and support from district clinical specialty/ obstetrics.

R1

I thing that it the responsibility of the CEO and the provincial office and they are not prioritizing programs since we started as DCST's we have been speaking about it. I am seating now with two of my hospitals having clinical managers but what they did, they motivated for pediatric clinical

manager, when we motivated at that time I was still having an outreach specialist coming from Durban she use to come to UGu when she was gone facilities decided to feel the post (pediatrics) so that what I am saying our focus is not the same when it comes to the people that are responding in the facility in large; when we are gone they will say maternity is fine according to their own assessment.

So now I am left with one facility without clinical manager and it is really 1 of the facility with the highest neonatal mortality. So she is right having a clinical manager on the doctor side, I think 2 ago I was asked what will be the responsibility of a clinical manager because they said there are many doctors in maternity they can work with the OM but I said to them it is not the same.

The clinical manager will have to plan clinical issues together with the OM, even when the doctors will be going on rounds in the labour ward; they need to be decided together. Even the hand over at 4h we want to have somebody who will be on call and do a proper round and hand over. So those things need to be decided by the OM and the clinical manager.

I said over and above all these fancy perinatal meetings there are day to day running of the department that need these 2 people to ensure that even if we do have a high risk clinic when do we do electives, so those are the things that are planned and documented by these two leaders so that we don't get surprises.

So there are the things when asked sometimes they think that they are not important because you are looking at the gap in the department.

R3

We are suffering from the same disease, looking for clinical managers, you will find that some facilities are flexible I have got a district hospital having a clinical manager but the others are sharing one clinical manager in lot of department then it becomes a challenge.

Another challenge is whenever you want somebody to be trained because other doctors are rotating then they will give this clinical manager for different department (pediatrics, theater) to go for ESMOE training then you will never find any ESMOE training done until you come and do it yourself (DCST)

So it is really becoming a challenge because whenever you want somebody to be trained and cascade the training to the doctors they give the clinical manager, unfortunately he is responsible for many other departments. Whenever you will want a person for training he is overloaded with work from different department, we need somebody that is focused, if they can share maybe share between pediatrics and maternity.

R2

The role of perinatal audit is that within 24h the clinical manager and the OM seat together with the people involved, summarizes the case, know it by the end of the month all the cases have been summarized but you will find that it is not the case. Month end or toward the perinatal meeting they just pick a case randomly and quickly look at it when ask questions nobody did a thorough assessment showing that the people are not organized.

There was a presentation of a case, those involved were not familiar with the case somebody else summarized it the day before.

Those are the roles of clinical leaders, whatever a doctor or midwife do they have to work together and look into those. There is quite a lot of gaps in the labour ward when you look at those responsibilities of those people we should working as a team.

So in some labour ward we do have that combination (OM & clinical manager)

There are combinations but I don't know why it is not consistent

Staff rotation of doctors destroys whatever you put in place as a team work in an attempt to render quality of care.

It is not constant some district hospitals have some do not. Initially it was thought that it was needed only for big district hospitals but funny enough you will find small hospitals with a clinical manager and an OM and a bigger one without.

Lot of irregularities maternal health is not prioritized, now it is a matter of funding rather than size of the institution.

We should not only be focusing more on doctors, there are a lot that need to be done for nurses, OM, clinical leader they need orientation, confidence there is also a challenge with OMs they are too much operational when it comes to administrative and operational duties they don't have time to discuss cases, in some hospital they are more managerial, some are more clinical

- One has an office close to maternity / labour ward but is never there, there's a lack of balance between duties.
- It is not that they want to be in maternity all the time, the issue is that we are losing nurses and midwives people are afraid of litigation.

I went to a facility they said because we are being integrated, when it comes to ANC, no more movements for pregnant women treat them in one room she said "I'd rather leave and go to chronic, sit and nobody will sue me, in this department there are a lot of litigations.

I was in a perinatal meeting a consultant told me "when I perform an ultrasound I don't want to commit to say the baby has no abnormalities because of litigation, I can't guarantee that whatever I write won't be used against me, it's a matter of litigation if I write no abnormality and it turns out to be an hydro I will be sue.

It was so critical but you can't force him because he is looking at the situation, it is the same with midwives, they are running to PHC. They even come to me you will find a midwife looking for a PHC school they are looking for PHC posts, specializing in PHC; they don't want to take responsibility.

They want a 8h clinic not involved in deliveries, we are losing midwives, even ADM those who leave are not replaced and the production of midwives in training schools is not enough.

Recruitments procedures are difficult because posts are frozen, when they are unfrozen you cannot get the staff you need, especially in rural areas, if you get them for 3 months they leave for greener pastures.

If you don't have a stable staff you are unable to make progress, it is a vicious circle that you are unable to break not having the quality of staff that you desire and there is no retention strategies.

I started a mentorship program, I am afraid to say I have lost at least 5 midwives, ADM are leaving they are going to regional hospitals, they are running away from independent roles/ posts (CHC, MOU) at regional hospitals we have ADM, consultants, registrars I could not understand but they said here I am not responsible/ in charge.

So quality of ADM I had decided to go to regional hospitals where they have 35 midwives, they are not interested in post in CHC; **they need mentorship to be under supervision.**

We need to look at our training, we were told you need to stand and be independent and make decisions, they don't want to sit under the decision position. They get frustrated and don't have support and run away.

The role of ADM being a clinical leader need more training, CEO and medical managers need to understand their role in the labour ward, if they don't they will not support or protect them. She will find herself exposed especially with a doctor who is not doing the right thing.

There is one aspect that we are omitting ADM are not paid (HR) big post less pay, provincial policies are not implemented in the same way.

Where Oms trained prior taking the role as clinical leaders?

They were appointed as Oms, even the term clinical leader only came in force with DCSTs. When you say OM it is equal to day to day running of a department they need to change the terminology into clinical leader from OM, then it rings a bell.

The problem lies in the terminology used when they were appointed, now we need maybe to re-orientate them on clinical leadership, I wish you can get a workshop for us where we bring all OMs and do a clinical leadership mass workshop and say this is how we are going to implement it and move forward with everybody aware of what clinical leadership is and what is expected of clinical leaders.

Question 3

On our last question, we spoke of the roles, the attributes, the support need and the challenges they are facing. How would you say clinical leadership has been provided, how would you evaluate clinical leadership.

R1

I think most of the Oms they do in-service training they do orientation induction for their staff, they do perinatal meetings, they attend to negative incidence to address negative incidence because we have quality managers who are assisting us because adverse invent committees also want this so they do have operational plans at the beginning of the year and work plans they do performance agreement with their managers those having clinical managers they work together with them to ensure that the day to day running of the department is addressed, high risk clinic, the labour ward, they do the rounds

They are able to give you the result of the clinical audit as they have clinical audit action plans which sometimes it is not reducing whatever it has aimed at reducing it is one and the same thing month after month have you seen the result being 70 – 70 the whole year we don't reach the quality improvement target/ project sometimes you feel January to June the results are the same we are not closing this project sometimes they also focus on staffing.

As she aid there is high turnover as well, they ensure that all programs are implemented they are also responsible for that as OMs in the entire province, the siyangqoba, partogram, PMTCT.

From what you have it means there is no standard tool that somebody can use to say clinical leadership has been provided or not

No, I think that a gap, there is a very big gap because usually when I go to a facility I will have something like we are using the loos given to us by Anna long time ago you use that baseline tool to measure yourself but you don't have anything of a supervisory clinical nature, we were talking with Pinky about supervision after training when I come for review to see whether they are doing the right/correct thing, it may look good but with no standard tool you may leave to only remember other important things later we

Need something like an ESMOE tool which tells you each step of the things you will be look at/ for on that particular day like a PHC manual tool which will guide you on what to check.

Even clinically we need something like that, that we can develop to say what is expected of a clinical leader on a day to day basis

I audited a case the other day in a CHC where a woman was admitted with a pathological CCG in the early hour of the morning after 4 the matron was on call, only when she was doing the round of the hospital that she picked up that the ambulance was called at 12 and it hasn't arrived she quickly organize an ambulance at 6h00 but we lost the baby, and she was saying luckily I called the ambulance, when she was doing her official hours in her department she did nothing only when she did the round as a matron that she acted and late can you see now the clinical leadership, that to say the Om and ANM are not doing rounds during official hours if you have a tool they will know what to do on a daily basis that will be documented, when I come to her she will be able to show the problems she is facing even the ANM we only pick up negative incidences and that one was reported by the district office blaming the ambulance but when I audited the file I asked whether it was during the week when they are on duty but they didn't know about the case so that is a lack of clinical leadership from the managers.

Two issues here, Oms need a tool to guide them in their daily work; DCST's need a tool to monitor Oms activities

Also clinical leadership should involve empowering your staff, if your staff are able to say we've called the ambulance it has not arrived, what do we do, if they don't know they seat paralyzed it means you have not empowered them to move further in decision making and only wait for you.

If you don't do it yourself, a clinical leader should be a role model automatically they will do what you do.

When they don't want to take responsibility they shift all the action/ blame on the doctor from 12 to 16 there was an OM and so many people shift of responsibilities. Lack of taking responsibility is one the problems.

So they feel the only person that need to be reported to clinically is the doctor not an OM, saying this is the person to sort all clinical problems, because it is not for OM and ANM, they decide not to report to them.

So the problem is with the system, there are systems issues that need to be sorted.

Part of the reason we are conducting the study is to develop a tool to evaluate/ measure clinical leadership, so what are the things you think should be part of tool, what are the things we should consider including in that tool so that we can measure the provision of clinical leadership

In-service training should be there (drills) orientation and in-service because you seat with people who were never orientated before then in-service them regularly, and should be standardized and documented, partogram audit, mentorship and proof of mentorship, usually we say we have mentored people because we have talked to them, then the person will feel I was never mentored and nobody is mentoring me and there are new midwives who come in and are lost because they are not mentored at all

Mentorship that is clinically based beside the one we do under the form of motivation, we need clinical mentorship which is documented when I adopt you as my mentee what have I done, what activities that we have done together, which activities that we did together you can perform on your own and you are confident, so those are the things that we need to look at now other than the mentorship/ leadership that we have been doing all along motivating each other.

We need specific clinical leadership; a person will come in my unit I ask her which procedures are comfortable with, which are you not then I start mentoring that person with a note pad then I leave her when she can stand but I keep on evaluating her. So those are the things we need, they should be written and documented then when you come to the unit you evaluate the OM into mentorship and what are the documents supporting your mentorship.

So why don't we have funders/ partners coming to do those programs? Everybody is coming with HIV, pediatrics nobody is funding labour ward

Discussion: it depends on who has the money; child health has got too much funding's, maternal health is not funded

When you request ESMOE training for a week they will tell you there is no money, then you turn around and change the submission and say I have 2 maternal deaths HIV+, 3 children deaths because PCR+ then they will fund, we are losing focus only on HIV, even for training if it does not have HIV, no funding they will plainly tell you that we don't fund anything besides HIV.

Because the mentorship, if we can get something similar to KINC we can get a nice mentoring for labour ward, we need to mentor them to mentor other, the caliber that is following will find things weaker and weaker, will end up leaving the department with nothing

No proper standard because nobody brings proper orientation that goes with regular in-service training. So in your tool don't forget perinatal meetings/ audits because in some facilities it's still doctor thing midwives are distancing themselves we have to push them to present cases , PIP must be team work not only doctors, in some areas they have started.

OM doing clinical wards rounds with midwives, it as if we are clerking patients, how are you, I am ok and you leave. When there's a negative incidence everybody runs that a problem, if have those round we discuss cases on a daily basis.

Quality improvement plans, you are directly involved and see if we are making progress or not, things with funding go smoothly.

We request, let change the mood, it is not funded anywhere, look at the HAAST building how beautiful they are.

Program to target the labour ward midwives, task team for midwifery to improve skills in the labor ward

Equip them to be able to stand for their opinion

Resources enabling them to provide clinical leadership

