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Full Length Research Paper

Women's satisfaction with hospital-based intrapartum care: A Jordanian study

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Exploring patient satisfaction can contribute to quality maternity care but is not routinely conducted in many Middle Eastern countries. This study investigated the prevalence and factors associated with satisfaction during labor and birth among Jordanian women using a descriptive cross-sectional design. Women (n=298) were recruited from four maternal and child health centers in Al-Mafraq city, Jordan. Participants completed an intrapartum care scale which measured satisfaction with three areas of care: interpersonal, information and involvement in decision making, and physical environment. Overall, only 17.8% of women were satisfied with intrapartum care. Around 13% of women were satisfied with interpersonal care, 20.5% with information and involvement in decision making, and 18.8% with physical birth environment. Regression analyses revealed that low satisfaction was associated with experiencing an episiotomy, poor pain relief during labour, and vaginal birth. Health care professionals, policy-makers as well as hospital administrators need to consider the factors that contribute to low satisfaction with childbirth in any effort to improve care.

Key words: Labour, birth, Jordan, maternity care, midwife, patient satisfaction.

INTRODUCTION

Patient satisfaction is crucial for maintaining and monitoring the quality of health care and can inform service development and delivery (Bazant and Koenig, 2009; Camacho et al., 2012; Martin and Fleming, 2011; Rudman et al., 2007). The interest in patient satisfaction is not only based on a desire to deliver more responsive care and ensure the views of service users are considered, but to develop humanized health care and positively influence health care experiences of consumers (Rudman et al., 2007).

Intrapartum satisfaction is a broad, multi-faceted concept that includes women's experience of labour, birth and immediate postpartum (Bertucci et al., 2012). Satisfaction in this context is often about giving birth in a manner that suits the needs of each woman. Furthermore, as satisfaction is multidimensional, women may be satisfied with some aspects of an experience and dissatisfied with others (Bertucci et al., 2012).

Satisfaction has been investigated in relation to various dimensions of care. First, satisfaction has been associated

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with interpersonal factors such as effective communication between women and care providers during labour and birth; providing opportunities to have an active say during labour and birth; being able to choose among options; deciding when certain actions will be done; and being given information as to why certain decisions are being made (Harriott et al., 2005; Rudman et al., 2007; Waldenström et al., 2006). Perceptions of support from care providers during labour are reported to improve childbirth outcomes and women's satisfaction (Hodnett et al., 2009). Second, satisfaction with intrapartum care has been linked to information-giving and participation in decision-making (Bazant and Koenig, 2009; Dencker et al., 2010; Gungor and Beji, 2012; Janssen et al., 2006; Martin and Fleming, 2011; Rudman et al., 2007; Waldenström et al., 2006). Involvement in decisions about labour procedures can affect women's perceptions of satisfaction. Events such as operative births, long and painful labour, inadequate pain relief, increased obstetric interventions and transfer of the baby to a neonatal unit can adversely affect satisfaction with intrapartum care (Hatamleh et al., 2013a; Oweis, 2009; Rudman et al., 2007; Waldenström et al., 2006). Third, the physical environment in which care is provided is also believed to impact on patient health and safety, effectiveness of care, and morale of staff (Foureur et al., 2010; Sheehy et al., 2011; Ulrich et al., 2008). In most developed western countries, attempts have been made to make the labour and birth environment less clinical and more homelike (Sheehy et al., 2011). Satisfaction with the physical environment is a significant predictor of women's overall satisfaction and positive experience in labour and birth (Foureur et al., 2010; Hodnett et al., 2009).

In Jordan, outcomes for childbearing women and children have improved over the past 20 years. Infant mortality rates have decreased from 40 per 1000 live births in 1985 to 23 per 1000 live births in 2010 (Department of Statistics and Macro International Inc, 2010). Maternal mortality ratios have decreased from 41 deaths per 100,000 live births in 2002 to 19.1 deaths per 100,000 live births in 2008 (Department of Statistics and Macro International Inc, 2010). Almost all (99.5%) births in Jordan are now attended by trained health personnel (Department of Statistics and Macro International Inc, 2010). Despite these improvements significant deficits in the provision of basic maternity services remain. Maternity services are currently focused on screening and treating complications of childbearing and most births are performed by resident doctors or obstetricians. The role of midwives is to assist doctors in the birth. Midwives also are required to attend to many labouring women simultaneously, making it difficult to provide individualized quality care (Abushaikha and Oweis, 2005).

In Jordan, labour and birth is associated with many obstetric interventions such as a high number of vaginal examinations and routine episiotomy (Department of Statistics and Macro International Inc, 2010). Care providers rarely provide emotional care or antenatal and/or postpartum

education. Women have a limited role in decision-making regarding their care, and health professionals are the primary decision-makers who judge whether procedures during pregnancy, birth, and post-partum are warranted. In addition, a woman's family are not allowed to attend the labour and birth (Abushaikha, 2007; Hatamleh et al., 2008, 2013a, b; Khalaf et al., 2007; Khresheh et al., 2009; Oweis, 2009; Shaban et al., 2011).

However, empirical data about Jordanian women's satisfaction with health care services during childbirth are very limited. There have been no studies to determine whether the structure, processes or outcomes of care predict women's satisfaction with intrapartum care. Therefore, the specific aims of this study were to:

1. Determine women's perceptions of satisfaction with intrapartum care;
2. Explore satisfaction in relation to three dimensions: interpersonal care, information and involvement in decision-making, and physical birth environment; and
3. Investigate predictors of women's satisfaction with their intrapartum care.

METHODOLOGY

Design

A descriptive cross-sectional design was used for this study.

Participants

A convenience sample of women attending one of the four maternal and child health centers in Al-Mafraq city in the north-east of Jordan were invited to participate and asked to complete the survey while waiting for their appointment. Women who were eight weeks postpartum, had given birth to a full term singleton live baby, and could understand Arabic were recruited into the study. Women whose babies experienced complications requiring admission to special care nursery were excluded. The 8-week time point for recruitment and data collection was aimed to ensure that women would reliably recollect their recent birthing experiences (Martin and Fleming, 2011).

Using power analysis of medium effect size, a power of 0.8 and a level of significance at 0.05 (Cohen, 1992), the estimated sample size needed was calculated to be 102 women (Cohen, 1992). Over sampling was undertaken to allow for attrition.

Measures

The questionnaire was developed after an extensive review of the literature. Variables measuring intrapartum care were drawn from previous studies of recent mothers' experiences of maternity care conducted in Australia, Sweden, and Canada (Biro et al., 2003; Janssen et al., 2006; Rudman et al., 2007; Waldenström et al., 2006). The questionnaire had two sections. The first section included questions about participants' age, level of education, parity, annual income and occupation. Questions were also asked about the recent childbirth experience such as place of birth, gender of the baby, length of labour and birth, effectiveness of pain relief techniques, birth attendant, perineal trauma (that is, episiotomy) and if the woman had an opportunity to talk to a health

Table 1. Characteristics of the satisfaction with intrapartum care measure.

Variable	No. of items	Total mean score	SD	Cut-off score = total mean +SD
Overall satisfaction with intrapartum care	14	36.12	8.88	Scores ≥ 45 considered satisfied
Subscale 1: Interpersonal care	5	11.28	3.62	Scores ≥ 15 considered satisfied
Subscale 2: Information and decision making	4	10.87	3.03	Scores ≥ 14 considered satisfied
Subscale 3: Physical birth environment	5	11.54	4.21	Scores ≥ 15 considered satisfied

professional about her feelings in relation to the birth.

The second section was a scale measuring women's satisfaction with the three dimensions of intrapartum care. Subscale one contained items related to "interpersonal care" by the midwife/doctor who provided most of the care during labour (5 items). The second subscale included questions about women's satisfaction with information they received and involvement in decision-making (4 items). The last subscale contained questions about physical birth environment (5 items). Participants were asked to rate their satisfaction with intrapartum care on a five point Likert scale of 1 = strongly disagree to 5 = strongly agree. Three items 'during labor and/or birth, decisions made without taking my wishes into account', 'I felt pressured to have baby quickly', and 'I felt labor was taken over by strangers and/or machines' were reverse scored. The cut-off score of the scale and subscales was calculated using the total mean score plus one standard deviation (SD). The cut-off scores are as shown in Table 1.

The questionnaire was translated into Arabic and back-translated to ensure content validity and semantic validity by four bi-lingual scholars who lived in Jordan but had completed postgraduate degrees in English-speaking countries. Face and content validity was assessed by a panel of experts in midwifery and nursing who reviewed the items for clarity, relevance, comprehensiveness, understandability, and ease of administration.

The questionnaire was piloted with a group of 20 childbearing Jordanian women for face validity. Results of the pilot study showed that the questionnaire was easy to administer, clear to read and required 10 minutes (on average) to be completed. The Cronbach's alpha value for the satisfaction with intrapartum care scale was 0.88. The reliability coefficients for each sub-scale of the satisfaction instrument ranged from $r = 0.76$ to 0.90 .

Procedure

Approval for the study was obtained from the Ministry of Health and Human Research Ethics Committee at Al al-Bayt University. The study was conducted from January to May, 2012. Midwives in each clinic initially identified women who met the inclusion criteria and were willing to speak with a research assistant. Verbal and written information about the study were provided and written consent obtained. The questionnaire was administered during an interview at the time of the clinic appointment. The interview was conducted away from the clinics in order to provide privacy and to ensure the absence of the health care providers.

Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 17, personal computer version. Frequencies, means, and standard deviations were calculated as appropriate on the variables. The properties of the instrument were assessed using Cronbach's alpha for reliability. Relationships between dependent variable (satisfaction with three dimensions of

intrapartum care together) and independent variables (demographic, obstetric, and childbirth experience variables) were examined using Chi-square analysis. To determine the relationship between obstetric variables and dissatisfaction with intrapartum care, stepwise multiple regression analyses were undertaken. Statistical significance was set at $p < 0.05$.

RESULTS

Characteristics of participants

In total, 304 women agreed to participate. Questionnaires with more than 3 questions (10% of the questionnaire) unanswered were deleted ($n = 6$). From the 298 remaining questionnaires, 210 (70%) were from multiparous women. Majority of the women (63%) were between 25 and 35 years old. Majority of the women were not employed (73.8%), and 42% reported a family income of between 301 to 500 JD per month which is considered low. Participant characteristics are shown in Table 2.

Of the sample, 220 (73.8%) women gave birth in a public hospital and 78 (26.2%) in a private hospital. During labour and birth, 51% of the women were primarily assisted by a midwife only, 12.8% of the women were primarily assisted by medical staff, and the remainder (36.2%) received care from both doctors and midwives in attendance. Ninety percent of the women had a labour lasting less than 11 h. Caesarean sections accounted for 10% of births. Over forty percent (43.3%) of the women indicated that their labour was more painful than expected and almost two-thirds (63.8%) were unhappy with pain relief during labour. Just less than half (46.3%) of the women reported having an episiotomy and 8% reported complications during labour and/or after the birth including postpartum haemorrhage. Nearly two-thirds of the women (64.1%) reported not being offered an opportunity to talk to any health professional about the birth and 58.8% indicated they would have liked to.

Satisfaction with intrapartum care

The total mean satisfaction score was 36.12 (SD \pm 8.88). Scores of ≥ 45 were considered positive towards increased satisfaction with intrapartum care. Only 17.8% ($n=53$) of the participants scored ≥ 45 . The remaining 82.2%

Table 2. Participant characteristics (n=298).

Demographic characteristic	Sample [n (%)]
Age group	
Less than 25 years	66 (22.1)
25 – 35	190 (63.8)
35 years and above	42 (14.1)
Education	
Low (9 years compulsory school/upper secondary school)	26 (8.7)
High school	115 (38.6)
Diploma	63 (21.1)
Bachelor	92 (30.9)
Others	2 (0.7)
Total monthly income	
Below 150 JD	9 (3.0)
150-300 JD	121 (40.6)
301-500 JD	124 (41.6)
Above 500 JD	44 (14.8)
Occupation	
Employed	78 (26.2)
Not employed	220 (73.8)
Gravida	
Primiparous	88 (29.5)
Multiparous	210 (70.5)
Experience during labour and birth	
Normal vaginal birth	267 (89.9)
Caesarean section	31 (10.1)
Cared for by midwife only during labour and/or the birth	152 (51)
Labour more painful than expected	129 (43.3)
Unhappy with help to relieve pain during labor	190 (63.8)
Episiotomy	138 (46.3)
Complications during labour and/or after the birth	24 (8)
Haemorrhage after the birth	14 (4.7)
No opportunity to talk about the birth	191 (64.1)
Wanted to talk to a health professional about the birth	176 (58.8)

82.2% (n = 245) women scored lower suggesting dissatisfaction with the three dimensions of intrapartum care. Items including 'decisions made without taking my wishes into account', 'I felt pressured to have the baby quickly', 'the doctors/midwives were helpful during labour and/or the birth', 'I felt labour was taken over by strangers and/or machines' were the four highest scored items as outlined in Table 3.

The mean subscale score for interpersonal care was 11.28 (SD ± 3.62). Scores of ≥15 were considered positive. Only 13.1% of the participants (n = 39) scored ≥15. The remaining 86.9% (n = 259) scored low suggesting

suggesting dissatisfaction with interpersonal care.

The mean subscale score for satisfaction with information and involvement in decision making dimension was 10.87 (SD ± 3.03). Scores of ≥14 were considered positive. Only 20.5% (n = 61) of the participants scored ≥14. Majority of the women (79.5%) women scored lower suggesting they were dissatisfied with this dimension.

The mean subscale score with the physical birth environment was 11.54 (SD ± 4.21). Scores of ≥15 were considered positive. Only 18.8% of participants (n = 56) scored ≥15. The remaining 81.2% (n = 242) of the women scored low suggesting dissatisfaction with the

Table 3. Satisfaction with intrapartum care scale, subscale, and item means, and standard deviations (n = 298).

Characteristic	Mean	SD
Total scale (14 items) Scores ≥ 45 considered satisfied	36.12	8.88
Subscale 1: Interpersonal care (5 items) Scores ≥ 15 considered satisfied	11.28	3.62
When you arrived at the hospital, staff were friendly and welcoming	2.10	0.628
Doctors and midwives were encouraging and reassuring	2.27	0.958
During labor and/or birth, the midwives/nurses were helpful	2.17	0.845
During labor and/or birth, the doctors were helpful	2.66	1.460
The overall care during labor and/or birth was good	2.09	0.856
Subscale 2: Information and decision making (4 items) Scores ≥ 14 considered satisfied	10.87	3.03
The midwives and doctors always kept me informed about what was happening during labor and/or birth	2.45	0.970
During labor and/or birth, decisions made without taking my wishes into account	3.01	1.070
I felt pressured to have the baby quickly	2.84	1.064
I felt labor was taken over by strangers and/or machines	2.57	0.878
Variable 3: Physical birth environment (5 items) Scores ≥ 15 considered satisfied	11.54	4.21
The level of light was adequate	2.13	0.911
The room was spacious and adequate for my needs	2.30	0.958
The level of noise was appropriate	2.44	1.148
Trays and other equipment were clean	2.28	0.913
I was able to find the supplies I needed	2.41	1.015

Table 4. Factors associated with low satisfaction with intrapartum care.

Item	No. of women	χ^2	df	Significance
Birthed at a public hospital	172	40.984	1	<0.001*
Vaginal birth	215	333.992	2	<0.001*
Labour more painful than expected	115	39.608	2	<0.001*
Unhappy with pain relief during labour	179	174.106	2	<0.001*
Postpartum haemorrhage	12	9.333	2	0.009*
Episiotomy	117	37.041	2	<0.001*
Cared for by a midwife during labor and/or birth	111	37.845	2	<0.001*
No one asked how the woman felt about what happened during labour and/or birth	142	67.975	2	<0.001*

*Statistically significant association.

physical birth environment. Means and SD of total scale, subscales and subscale items are shown in Table 3.

Predictors of satisfaction with intrapartum care

There was no association between women's sociodemographic data (age, education, occupation, income, and parity) and satisfaction with intrapartum care. Obstetric variables associated with low satisfaction with intrapartum care (as outlined in Table 4) were birthed at a public hospital, vaginal birth, having a labour that was more painful than expected, poor pain relief during labour

labour, postpartum haemorrhage, episiotomy, being cared for by a midwife, and not being asked about feelings in relation to the labour and/or birth.

Eight variables statistically associated with low satisfaction were entered into a stepwise multiple regression. The multiple regression analysis resulted in five variables being excluded (Birthed at a public hospital, labour more painful than expected, postpartum hemorrhage, cared for by a midwife, and not being and/or birth). Three variables (having an episiotomy, vaginal birth, and unhappy with method of pain relief during labour) were retained as predictive of low satisfaction with intrapartum care. The regression model accounted for approximately

Table 5. Regression analysis to identify predictors of low satisfaction with intrapartum care.

Item	Standardized coefficients		
	β	t	Significance
Had an episiotomy	-0.766	-6.740	<0.001*
Unhappy with pain relief during labour	0.345	3.110	0.008*
Vaginal birth	0.333	3.003	0.009*

*Statistically significant association

84% ($r^2 = 0.838$) of variance in low satisfaction with intrapartum care (Table 5).

DISCUSSION

This study investigated women’s satisfaction with intrapartum care. Majority of the women in this study reported low satisfaction with overall care and dimensions of care (interpersonal care, information and involvement in decision making, and physical birth environment). The rate of satisfaction is much lower than those reported in the high income countries such as Sweden, Australia and USA (Britton, 2006; Rudman et al., 2007) but similar to rates reported in low income countries (Mohammad et al., 2011; Oweis, 2009; Senarath et al., 2006). Similarities in the rate of satisfaction with intrapartum care in low income countries may be related in part to cultural norms that manifest in domination of the medical model of maternity care and lower status of women.

In this study, many factors adversely affected satisfaction with intrapartum care. Women who reported that labour was more painful than expected, received inadequate pain management, had an episiotomy and/or postpartum hemorrhage was less satisfied with their intrapartum care. This is consistent with other studies which reported that women who have a long, painful, and intense labour, and have multiple obstetric interventions including induction of labour, increased the number of vaginal examinations, episiotomy and being in the lithotomy position during childbirth report less satisfaction with intrapartum care (Bryanton et al., 2008; Hatamleh et al., 2013a; Nilsson and Lundgren, 2007). It is not clear whether these factors drive low satisfaction or whether they are a result of them.

In Middle Eastern countries, the main goal of care providers during labour and birth has been to ensure a safe and positive labour experience with minimal pain and discomfort (Abdel Ghani and Berggren, 2011). However, there is strong evidence from high income countries that women who have continuity of midwifery care, continuous support during labour, a good relationship with their caregiver, and good support during labour and birth are more likely to require less pain relief, have an intervention-free labour and birth, higher

perception of control, and be more satisfied with their intrapartum care (Hatem et al., 2008; Hodnett et al., 2009; Leap et al., 2010a, b). However, in Jordan, continuity of care and support in labour are very difficult to achieve. It is common for midwives to be required to attend to many laboring women simultaneously (Oweis, 2009) making it difficult for them to provide individualized quality care. In addition, health care providers in Jordan tend only to provide physical care to labouring women, are unable to provide emotional support but most hospitals do not allow women to bring a supporter with them to provide social support during labour and birth (Hatamleh et al., 2008; Khresheh and Barclay, 2010; Sweidan et al., 2008). A lack of continuity of care and a lack of professional and social support may well increase the pain experienced by labouring women in Jordan and increase their need for pharmacological methods to decrease pain during labour and birth.

This study also found that insufficient time was given to women to process their birth experience and this was associated with low satisfaction. Previous studies in other countries reported a similar low priority was given to women’s postpartum emotional response to labour and birth (Creedy et al., 2000; Gamble et al., 2005). Changing to a continuity of care model may increase the amount of time midwives can devote to each woman during labour and birth, improve the quality of physical and emotional care provided by midwives. Emerging evidence from high income countries suggests that continuity of care enables midwives to offer individualized physical and emotional care and ongoing education to each woman throughout their pregnancy, labour and birth, improving women’s confidence to manage pain and birth with confidence (Sandall et al., 2010).

Jordanian women in this study who gave birth at public hospitals reported less satisfaction with their intrapartum care. These results could be explained in light of the high midwife-labouring woman ratio in Jordanian public hospitals, which is usually much higher than that in private hospitals (Oweis, 2009). In contrast to private hospitals, women in public hospitals mostly receive inconsistent, fragmented care and family members are not allowed to attend the labour and birth. Women have complained about these aspects of care and other researchers have recommended changes to improve the model of care offered (Khresheh and Barclay, 2010; Shaban

Shaban et al., 2011). Vaginal birth in this study was associated with low satisfaction with intrapartum care. This could be related to childbirth practices in Jordan and other Arab countries where women are subjected to unnecessary, painful, and harmful procedures such as frequent vaginal examinations, routine episiotomy, and adoption of lithotomy position for giving birth (Shaban et al., 2011). These procedures are associated with increased pain experienced and may increase dissatisfaction with care. It is possible these procedures contributed to women feeling vulnerable and reporting more pain and less satisfaction with care.

The current study found that intrapartum care by a midwife was associated with lower satisfaction. Evidence of the association between attendance of midwives during labour and birth and satisfaction with intrapartum care is mixed. A recent systematic review found labouring women prefer the attendance of midwives (Walsh and Devane, 2012), while a study conducted in Syria to identify women's preferences for birth attendant showed that many (60.4%) preferred to be attended to by doctors compared to midwives (21.2%) (Bashour and Abdulsalam, 2005). This finding may reflect cultural stereotypes and expectations of Middle Eastern cultures where midwives are perceived to be of lower status compared with medical professionals (Shaban et al., 2012). As a consequence, most Jordanian women prefer to receive their care from doctors (Department of Statistics and Macro International Inc, 2010).

There is limited data about the influence of women's demographic background and dissatisfaction with intrapartum care in Jordan. The current study found no association. Worldwide, available findings regarding the association between demographic variables and satisfaction with intrapartum care are mixed, with some studies reporting that age, parity and marital status were associated with satisfaction with intrapartum care (Senarath et al., 2006) and other studies not fully supporting this (Rudman et al., 2007).

This study showed low rates of satisfaction with care during labour and birth. Health care professionals, policy-makers as well as hospital administrators need to review the procedures and policies regarding childbirth practices in their hospitals. This information will help in planning and implementing appropriate strategies to assist women have a positive birth experience. Increasing individualized care in labour, increasing support in labour and decreasing unnecessary interventions may contribute to improving satisfaction with the labour and birth experience.

Conflict of Interest

The authors have no conflicts of interest and no financial disclosures to report.

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Review

Quality issues in midwifery: A critical analysis of midwifery in Nigeria within the context of the International Confederation of Midwives (ICM) global standards

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Advances in health care system are a challenge to the professional midwife in the quality of midwifery workforce. The three pillars of quality midwifery workforce need to meet the changing health needs of both the rural and modern highly industrialized society. Insisting on the traditional ways of doing things in midwifery seems inadequate in meeting these challenges. New and creative approaches are needed if midwifery as a prominent profession in health care delivery will professionally remain competitive and contribute effectively and maximally to the demands of nation's health care services. Midwife leaders will be taking a step in the right direction in fostering the climate that promotes creativity in midwifery. Midwifery in Nigeria had witnessed many changes, given the challenges of a low/poor resource setting. This paper attempts a discourse on issues affecting midwifery as a profession using the International Confederation of Midwives (ICM) global standards.

Key words: Quality issues, midwifery, International Confederation of Midwives (ICM) global standards.

INTRODUCTION

Globally, the health care industry has undergone and continues to undergo competitive changes at a rapid pace due to the ongoing health care reform. Coping with this changes require new and creative model of education, service, management and organization. Midwifery is as old as the history of human species evidenced archeologically by a woman squatting in childbirth supported by another from behind in 5000 BC. Midwifery is a health care profession in which providers offer care to childbearing woman during pregnancy, labour and postpartum period. It involves providing care to newborn, primary care to well women, family planning and menopausal

care. Through the century, midwifery has grown, changing its mode of practice. Yet there are several critical issues in midwifery practice which are not in tandem with the International Confederation of Midwives (ICM) global standard of midwifery which alters the progress of midwifery profession today in the some countries like Nigeria.

Nigeria's health system has both midwives and nurse-midwives. A midwife would have completed a three-year basic midwifery programme. A nurse-midwife would have completed an eighteen (18) months midwifery course in addition to her nursing training. Traditional birth attendants

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(TBAs) also provide midwifery services, most commonly in rural areas. Since 1979, the government has taken the view that TBAs should be integrated into the primary health care system and has approved training programmes to upgrade the skills of TBAs. However, a 2002 study in Edo State found that just 16% of TBAs were registered with the Local Government, indicating that TBAs were far from being integrated into the system (Ofili et al., 2005). There are no official estimates of the number of TBAs practising in Nigeria, but the 2008 Demographic and Health Surveys (DHS) found that 22% of live births were attended by a TBA, that is, approximately 1.35 million births per year, so there must be a considerable number.

In Nigeria today, it is compulsory for newly-qualified, university-educated midwives to spend a year in the National Youth Service, which usually involves a rural posting to a state other than their home state (Africa Health Workforce Directory, 2008). However, in the longer term, health professionals are reported to be unwilling to live and work in rural areas due to poor communications with the rest of the country, poor prospects for career progression and poor employment and education prospects for their families (Uneke et al., 2008). To tackle this problem, in 2009 the Midwives Service Scheme (MSS) was launched. The MSS was a joint initiative between the three tiers of government in Nigeria, with the objective of mobilising midwives (including unemployed and retired midwives) to work in underserved areas (Federal Ministry of Health, 2009). By July 2010 the scheme had resulted in 2,622 midwives being deployed to primary health care facilities in rural areas (National Primary Health Care Development Agency, 2011).

Although the Federal government is responsible for the management of teaching hospitals and medical schools for the training of doctors, the individual states are responsible for the training of nurses, midwives and community health extension workers (CHEWs). In 2010, there were 76 Nursing and Midwifery Council of Nigeria (NMCN)-accredited schools of midwifery in Nigeria. In 2003, a 3-year Basic Midwifery Programme was introduced by the NMCN which allowed students to train as midwives without first obtaining a nursing qualification, and 17 of the 36 states decided to run the programme in 22 schools (16 state-owned and 6 NGO-owned).

In total, 795 students enrolled in 2003, of whom 475 sat for the final examination in 2006 and just 223 passed (Nursing and Midwifery Council of Nigeria (NMCN), 2011). After the basic programme, midwives can go straight into practice or further their education by either doing a further 18 months' General Nursing Training, or entering the second year of a four-year BNSc course. Registered nurses can complete a Post Basic Midwifery programme, which is an 18-month course, taking a

maximum of 30 students per institution per year (NMCN, 2011). Under the Midwives Service Scheme (MSS), Schools of Midwifery run refresher training for unemployed and retired midwives to update their skills so they can be deployed to under-resourced areas. This paper therefore attempts an analysis of midwifery in Nigeria within the context of ICM global standards.

ICM GLOBAL STANDARDS

The use of global standards and their guidelines ensures that midwives in all countries have effective education, regulation and strong associations. ICM has developed various interrelated ICM core documents which guide Midwives Associations and their Governments to review and improve on the education and regulation of midwives and midwifery, and enable countries to review their midwifery curricula for the production and retention of a quality midwifery workforce. ICM's three pillars are education, regulation and strong member associations and are built upon the foundation of updated core competencies. These three pillars are interdependent and provide a complete package of information for midwives, policy makers, and governments. The ICM 'three pillars' focused on:

1. Global Standards for midwifery education along with companion guidelines.
2. Global standards for midwifery regulation and strengthening midwifery associations.
3. Updating and expanding the 2002 essential competencies for basic midwifery practice and affirming the evidence base.

Matthews et al. (2006) identified four important factors for empowering midwives namely control, support, recognitions and skills. These reflect the professional distinctiveness of midwifery but accounts for the specific role and working environments of the midwife. In some countries, most especially the developing ones like India, efforts and support are needed nationally as well as internationally to improve midwifery profession. The reasons for the dilution in midwifery profession are amended regulations, lack of social or political priorities and change in health programme directions (Mavalankar et al., 2011).

ISSUES AFFECTING MIDWIFERY PRACTICE ACCORDING TO THE THREE PILLARS OF MIDWIFERY

Midwifery education

Midwifery education is largely below the ICM standard resulting in provision of poorly qualified midwives in

Nigeria. In some countries, midwifery is still at the diploma level whereas it has risen to master's and doctorate level in other countries. How can a profession be recognized and gain autonomy when most of the members are diploma holders, poorly trained, rarely updates their knowledge while in service and lacks enabling environment to learn or practice skills?. The lack of books, equipment and facilities in schools of midwifery and in clinical areas has grievously affected midwifery practice. Tutors and students have few materials for teaching and learning. In Nigeria, the students are taught theoretically both in the clinical areas, to improvise equipment leading to the practice of traditional midwifery care but ICM recommends minimum of 40% theory and a minimum of 50% practice. Hospital and clinics mostly in the rural areas lack equipment and amenities to practice midwifery care leading to lack of evidence based care and inability to practice acquired skills. Provision should be made to support and supervise individuals who teach students in practical learning sites. Unfortunately, student midwives are hardly supervised or supervised by community health extension workers or by midwives who are not knowledgeable on the current standard of practice.

Saramma et al. (2011) observed lack of adherence to minimum standards of education and accreditation in Asia, contributing to poor quality of training. Soqupinar et al. (2007) lamented on the importance of standardized and high quality midwifery education in Turkey as it is below standard. According to Ezeonwu (2010) and Lugina et al. (2001), textbooks and journals are scarce, outdated or irrelevant to the local context undermining teacher' abilities to teach and students to learn. The opportunity for midwifery educationist to collaborate with service colleagues and researchers should be created across the country. This will lead to development of appropriate curricular; meet the educational and service needs of the professional colleagues. The challenge is not only on the skill and knowledge to enhance practice, but also to be actively committed and resourceful, as well as being politically sensitive in current and future service provision challenges (Bradshaw et al., 2010).

Use of research/evidence based practice

Research is vital in every profession in achieving its optimum goal and midwifery is no exception. Health care was founded on tradition of assumption, personal preferences, intuitions and rituals but the recent move towards accountability, quality assurance system and audit has necessitated a re-evaluation of the way in which health care is delivered. Currently, there is a concerted effort to move away from ritualistic care procedures and to replace them with clinical practices founded on scientific research evidence. There is few published research data

relevant to midwifery practice. Butler et al. (2009) identified six key priority areas for midwifery research in Ireland. They include promoting woman centred care (management), promoting the distinctiveness of midwifery (education), satisfaction with care (clinical), care in labour (clinical), preparation for practice (clinical) and promoting research/evidence based practice (education). Underpinning this new evidence based culture is the need for more research in midwifery for professional strength. Evidence based practice is the integration of the best research evidence with clinical expertise and patient values (Sackett et al., 2000). ICM recommends use of evidence-based approaches to teaching and learning. In Nigeria, midwifery practice is still at its historical level as the use of evidence based practice is at low ebb. This can be attributed to poor knowledge of and attitudes of midwives to research, poor response to updating knowledge (though changing) and non supportive working environment. Research output of midwife educators is grossly low because it is not a criterion for advancement in their career except for those who are in the University. This may have impact on students' knowledge and skill, current standard of practice and eventually on quality of care.

MIDWIFERY REGULATION

Professional update and remuneration

In-service training is an essential element in keeping every professional up to date. Often, midwives encounter situations which they never experienced in their initial training, so continuous educational update, in-service training, quality control and supervision is essential for effective midwifery outcome and autonomy. ICM states that for eligibility to continue to hold a license to practice midwifery is dependent upon the individual midwife's ability to demonstrate continuing competence. Assessment and demonstration of continuing competence is facilitated by a re certification or re licensing policy and process that includes such things as continuing education, minimum practice requirements, competence review (assessment) and professional activities. The register of midwives must show the practicing status of the midwife and must be publicly available. According to the Nursing and Midwifery council, UK, it is the responsibility of every midwife to keep her knowledge and skills up to date throughout her working career. Members of the global network Health Information for All (HIFA) (2015) have identified a pervasive peak of information, knowledge gaps and unsafe practices among midwives in low-income countries both during training and practice.

Ijadunola et al. (2010) observed that ninety one percent of the maternity staff in the south-west Nigeria have poor knowledge on emergency obstetric care services. They

suggested urgent reorientation/retraining of the staff in line with the global best practice. Kaye (2000) reported severe lack of knowledge on obstetric emergencies, such as haemorrhage, obstructed labour, sepsis and eclampsia, lack of standard treatment guidelines, poor quality antenatal and delivery care among midwives in Uganda. Murira et al. (2010) as cited by members of HIFA challenge working group, Pakenham-Walsh et al. (2011) concluded that there is lack of confidence and skills among midwives in communicating health message to women. Ith et al. (2012) observed a gap between evidence based standard of practice and the current practice of the skilled birth attendants in labour, births and immediate post partum care which is largely driven by lack of supportive working environment.

The quality of time spent by patients is very essential. Study carried out in Australia showed that nurses spent 37% of their time with patients and overtimes, spent significantly less time talking with colleague and more time alone (Johanna et al., 2011).

Midwives are poorly remunerated because of the history of nurse-midwife, making it impossible for some countries to have a separate cadre for midwives. Midwifery service scheme was established by the federal government of Nigeria in collaboration with the nursing and midwifery and National Primary Health Care Agency to employ fresh graduates and retired midwives. Due to lack of recognition, remuneration and assertiveness, they are paid a sum of thirty dollars (\$30) which is almost equivalent to a salary earned by a high school graduate. It is important to stress that poor remuneration has constantly been a factor for brain drain and poor retention of midwives. Saramma et al. (2011) noted that majority of Asian countries do not include midwifery as a separate cadre in human resources planning, resulting in non availability and distribution of midwives.

The use of expired license or no license by midwives in practice is a grave problem in Nigeria likewise in some other countries. As grave as it is, little or nothing is being done about it as there is no formal strategy to check those practicing with expired license mostly at the private hospital, primary health centres and even state government hospitals. The Nursing and Midwifery Council of Nigeria (NMCN) is the only professional Council for nurses and midwives. Its mission statement is "Maintaining Excellence in Nursing Education and Practice". As a parastatal of the Federal Government, the NMCN is responsible for accrediting training institutions, registering new nurses and midwives, and disciplining nurses/midwives, but does not always have sufficient resources to fulfil these duties properly (NMCN, 2011).

Professional autonomy and opportunity

The profession is largely invisible because of the history

of nurse-midwifery and referring to midwives as nurses, although, in Nigeria, the norm is dual qualifications RN, RM. There should be legislative protection of the title, which will enable the midwifery regulatory authority to prosecute someone who breaches the legislation by holding themselves out to be a midwife when they are not on the register of midwives. Although the concept of dual qualifications is the norm in Nigeria, yet there are many midwives who are practicing and would like to be addressed as such. The board members of Nursing and Midwifery Council of Nigeria shows there is no strong midwifery representation as compared to nursing and as a matter of concern has Obstetrician and Gynaecologist.

Dennis-Antwi (2011) commented that midwifery associations face leadership challenges or are non-existent because midwives are recognized under National Nursing association. Secondly due to the medicalization of childbirth, midwifery practice is being taken over by obstetrician most especially in the hospitals. In English speaking Africa countries, midwifery services are undermined by lack of standardized education and weak regulatory systems. This contributes to poor recognition of midwifery; limited or no career pathway, lack of involvement in policy decision-making. Zammit et al. (2011) observed that midwifery practice in Malta is being taken over by obstetricians, antenatal care by midwives are limited in the main state hospitals and is restricted from practicing autonomously.

According to ICM, the scope of practice must support and enable autonomous midwifery practice and should therefore include prescribing rights, access to laboratory/screening services and admitting and discharge rights. As autonomous primary health practitioners, midwives must be able to consult with and refer to specialists and have access to back up emergency services in all maternity settings. Associated non-midwifery legislation may need to be amended to give midwives the necessary authorities to practice in their full scope.

Young midwives from countries like Ghana and Uganda are recently withdrawing from the profession and moving to other health related career with higher academic development due to poor recognition and non existence of opportunities in midwifery (Dennis-Antwi, 2011). Uz et al. (2011) noted that in some countries there are job opportunities for midwives leading to many people moving into the profession while in some countries like Iran, there is job scarcity and poor job description for midwives. A study by Hatem et al. (2008), comparing midwife-led care and medically led care showed that midwife led care was associated with several significant benefits and no adverse effect. The women received less regional analgesia, episiotomy, antenatal hospitalization, instrumental birth and less fetal loss before 24 weeks gestation. There were more spontaneous vaginal delivery, proper and early initiation of breastfeeding and

feeling of control during labour. According to Janssen et al. (2009), planned home birth attended by registered midwives was associated with very low and comparable rates of perinatal death and reduced rates of obstetric intervention and other adverse perinatal outcome compared to planned hospital birth attended by a midwife or physician.

Male involvement in midwifery

The last 15 years had witnessed increasing global recognition of the importance of men involvement in sexual and reproductive health most especially in high fertility countries such as Nigeria. Over the years, male have been segregated from midwifery profession until recently. Introduction of men to midwifery is still a mirage in some countries. Midwifery is seen as a female profession. However, midwives call on or involve male doctors in care of their patients forgetting that they are of the same gender.

Schools of midwifery in some country like Nigeria do not admit males because of their perception that it is a female profession; as well as for religious and cultural reasons. Male midwives in Nigerian got the opportunity through degree programme. The perception that it is unsuitable for men to work in maternity wards is widespread, certain cultural sensitivities exist but cannot be abolished if the profession do not change its *modus operandi*. The general clamour for men in nursing should be extended to midwifery. Countries like USA and UK are good examples of what men can do in the perceived female profession. The involvement of men in midwifery will contribute a lot to the progress of the profession as they can lobby, fight and stand more for their right coupled with the societal advantages of the gender.

Barker (1982) supported male midwifery saying that it will foster a more open attitude to childbirth, encouraging husbands to be present and share the experience of labour and delivery. Douglas (1981) argued that if male medical practitioners and male obstetrician can examine a woman, then there is no reason why a male midwife cannot do the same. Some husband stated that they will feel more comfortable in the labour room with their wives if the midwife conducting the delivery is a male (Sweet, 1984).

A study carried out by Abeer et al. (2011) on male Egyptian student nurses revealed increased discrimination by the female patients and unfavourable attitude by the clinical instructors.

Legal issues

Communication gap

Communication is very essential in services delivery as it

establishes professional relationship. To achieve organizational or professional goal, efficient communication between the members and or the clients is vital. The existence of inter and intra professional communication gaps among the health care professionals has resulted to poor quality of service delivery over the years. These communication gaps are due to lack of assertiveness, superiority and low level of knowledge. Robbie (2000) observed that professional midwives often treat women badly during birth by ignoring their needs and requests, talking to them disrespectfully. The midwives are equally treated badly by the health care system in which they work; they are always underpaid, mistreated by physicians and work longer hours under stressful conditions. According to Timmins et al. (2005), nurses and midwives use assertive behaviour more frequently with their colleagues than with the management/medical colleague as it emerges as a supporting factor for responsibility to patients/clients. This suggests the need for nurses and midwives to learn how to behave assertively most especially with other professional colleagues in order to gain autonomy, possess their right and be recognized, and this should begin from pre to post registration educational training. Study carried out by Harris et al. (2011) revealed the need for professional understanding between midwives in different locations as skills in risk assessment and decision making are highly crucial in rural midwifery care which is undermined by contact with colleagues.

Informed consent

Informed consent appears to be a challenging and sometimes problematic area of practice for midwives. Patient's bills of right are rarely observed by health professional in the clinic/hospital because of their perception of being in charge, making it impossible to inform the patients of any procedure. This is very common in midwifery practice especially during delivery. In certain procedures like vaginal examination, examination of newborn, checking of vital signs/fetal heart rate, midwives rarely explain the procedures to the patients and when done, hardly wait for the patient to consent before commencing on the procedure. Informed consent is a legal right of every patient and also protects a health professional legally. NMC (2002) commented that midwives do not adhere to the code of professional conduct which stipulates the requirements for informed consent. It is not always clear, for example, what amount of information is required to be supplied to women to ensure fully informed consent. Similarly, it is unclear whether midwives can provide unbiased information, and what midwives' communication responsibilities are, when other health care providers become involved in care and treatment

decisions.

The 2008 Midwifery Council of Nigeria report also highlights a lack of informed consent and communication with clients as two of the themes from the 35 complaints they received that year was about professional conduct. Skirton et al. (2007) study on antenatal screening and informed choice in the United Kingdom revealed that parents and professionals regarded screening tests as routine and therefore not requiring a decision. Symon (1997) highlighted that carrying out a procedure without consent can be constructed as a trespass or an actual assault. For consent to be valid, the person must have the mental capacity to consent, must be given sufficient information and finally must give voluntarily consent (Kulkielka, 2002).

Documentation

Documentation is a process in which the patient's experience from admission to discharge is recorded. It enables all clinical staff involved in the patient's care to detect changes in the patient's condition and response to treatment and care delivery. This allows health teams to make decisions about the best treatment options for the patient based on accurate, objective and current information. Documentation is an essential part of the nurses' and midwives' care of their patients but it is often viewed as a burdensome activity. This is very vital as it provides a record of evidence of care, actions, assessments and discussions held with the patient we cared for. Documentation of care, statistic, results and practice is rarely done in midwifery especially in developing world and mostly in rural practice where few midwives are assigned to a large population. Most often, community midwives rarely document statistics such as death or severe diagnosis to protect their job and cover their wrong practice.

Professional associations

In Nigeria, the only professional association is the National Association for Nigeria Nurses and Midwives. The implication of this is that midwives may not be able to address issues that are peculiar to midwifery.

Number of practicing midwives

There is massive reduction in the number of practicing midwives and is attributed to reduced number of people going into the profession and increased number of midwives, leaving the profession to another. This has made it impossible to achieve the recommended required number of midwives per population in all countries. WHO

(2006) estimated a shortage of 4.5 million midwives, nurses and doctors with the shortage most severe in 57 priority countries. Only 40% of births in low income countries are assisted by properly skilled birth attendants (Fauveau et al. 2008). One to one midwifery practice provides a higher degree of clinical outcome with reduced rate of medical interventions like the use of epidural anaesthesia, shorter second stage of labour, episiotomy and perineal laceration, without compromising safety of care (Page et al., 1999).

According to Kadidiatou et al. (2011), there is massive shortage of midwives in health institutions and reduced number of midwifery institutions in proportions to the population. This is more common in developing countries such as Afghanistan, Bangladesh, Cambodia, Congo, Ethiopia, Tanzania, Rwanda etc. Bogossian et al. (2011) specified difficulties affecting midwifery practice in Australia as low number of midwives/independent practitioners and qualified midwives to teach and undertake research in academics. According to Blami et al. (2011), many midwives in the French speaking countries of West Africa, such as Benin, Burkina Faso, Togo, Mali, Niger and Cote d'Ivoire are abandoning midwifery and changing to other professions such as surgery, ophthalmology or dentistry due to fat allowances. In Nigeria, many people are going to midwifery schools because it is a requirement to practice, for employment opportunity or intention to travel to a developed country.

Alternative setting for midwifery care

The last 100 years has seen several major shifts in settings for maternity care. At the turn of the 19th century, most births took place at home; by 1940 about 40% of life birth occurred in the hospital and totally the figure has risen to 98% (DHHS, 2005). Midwifery care is still moving from the home to the hospitals in developing countries; women are encouraged to go to the hospitals to obtain care by a skilled birth attendant whereas in developed countries it is shifting back to domiciliary midwifery care. United Nations Population Fund (UNFPA) report showed that 35% of deliveries that took place in health facilities in Nigeria in 2010 were attended by a skilled birth health personnel and this has been static for the past five years. The 2008 DHS report showed that 25% of live births were attended by a nurse or midwife, 5% by unlicensed (auxillary) nurse/midwife and nine (9%) by a doctor in Nigeria. In some developed countries, increasing numbers of families are once more choosing childbirth at home or in alternative birth setting rather than hospitals. This provides families with increase control of the birth experience and options for birth surroundings unavailable in hospitals. Study by Hodnett et al. (2005) showed that home-like setting for childbirth have modest benefits such

as reduced medical interventions and increased maternal satisfaction when compared to conventional institutional settings. Hodnett (2001) supported the fact that there are some benefits from home-like settings for childbirth, although increased support from caregivers may be more important.

Innovation

Technological concept

Technological advances are taking over the natural normal birth, even though it has largely improved the morbidity and mortality rates. It is killing the natural feeling of midwifery, affecting the therapeutic touch that comes with the care and is changing midwifery care to obstetric care. Childbirth in some countries like UK, USA are defined in medical norms and takes place with a medical context, as such is no longer purely a social or personal event nor the province of a woman. The expansion of medical jurisdictions into the realm of previously non-medically defined events has led to the medicalization of childbirth (Gable et al., 1989).

Medical frames of references and knowledge have been accepted and legitimated within a system of maternity care which has brought not only a surge in engineering obstetrics but a steady erosion of maternal choice, control and satisfaction in relation to many aspects of pregnancy and labour, usually justified as safety (Cahill, 2001). With the advances, telemedicine came into existence, improving and taking health care to the hard to reach areas. Telemedicine is the use of telecommunication and information technologies for the delivery of clinical care (Daniel et al., 2013).

Many midwives are unaware of this new advancement and even when aware feels inferior to call for assistance. The inter/intra professional gap existing in some countries had affected the quality of care and use of telemedicine. It is important that midwives are trained on how to use equipment like digital thermometer, electronic sphygmomanometer, computer and electronic foetal monitors as they are very vital in midwifery care. This is even more important now that the government is making every effort to improve maternal and child health in Nigeria irrespective of the geographical domain. Some states in Nigeria offer pregnant women mobile phones to enhance adequate monitoring of antenatal care

DISCUSSION

The applicability of the ICM global standards in developing nations like Nigeria is a concern. The tripod (education, regulation, and strong member associations)

appears to be weak and attracting little or no attention. Education of midwives is not consistent with professional education which may make professionalization of midwifery to be impossible. As it is, midwifery has been subsumed under nursing. This has implication for the curriculum, leadership and competencies of midwives. This has singularly led to many of the challenges facing midwifery workforce. These challenges include but not limited to poor recruitment and retention of midwives; lack of identity and respect as an autonomous profession; the profession is not attractive. In many countries, because midwives are identified by patients and public as nurses and dual role of nurse- midwife causes role confusion and redeployment of midwives to other areas of nursing, midwives leave public health system to work with governmental and non-governmental agencies as obstetric nurses and also migrate to other countries for higher pay.

The regulation of midwives and midwifery is also embedded in nursing. This does not give room for the expanded role of the midwives and their career progression. Nursing and midwifery can be under one regulatory body with each profession having its operating unit but this is not so. The last leg of the tripod is strong professional association. In Nigeria, Decree 89 of 1979 has brought an end to midwifery board and midwives have remained members of National Association of Nigerian Nurses and Midwives (NANNM). The employment condition is also not helpful to remain as a midwife.

THE WAY FORWARD

The way out of ensuring quality in midwifery is centred on the pillars of ICM. This can be achieved by providing opportunities for multidisciplinary content and learning experiences that complement the midwifery content. Carrying out regional or national training, follow-up, monitoring and supervision of registered midwives ensuring that they are abreast with current research, skill and knowledge will be beneficial. The NMC&M should conduct on site surveys to evaluate compliance with set standard and country licensure rules. It should also periodically investigate complaints, allegations of poor midwifery care and ensuring that the culprits are duly punished. The government and other employers should ensure adequate staffing and proper staffing policy, for remuneration and recruitment.

The quality of midwifery care must be measured to ensure effectiveness and efficiency. Economic issues, services (which focuses on satisfaction such as appointment, waiting times) and clinical (which evaluates the relationship of specific processes of care and/or patient health states outcomes) will provide a good indicator. Efforts should be made at scaling up skilled attendance with midwives who possess the full range of midwifery

core competencies. Tutors and supervisors of schools of midwifery must be competent and experienced in midwifery, as well as educational and training technologies.

There should be legislative protection of midwifery profession by prosecuting someone who breaches the legislation by holding themselves out to be a midwife when they are not on the register of midwives. The legislative protection of midwifery profession must support and enable autonomous midwifery practice. The association must make publicly the register of midwives showing their practicing status. Mandate and implement eligibility to continue to practice midwifery through demonstrating continuing competence by the midwives before recertification or relicensing.

IMPLICATION FOR MIDWIFERY

If all women delivered with a competent, well equipped midwife, two thirds of maternal and newborn deaths could be averted, and roughly 3.6 million lives saved by 2015 (Gilmore, 2013). Midwives need the space and opportunity to play a far larger role if we are to meet the challenges of the millennium development goals (MDGs). Hence, the need to tackle these issues affecting midwifery cannot be over emphasized, there is need to embrace opportunities that could improve the quality of midwifery workforce. Removing these challenges will however provide great opportunity for improving midwifery education, practice, midwife burnout, professional autonomy and associations. There is need for every country to adopt the ICM recommended global standard for midwifery.

Conclusion

There is need to address quality issues in Midwifery, if professional midwives will provide quality midwifery care to their clients. These quality issues include application of global standards as identified by the ICM. The ICM's three pillars, which are; global standard for education, global standard for regulation, as well as the global standard for strong member association. These global standards have implication for midwifery education, practice, administration and research for the growth of midwifery. There is need for strong midwifery representation within the board members of the Nursing and Midwifery Council of Nigeria; professional knowledge update; professional autonomy; good remuneration for midwives as well as male involvement in midwifery. Midwifery as a focal point in maternal and child health care delivery needs individuals with forecasting and creative ability not only for the evolution of professional midwifery but for the continuous development and practice

practice of quality midwifery care.

Conflict of Interests

The author(s) have not declared any conflict of interests.

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