International Journal of Nursing, Midwife and Health Related Cases
Vol.1, No.2, pp.1-16, September 2015
Published by European Centre for Research Training and Development UK (www.eajournals.org)

PERCEPTION AND PRACTICE OF MIDWIFE-LED MODEL OF CARE AMONG SKILLED BIRTH ATTENDANTS IN SELECTED HEALTH FACILITIES IN A SOUTHERN STATE IN NIGERIA

Esienumoh, Ekpoanwan E.[1], Okon, Iquo E.[2], Ojong, Idang N.[3], Akpan, Margaret I.[4], Armon, Margaret A.[5], Whiley, Emily E.[6]

1, 3, 4, 5 & 6, Department of Nursing Science, University of Calabar, Calabar, Nigeria.
2, Family Health International, Calabar, Nigeria.

ABSTRACT: *Globally, there is noticeable threat to midwifery practice because of limited autonomy of midwives in some settings. The situation is not different in Nigeria, despite the evidence that access to midwife-led care is the most important factor in achieving improved outcomes in maternal and newborn health. It is, therefore, imperative to determine the perception and practice of midwife-led care among skilled birth attendants in selected health facilities in a southern State in Nigeria. Following ethical approval, a mixed method design was undertaken to study a convenience sample of 125 skilled birth attendants from health facilities in four randomly-selected local government areas of the State. Quantitative and qualitative data were obtained through questionnaire and focus group discussions respectively. Quantitative data were analysed using SPSS version 18 and qualitative data were manually analysed. Results showed that 79.2% had knowledge; 56% exhibited poor practice of midwife-led care. There was statistically significant association between knowledge and practice of midwife-led care at 0.05 level of significance with 1 degree of freedom. Also there was a statistically significant relationship between knowledge and acceptance of midwife-led care at 0.05 level of significance with 123 degrees of freedom. Qualitative data corroborated the quantitative data. Gaps were revealed in the knowledge/perception and practice of midwife-led care in this setting. These have implications for continuing education for midwives and policy formulation towards strengthening midwifery for enhanced maternal and newborn outcomes.*

KEYWORDS: Perception, Practice, Midwife-led model, Skilled birth attendants

INTRODUCTION

The process of childbirth is described as a unique experience and the expectation by women in most situations is a safe vaginal birth (Yilmaz, Bal, Beji, & Uludag, 2013). The age-long practice is to assist the woman during this process. Traditionally, midwives have been associated with care of women during the birth process (Barnawi, Richter, & Habib, 2013). There is international agreement on the definition of the midwife which clearly states the necessary qualifications for midwifery practice, the types of care that can be given by midwives and the location where midwives can practice.

The International Confederation of Midwives (ICM) defined the midwife as ‘a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered and/or legally licensed to

practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery' (ICM, 2011).

The midwife is acknowledged as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, promotion of normal birth, detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures in the absence of medical help (ICM, 2014; WHO, 2014). The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. Overall, the job description for the midwife involves antenatal education, preparation for parenthood and may extend to women's health, sexual or reproductive health and child care (ICM, 2013).

A midwife may practise in any setting including the home, community, hospital, clinics or health units (Page & McCandish, 2006).

Midwifery focuses on the well-being of mother and child and has been described as an emerging academic discipline with a relatively little formal specific theory to guide its practice and research. Theory in midwifery provides the direction on how midwives can work to attain the focus of their profession (Fahy & Parratt, 2006). However, in recent times, specific theories and models to guide care rendered by midwives are emerging and some have been described (Bryar, 2011). These include the Midwife-led model of care (MLC) and shared model of care, that is, midwife-physician model (Hatem,Sandall, Devane, Soltani & Gates, 2009). Some midwifery-specific theories include the 'birth territory'(Fahy & Parratt, 2006) and 'becoming a mother versus maternal role attainment'(Mercer, 2004).

It has been observed that midwifery practice is threatened in many settings, thus midwives do not exercise their autonomy to practice their profession (ICM, 2011). To avert this situation and implicit extinction of midwifery, the ICM recommends that Midwife-led model of care be encouraged in member nations which include Nigeria. The Midwife-led care is defined as 'care where the midwife is the lead professional in the planning, organisation and delivery of care given to a woman from the initial booking to the postnatal period' (ICM, 2011; RCOG, 2013a).

Although it is difficult to exclusively categorise maternity models due to the influence of generic policies and guidelines, however, the underpinning philosophy of the midwifery model of care is on the normality and the natural ability of women to experience birth with minimum or without routine intervention (Hatem et al., 2009). This means that midwifery care perceives labour as a normal physiological process characterised by spontaneous onset between 37 and 42 weeks in a woman whose pregnancy has been uncomplicated. It also recognises that labour has great implication for the woman's psychological wellbeing and her relationship with her family. Thus, the right of the woman to be provided with good information and be involved in her care and that of her baby constitute a key principle in midwife-led-care (RCM, 2012).

Women who qualify MLC are the women in good general health following a straight forward pregnancy and without problems in a previous pregnancy or labour, who enter spontaneous labour at term, expecting one baby in a cephalic presentation' (RCM, 2012). Also, where complication concern arises in the mother or foetus or the progress of labour, then referral for obstetric opinion will take place. The MLC requires good documentation of care reflecting accurate picture of events to enable smooth and safe referral where it is required (RCM, 2012).

The rationale for this model is that childbirth is a natural process and the midwife has the competency by his/her preparation to cope with the care of women throughout the normal childbearing cycle. As stated by ICM (2011), midwives should lead in the planning of care for low risk women. Although the expanded role of the midwife includes that he/she identifies and starts intervention in emergency obstetric situations where there is no Obstetrician (Marshall & Raynor, 2010). This gave rise to specialised capacity building for midwives in 'Life-saving skills (LSS)/Emergency obstetric care to empower the midwife to provide basic emergency obstetric care and refer where necessary (WHO, PATHS, & DFID, 2005). The Royal College of Midwives clarified that 'midwifery is concerned with normal childbirth and obstetrics is concerned with pathological or abnormal birth' (RCM, 1999 p. 4). This view is supported by the ICM and the Royal College of Obstetricians and Gynaecologists (ICM, 2011, RCOG, 2013).

The focus of this study is the midwife-led care. This model of care is conceived based on the global palpable threat to midwifery and midwives with regard to their freedom to provide midwifery services and models of care (ICM, 2011; Hatem, Sandall, Devane, Soltani & Gates, 2008). The philosophy of this model of care is that pregnancy, birth and post natal period are normal life events for the mother and her baby. It has been observed that in some clinical settings, midwives' autonomy is restricted (ICM, 2011), this observation corroborates the observation in the setting for this study thus giving impetus to this study on the perception and practice of midwife-led care among skilled birth attendants.

Purpose of the study

The overarching aim of this study was to determine the perception and practice of midwife-led care by skilled birth attendants in selected health facilities in the Southern Senatorial district of the State.

Research questions

The following research questions were raised to guide the study:

1. What do skilled birth attendants know about midwife-led care in the Southern senatorial district of a State in Nigeria?
2. What is the opinion of skilled birth attendants about midwife-led care in the Southern senatorial district of a state in Nigeria?
3. Is midwife-led care practised in the Southern senatorial district of a state in Nigeria?
4. Is the midwife-led model of care accepted in the Southern Senatorial district of a state in Nigeria?

Hypotheses

1. There is no significant association between knowledge of skilled birth attendants and the practice of midwife-led model of care.
2. There is no significant relationship between knowledge of skilled birth attendants and acceptance of midwife-led model of care.

Significance of the study

Data generated in this study revealed how midwife-led care is perceived and practised in this setting. This is expected to guide policy formulation in maternity settings to promote midwife-led care to enhance pregnancy and birth outcomes.

LITERATURE REVIEW

Perception of midwife-led care

The increasing level of medicalization of childbirth and the high rate of caesarean section are a source of concern to maternity care providers. These increasing interventions tend to undermine the confidence of women in birthing spontaneously (Walsh & Devane, 2012). Also, cost of childbirth is increasing as a result of the interventions. This scenario has triggered researches in recent times with suggestion that midwives can rise up to the challenge of addressing medicalization (Boreham, Holm, Ashcroft, & Elstein, 2003; Wagner, 2008). In some settings, these researches have focused on alternative places of birth such as birth centres and the midwife-led units and such alternative places have midwives as the primary carers (Walsh & Devane, 2012).

Several research studies have demonstrated lower rates of labour and birth interventions where midwives lead care, for example, in home births (Fullerton, Navarro, & Young, 2007). Thus, it is inferred that midwives are associated with improved outcomes. Midwife-led care has been described as autonomous care rendered by midwives to women designated as healthy and low-risk for pregnancy and birth at entering the maternity services. Such women are cared for solely by the midwife. If complications develop, the woman is referred to the obstetrician. The midwife-led care is practised in the midwife-led units (MLU) which is usually staffed and managed by midwives (Walsh & Devane, 2012).

Evidence from a systematic review showed that the midwife-led model is associated with reduction in interventions in labour and birth; also reduction in foetal and neonatal deaths (Hatem, Sandall, Devane, Soltani, & Gates, 2009). In a metasynthesis of qualitative studies to explore why there is reduced intervention in labour and birth in the midwife-led care, it was found that the midwife-woman relationship generated benefits which greatly influenced labour and birth outcomes. Such benefits include increased maternal and midwife autonomy as well as a sense of empowerment of the woman, thus enabling her to cope with the demands and be in control of labour and birth (Hodnett, Gates, Hofmeyr, & Sakala, 2009). Midwife-led care is also perceived as woman-centred, cost-effective, safe (Olsen & Jewell, 2006) and satisfying care (Royal College of Midwives, 2011).

Practice of midwife-led care

Variations of maternity care practice have been discussed in literature. These include the Midwife-led care and the Consultant-led care. A randomised trial was carried out to compare the effects of midwife-led and consultant-led care for healthy women without risk factors for labour and birth, rate of interventions, natural, maternal satisfaction, neonatal and maternal outcomes. It was found that midwife-led care was as safe as the consultant-led care and that the midwife-led care was associated with less intervention (Begley, Devane, & Clarke, 2009). Following this finding, it was suggested that this model of care should be the norm for low-risk women and that it should be established where it is not being practised. To the best of our knowledge, there are no literature on midwife-led care and its practice in Nigeria.

RESEARCH METHODS

Research design: Mixed method design was used for this study. This consisted of both quantitative (survey) and qualitative (phenomenology).

Research Setting

The study was conducted in the Southern Senatorial District of a southern State in Nigeria. This district was selected because it has a complement of the three levels of health care facilities, that is, the primary, secondary and tertiary.

Study population

The study population consisted of the 349 skilled birth attendants in this area and out of which 311 were midwives and 38 were medical practitioners.

Sample and Sampling technique

From the target population of 349, 125 skilled birth attendants representing 35.8% of the population participated in the study which took place from September to November, 2014.

Multistage random sampling technique was used to select four out of the seven Local Government areas in the Southern Senatorial District of the State. Thereafter, a simple random sampling was used to select health facilities that provided maternity care in this area. Within these health facilities, convenience sampling method was used to recruit 125 skilled birth attendants who were currently practising in maternity care and were willing to participate in the study. Out of these, 109 were midwives and 16 were medical practitioners.

Respondents were selected into the qualitative aspect of the study through purposive sampling.

Data collection

Quantitative data were collected through a structured questionnaire with 37 items divided into five sections thus:

Section A – Socio-demographic characteristics

Section B – Knowledge of midwifery-led care

Section C – Opinion about midwifery-led care

Section D – Practice of midwifery-led care

Section E – Acceptance of midwifery-led-care

Face validity of the instrument was ascertained and for reliability, a test-retest reliability coefficient of 0.80 was obtained.

Copies of the questionnaire were administered face-to-face to the respondents and these were retrieved immediately.

Pre-determined scoring of items

To facilitate objective measurement of knowledge and practice, pre-determined scores were allotted to the items on the questionnaire in sections B and D. Good knowledge and good practice were allotted 1 respectively while 0 was allotted to poor knowledge as well as poor practice. Overall, a score of 50% was accepted as good knowledge or good practice as applicable.

Qualitative data were generated through two focus group discussion (FGD) sessions of midwives in a secondary and the tertiary health facilities. The FGDs were conducted following completion of the quantitative data collection. The purpose of this was for triangulation and exploration of the midwives' knowledge, perception, practice as well as acceptance of midwife-led care. This aspect of the study was used to elicit subjective data from the respondents in order to enhance interpretation of the objective data obtained from the questionnaire. Each FGD session involved ten midwives, a recorder as well as a moderator who steered the interaction with the aid of a discussion guide. The discussions were audio-recorded.

Data analysis

Quantitative data were analysed through the use of SPSS version 18 and Chi square statistic and Pearson Product Moment Correlation Coefficient were used to test significance of the Hypotheses at 0.05 level of significance. The recorded FGD sessions were transcribed, manually, data coded, categorized and grouped into themes.

Ethical consideration

Approval for the study was obtained from the various authorities of the health facilities where the study took place. Also at individual level, informed verbal consent was obtained from the participants and they were assured of anonymity and confidentiality of data.

RESULTS

Table 1. Socio-demographic data of respondents (n = 125)

Items	Frequency (n)	Percentage (%)
Age		
26-35	43	34.4
36-45	39	31.2
46-55	33	26.4
56 and above	10	8.0
Professional qualification		
Midwife	109	87.2
Medical practitioner	16	12.8
Place of practice		
Primary Health care	22	17.6
Secondary Health care	71	56.8
Tertiary Health care	32	25.6
Years of practice experience		
1-10	64	51.2
11-20	12	9.6
21-30	22	17.6
31 and above	27	21.6

A total of 125 subjects participated in the study, most of them were aged between 26 and 35 years, 43(34.4%) while only 10 (8%) were within age bracket of 56 and above. Out of these, 109 (87.2%) were midwives and 16 (12.8%) were medical practitioners; 22 (17.6%), 71 (56.8%) and 32 (25.6 %) practised in the primary, secondary and tertiary health care facilities respectively. Majority of the respondents 64 (51.2%) had 1 -10 years of experience the least number of respondents, 12 (9.6%) had 11-20 years work experience (Table 1).

Table 2a. Knowledge of skilled birth attendants on midwife-led care (n = 125)

Items	Yes (n; %)	No (n; %)
Midwifery-led model of care assumes that pregnancy, birth and post natal periods are normal life event for mother and baby	122 (97.6)	3 (2.4)
In this model, midwife is the lead professional in planning, organisation delivery of care to low risk women from pregnancy to post natal period.	108 (86.4)	17 (13.6)
Assisted technology interventions are minimized e.g. episiotomy, forceps delivery, vacuum delivery, caesarean section and epidural analgesia	111 (88.8)	14 (11.2)
Women who require obstetric/ other specialist attention are appropriately referred	113 (90.4)	12 (9.6)
Low risk pregnancy, labour and puerperium can be managed by midwives only	84 (67.2)	41 (32.8)
Obstetricians should lead care mainly in pathological and abnormal births	60 (48.0)	65 (52.0)

Table 2b. Summary of knowledge of skilled birth attendants on midwife-led care

Items	Frequency	%
Good knowledge	99	79.2
Poor knowledge	26	20.8

Knowledge of midwife-led care

Knowledge of the respondents on midwife-led care is presented in Table 2a. Although 108 (86.4%) of the respondents stated that in this model, the midwife is the lead professional in planning, organisation and delivery of care to low risk women from pregnancy to post natal period; only 84 (67.2%) had knowledge that low risk pregnancy, labour and puerperium can be managed by midwives only. Similarly, 65 (52.0%) did not know that obstetricians should lead care mainly in pathological and abnormal birth.

Furthermore, 122 (97.6%) of the respondents knew that midwifery-led model of care assumes that pregnancy, birth and post natal periods are normal life events for the mother and baby; 111 (88.8%) respondents stated that assisted technological interventions which include caesarean section, forceps delivery, vacuum delivery are minimized with the midwifery model and 113 (90.4%) knew that women who require obstetric and other specialist attention are appropriately referred.

In summary, as indicated in Table 2b, 99 (79.2%) of the respondents had good knowledge while 26 (20.8%) had poor knowledge of midwifery-led care.

Findings from the FGD supported the data from the questionnaire. While some participants expressed knowledge on some aspects of the midwife-led care, some did not have any idea of what the model was all about. For example,

> ‘our scope as midwives is normal delivery and everything abnormal is referred to the doctor’ (G. 4).
>
> ‘I have not heard of midwife-led care before’ (U.5)

This was corroborated by U. 8, 7 and 1.

Table 3. Opinion of skilled birth attendants about midwife-led care (n = 125)

Items	Strongly agree n (%)	Agree n (%)	Disagree n (%)	Strongly disagree n (%)	Undecided n (%)
Midwife should not lead the care of any woman during pregnancy, labour and postpartum period	8 (6.4)	9(7.2)	30(24.0)	76(60.8)	2(1.6)
Midwife-led model of care should not be encouraged	6(4.8)	2(1.6)	29(23.2)	83(66.4)	5(4.0)
Midwives should only lead care at the PHC levels	2(1.6)	16(12.8)	29(23.2)	75(60.0)	3(2.4)
Midwife-led care will encourage midwives to use their knowledge and skills and develop proficiency	69(55.2)	36(28.8)	3(2.4)	14(11.2)	3(2.4)

Midwife-led model of care will increase maternal and neonatal mortalities.	4(2.4)	4(2.4)	27(21.6)	87(69.6)	3(2.4)
Midwife-led model of care will create conflict between medical practitioners and midwives	3(2.4)	14(11.2)	36(28.8)	69(55.2)	3(2.4)
Midwife-led care will encourage early initiation of breast feeding	78(62.4)	35(28.0)	3(2.4)	6(4.8)	3(2.4)

The results of opinion on midwifery-led model of care are presented in Table 3.

For ease in description, items in under strongly agreed and agreed would be merged while the disagree and strongly disagree items will also be merged.

A few respondents, 17 (13.6%) were of the opinion that midwives should not lead care of any woman during pregnancy, labour and postpartum period, while the majority 106 (84.8%) had a contrary view and 2 (1.6%) were undecided. Although a few 8 (6.4%) were of the view that this model should not be encouraged; some, 18 (14.4%) said it should only be practised at the primary health care level and 17 (13.6%) had the opinion that the midwifery-led model of care will create conflict between medical practitioners and midwives. However, 105 (84.0%) were of the opinion that this model of care will encourage midwives to use their knowledge and skills and develop proficiency and 114 (91.2%) respondents viewed that this model can contribute to reduction of maternal and neonatal mortalities; also 113 (90.4%) respondents were of the opinion that the midwife-led model early initiation of breast feeding is encouraged.

As revealed by the FGD, were of the opinion that that midwives are well trained and so are capable to render care to the woman in childbearing. However, without a supporting policy, this model can create conflict between medical practitioners and midwives.

> '… as long as pregnancy period is normal … a well trained midwife should be able to care for the woman from the day she came in for registration until baby is born' (U.3).

> ' in the past, our mothers who were not educated were able to attend to women in labour, so midwives with all their preparation can be able to attend to normal case to the end' (G.4).

> '…without an enabling policy, I think midwife-led care will generate conflict between medical officers and midwives' (G.4).

Practice of midwifery-led care

Table 4a. Practice of midwifery-led care (n = 125)

Items	Yes N(%)	No N(%)
In my health facility, midwives are solely responsible for care during antenatal, labour and immediate postpartum periods of low risk women	82(65.6)	43(34.4)
Midwives carry out abdominal examination during the antenatal period in the clinics	112(89.6)	13(10.4)
In my health facility, midwives only take vital signs, anthropometric measurement and give health talks while doctors carryout physical examination during the ante natal period	25(20.0)	100(80.0)
In my facility there is a unit dedicated to midwife–led care where midwives are solely in-charge of care	0(0.00)	125(100)
In my facility, care of low risk women is a shared responsibility by midwives and doctors	101(80.8)	24(19.2)
In my facility midwives do not assist women at birthing when doctors are available	11(8.8)	114(91.2)

Table 4b. Summary of practice of midwifery-led care among skilled birth attendants

Items	Frequency	%
Good	55	44.0
Poor	70	56.0

Practice of midwife-led care is presented in Table 4. The data revealed that 82 (65.6%) respondents stated that in their health facility midwives are solely responsible for care during antenatal, labour and immediate postpartum period of low risk women; although for some, 101 (80.8%) respondents, care of low risk women is a shared responsibility between the midwives and medical practitioners. Twenty-five (20%) respondents stated that in their setting, midwives only check vital signs, anthropometric measurements and give health talks while medical practitioners carry out physical examination in the antenatal period; 11 (8.8 %) stated that midwives do not directly assist birthing when medical practitioners are available. As revealed by all the respondents, 125 (100%), none of the health facilities had a midwifery-led unit. Summary of practice shows that 70(56.0%) showed poor practice of midwifery-led care while 55 (44.0%) demonstrated good practice.

The qualitative data revealed that midwife-led care was not practised at the secondary and tertiary health facilities, rather what obtains is joint care between midwives and obstetricians/other medical practitioners. Besides, the policy of the health facility does not support midwife-led model because, at some point, the woman, though low-risk, is expected to be attended by a medical practitioner. A respondent said:

> ‘it is not all that possible in our hospital for a midwife alone to care for a pregnant woman right from pregnancy till delivery. Why I say so is that there are certain investigations that you need a doctor to request for … also, the primigravida coming

to the hospital for the first time, she may desire to see the doctor and no matter how much the midwife tries to persuade her, she would not be satisfied until she is attended to by a doctor (U.2).

Routine practices and culture of the health facilities are said to be hindering factors to the practice of midwife-led model.

'if midwife-led model is to be practised, there should be a policy supporting midwives to do so because we are used to shared care between midwives and doctors for low-risk women …' (G.4). this view was supported by G.3.

Acceptance of midwife-led care

Table 5. Acceptance of midwife-led care (N=125)

Items	Strongly agree N(%)	Agree N(%)	Disagree N(%)	Strongly disagree N(%)	Undecided N(%)
Midwife-led model of care should be encouraged for low risk pregnancy, labour and puerperium	70 (56.0)	37(29.6)	10(8.0)	3(2.4)	5(4.0)
Midwifery–led model of care is totally unaccepted	15(12.0)	3(2.4)	41(32.8)	60(48.0)	6(4.8)
We do not have enough midwives to implement midwifery-led model care	16(12.8)	56(44.8)	27(21.6)	20(16.0)	6(4.8)

For ease of description, all items under strongly agree and agree are merged while those under strongly disagree and disagree are merged. Thus, with regard to acceptance of the midwife-led model, 107 (85.6%) accepted that this model should be encouraged; 18 (14.4%) opposed the model stating that it is totally unacceptable while some , 72 (57.6%) stated that the number of available midwives are not enough to implement the midwife-led model of care.

Most of the participants in the FGD accepted that midwife-led model should be encouraged but some wondered how possible it would be especially with the practice of assigning every pregnant woman to an obstetrician.

'midwife-led care is acceptable' (U.6).

' Although this model is acceptable by midwives, in our setting all the women including the low-risk are assigned to obstetricians and so the midwives do not have free hand to render care independently to the women' (U.2).

Test of hypotheses

Null hypothesis I: There is no significant association between knowledge of skilled birth attendants and the practice of midwife-led care.

Table 6. Chi-square analysis of knowledge of skilled birth attendants by practice of midwife-led care

Knowledge of skilled birth attendants on midwifery-led care	Practice of skilled birth attendants		Total	df	X^2 Cal	X^2 Cri
	Good practice	Poor practice				
Good knowledge Poor knowledge	50(43.6) 5 (11.4)	49 (55.4) 21 (14.6)	99 26	1	8.06	3.84
Total	55	70	125			

*Significant at 0.05, df =1, X^2 calculated= 8.06, X^2 critical = 3.841

Using Chi square (X^2) statistic, the result as presented in Table 6 showed a statistical relationship between knowledge and practice of midwife-led care among skilled birth attendants, when the calculated X^2 of 8.06 was greater than the tabulated X^2 of 3.841 at 0.05 level of significance with 1degree of freedom. Hence the null hypothesis was rejected. This, therefore, implied that there is a significant relationship between knowledge of the skilled birth attendants and the practice of midwife-led care in the selected health facilities in Southern Senatorial district of the State.

Null hypothesis II: There is no relationship between knowledge of skilled birth attendants and the acceptance of midwife-led care

Table 7. Pearson product moment correlation analysis of relationship between knowledge of skilled birth attendants and acceptance of midwife-led care (n=125)

Variables	$\sum x$ $\sum y$	$\sum x^2$ $\sum y^2$	$\sum xy$	r-value
Knowledge of midwifery-led care Acceptance of midwifery-led care	4866 4268	31,652 25,110	257,630	0.84

Significant at 0.05, df = 123, critical value = 0.178

Results in Table 7 indicated that the calculated r-value of 0.84 was obtained at 0.05 level of significance with 123 degrees of freedom. This value when compared with the critical r-value of 0.178 was found to be greater. On the basis of this observation, the null hypothesis was rejected. This implied that there is a significant relationship between knowledge of skilled birth attendants on midwifery-led care and acceptance of midwifery-led care in selected health facilities in Southern Senatorial district of the State.

DISCUSSION

Knowledge of midwife-led model of care

Generally the respondents showed good knowledge in some aspects of the midwife-led model of care such as this model being concerned with birth process as normal life's event; leadership of care of low risk women by midwives and reduction of technological intervention. This view corroborates the findings of Hatem et al. (2009) who carried out a systematic review on midwife-led versus other models of care for childbearing women. Hatem et al. (2009) noted that the underpinning philosophy of the midwife-led care is

normality and this was associated with several benefits for mother and baby which included the woman feeling in control during labour, having spontaneous vaginal birth, initiation of breastfeeding and reduction in instrumental births. These authors also discovered that there were no identified adverse effects with the midwife-led care. These views were supported by a meta-analysis which also revealed that with MLC, the women were in control of the birthing situation, thus facilitating positive outcome (Walsh & Devane, 2012).

Although there was good response that midwives can autonomously manage normal pregnancy, birth and puerperium, this knowledge was relatively marginal. Thus, it implies that the respondents may not be confident in the capabilities of midwives to cope with such responsibilities. This contradicts the assertion of ICM (2013) that the midwife is an accountable professional and renders care on his or her own responsibility. The respondents demonstrated poor knowledge with regard to obstetricians leading care mainly in pathological and abnormal births. This implied that obstetricians should lead care in low risk women, whereas, the emphasis is that obstetrics is concerned with pathological childbirth (RCM, 1999).

These areas of poor knowledge may connote that midwives are depriving themselves or are being deprived of their roles in rendering care to mothers and their babies. This situation may gradually make the midwife irrelevant in the health care team. The poor knowledge shown may also imply that some midwives do not clearly understand their roles. The International Confederation of Midwives (ICM) supported by World Health Organisation and Royal College of Obstetricians and Gynaecologists clearly endorses midwife-led model of care (ICM, 2011; RCOG, 2013b; WHO, 2009). The justification for emphasis on this model as highlighted by ICM is that midwifery is threatened in some settings globally, thus midwives so affected are limited in their practice (ICM, 2011).

Opinion about midwife-led care

Most respondents were of the opinion that midwives should lead care of low risk women, also that this will contribute to the reduction of maternal and neonatal mortality as well as encourage early initiation of breast feeding. These views corroborate the findings of Hatem et al. (2009). Contrarily, a few said that midwife-led care should be discouraged because it will create conflict between the midwives and medical practitioners. However, to avert the potential conflict, some respondents opined that there should be a supporting policy for midwife-led care in this setting. As discussed previously, midwife-led care has the goodwill of the Royal College of Obstetricians and Gynaecologists and the World Health Organisation (RCOG, 2013; WHO, 2009). An opposing view was expressed in a blog posted in the in the internet (Tuteur, 2015). Her reason is that midwives are less knowledgeable and so, care should always be led by the obstetrician. There is dearth of literature on contrary opinions about midwife-led care.

Practice of midwife-led care

Although some of the midwives stated that in their settings, they are solely responsible for ANC, birth and immediate post partum care of low risk women, majority stated that care of low risk women is shared between midwives and medical practitioners and a few said that in their setting, midwives only check vital signs, measure height and weight of the women and give health talk while medical practitioners carry out physical examinations including

abdominal palpations during the antenatal period. Additionally, some respondents stated that midwives do not conduct births when medical practitioners are available. These findings indicate that MLC is not practised in this setting. The implication of the midwives not carrying out midwifery functions/roles affects the midwifery profession and the women negatively. As found by Hatem et al. (2009) the women are deprived of satisfaction and other positive birth outcomes already mentioned in this text, besides, this practice may affect the skills of midwives negatively. Where skills are not continually utilised, it may result in loss of proficiency. Furthermore, it was found that there were no units designated for midwife-led care in all the settings in this study. This may be an indication that midwifery is still lagging behind in this context and is not given its appropriate place as recommended by the ICM. It is posited that MLC should be practised in a designated unit (ICM, 2011).

Acceptance of midwife-led care

As a follow-up to practice of midwife-led model, while some respondents accepted that this model of care be encouraged, some said that it was totally unacceptable. The implication of this is that if this model is not encouraged, midwifery may lose its relevance in the health care team in this context. The view of some respondents that this model should be discouraged corroborates the observation of ICM (2011) which states that midwifery is suffering a palpable threat and that midwives are losing their freedom to provide midwifery services in some settings.

CONCLUSION

Midwives in the study setting are not functioning in their full capacity and competency as recommended by the ICM and supported by the Nursing and Midwifery Council of Nigeria. The study seemed to present an image of a struggling midwifery force that is under a threat both intra and extra professionally as it appears that some midwives underestimate their capabilities and compromise their roles. Awareness should be created to improve knowledge, enhance acceptance and practice of MLC.

Implication for research and practice

To be relevant in the health team and the forth-coming Sustainable Development Goals which include bringing to an end of all preventable maternal deaths, midwifery should be strengthened by all the stake holders which include leaders of the profession, regulation by the Nursing and Midwifery Council, professional association, as well as the midwifery practitioners.

Sensitization, advocacy and lobbying of relevant authorities are of utmost importance to uplift midwifery in this context. This should be taken up by leaders of the profession especially at policy decision levels. Midwives should be part of policy-making at all levels of the healthcare delivery system to ensure adequate input towards strengthening midwifery practice for enhanced maternal and child outcomes as well professionalism. Also, intra professional sensitisation, mentoring and networking among midwives should be emphasised to ensure that they perform their roles optimally in the health care system. Further studies on midwife-led care should be carried out using a paradigm that will facilitate immediate utilisation of the research findings.

REFERENCES

Barnawi, N., Richter, R., & Habib, F. (2013). Midwifery and Midwives: A Historical Analysis. *Journal of Research in Nursing and Midwifery (JRNM) (ISSN: 2315-568x) Vol. 2(8) pp. 114-121, 2*(8), 114-121.

Begley, C., Devane, D., & Clarke, M. (2009). An evaluation of midwife-led care in the Health Service Executive North Eastern Area: The report of the MidU study. Health Service Executive.

Boreham, N., Holm, S., Ashcroft, B., & Elstein, M. (2003). Prospective semistructured observational study to identify risk attributable to staff deployment, training and updating opportunities for midwives. *British Medical Journal, 327*(7415), 584-586.

Bryar, R. (2011). Theory for midwifery practice: where the future meets the past. *Evidence Based Midwifery*(12), 34.

Fahy, K. M., & Parratt, J. A. (2006). Birth territory: a theory for midwifery practice. *Women and Birth, 19*(2), 45-50.

Fullerton, J., Navarro, A., & Young, H. (2007). Outcomes of planned home birth: An integrative review. *Journal of Midwifery and Women's Health, 52*, 23-33.

Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2009). Midwife-led versus other models of care for childbearing women http://www.thecochranelibrary.com

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2009). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*(4).

ICM. (2011). *Midwifery-led care, the first choice for all women*. The Hague, The Netherlands.

ICM. (2013). *Essential competencies for basic midwifery practice*. Hague.

ICM. (2014). *Philosophy and model of midwifery care*. The Hague, Netherlands: ICM.

Marshall, J. E., & Raynor, M. D. (2010). *Advancing Midwifery Skills in Midwifery practice*. London: Churchill Livingstone.

Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship, 36*(3), 226-232.

Olsen, O., & Jewell, D. (2006). Home versus hospitall birth. *Cochrane Database of Systematic Reviews, 2*(CD000352).

Page, L., & McCandish, R. (2006). *The New Midwifery. Sensitivity in Practice*. Edinburgh: Churchill Livingstone.

RCM. (2012). *Evidence-based guidelines for Midwifery-led care in labour*. London.

RCOG. (2013a). *RCOG position on the Cochrane review into midwifery-led care*. London.

RCOG. (2013b). *Royal College of Obstetricians and Gynaecologists statement on the Cochrane review into midwifery-led care*. London.

Royal College of Midwives. (2011). *Birth Centres: position statement*. London.

Tuteur, A. (2015). Midwife-led care kills babies and mothers.

Wagner, M. (2008). *Born in the USA: how a broken maternity system must be fixed to put women and children first*. Berkley: University of California Press.

Walsh, D., & Devane, D. (2012). A metasynthesis of midwife-led care. *Qualitative Health Research, XX*(X), 1-14.

WHO. (2009). *Wiysonge CS. Midwife-led versus other models of care for childbearing women: RHL commentary*. Geneva, Switzerland.

WHO. (2014). *Midwife-led versus other models of care for childbearing women*. Geneva, Switzerland.

WHO, PATHS, & DFID. (2005). *Training Manual on Life Saving Skills for Nurses and Midwives*.

Yilmaz, S. D., Bal, M. D., Beji, N. K., & Uludag, S. (2013). Women's Preferences of Method of Delivery and Influencing Factors. *Iranian Red Crescent Medical Journal*, *15*(8), 683-689.