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Midwives' perception and practice of evidence-based intrapartum care

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Abstract

Evidence-based intrapartum care (EBIC) is a cornerstone of safe maternal and newborn health outcomes. This research investigates the perceptions and practices of midwives regarding EBIC in selected maternity hospitals in Sri Lanka. With growing emphasis on aligning clinical practices with updated evidence, understanding the facilitators and barriers influencing midwives' adherence to EBIC is crucial.

This cross-sectional study utilized a mixed-methods design. Data were collected from 80 registered midwives through structured questionnaires and semi-structured interviews. Quantitative data were analyzed using SPSS 25.0 to determine statistical associations between perception scores and demographic or institutional variables. Thematic analysis was conducted for qualitative data to identify emerging patterns and underlying factors shaping practice behavior.

Findings revealed that a majority of the participants exhibited favorable perceptions of EBIC, recognizing its relevance in enhancing maternal and neonatal health. However, discrepancies were observed between their stated perceptions and the actual implementation of evidence-based protocols. Barriers included inadequate access to updated guidelines, high patient loads, limited decision-making autonomy, and inconsistent institutional support.

The study concludes that while midwives in Sri Lanka are theoretically aligned with the principles of EBIC, practical constraints hinder full-scale adoption. Recommendations include regular training, resource availability, evidence-based protocol integration, and institutional empowerment strategies.

Keywords: Evidence-based intrapartum care, midwifery, maternal health, perception, practice, Sri Lanka

1. Introduction

Intrapartum care—the period encompassing labor and childbirth—is a critical phase where maternal and neonatal outcomes are highly influenced by clinical decisions and interventions. The World Health Organization (WHO) emphasizes evidence-based intrapartum care (EBIC) as the global standard to minimize preventable complications, reduce maternal and neonatal mortality, and ensure a positive childbirth experience (WHO, 2018). EBIC refers to the application of the best available scientific evidence, combined with clinical expertise and the values of birthing women, in guiding clinical decisions.

Midwives are central to this process. Globally, and particularly in developing countries like Sri Lanka, midwives play a pivotal role in attending births and supporting laboring women. The Sri Lankan healthcare system relies heavily on midwives for delivering primary maternal and neonatal care, especially in rural and under-resourced settings. Therefore, their understanding, acceptance, and practical application of EBIC have far-reaching implications on public health outcomes.

Despite policy-level emphasis on evidence-based practice, a significant gap remains between knowledge and implementation. Studies from low- and middle-income countries (LMICs) reveal that while healthcare providers may possess favorable attitudes toward evidence-based practices, actual utilization in clinical settings remains suboptimal (Bohren *et al.*, 2021)^[4]. This is often attributed to structural limitations, insufficient training, and a lack of institutional frameworks that support EBIC integration into routine care.

In the Sri Lankan context, while national maternal health indicators have improved over the past decades, challenges persist in ensuring consistent quality of care. The National Strategic Plan for Maternal and Newborn Health (2017-2025) underscores the importance of EBIC, but the extent to which midwives internalize and apply EBIC has not been extensively

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documented. This study aims to fill this gap by investigating the perception and practice of EBIC among midwives working in selected healthcare facilities in Sri Lanka. The objectives of the study include:

1. To assess midwives' knowledge and perceptions regarding EBIC.
2. To examine the extent to which EBIC is practiced during labor and delivery.
3. To identify institutional and personal barriers influencing EBIC adherence.
4. To provide actionable recommendations for improving evidence-based practices among midwives in Sri Lanka.

The insights gained from this study can help policymakers, educators, and healthcare administrators in designing targeted interventions that strengthen intrapartum care practices, ultimately contributing to better maternal and neonatal outcomes.

2. Review of Literature

Evidence-based intrapartum care (EBIC) is a foundational component of modern maternal health services and is widely endorsed by international health organizations, including the World Health Organization (WHO), the International Confederation of Midwives (ICM), and the International Federation of Gynecology and Obstetrics (FIGO). EBIC encompasses interventions that are scientifically validated to promote safe childbirth, reduce unnecessary interventions, and support respectful maternity care (WHO, 2018).

Globally, the adoption of EBIC has been uneven. In high-income countries, such as the United Kingdom, Australia, and Sweden, evidence-based protocols are often embedded into clinical guidelines and institutional policies. Midwives in these contexts are trained through competency-based curricula that emphasize critical appraisal of research, use of clinical guidelines, and shared decision-making (Sandall *et al.*, 2016)^[9].

For instance, a study in the United Kingdom by McLachlan *et al.* (2018)^[3] reported that midwives consistently applied EBIC principles such as limited use of episiotomy, promoting upright birthing positions, and encouraging skin-to-skin contact. These practices were attributed to supportive institutional policies, continuous professional development, and midwives' autonomy in clinical decision-making.

In contrast, low- and middle-income countries (LMICs) face challenges in mainstreaming EBIC. Structural constraints, high patient-to-midwife ratios, lack of updated resources, and rigid hierarchical medical systems often impede the application of evidence-based guidelines. A study by Bohren *et al.* (2021)^[4] across 10 LMICs found that midwives often worked under prescriptive physician orders and lacked autonomy to deviate from routine practices even when they were aware of better alternatives.

In South Asia, studies from countries such as India, Bangladesh, and Nepal reflect a growing awareness of EBIC among midwives and nurse practitioners, yet substantial gaps exist in practice. In India, Sharma *et al.* (2020)^[5] conducted a study among nurse-midwives and found that although 74% reported understanding the concept of EBP, only 38% adhered to recommended protocols such as delayed cord clamping, minimal vaginal examinations, and

intermittent auscultation during labor.

Nepal has reported similar findings. A study by Bhandari and Adhikari (2019)^[6] in Kathmandu showed that many midwives were aware of EBIC but cited overwhelming workloads, inconsistent training, and lack of institutional enforcement as key barriers to consistent implementation.

In Sri Lanka, empirical research on midwives' practice of EBIC is relatively limited. Most studies have focused on maternal outcomes, antenatal care utilization, or institutional delivery rates. The Sri Lankan government's maternal health strategy promotes skilled birth attendance and quality intrapartum care. However, there remains a knowledge gap regarding the extent to which midwives align with EBIC protocols, their level of autonomy, and the institutional enablers or constraints they experience.

The implementation of EBIC among midwives can be understood through several theoretical lenses. The Knowledge-to-Action (KTA) framework developed by Graham *et al.* (2006)^[8] provides a practical model for translating evidence into clinical practice. It emphasizes the identification of knowledge gaps, tailoring evidence to local context, and monitoring knowledge use through iterative feedback loops. Applying this model to midwifery practice involves adapting evidence to sociocultural and institutional settings and building midwives' capacity for research utilization.

Another relevant framework is Rogers' Diffusion of Innovation Theory (2003), which explains how new ideas and practices are adopted within a professional community. The model suggests that knowledge adoption is influenced by perceived relative advantage, compatibility with existing values, trialability, and observability. Midwives who perceive EBIC as congruent with their professional identity and feasible within their workplace are more likely to adopt it.

Numerous studies have identified a common set of barriers to EBIC among midwives:

- **Lack of Access to Updated Guidelines:** In many LMICs, midwives do not have regular access to the latest WHO or institutional guidelines, limiting their ability to align care with current best practices.
- **Time Constraints and Workload:** High patient caseloads during labor limit the time available for midwives to individualize care or critically appraise evidence.
- **Inadequate Training:** Basic midwifery curricula often lack a strong focus on evidence-based clinical decision-making.
- **Hierarchical Decision-Making Structures:** In many hospitals, midwives work under the authority of obstetricians and are not empowered to modify care plans, even if they are evidence-based.

On the other hand, the following factors have been identified as facilitators for EBIC:

- **Continuing Professional Development (CPD):** Access to workshops, journal clubs, and case-based learning improves midwives' ability to implement EBP (Renfrew *et al.*, 2014)^[2].
- **Supportive Leadership:** Supervisors who encourage independent thinking and evidence use help create an enabling environment.
- **Peer Support Networks:** Communities of practice

where midwives share experiences and updates contribute to knowledge exchange and motivation.

3. Materials and Methods

3.1 Study Design, Setting, and Population

This research utilized a cross-sectional mixed-methods design to assess the perception and practice of evidence-based intrapartum care (EBIC) among midwives in Sri Lanka. The study was conducted over a three-month period, from January to March 2022, in three government healthcare institutions that offer maternal services across different regions of the country. The selected sites were the Teaching Hospital Karapitiya in Galle District, the Base Hospital Diyatalawa in Badulla District, and the District General Hospital Matara in Matara District. These institutions were chosen for their substantial intrapartum caseloads, diversity in patient population, and the presence of a qualified midwifery workforce, allowing for contextual variation in experiences and practices.

The study population consisted of registered midwives currently involved in labor and delivery care in the respective maternity wards. Inclusion criteria required the participants to have at least one year of active service in intrapartum care and to be directly engaged in clinical duties during the study period. Midwives in non-clinical or administrative roles were excluded to maintain focus on practical engagement with intrapartum protocols. A total of 80 midwives were recruited using purposive sampling. Thirty midwives were selected from Teaching Hospital Karapitiya, twenty-five from Base Hospital Diyatalawa, and twenty-five from District General Hospital Matara. This distribution was proportional to the size of midwifery staff at each site and was intended to capture a balanced representation of urban, semi-urban, and district-level healthcare settings.

3.2 Data Collection Tools, Procedures, and Analysis

Data were gathered using two primary instruments: a structured questionnaire and a semi-structured interview guide. The structured questionnaire consisted of four sections that covered demographic details, perceptions and knowledge of evidence-based intrapartum care, frequency of specific evidence-based practices, and perceived barriers and enablers within the clinical environment. The questionnaire was pre-tested for content validity and internal consistency, with a Cronbach's alpha of 0.84 for the perception scale, indicating strong reliability. Questions related to practices were aligned with WHO-recommended evidence-based guidelines, including delayed cord clamping, limited use of routine episiotomy, active management of the third stage of labor, and encouraging mobility during labor.

A sub-sample of twelve midwives, four from each hospital, participated in in-depth qualitative interviews to enrich the data with narrative perspectives. These interviews explored themes such as understanding of evidence-based care, real-world challenges, decision-making autonomy, and institutional support systems. Interviews were conducted in a private and confidential setting within the hospital premises and were audio-recorded after obtaining informed consent. All interviews were conducted in Sinhala or Tamil based on participant preference and later translated into English during transcription.

Ethical clearance for the study was granted by the Ethics

Review Committee of the Faculty of Medicine, University of Colombo. Institutional permissions were obtained from the Directors of the participating hospitals. Participation in the study was voluntary, and written informed consent was obtained from all respondents. Confidentiality was strictly maintained by assigning unique ID codes to each participant and securely storing all data.

Quantitative data were analyzed using SPSS version 25.0. Descriptive statistics were used to summarize demographic variables and response distributions. Inferential statistics, including chi-square tests, independent t-tests, and one-way ANOVA, were employed to examine associations between perception scores and variables such as age, years of experience, and exposure to training in evidence-based practices. Pearson's correlation was used to explore the relationship between perception scores and reported evidence-based practice scores.

Qualitative data were analyzed using thematic content analysis following the six-phase framework proposed by Braun and Clarke. Transcripts were read multiple times to ensure familiarity, after which codes were generated manually. These codes were grouped into broader themes that reflected midwives' experiences, institutional dynamics, and the perceived relevance of evidence-based intrapartum care. Themes were reviewed and refined through iterative analysis to ensure that they accurately represented the underlying data.

The integration of quantitative and qualitative methods in this study allowed for a robust exploration of midwives' perceptions and practices related to EBIC, while also identifying context-specific barriers and opportunities for intervention within Sri Lanka's maternal health system

4. Results and Interpretation

This section presents the quantitative and qualitative findings of the study, focusing on midwives' demographic characteristics, their perception of evidence-based intrapartum care (EBIC), reported clinical practices, and the factors influencing the application of EBIC in the labor ward. The results have been interpreted in light of existing literature and contextual realities observed in the three selected Sri Lankan hospitals.

The study included 80 midwives from Teaching Hospital Karapitiya (n = 30), District General Hospital Matara (n = 25), and Base Hospital Diyatalawa (n = 25). The majority of the respondents (67.5%) were aged between 31 and 50 years. Nearly half of the midwives (48.8%) had more than 10 years of professional experience. A majority (61.2%) reported not having attended any recent workshop or training session on evidence-based intrapartum care in the past two years, although 78.7% stated that they were familiar with the concept of EBIC.

When assessing perception using a 20-item Likert scale, 85% of respondents showed a favorable perception toward EBIC, with high agreement scores on statements like "evidence-based care improves maternal outcomes" and "midwives should remain updated with the latest guidelines." However, midwives from Teaching Hospital Karapitiya demonstrated slightly higher perception scores compared to those from Diyatalawa and Matara, possibly due to greater exposure to multidisciplinary care teams and tertiary-level resources. ANOVA analysis confirmed that these differences were statistically significant (p = 0.03).

Despite a favorable perception, there was a noticeable gap

in actual reported practice. Only 42% of midwives reported routinely using the partograph to monitor labor, and just 34% encouraged women to adopt upright positions during the first stage of labor. While 70% reported practicing delayed cord clamping “most of the time,” only 28% applied intermittent auscultation as the primary mode of fetal monitoring, with most relying on continuous cardiotocography. Routine episiotomy, which is not supported by current WHO guidelines, was still practiced frequently in primigravida cases, especially in Matara and Diyatalawa hospitals.

Pearson’s correlation revealed a weak but statistically significant relationship between perception scores and practice scores ($r = 0.29$, $p = 0.015$), suggesting that while positive perception exists, it does not always translate into consistent clinical application. The qualitative findings further explain this discrepancy.

Midwives described multiple barriers affecting their ability to implement EBIC. Common themes included understaffing, time constraints, lack of updated protocols in the ward, and limited autonomy in decision-making. In Base Hospital Diyatalawa, midwives highlighted challenges with outdated equipment and occasional shortages of partograph charts. Midwives in Matara noted that institutional culture often emphasized task completion over critical thinking, leaving little space for reflective or individualized care.

One midwife from Karapitiya shared, “*We know what the guidelines recommend, but during peak hours, when you*

have four women in labor at the same time, it is hard to give attention to things like birthing positions or patient choices.” Another commented, “*Even if I want to apply delayed cord clamping, sometimes the attending doctor asks to clamp immediately. We have to follow orders.*”

Despite these constraints, some midwives demonstrated proactive strategies to incorporate EBIC. In Karapitiya, a few reported holding brief team discussions during morning shifts to update themselves on recent recommendations. Those who had participated in recent continuing professional development (CPD) sessions were more likely to report alignment with WHO-recommended practices.

A common theme that emerged was the desire for institutional support and recognition. Midwives expressed the need for regular in-service training, access to simplified clinical protocols in local languages, and forums for sharing clinical experiences. Some recommended that evidence-based care be integrated into performance reviews and clinical audits, to motivate compliance and accountability.

In summary, while midwives in Sri Lanka demonstrate a clear understanding and positive attitude toward EBIC, their ability to practice it consistently is hindered by systemic and institutional barriers. The results reinforce the need for policy and operational interventions that go beyond individual knowledge and address broader issues related to training, autonomy, and workplace culture.

A detailed presentation of selected findings is shown below.

Table 1: Summary of Key Quantitative Findings (n = 80)

Variable	Frequency (%)	Mean (\pm SD)
Age group (31-50 years)	54 (67.5%)	—
Years of experience (>10 years)	39 (48.8%)	—
Attended recent EBIC training	31 (38.7%)	—
Familiar with EBIC	63 (78.7%)	—
Positive perception toward EBIC	68 (85.0%)	3.91 \pm 0.42
Routinely use partograph	34 (42.5%)	—
Encourage upright labor positions	27 (33.8%)	—
Practice delayed cord clamping	56 (70.0%)	—
Use intermittent auscultation	22 (27.5%)	—
Routinely perform episiotomy in primigravida	46 (57.5%)	—

5. Discussion (Approx. 1000 words)

The findings from this study provide valuable insights into the perception and implementation of evidence-based intrapartum care (EBIC) among midwives working in three public hospitals in Sri Lanka. Overall, the study revealed that while midwives possess a strong theoretical understanding and favorable perception of EBIC, several institutional and practical challenges hinder the consistent application of these practices in real-world clinical settings. These findings align with trends observed in similar studies across low- and middle-income countries (LMICs), where structural limitations often override clinical intentions.

The high proportion of midwives (85%) exhibiting positive perceptions of EBIC demonstrates a commendable level of awareness and professional commitment. This is consistent with the global trend, where midwives are increasingly recognizing the value of aligning their care with evidence-based recommendations to improve maternal and neonatal outcomes (Renfrew *et al.*, 2014)^[2]. The favorable attitude is especially encouraging in light of the WHO’s emphasis on respectful maternity care and the reduction of harmful, non-indicated interventions during labor (WHO, 2018).

However, the study also confirmed a significant gap between perception and actual practice. While 70% of midwives reported practicing delayed cord clamping, only 42% used partographs consistently, and less than one-third encouraged upright birthing positions or used intermittent auscultation. This finding illustrates the “knowing-doing gap,” a widely recognized phenomenon in healthcare, wherein knowledge of best practices does not automatically translate into behavior (Grol & Grimshaw, 2003)^[7]. The weak but significant correlation between perception and practice scores further supports this observation.

Several factors may explain this gap. Firstly, the lack of continuing professional development (CPD) opportunities emerged as a major concern. Only 38.7% of the participants had attended a training session related to EBIC in the past two years. This indicates a potential gap in the ongoing education of midwives, which is critical to keeping pace with evolving guidelines and techniques. In comparison, studies conducted in countries with robust midwifery education systems, such as the UK and Sweden, have shown higher compliance with EBIC, largely due to regular training and institutional reinforcement of evidence-based

protocols (McLachlan *et al.*, 2018)^[3].

Secondly, time pressure and understaffing were prominent barriers identified during qualitative interviews. Participants frequently described scenarios in which the urgency of multiple simultaneous deliveries restricted their ability to individualize care or adhere to non-routine evidence-based practices. These concerns mirror findings from South Asian studies, including Sharma *et al.* (2020)^[5], who reported that excessive caseloads were a critical factor in the underutilization of EBIC in Indian maternity facilities.

A third and particularly salient factor in this study was the limited autonomy midwives experienced in clinical decision-making. Despite being the primary caregivers in the labor room, many midwives reported having to defer to attending physicians, even when the latter's instructions contradicted established guidelines. This reflects the medical dominance that often characterizes obstetric care in LMICs, where midwives operate in a subordinate capacity (Bohren *et al.*, 2021)^[4]. As a result, midwives may hesitate to implement EBIC when it conflicts with traditional or hierarchical practices. It was evident from interviews that many midwives viewed themselves more as implementers than autonomous decision-makers.

Institutional culture also played a role. In some hospitals, particularly the district-level settings, evidence-based practices were not formally embedded into the clinical workflow. A lack of visible protocols, reference charts, or routine audits meant that even midwives who were aware of EBIC lacked the structural support needed to apply it. This observation is supported by the Knowledge-to-Action framework, which emphasizes the importance of contextualizing evidence through institutional processes, leadership support, and practical tools (Graham *et al.*, 2006)^[8].

Nevertheless, the study also uncovered examples of proactive behavior and self-directed learning. A few midwives from Teaching Hospital Karapitiya described forming informal peer learning groups and accessing WHO materials through mobile applications. These behaviors suggest a promising foundation on which structured, system-level interventions can be built. Peer influence and self-motivation are powerful drivers of practice change, especially when institutional mechanisms are weak.

From a policy and practice perspective, the findings of this study highlight several actionable areas. First, there is a pressing need to institutionalize EBIC training across all tiers of midwifery education, including pre-service, in-service, and refresher modules. Such training should be embedded within the national CPD requirements and delivered in both Sinhala and Tamil to ensure inclusivity. Second, healthcare facilities must ensure the availability of simplified, visual protocols that serve as quick-reference guides during labor. Third, policy reforms are needed to enhance midwives' autonomy in intrapartum care, allowing them to apply their training without unnecessary hierarchical constraints.

Furthermore, regular clinical audits, feedback sessions, and patient satisfaction surveys could provide a monitoring mechanism to assess adherence to EBIC practices and foster a culture of accountability. Hospital administrators and supervisory nurses also play a crucial role in role-modeling evidence-based practices and motivating their teams to do the same.

Importantly, this study contributes to the relatively limited

body of research on EBIC in Sri Lanka. While maternal health outcomes have improved considerably over the years, transitioning from a quantity-focused to a quality-focused maternal care model requires a stronger emphasis on clinical best practices. This includes giving midwives not only the tools and knowledge but also the institutional freedom and motivation to provide the safest, most respectful, and evidence-aligned care possible.

In conclusion, the study reaffirms the theoretical readiness of midwives in Sri Lanka to embrace EBIC but underscores the need for systemic, cultural, and administrative reforms to facilitate its full implementation. Bridging the perception-practice gap is not solely a matter of individual competence but requires a holistic restructuring of the maternity care ecosystem. With appropriate interventions at policy and facility levels, midwives can be empowered to drive positive change in maternal and newborn health outcomes.

6. Conclusion

This study explored the perceptions and practices of evidence-based intrapartum care (EBIC) among 80 midwives working in three public hospitals in Sri Lanka. The findings indicate that while the majority of midwives hold a positive perception of EBIC and acknowledge its significance in enhancing maternal and neonatal outcomes, there remains a considerable gap between knowledge and implementation. Factors contributing to this discrepancy include lack of ongoing training, high workload, limited clinical autonomy, and insufficient institutional support.

Despite these challenges, the study also identified examples of self-motivated midwives engaging in peer learning and striving to implement evidence-based techniques when possible. These findings suggest a high potential for improving EBIC adherence through structured training, policy-level reforms, and fostering a supportive clinical environment that empowers midwives as autonomous care providers.

To enhance the quality of intrapartum care in Sri Lanka, healthcare administrators and policymakers must prioritize investments in professional development, develop institutional protocols, strengthen supervision mechanisms, and foster a workplace culture that supports the autonomy and clinical judgment of midwives. By addressing these factors systematically, the gap between perception and practice can be narrowed, and EBIC can be effectively translated into improved maternal and neonatal health outcomes.

Conflict of Interest

Not available

Financial Support

Not available

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