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Midwives' Leadership Style And The Functioning Of Two Maternity Health Centres In Rivers State

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ABSTRACT
This study investigated midwives' leadership style and the functioning of two maternity health centers in Rivers State. Two objectives, two research questions, and a null hypothesis guided the study. The cross-sectional descriptive research design was adopted for the study. The population of the study comprises all staff of the two-comprehensive health centers in Obio Akpor Local Government Area of Rivers State. The sample of the study was 85 health workers. A 40-item questionnaire was adopted as an instrument for the study. Data were analysed with a weighted mean and independent T-test. The findings revealed that midwives need to possess interpersonal skills as well as charisma to take on a leadership role in the selected health centers in Rivers State. Also, there are observable barriers to effective clinical leadership in the selected health centers in Rivers State. Based on these findings, it was recommended that policy guidelines aimed at improving the work performance of midwives based on national best practices award schemes for nurses and midwives in Nigeria should be introduced.
Keywords: midwives, women, leadership, style, maternity, health, centers

INTRODUCTION

Nowadays, both evidence-based medicine and nursing are widely recognized as tools for establishing effective healthcare organizations of high productivity and quality of care. Quality of care is a vital element for achieving high productivity levels within healthcare organizations. Additionally, quality of care is also referred to as the degree to which the probability of achieving the expected health outcomes is increased and in line with updated professional knowledge and skills within health services in which management and leadership of healthcare professionals are critical for strengthening the quality and integration of care (Joab, 2020).

Management and leadership in maternity centers is a complex and challenging one that involves more than mastering a set of leadership skills or matching the appropriate leadership behaviour with a specific situation. The reason is that maternity centers such as the Primary Health Care (PHC) play host to a lot of women who deliver babies daily in both rural and urban areas in Rivers State, Nigeria. The effective management of these deliveries depends on how well-organized the maternity wards are. The expected

outcome of labour is safe vaginal delivery or a successful cesarean section. Whoever is in charge whether a midwife or a doctor must have some leadership skills that will ensure the commitment of subordinates (Joab, 2020).

The Institute of Medicine (IOM) has described six characteristics of high-quality care that must be: (1) safe, (2) effective, (3) reliable, (4) patient-centered, (5) efficient, and (6) equitable. In addition, the qualities of a good leader in midwifery practice include being authentic, emotional intelligence, visionary, passionate, and self-effecting. The PHC in Rivers State, Nigeria is considered to be a more appropriate approach to addressing the attributes of high-quality healthcare as described by IOM through improving quality access to healthcare services as well as disease prevention at the grassroots level of our socio-political lives. Thus, the availability and efficiency of PHC is a key determinant of the overall health and wellbeing of a people, and a useful yardstick for the assessment of a nation's health system (Kadiri-Eneh, Uzochukwu, Tobin-West, & Azuike, 2018). Just like in other organizational settings where the employees constitute a key driving force, the efficiency of PHC workers especially such midwives is vital for the success of the globally accepted, novel philosophy and approach to health care delivery.

Effective leadership is crucial to maximizing the effective management of care in the hospital setting such as the PHC in Rivers State, Nigeria. This is similar to what is obtained in many areas of the developed world. Modern hospital care such as the PHC in Rivers State, Nigeria is confronted by workforce challenges, changing consumer expectations and demands, financial constraints, increasing demands for access to care, mandates to improve patient-centered care, and issues regarding the levels of quality and safety of health care (Daly, 2014; MacPhee, 2013). Additionally, increasing calls to nurture effective leadership practices among professionals such as the midwives draws on strong evidence of an association between the role of midwives in leadership and several systems outcomes, such as patient satisfaction, organizational financial performance, staff satisfaction and engagement as well as the overall quality of care and health outcomes (Shipton, Armstrong, West, & Dawson in Joab, 2020; West, Armit, & Loewenthal, 2015).

Most noteworthy, Nigeria is not alone in the dire need of effective leadership in various sectors and organizations such as the health sector. Different countries around the world have been observed in attempting to highlight and stress the concept of effective leadership styles in various ways in their organizational daily activities, programmes, and performance. Take for instance, in Ethiopia, there is rapid and increasing awareness in various sectors and fields in line with a sharp increase in the number of nurses, including the health institutions such as university teaching hospitals, colleges, schools of nursing/midwifery, and others (Joab, 2020).

Based on the foregoing, leadership is not only complex but broadly regarded as essential for effective health systems development (Gilson & Daire in Joab, 2020), and it is one of the building blocks in the World Health Organization (WHO) as well as health systems framework (Curry, *et al*., 2012). Hence, West, (2015) as well as Gilson and Daire, (2011) described leadership as the most influential factor in shaping organizational culture. Leadership has therefore become a major and basic concern for health care organizations in Nigeria because this is one organization that can be characterized as a place where lives are at stake (Joab, 2020). Hence, the researchers investigated midwives' leadership style and work outcome on the functioning of two maternity health centers in Rivers state

Statement of Problem

Recently, the interest in highlighting maternal health system but with little to reference on leadership functional capacity of midwives. It is most noteworthy that the best-planned programs can fail without leaders' who are effective, thus the most challenging task in health systems is to grow people who can develop coherent vision, technological expertise, political skills, and ethical orientation to lead challenging policy-making and implementation processes

However, the described leadership attributes are yet to be empirically confirmed as existing or not existing concerning work outcomes among midwives in maternal health centers, especially in Rivers State. Hence, what bothered the researchers is, in what ways can midwives' leadership style impact work outcome on the functioning of maternity health centers in Rivers State? The following research questions were also answered:

1. What are the perceived skills required as a midwife or health practice to be a leader in the selected health centers in Rivers State?
2. What are the barriers to effective clinical leadership in the selected health centers in Rivers State?

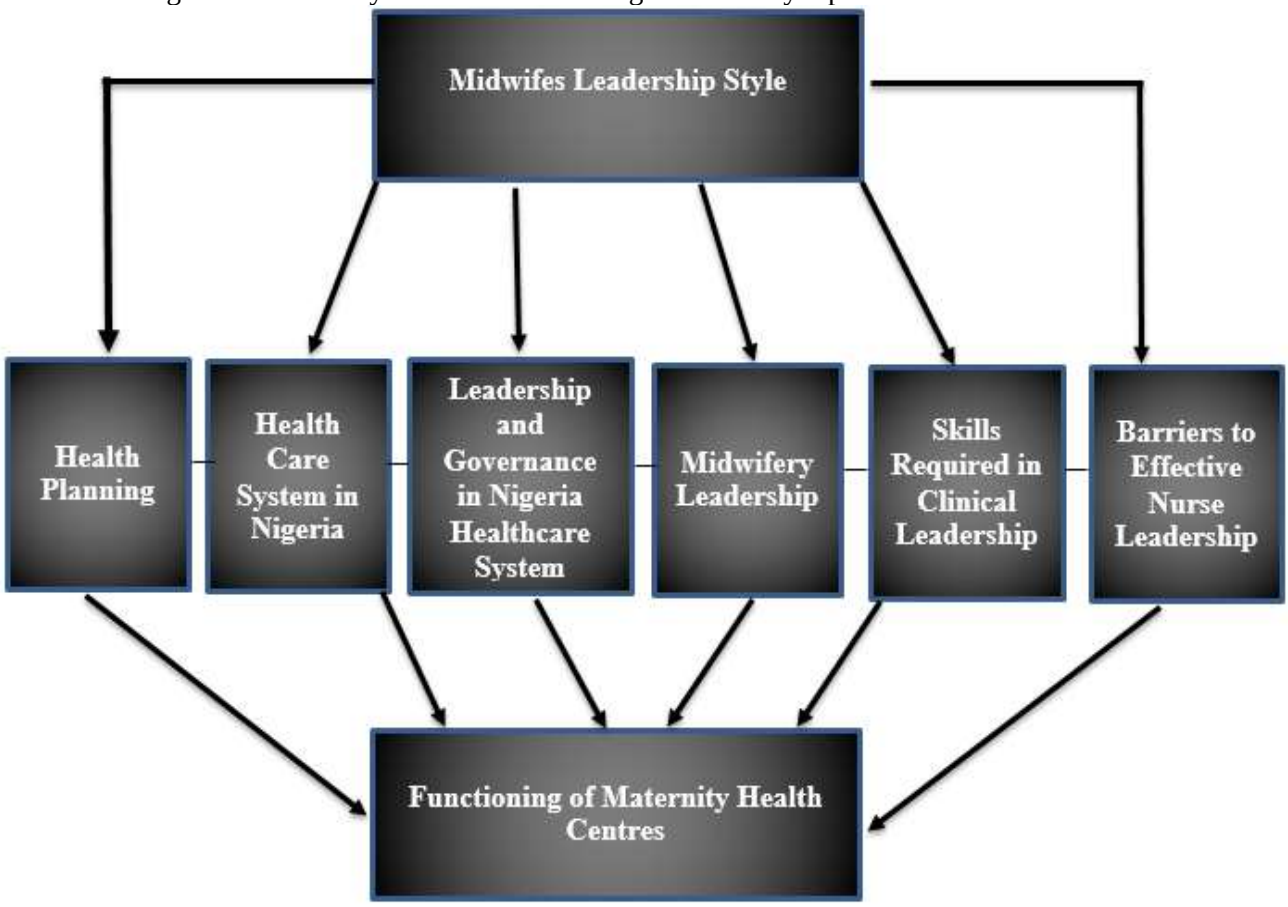
Hypothesis

A null hypothesis guided the study and was tested at a 0.05 significance level.

H_{01}: There is no significant relationship between perceived skills required on midwives' leadership style and the functioning of two maternity health centers in Rivers State.

Conceptual Framework

The concepts of this study are hinged on the dimensions of midwives' leadership style and work outcome on the functioning of two maternity health centers as diagrammatically represented below.



Researchers' conceptualization (2020)

Health Planning

Health planning is the orderly process of defining health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action, concerned not only with the adequacy, efficacy, and efficiency of health services but also with those factors of ecology and of social and individual behavior that affect the health of the individual and community (World Health Organization, 2015). It is a process to produce health and its planning process is done by the ministries of health in the government agencies and can also be

delegated to different non-government bodies. The health planning process can also be carried out by service providers (private organizations) like private hospitals, pharmaceutical companies, and other service providers (Abudu in Joab, 2020).

Health professional bodies (like Doctors, nurses, to name a few) are also involved in the health planning process where they input issues that are of interest to them. Citizens of Nigeria who are the consumers are also involved in the process through advocacy groups, meetings, forums (Fotso, *et al*., 2011). Unfortunately, the health planning process in Nigeria has not been properly handled and executed. This is due to the inability of the government to implement the content in the policy guidelines in detail. Lack of proper health planning has led to the continuous vulnerability to diverse diseases by Nigerian citizens (Onokerhoraye in Joab, 2020). Change in government is also a method of frustrating the implementation of health plans because, once a new government takes over power, they put aside the works of the former government and start to initiate a new one. In summary, there is no continuity and consistency in national planning in Nigeria (Ijadunola, 2010). The health planning process involves the following; surveying the environment (what is), setting directions (what ought to be), problems and challenges (differences between what is and what ought to be), range of solutions, the best solution(s) (preferred ways to get to what ought to be), implementation (putting in place the best solution), and evaluation (did we get from what is to what ought to be?) (The Health Planner's Toolkit, 2008).

If this health planning process put together by the Health Planners can be used judiciously in Nigeria, it is believed that the rate of spread of diseases will drastically reduce and people will live a more healthy life, thereby bringing an increase in the economic development of the country because, it is only when the citizens are healthy that they can work, and only then can the government collect taxes from them (Adeyemo, 2005)

Health Care System in Nigeria

The organization of the Nigerian health care system is into three parts; the federal, state, and local government levels. All these tiers of government are involved in the provision of services, financing, and giving account (stewardship) among other things to Nigerians.

The Federal Level

The federal government is mostly responsible for making health policies and also providing planning and technical support to the general health system in Nigeria. They also monitor and coordinate the level at which the state governments implement the national health policies. They provide health care services to the citizens through the establishment of psychiatric, orthopedic, and teaching hospitals and the provision of national laboratories (Asuzu in Joab, 2020). The government also has the responsibility of monitoring diseases, managing vaccines, providing and regulating drugs, and training health care experts.

The State Level

Under the state governments, the state ministries of health and state hospital management boards are responsible for managing health care facilities and programs. The states operate general hospitals and also provide technical support for primary health care facilities (Abdulraheem, *et al.*, 2012). The state health authorities are also responsible for the training and development of health technicians, midwives, and nurses. They also provide technical support to local government health facilities (Oyibocha, *et al*., 2014).

The Local Government Level

The 774 local governments in Nigeria are mainly responsible for primary health care by, organizing health services through the wards. They provide basic health services, conduct monthly sanitation, and also monitor the health hygiene of the communities (Abimbola, *et al*., 2014).

Leadership and Governance in Nigeria Healthcare System

This is a critical aspect of the building blocks of the health system because it deals with the role(s) of government at all levels on the health of its citizens. The government oversees and coordinates all the activities of both the public and private health sectors of the health system in the country (Uneke et al, 2012). Without good government in place, there will be no coordination, financing, policy/guideline, and other things needed to carry out an effective and efficient health care system. The central (or federal) government delegates its authority to various provinces, state or local authorities, or agencies to monitor health practitioners by carrying out a supervisory function and forming policy guidelines to be followed

(Lewis, 2006). Leadership and governance are important building blocks because the quality of any health care system in any country is dependent on the quality of leaders of that country. The policies developed by the government changes according to the changes in the population and also on the clamor of health needs by the citizens (Ejimabo, 2013).

Midwifery Leadership

The NMC Code as cited by Joan, (2020) stated that nurses, midwives, and health visitors: Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare system. Traditionally, leadership positions in midwifery have tended to be associated with either management or more senior strategic roles within the service, such as heads of midwifery, matrons and consultant midwives, or within the RCM, the NMC and lead midwives for education (LME) within higher education institutions (HEIs) (Ralston in Joab, 2020). However, Curtis, Ball, and Kirkham (2006) found that a 'them and us' relationship exists amongst midwives in practice and those in the managerial hierarchy that may have led to the perceived distance between them.

Alimo–Metcalfe in Joab, (2020) suggested that failures in leadership roles are often related to the isolation of those holding more senior management positions. Warwick, (2007) adds that visibility may enhance the effectiveness of leaders in clinical practice. However, other leadership positions are held by midwifery team leaders, labour ward coordinators, and midwifery managers who support front-line staff more directly (Byrom & Kay, 2011). Other specialist roles have emerged around areas, such as safeguarding women and babies, substance misuse, and risk management but appear to be associated with enhancing care for disadvantaged women rather than leadership roles.

The consultant midwife leadership role was introduced in an attempt to redress the balance of power between the obstetricians and midwives, remove the hierarchy and retain clinical expertise at the bedside (Sullivan in Joab, 2020; O' Loughlin, 2011). However, the creation of the position may have reinforced the hierarchy in the maternity services by adding another level. O'Loughlin (2011) observed that the consultant midwife role may disempower other midwives by removing control over their work. The consultant midwife's lack of operational responsibility, and therefore power, may hamper her/his ability to change practice, and therefore requires that they practice alongside and are supported by their managerial colleagues.

Skills Required in Clinical Leadership

Developing effective clinical leadership is an essential element of organizational success As well as being compassionate, patient, and caring, as a nurse you also need to be able to demonstrate leadership skills from the start of your career. A nurse plays multiple roles in providing health care, working as Clinical care providers, Nursing care provider, Administrator, Programme, and Facility Manager. In all these positions s/he is a leader. The nurse should have many skills to play these roles in the health sector (Kumar & Rinu, 2018). The five essential skills required for nurses in their role as leaders are:

1. Active Listening as Main Communication Skill. Good communication between nurses and patients is essential for the successful outcome of the health care of each patient. To achieve this, however, nurses must understand and help their patients, relatives, and team members demonstrating courtesy, kindness, and sincerity and responding to the needs as a leader [Kourkouta & Papathanasiou, 2014).
2. Emotional Competencies. Emotional competencies are more important for success in professional life than intellectual intelligence. There is a considerable body of research suggesting that a person's ability to perceive, identify, and manage emotions provides the basis for the kinds of social and emotional competencies that are important for success in almost any job [Mayer & Salovey in Joab, 2020).
3. Conflict Resolution: Nurses as team leaders need to encourage team members to bring in different opinions to enrich the work of the team. Their role as leaders is to ensure that these differences are dealt with healthily and should not lead to conflict. A conflict brings down the productivity of the team and vitiates the environment preventing members to put in their best. At an

organizational level, the process of conflict resolution is an opportunity for growth and change in a work environment [Kumar, Deshmukh & Adhish, 2014).

4. Networking: Nurses must have networking skills. Networking is the exchange of information or services among individuals, groups, or institutions; specifically: The cultivation of productive relationships for employment or business [Merriam-Webster, 2018]. The ability to network is becoming more and more important. Maintaining good relations fosters trust and fidelity commitment [Anderson & Jack in Joab, 2020].
5. Managing Difficult Colleagues. One always comes across people who are difficult to deal with. A leader must get work done from all his team members, hence must deal with such people effectively. A difficult person is anyone who causes anyone else irritation, upset, stress, or anxiety. so, a good leader should have the skills to manage difficult colleagues for a better outcome [Kumar, Kumar, Adhish & Reddy, 2015]. But in Nigeria, leadership skills among Nurses don't receive adequate attention in the nursing curriculum and in-service training. And the essential skills of nurses and how the nursing curriculum support building leadership skills in the health care sector.

Barriers to Effective Nurse Leadership

The barriers related to nurses enacting their leadership role are very complicated. The restrictions that prevent the advanced practice nurses from practicing to the full scope of their practice require change on a policy and board level. Nurses enter into leadership roles for many different reasons. Bondas (2006) identified four different paths for nurse leaders based on qualitative analysis. The four themes identified include the path of ideas, the career path, the path of chance, and the temporary path. The path of ideas is when the nurse makes a conscious choice to become a nurse leader. This type of leader often seeks new knowledge and education to be prepared to function in the role (Hughes, 2018).

The leader who chooses the path of ideas is characterized by wanting to make a difference in patient care, the particular unit, or the organization through an intentional pursuit of a leadership position. The nurses who choose the career path explicitly want to become formal leaders for different reasons. The career path leaders may pursue the role to work daytime hours, to move more freely around within the organization, to obtain more control of work hours, to earn a higher salary, to be challenged more at work, and the possibility of increased visibility in the organization (Hughes, 2018). The path of chance is when a nurse is offered a leadership position without seeking the leadership role. Sometimes the path of chance happens when a vacancy in a leadership position occurs unexpectedly. These nurses moved into the leadership position because someone encouraged them to perform in the leadership role. The final theme involved the temporary path of leadership. This path was similar to the path of chance but slightly different. In the temporary path, there is an opportunity for a leadership trial with the option to return to a previous position (Hughes, 2018). The nurse function as a substitute until a formal leader is hired for the position.

The experience of a leader substitute was negative if the person never had the chance to lead again within the organization. Some of the temporary path leadership experiences created bitterness (Bondas 2006). The evidence is clear that nurse leaders can and do make an impact. Effective nurse leadership has been demonstrated to have a positive effect on patient safety (Collette 2015), the development of a safety climate (Lievens and Vlerick 2013, Liang et al. 2016), lower patient mortality (Wong et al. 2013), safe medication practices (Farag et al., 2017), patient satisfaction (Wong et al. 2013) and the quality of patient care (Ma, et al. 2015). Furthermore, specific nursing leadership styles have been shown to positively influence nurse job satisfaction (Morsiani et al. 2016; Ma et al. 2015), nurse intent to stay (Abualrub & Alghamdi, 2012), nurse engagement (Brewer, *et al.* 2016; Lewis & Cunningham 2015), nurse innovation (Weng, *et al*. 2015) and to reduce nurse incivility (Kaiser 2017; Bortoluzzi, *et al*. 2014).

On the other hand, ineffective nurse leadership is associated with negative effects on nurse satisfaction, nurse effectiveness, and nurse productivity (Cummings et al. 2010). In the complex, ever-changing healthcare system it is vital to have effective nurse leaders. Developing effective nurse leaders may be more important now than at any previous time in history as many nurses are nearing the age of retirement.

According to Peltzer, *et al*., (2015), the most frequently identified barrier to developing leadership skills to serve in these roles was time constraints, insufficient time during and outside of work to pursue leadership development. Other barriers included limited organizational leadership opportunities, lack of funding for advancement as a leader, and perceived need for further leadership development before serving in a leadership role. Keys (2014), identified limited organizational opportunities for upward mobility as a barrier to their leadership development. Another concern was that the nurses did not attend any formal leadership training and felt that they were not educationally prepared for leadership before moving into the position, particularly in the areas of business and management skills. Some nurses commented that they believe having their Master's Degree in nursing before moving into the position would have better prepared them for the role. Lack of leadership resources was also one of the barriers for nurses moving into leadership roles identified in a survey of 3,498 registered nurses in Florida (Denker, *et al*. 2015). Of those surveyed, 1012 (75%) identified nurses not being seen as revenue generators compared to physicians and the absence of nurse visibility in policymaking (947,70%) as major barriers to nurses moving into leadership roles within healthcare. Additional barriers identified include a lack of a unified voice among nurses, public perception of nursing roles, and current compensation for nurses (Denker, *et al*., 2015).

In addition, these nurses described inflexible organizational cultures, feeling stereotyped and undervalued, and a need to be available at all times as barriers to professional success and fulfilment. The most frequent mention barrier was not understanding the gravity and demands of the position before accepting the role. Specifically, the nurse managers did not realize that they would have the 24-hour responsibility for the unit (Keys, 2014). Lack of leadership resources was also one of the barriers for nurses moving into leadership roles identified by Denker et al. (2015). The constant uncertainty and restructuring of the health care system was seen as a barrier to nursing leadership.

The constant upheaval and workload that result from some of the dramatic pendulum shifts in priorities are rarely evaluated for the impact of the change on patient care or staff. Another barrier identified was the lack of role clarity. Nursing has been taken out of the leadership role titles to be replaced with such titles as Team Leader, Program Manager, or Division Manager. The final barrier identified was the long work hours related to the dramatically increasing workload across the nursing sector. The middle managers expressed considerable anxiety about time pressures and their impact to perform well in their current role and manage their family and other responsibilities. The perception that senior nurses were expected to manage even more complex workloads in conflict-ridden environments resulting in an even harder work-life balance to achieve was a disincentive for middle-level managers to move into the more senior roles (Mass, *et al*. 2006).

In essence, barriers identified for nurse leadership development include a lack of funding (Peltzer, *et al*. 2015), time constraints (Peltzer, *et al*. 2015), a lack of specific education that focused on clinical leadership and health team management (Dwyer 2011), a lack of a structured pathway for developing nurse leaders (Dwyer 2011), and a lack of available leadership training (Keys, 2014; Fealy, *et al*. 2011). Barriers to nurses moving into higher leadership roles include: limited organizational opportunities (Peltzer, *et al*. 2015), lack access to working at the strategic level (Elliott et al. 2016), inflexible organizations (Keys, 2014), nurses not being seen as revenue generators compared to physicians and the absence of nurse visibility in policymaking (Denker, *et al*. 2015), a lack of formal leadership training (Keys, 2014; Fealy, *et al*. 2011), and nurses feeling devalued by the system (Dwyer, 2011). In addition, nurses may choose to not seek out the middle nurse manager or executive leadership roles because of the time constraints, long hours, conflicting priorities, and stress related to the leadership position

METHODOLOGY

Research Design

The study adopted a cross-sectional descriptive design of assessment of a midwife's leadership style and work outcome in two selected comprehensive health centers in Rivers State. It utilized this design because there was no manipulation of the variables.

Study Area

The study was carried out in two selected comprehensive health centers located in Rivers State which are; Mgbundukwu model health center which is situated in Umuoji street mile 1 Diobu and Rumuigbo Health Centre situated in Rumuigbo town both facilities are in Port Harcourt and Obio/Akpor Local Government Area respectively. Port Harcourt is the capital and largest city in Rivers state in Nigeria. It lies along the Bonny River and is located in the Niger delta. As of 2016, the Port Harcourt urban area has an estimated population of 1,865,000 inhabitants, up from 1,382,592as of 2006 (Arizona-Ogwu,2011). The main city of Port Harcourt is the Port Harcourt city in the Port Harcourt Local Government Area, consisting of the former European quarters now called Old GRA and new layout areas. The urban area (Port Harcourt metropolis) on the other hand is made up of the local government area itself and parts of Obio/Akpor and Eleme accordingly.

Study Population

The population of the study consists of 97 staff in the two selected health centers (Mgbundukwu model health center: 50, and Rumuigbo Health Centre: 47). The population of the study consisted of the following as shown in the table below:

Staff	Mgbundukwu model health center	Rumuigbo Health Centre
Doctors	3	3
Midwives	7	6
Pharmacist	-	2
CHEW	8	8
CHO	3	3
Lab technicians	2	4
Record Officer	1	3
IHVN	7	7
Cleaner	4	4
Coppers	3	
Security	2	2

Inclusion criteria

This included all the midwives, nurses, Community Health Extension Workers (CHEWs), and doctors working in the two health centers, and who are not on leave.

Exclusion criteria

1. Those who are on leave in two selected health centers
2. Those who will not be available during the data collection period.

Sampling and sampling technique

The census sampling technique was used to select participants from each of the selected PHCs. The participants consisted of Midwives, nurses, Community Health Extension Workers (CHEWs), and doctors. This technique is adopted because all the population the mentioned cadres will be used. The population consisted of 97 staff from the two selected comprehensive health centers. Only 85 (82.45%) of respondents were retrieved during data collection.

Methods of Data Collection/Instrumentation

A total of 97 questionnaires was administered to the respondents in the two selected health centers. A self-structured administered questionnaire was used to gather information from the respondents.

Validity/Reliability of Instrument

Validity is the ability of an instrument to measure what it is supposed to measure. The questionnaire submitted to the supervisor(s) ascertain for face and content validity and confirm that the instrument will be able to measure the objectives for which it was designed. Necessary corrections and suggestions were effected by the researcher before the final draft of the questionnaire was produced. The reliability of any measuring instrument is the degree of consistency of the results of its repeated measures of an attribute it is measuring. To ascertain the degree to which the instrument is consistent, the researcher administered 10 questionnaires to workers in Ozuoba and Aluu health centers at a two-weekly interval. After retrieval, Cronbach's alpha was used to test for the reliability of the instrument. The result of the test was 0.81 and which made the instrument reliable.

Method of Data Analysis

The data generated from the respondents were analysed using the Statistical Package for Social Sciences (SPSS) 23. Mean and standard deviation will be calculated and the data organized in tables using frequencies and percentages. Mean scores above 2.5 will be accepted (4+3+2+1=10/4=2.5) while mean scores below 2.5 will be rejected. T-test will be used to get the difference in means of variables while Chi-square test was used to measure the association between variables at p=0.05.

RESULTS

Table 1: Mean and Standard Deviation scores on the perceived skills required a midwife or health practitioner to be a leader in the selected health centers in Rivers State

	Skills required as a midwife	Mgbundukwu model health centre (N=44)		Rumuigbo Health Centre (N=41)		Mean Set	Remark
		X_1	SD_1	X_2	SD_2	$\frac{X_1 + X_2}{2}$	
1	Excellent communication	3.34	0.57	3.34	0.53	3.34	Agree
2	Clinical experience	3.05	0.43	3.05	0.38	3.05	Agree
3	Management skills	3.30	0.79	3.37	0.77	3.33	Agree
4	Fair/trust/integrity	3.07	0.50	3.02	0.52	3.05	Agree
5	Time management	3.57	0.50	3.51	0.51	3.54	Agree
6	Understands other disciplines	3.14	0.63	3.22	0.42	3.18	Agree
7	Team working	3.07	0.45	3.05	0.38	3.06	Agree
8	Flexibility	3.16	0.78	3.22	0.79	3.19	Agree
9	Change management	2.89	0.62	2.85	0.57	2.87	Agree
10	Organisational skills	3.20	0.55	3.12	0.51	3.16	Agree
	Grand Mean					**3.18**	**Agree**

Results in Table 1 revealed that the respondent agreed to all the list items (1,2,3,4,5,6,7,8,9 and 10) as the perceived skills required for a midwife or health practitioner to be a leader with a mean score far above the criterion mean of 2.5. A grand mean score of 3.18 was obtained, this implies that excellent communication, clinical experience, management skills, fair/trust/integrity, time management, teamwork, organizational skills, etc. are the perceived skills required as a midwife or health practitioner to be a leader in the selected health centers in Rivers State.

Table 2: Mean and Standard Deviation scores on the barriers to effective health professional clinical leadership in the selected health centers in Rivers State

S/N	**Barriers to effective clinical leadership** The leader is ineffective due to;	**Mgbundukwu model health centre (N=44)**		**Rumuigbo Health Centre (N=41)**		**Mean Set**	**Remark**
		X_1	**SD_1**	**X_2**	**SD_2**	**$\frac{X_1 + X_2}{2}$**	
11	Lack of time and or high clinical demand	2.98	0.79	3.05	0.77	3.01	Agree
12	Having to deal with bureaucracy	3.14	0.85	3.22	0.79	3.18	Agree
13	Lack of an opportunity to be a clinical leader	3.50	0.76	3.56	0.67	3.53	Agree
14	Limited funding/resources	3.61	0.58	3.66	0.53	3.64	Agree
15	Lack of mentoring	3.11	0.65	3.00	0.87	3.06	Agree
16	Problems with the whole health system	3.70	0.59	3.78	0.52	3.74	Agree
17	Limited training opportunities	2.73	0.82	2.80	0.68	2.76	Agree
18	Lack of confidence	3.30	0.88	3.39	0.80	3.34	Agree
19	Resistance to change	2.52	0.85	2.44	0.90	2.48	Disagree
20	Lack of support from management	2.82	0.87	2.85	0.76	2.84	Agree
	Grand Mean					**3.16**	**Agree**

The result in Table 2 revealed that the respondent agreed to most of the listed items (1,2,3,4,5,6,7,8 and 10) as the barriers to effective health professional clinical leadership with a mean score (3.01, 3.18, 3.53, 3.64, 3.06, 3.74, 2.76, 3.34, and 2.84) far above the criterion mean of 2.50. While the respondent disagreed with item 9 that Resistance to change is a barrier to effective health professional clinical leadership with a mean score (2.48) which is below the criterion mean of 2.50. A grand mean score of 3.16 was obtained, this implies that lack of time and or high clinical demand, bureaucracy, lack of an opportunity, limited funding/resources, lack of mentoring, lack of confidence, etc. are the barriers to effective health professional clinical leadership in the selected health centers in Rivers State.

Table 3: Independent T-test analysis of the mean rating scores of the relationship between perceived skills required on midwife's leadership style and the functioning of two maternity health centers in Rivers State

Group	N	Df	x^2cal	Sig. (2-tailed)	Level of Sig.	x^2 crit.	Decision
Skills required	85	1	4.210	0.040	0.05	3.84	$H0_1$ Rejected
Work outcome							

Table 3 revealed that the x^2cal is 4.210 with df = 1 and p<0.05. The obtained x^2cal value of 4.210 is greater than x^2 crit. = 3.84, therefore the null hypothesis that the skill required has no significant influence on the work outcome of a midwife is rejected. This indicates that there is a significant relationship between perceived skills required on the midwife's leadership style and the functioning of two maternity health centers in Rivers State.

DISCUSSION OF FINDINGS

Perceived Skills Required on Midwife's Leadership Style

Findings on this study as observed in Table 1 revealed that the respondent agreed that excellent communication, clinical experience, management skills, fair/trust/integrity, time management, teamwork, organizational skills, etc. are the perceived skills required as a midwife or health practitioner to be a leader in the selected health centers in Rivers State which also agrees with [Kourkouta & Papathanasiou, 2014) on their assertion that nurses must understand and help their patients, relatives and team members demonstrating courtesy, kindness, and sincerity and respond to the needs as a leader

Barriers to Effective Communication

The findings of the study as presented in Table 2 revealed that the respondent agreed that lack of time and or high clinical demand, bureaucracy, lack of an opportunity, limited funding/resources, lack of mentoring, lack of confidence, etc. are the barriers to effective health professional clinical leadership in the selected health centers in Rivers State. This result is also in agreement with the assertion of Peltzer, *et al*. (2015) who state that the most frequently identified barrier to developing leadership skills to serve in these roles was time constraints, the insufficient time during and outside of work to pursue leadership development. Other barriers included limited organizational leadership opportunities, lack of funding for advancement as a leader, and perceived need for further leadership development before serving in a leadership role. Keys (2014), identified limited organizational opportunities for upward mobility as a barrier to their leadership development. Another concern was that the nurses did not attend any formal leadership training and felt that they were not educationally prepared for leadership before moving into the position, particularly in the areas of business and management skills.

CONCLUSION

Based on the findings of this study, the health workers in the two selected health centers recognized that there are barriers to leadership functioning and midwives have critical leadership roles to perform through the development of attributes of charisma and interpersonal skills. This will go a long way to mitigating the effect of the barriers to the functioning of the health centers.

RECOMMENDATIONS

The following recommendations were made based on the findings of the study

1. Policy guidelines aimed at improving the work performance of midwives based on national best practices award schemes for nurses and midwives in Nigeria should be introduced.
2. Funding for the health sector should be adequately increased.

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