Changing roles of midwifery in maternal health care services in Turkey

Abstract

Aim: This study aims to identify whether the assigned roles to midwives and the scope of midwifery practice regarding maternal health is narrowed down in Turkey. **Materials and Methods**: Descriptive analyses and statistical tests addressing the study objectives were done by utilizing data sets of demographic and health surveys conducted in 1993, 1998, 2003 and 2008. **Results**: Private health sector has gained importance in Turkey in the last decades. The share of private facilities in delivery process has increased from 5% to 22%. The proportion of pregnant women seeking for antenatal care services (from 67% to 92%) and, the proportion of births attended by health professionals (from 80% to 94%) have risen significantly between 1993 and 2008. On the other hand, physicians have become main providers of antenatal care services during the same period and the percentage of certified midwife-attended births dropped noticeably from 43% to 26%. Vaginal birth in which midwives usually take the primary responsibility has reduced dramatically while cesarean rates have reached 40%, as of 2008. **Discussion**: There have been major alterations in Turkey's health care system after 1990s. It is recognized that midwives are losing their autonomy and quietly disappearing in birth process.

Key words: midwifery; health policy; cesarean section; antenatal care; delivery; Turkey

Introduction

The practice of midwifery is as old as mankind and dates back to pre-modern times and midwives were usually the only birth attendants in those days. The word midwife is originally defined as "being with woman". Over the centuries, midwifery has developed and improved as a specialty together with the progress in health care. Since it is an old

profession, midwifery education programs began in the 17th century in Europe and, midwives were highly respectable and recognized as educated elites especially in France in the 18th and 19th centuries [1]. The status of midwives in a country is said to give some hints about the status of women and "*the value placed on them by society*" [2].

Midwifery is the most important supply chain of maternal and child health services. In general, midwives are expected to provide maternity care and services to both mother and newborns through a collaborative work with other health professionals that are physicians and nurses [1]. However, this is not always the case in countries like Turkey where midwifery is not acknowledged as profession in its own right. Demographic and health survey and, country reports have revealed that physicians are the major provider of maternal and child health services [1].

Developments in medical science and medicalization of obstetric care can be regarded as the milestones in the midwifery profession. Prior to the advent of scientific medicine, birth was a social event [3], which took place in the presence of a midwife with only limited interventions [4]. The advancement of medical science starting with Industrial Revolution, childbirth is regarded as a medical event rather than a social one and it has become an increasingly medicalized phenomenon. Moreover, medicalization of pregnancy brings about the dependency on the health care provider and medical system [5]. This, in turn, results in the loss of autonomy of pregnant women as well as the monopolization of the information meaning that "*what is normal or anormal*" is only known by the physician while women have to rely on the what it provided by the health professional [6].

Accordingly, some researchers have argued that in the contemporary world births have been predominantly taken place under the surveillance of physicians and, antenatal care is largely provided by them, which means a loss of autonomy in the activities of

midwives as they have been superseded by physicians in the medical hierarchy [1, 7-9] and, a barrier to the development of midwifery provided services [4]. On the other hand, when there are fewer obstetricians in a community or a hospital, midwives are said to noticeably more autonomous and, be preferable to seeking the maternity care [1]. Today, it is widely stated that midwives confront a dilemma of negotiating their identities and they are obliged to seek new responsibilities and appropriate roles for their continued existence [7].

The midwifery model of care is accepted as cost-effective [4] the most appropriate care for most women during pregnancy and birth [10-12]. In most of the developed countries like England, Australia and New Zealand, midwifery-led care becomes a norm and, certified midwives are the primary providers of care to pregnant women and newborn [13-15]. In addition to these, countries with highly effective healthcare programs such as Netherlands and Sweden utilize obstetricians only for high-risk cases [16]. There is a clear evidence that a twofold increase in the current number of midwives in the 58 countries doubled on condition that they have necessary skills and are well-equipped to handle the basic emergency obstetric and newborn care, maternal deaths, stillbirths and newborn deaths would the decline by 20 percent, 18 percent and 23 percent, respectively, as of 2015 [17]. Based on these facts, the researchers made a simulation and found out that if all women had an access to health facilities and were assisted by qualified midwives, 3.6 million lives would be saved in the next two years indicating a 60 percent reduction in maternal and newborn mortality [17].

Contrary to the crucial role of midwives in improving maternal and infant mortality and morbidity rates, midwives have limited ability to practice within the authorized scope of midwifery profession [1,9] and, there seems to be an increasing tendency for midwives to work under the supervision of physicians not only during pregnancy, but also in labour

process and postpartum period, particularly in the developing countries [10]. One of the consequences of subordinate position of midwives in the normal process of birth can be regarded as higher levels of cesarean rates experienced in the world [18-21]. On the other hand, many researchers claimed that a considerable reduction in the prevalence of caesarean deliveries is mostly likely to be attained with the increase in midwife-assisted births [22-25]. In one study, caesarean rate was found to be lower among midwives (9 percent) when compared to that of obstetricians (14 percent) and physicians (15 percent) [23]. Another study revealed a remarkably very low level of primary caesarean rate (2 percent) regarding the more than thirty thousand deliveries assisted by midwives [25].

Historically, the profession of midwifery was held in high esteem in the Turkish culture as well. In Ottoman's, for instance, midwives were the sole health care providers and birth attendants at that time [26]. With the legal reforms in 1928, uncertified midwives were banned from delivering births in accordance with the Law No.1219, and formal midwifery education began in vocational high schools on health services [22]. Today, the vocational high schools of health still provide educational programs alongside the midwifery department of universities since nurses and midwives are now required to have bachelor's degree according to the Munich Declaration in 2000 [22].

In the contemporary world, Turkey has become one of those countries experiencing a decrease in skilled midwife attended births although it has one of the highest number of midwives (70 midwives per 100,000 population as of 2010) in European region [27]. The criterion of World Health Organization (WHO) regarding the number of midwives in a country is also a useful tool for assessing the midwifery workforce supply. According to the standards of WHO, one midwife attends 175 birth on average. Accordingly, approximately 7429 midwives are needed to provide care at 1.3 million births occurred annually in Turkey.

Although it is a simple conceptualization of the criterion, it reveals that the number of midwives in Turkey look broadly irrespective of urban-rural breakdown according to the latest statistics pointing out that there are 44.468 midwives countrywide as of 2009 [28].

On the other hand, ineffective utilization of midwives is seen as a major problem in Turkey due to health reforms, regulations and, lack of voice in policy development. Many skilled health professionals has mentioned that the declining trend of midwivery assistance before, during and after delivery is mainly due to the development of Health Transformation Program (HTP) [29-30]. This is a comprehensive health reform program which was commenced in 2003 following the urgent action plan of the government, titled "Health for All". The main focus of the program has been explained as the provision of high quality health care services for the whole population regardless of individuals' socio-economic characteristics [31-32]. Many researchers mention that publicly financed health care systems are eventually transformed into market-oriented health care systems to ensure effective and efficient allocation of resources in health care while improving the ability to fulfill the demands of customers based on the principles of equity [33-34]. Thus, the authorities will gain benefit from the competiton among service providers, which will result in strengthened primary health care services [33]. In a similar way, the motive behind HTP is to attain a market-oriented health care system. The leading goals of HTP can be summarized as health insurance system for the overall society, sustainability [35], administrative and financial autonomy in health facilities [31-32], decentralization, reconstruction of public sector [35-36] with increased privatization of services [37].

One of the most controversial arguments regarding the reforms of HTP is the establishment of family medicine scheme in Turkey. The rationale behind the reorganization of health care system is said to be largely related to improve primary health care [31-32, 35].

Indeed, family medicine scheme is not a new phenomenon in Turkey. It was first introduced with the Socialization Act in 1961 [9, 35]. At that time, “community health centers” provided the primary health care services with a holistic approach and, family medicine scheme, which did not required a specialty in family medicine, was integrated into the functions of community health centers [39]. Recent family medicine model implemented in Turkey does not similar to the ones in the world. This country specific model includes the diagnostic and curative medical services as well as the rehabilitation, in which the central role is assigned to family physicians within the scope of primary health care services [32].

Family medicine scheme has been criticized by different professionals in terms functionality, structural transformation and its appropriateness [30, 40-44]. In addition to these, there are strong arguments that family medicine model have resulted in the loss of visibility of midwives in the primary health care services [29-30]. Prior to the health reforms, maternal and child health and family planning units and health houses/centers are one of the major employers of midwives in Turkey [45], but now these health facilities and in turn, midwives have lost their functionality with the new health reforms and family medicine units. Moreover, with the family medicine model, midwives in Turkey are believed to be dependent and, to have limited responsibility like assisting the family physician [30] In line with these, health statistics have shown that midwives have been increasingly assigned to health facilities other than their major place of work that health houses and community health centers. This could put them into a subordinate position and may take away from their primary responsibilities.

Besides that, family medicine staff is liable to the contract-based schemes in this model, which might result in negative workinng conditions such as high work load, intensive working hours and work without insurance. Turkish Medical Association reported that 36-

65% nurses and midwives did not want to take part in family medicine system in 2006 due to such discouraging work environment [30]. Moreover, when family physicians were asked about with whom they wanted to work in their team, midwives had the fifth place following the nurses, lab technicians, medical secretaries and x-ray technicians [46].

Based on these arguments, the aim of this paper is to examine the role of midwives in the health care system and how their scope of practice has changed, with the implicit assumption that higher rate of cesarean section reflects lower level of midwifery care.

Materials and Methods

The analyses were primarily based on the data sets of Turkish Demographic and Health Surveys (TDHS) conducted as a part of the international DHS project by Hacettepe University Institute of Population Studies in collabration with Macro International, Ministry of Health, European Union and State Planning Organization in 1993, 1998, 2003 and 2008. The aim of those nationally representative surveys was to provide information on levels of and trends in fertility, infant and child mortality, family planning, maternal and child health in Turkey. The sampling approach used in the sample design of the those surveys was almost identical and characterized as weighted, multistage, stratified cluster sampling [47-50].

Actually, demographic and health surveys has been conducting every five years since 1968 in Turkey. The changing trend in midwifery provided maternity services would be better understood if all the data collected during the 40 years were comparable. For this reason, the data sets used in this study was narrowed down as the sample design, questionnaire desing and the methodology of the last four surveys are almost identical.

In each survey there were mainly two main types of questionnaires through which face-to-face interviews were conducted: Household Questionnaire and Individual Questionnaire. Household Questionnaire was used to enumerate all usuall members of and visitors to the selected households and collect information relating to the socio-economic position of the households. In addititon to the provison of basic demographic data for Turkish households, women eligible for individual interviews were identified. Regarding individual Questionnaire, it was completed with ever-married women betwen the ages of 15 to 49 and it was designed to collect detailed information on reproduction, marriage history, contraceptive use, pregnancy, fertility preferences, mother and child health, and anthropometry [50].

Both questionnaires began with an informed consent section. After getting the household respondent's and women's approval, these sections were signed by interviewers to ensure the voluntary participation of respondents. It should be highlighted that The Scientific and Technological Research Council of Turkey (TUBITAK), the financial supporter of TDHS-2008, determined the survey activities to be exempt from ethical review committee approval.

In addition to TDHS data sets, health statistics of Ministry of Health and Turkish Statistical Institute were utilized to identify the supply of physicians and skilled midwives according to the their place of work.

In this study, the unit of analysis was the last live births to women at the age of 15-49 occurred in the five years prior to the survey date. The variables used in descriptive analyses were based on the information about antenatal care provider, assistance of health professional during delivery, place of delivery and type of delivery (Table 1). Besides, as part of an antenatal care, women were asked a range of checks, tests and assessments that

monitored them and their developing baby during their pregnancies. By using this information, independent-samples t-test was performed to specify whether the contents of antenatal check-ups and the level of information given during pregnacy revealed a significant differentiation between physicians and midwives. It was assumed that dependent variables -control and information- were normally distributed for antenatal care provider. To do this, the variables concerning the antenatal check-ups and the type of information given during antenatal care services were first recoded and standardized (0=no, 1=yes). Then, the standardized variables were summed up to create two variables, namely "control" and "information". In other words, these new variables were treated as a scale showing the extent of antenatal check-ups and the information given during antenatal care services. Afterwards, mean values of 'control' and 'information' were tested according to antenatal care provider. Physicians were taken as a reference group. Unfortunately, the data of TDHS-1993 was not used for t-test procedure, because the questions on antenatal care were not asked in detail as they were in the other three surveys.

It should be mentioned that the number of tests or measurements asked in each survey was different (Table 2). Nine items were asked in 1998 and 2003 and, six in 2008. Measurement of weight and blood pressure, blood and urine test, and ultrasound were common variables in each questionnaire. In TDHS-1998 and TDHS-2003, additional questions such as measurement of height and abdomen, internal examination and fetal heart beat were included as well.

Regarding the information given during antenatal care services, women were asked whether they were informed about nutrition during pregnancy, emergency situations, type of delivery, breastfeeding and family planning. At this stage, TDHS-1998 and TDHS-2008 were considered in statistical analysis, because TDHS-2003 did not cover those questions.

Although the data sets of used in this study are nationally representative, it should be mentioned that this study has some limitations. First of all, the aim of Turkey Demographic and Health Survey is not directly related to evaluate the functions of midwives. Secondly, this study is restricted to the available variables in the data sets to present midwifery profession in terms of antenatal care and delivery services. Thirdly, it might be difficult for the interviewees to know whether the health care provider in antenatal and delivery care is a physician, nurse or a midwife. Thus, there might be an overestimation in the reporting of maternal health care provider as a physician. This may cause an underestimation in that of midwives' in these surveys. Final limitation is related to the difficulty in differentiating midwives from nurses in the questionnaires since they were categorized as a single variable meaning that there is a possibility that some nurses were regarded as midwives due to questionnaire design.

Results

Descriptive results revealed that between 1993 and 2008, an increasing proportion of the women had utilized antenatal care services. The majority sought this care from a skilled health professional. Ninety-two percent of women were examined by a health professional during their pregnancy whereas it was only 67 percent in 1993. Regarding the type of health provider examining pregnant women, physicians have become main providers of antenatal care during a 15-year period. On the other hand, the role of midwives in antenatal care services seemed to diminish within years. The percentage of women receiving antenatal care from midwives which was 16 in 1993 was halved in 1998 and decreased to 3 in 2008. Considering the assistance during delivery, the proportion of births attended by health professional increased by 18 percent from 1993 to 2008 while the percentage of midwife-

attended births dropped significantly during the same period. For instance, in 1993, almost 80 percent of women delivered with the assistance of health professional, with the majority being assisted by a midwife (43 percent). On the other hand, the share of midwifery assistance decreased to 26 percent as of 2008 (Table 1).

Regarding the tests and measurements done during antenatal check-ups, it is clear that regardless of antenatal care provider, year by year women were more likely to receive antenatal test and screening tests during their last pregnancies ended with a live birth (Table 2). On the other hand, the discrepancy between physicians and midwives became apparent for urine sample, blood sample and ultrasound although the gap among them was closed within years. When midwives were the antenatal care provider, they less likely did these three tests when compared to physicians.

Furthermore, there was an outstanding increase in cesarean rates which reached a 40-percent level in 2008. Besides, delivery at private health facilities has become popular in recent years. From 1993 to 2008, more women prefer to deliver at private hospitals, which indicates a fivefold increase in the share of private health sector (Table 1).

Table 3 and Table 4 show whether antenatal care given by midwives differs from that of physicians. Either for all births or vaginal births, when women received antenatal care from a midwife, mean number of tests and measurements were significantly lower than that of the physicians ($p<0.001$). On the other hand, the information were given to women about healthy pregnancy did not reveal a significant differentiation between physicians and midwives.

In addition to the findings from survey data, statistics of human resources for health give clues about the changing trend in the midwifery practice (Table 5). According to this information, there were 50,343 midwives and 123,447 physicians in Turkey as of 2010.

Among the midwives working in Ministry of Health, the majority of whom were working in hospitals. It is seen from the figures that the number of midwives working in hospitals was also increased between 2008 and 2010. During the same period, family medicine units and hospitals seemed to be the main place of work of midwives and they were gradually withdrawn from the community health centers mainly due to the fact that these facilities were completely closed down as 2010 (Table 1).

Discussion

In Turkey, the trend in seeking antenatal care services and assistance during delivery is twofold: increasing coverage while declining visibility of midwives. During a 15-year period, there has been a substantial reduction in the number of midwife-attended births (-40 percent) and in the proportion of antenatal care services given by them (-84 percent). On the other hand, the rising trend of physicians in delivery (from 10 to 19 percent) and especially in the provision of antenatal care (from 41 to 73 percent) is outstanding. Further, the in joint effort of physicians and midwives during deliveries is almost doubled in the same period. In terms of antenatal testing, it has been found that number of tests done by midwives was significantly lower than that of physicians. This is most probably because midwives generally do not do as many tests as medical physicians do or non-interventionist philosophy of midwifery may not encourage midwives to use costly tests or equipment such as ultrasonography [16]. For instance, in Netherlands, midwives are said to be reluctant to bring ultrasonography into their practices due to the fact that they believe that adoption of such 'obstetric' technology makes them indistinguishable from obstetricians [51]. Paradoxically in Turkey, the prevalence of antenatal tests done by midwives has shown sharp increases especially for ultrasonography. It is most probably related to the recruitment

of midwives at central hospitals where new equipments are largely available. It should be mentioned that Turkey is very different from the countries like Netherlands and Sweden in which provision of midwifery-led services is a norm and, ethical rules of midwifery practice are largely reflected in the medical hierarchy.

As mentioned before, midwifery focuses on childbirth as a natural process and midwives are expected to be autonomous health care providers who take care of the woman and well-being of the infant through pregnancy, labour and delivery, and after the birth. However, the findings of this study displayed that midwifery-provided maternity services are insufficient not because they are unqualified or unequipped but they unable to compete with physicians within the medical system in Turkey. Andrews et al. [52] demonstrated that clinical practice substantially affects the professionalism and, specialization level shows differentiation among various departments of medicine. Similar to this, the level of professionalism measured by Professional Attitude Inventory was found to be low among nurses and midwives working at delivery units in hospitals when compared to that of postpartum units and gynecology departments in Turkey [53]. This also highlights the fact that midwives have reduced responsibility in delivery services and are not allowed to implement the full scope of practice.

Health reforms implemented under the HTP might also accelerate the deteriorating professional status of midwifery in the medical hierarchy. Reforms similar to the ones in Turkey cannot be implemented in the absence of consensus among number of parties including stakeholders, government agencies and international donors [34]. Accordingly, HTP was also supported by the World Bank and IMF for the establisment of market-based health care services [54]. This program extensively relies on electronic medical records,

reliable cost control systems, universal coverage and, pay for performance systems, which seems to be imported from the United States [55].

In Turkey, hospitals are operated either privately or by government entities. The majority of the population utilizes health care in public sector and almost two people in ten attend private hospitals [28]. Private sector is of great importance in HTP because best use of comparative advantages between private and public sectors results in effective and efficient use of resources [34] In line with these expectations, a competition between public and private sectors has become a matter of fact especially after 2003. Historically, private practice was commenced before the foundation of Republic and, it gained a broader perspective with the implementation of Private Hospital Law in 1933 [56]. In 1960-70s, private hospitals predominantly became a supplement of public hospitals and medical faculties, but now private health facilities have become more attractive both for the health care providers and the patients regarding economic gain and client satisfaction and, are able to keep up with competitive market. Today, there are 1,439 hospitals in Turkey, of which 490 are private and their supplementary role has diminished within years as they have become highly available. In fact, recent years private sector has shown significant progress in recent years and, this improvement has accelerated after the implementation HTP.

HTP also leads to extensive structural changes in health facilities. That is, hospitals has turned into autonomous facilities in terms of administration and finance [36]. However, decentralizing authority has some risks such as "*loss of focus and expertise on specific reproductive health services*" [34]. Turkey has already been experiencing the loss of expertise in midvifery provided services.

Contrary to the structural and financial advantages of HTP, it has adversely affected first level primary health care services and its providers. First level primary health care

services was previously given especially by certified midwives in community health centers and health houses [45] They were usually the main medical service provider in rural and distant areas in Turkey. Midwives have played essential roles in the improvement of mother and child health services in those areas, but the number of commıunity health centers has systemically decreased between 2006-2009 [28]. Within the scope of HTP, family medicine system has been put into practice and, those health facilities have been either closed down or transformed into family medice units by using the infrastructure of them [35] meaning that midwives have reduced patient responsibility and reduced impact upon patient outcomes. Moreover, physicians are assigned to be family practitioners [32]. The reorganizaton within the HTP results in an 'unused capacity' -midwives- in the health care system. It is most probable that these health reforms and, lack of nursing workforce supply claimed by the MoH [32] have paved the way for the recruitment of midwives to work at health facilities is to narrow down the gap in nursing shortages.

Apart from these, high caesarean rates in Turkey are the signs of insufficient utilization of midwifery-led services. Considering the deliveries at health facilities, caesarean rates, which was 14 percent in 1993, has reached 41 percent in 2008 [57-58]. The alarming increase in ceasarean rates has caused the Ministry of Health to publish a circular in an attempt to reduce caesarean rates. Morever, current law prohibits physician from performing elective ceaserean section unless vaginal delivery puts mother's and/or infants's life or health at risk [59]. However, this might not be an influencial measure unless the midwifery care is regulated by new legislations and laws since there is a clear evidence that midwives play fundemental roles in averting the caesarean deliveries [22-25]. Unfortunately, under these circumstances, it seems to continue to rise. In addition to the underutilization of midwives, profit-oriented health care provision is an another motive behind the increased

caesarean rates. Studies revealed higher prevalence of caesarean deliveries in uncomplicated pregnancies in private hospitals compared to public hospitals [60] . The discrepancy was mainly explained by the growing privatization in health care accelerated with urbanization as well as the economic gain through surgical deliveries [61-62]. Some studies revealed that ceasearean operations become appealing for obstetricians as they can make more money [57] without sacrificing their productivity and time [63].

Government claimed that they overhauled the entire health care system to make it cost effective, but hospitals turn into profit-making businesses within the market-oriented health reforms. Performance-based incentives of physicians in public hospitals are to be indexed to the number of patients they examine. Physicians are said to be overworked and more concerned with dealing with patients quickly than really helping them. Indeed, the policymakers try to reduce costs by encouraging competition among health facilities. Ideally, market competition should be on the basis of both cost and quality [64]. However, the revised system seems to allow quantity to override quality.

Besides, private health facilities have become more attractive for patients [65] but also because the quality of health care services depending on the waiting time for receiving care, complexity of hospital procedures, the time allocated per patient [35], manner of hospital staff are better when compared to state or university hospitals. Turkish Medical Association argues that physicians' working hours are contentious in public health sector and they have to work in difficult conditions after the privatization of the health sector. Similar to patients, health care providers also prefer private hospitals due to high job satisfaction and low emotional exhaustion [66].

Overall, it is quite obvious that midwives cannot perform their major tasks although normal process of birth is the main responsibility of midwives. Health reforms, public

expectations and lack of legal regulations play significant role in declining visibility of midwives as they are forced to take a backseat to other health professionals.

Conclusion

New legislations/regulations introduced by HTP are solely related to overcome the lack of physicians and nurses in Turkey. This indicates that midwives continue to suffer from insufficient investments in their deployment, training, supervision.

Unfortunately, midwives are losing their autonomy and quitely disappearing in delivery process in Turkey within the current health care system. High rates of ceasarean deliveries can be used as a measure indicating how midwives have been withdrawn from delivery process. This study gives a basic idea of changing roles of midwives in antenatal care services and delivery process. Besides, it reveals that there is a lack of quantitative surveys on this issue although there are small-scaled researches highlighting the problematic areas in Turkey in terms of lack of investment in midwifery education, legal regulation, deployment and, supervision [26, 45]. Moreover, in-depth interviews and focus groups with midwives as well as other health care providers should be conducted to manifest the needs, deficiencies and requirements in the health care system. Although citizens' satisfaction of health care services is said to increase after the implementation HTP and family medicine system [32], the satisfaction of health care providers is lacking [35]. As these reforms affect both beneficiaries and service providers, the contentment of each parties should be prediocally in order to overcome the problems.

Furthermore, as mentioned before, within the new health program, all legislations and regulations are only related to physician and nurses whereas the responsibilities and functions of midwives are still customized by Law no. 1219, "Modes of Execution of the Art

of Medicine and Its Branches" enacted in 1928. Indeed, this law regularize the midwifery profession as an auxiliary staff providing assistance to nursing staff. In addition to this, there are some acts and regulations implicitly define the roles of midwives, but they are almost the same as the roles and duties of nurses. Thus, there is a lack of midwifery laws that defines midwifery as a seperate dicipline and profession.

In recent years, Turkey have made great progress in terms of maternal and child health, reproductive health, morbidity and mortality. It is undoubtful that midwives are of great importance in the improvement of maternal and child health. Therefore, it seems essential to provide them with increased scope of practice, high recognition and respect as an autonomous profession in order to attain a sustainable development in health indicators.

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Conflict of Interest

The authors have no conflicts of interest to disclose.

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