Original Article

Assessing the Effectiveness of an Educational Workshop Designed to Improve Caring Behaviors of Midwives at Public Hospitals in Jordan

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Abstract

Background: Despite caring being an important aspect of health-care providers' work, there is a growing concern about the lack of suitable caring behaviors in childbirth settings in developing countries. **Objective:** The objective is to design, implement, and evaluate an educational workshop to improve the caring behavior of midwives working in the labor ward of a large Jordanian public hospital. **Methods:** This is a pre- and post-interventional study. A workshop focused on teaching specific caring behaviors was held for 20 midwives who worked in the labor ward at one public hospital in Jordan and evaluated against women's ratings of midwives' caring behaviors and satisfaction with care after the intervention and 3 years later. **Results:** Significant increases were observed in the overall scores of midwives caring behaviors and women' satisfaction 6 weeks and 3 years after the intervention compared with prior scores. Women postintervention perceived midwives to be more caring than women before the intervention ($P = 0.001$). There were significant positive changes from preintervention scores at 6-week postintervention and 3-year postintervention on seven out of eight items of the "caring behavior scale." Increased overall satisfaction scores were observed 6 weeks and 3 years after the intervention compared with the scores before the intervention ($P < 0.001$). **Conclusion:** The study can inform midwifery educators on the importance of teaching and learning of caring behaviors to future midwives in their preservice preparation. The program that was developed can be used with some modification, as part of midwifery students' educational program or as an in-service program for employed midwives.

Keywords: *Caring behaviors, Childbirth, Educational intervention, Midwives, Satisfaction, Women*

Introduction

Caring has been considered as the essence of health professions.[1] Watson defines caring as: "the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity."[2] It is believed that true caring enhances patients' health and well-being and facilitates health promotion.[3] Watson developed a theory on human caring relationships suggesting that caring is a different way of being human, present, attentive, conscious, and intentional.[4] In childbirth, caring behaviors include simple actions that midwives can show to women, including kindness and respect, providing privacy, and making women feel comfortable.[3] Some authors claim it is the midwives' role to join the woman in her journey, to share joy and pain, and to remain connected to the woman through the process.[5] The comfort experienced in a caring relationship reduces the discomfort caused by the pain of labor and contributes to a positive birth experience.[6-7]

The importance of caring behaviors as part of the women-perceived quality of maternity care is increasingly promoted and accepted.[8,9] Understanding

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what women want from their care providers during childbirth has been the focus of some of the previous studies. For example, first-time mothers' perspectives of a good midwife during childbirth include relationship-mediated being, knowledgeable doing, physical presence, and being immediately available. In this way, the woman is cared for by a midwife is likely to have an optimum experience of birth.[8]

Client satisfaction with care is an essential component of quality and might increase the client's willingness to comply with treatment recommendations, thus influencing the effectiveness of care.[9] The World Health Organization recommends the evaluation of maternal satisfaction of the public health-care sectors to improve the quality and efficiency of maternity care.[10] Interpersonal behavior, i.e., the way caring is often demonstrated, is the most widely reported determinant of maternal satisfaction, with the largest body of evidence generated around provider behavior in terms of respect and nonabuse.[11,12]

Despite caring being an important aspect of health-care providers' role,[13] abuse and disrespect of women facing childbirth is an issue in many countries including Jordan, so much so that overt responses have been required.[12,14-17] A comprehensive review of the evidence of disrespect and abuse in childbirth identified categories of disrespect and abuse in childbirth including physical abuse, nonconsented, nonconfidential or undignified care, and discrimination based on the patient attributes.[12] Studies conducted internationally and locally revealed that uncaring behaviors by health professionals lead to unsafe practice, negligence, and unprofessional behavior.[16,18]

In Jordan, policy requires women to give birth in hospitals, and all receive midwife care, even if in some cases the birth is also attended by an obstetrician.[19] There is an increasing national expectation of respectful care being provided.[6,16] However, dissatisfaction with the care received from health-care providers has been reported.[16]

While global initiatives have been focused on improving the quality of routine maternity care and lifesaving skills, little attention has been directed to maternity caring behaviors.[20] Few studies, most in developed countries, have been conducted on improving caring behaviors in childbirth settings.[21,22] Strategies for improvement include education focusing on self-reflection about caring, techniques that integrate effective learning with cognitive or psychomotor training, and modified simulation training incorporating caring themes into the other teaching/learning objectives.[21]

Despite well-documented benefits of caring, strategies to improve the caring behaviors, few studies are available on the strategies to improve the midwives' caring behaviors,[5,8] and no Jordanian studies are available in this regard.

Objectives

This study aimed to deliver an educational workshop designed to improve the caring behaviors of midwives working at labor ward of a large public hospital and evaluate its effectiveness through the perceptions of women reporting on the caring component of the services they received.

Methods

Design and setting

This was a pre- and post-intervention study conducted with staff in the maternity ward of a large public hospital in the southern region of Jordan. This hospital provides birthing services for around 3000 women per year.

Participants

A convenience sample of all women hospitalized in the postpartum ward during the study, who had given birth by normal vaginal delivery, was used. The inclusion criteria for women were having the ability to read and write, willingness to participate in the study, and lacking a history of obstetric, medical, and psychological problems. All eligible women were approached in the postpartum ward before discharge to complete the questionnaires. They were informed about the study by the research assistant, who was not part of the ward team and 410 agreed to participate. In regard to participant midwives the session was mandatory; therefore all midwives (n = 20) who were working in the labor ward were involved.

Intervention

The intervention consisted of 1-day educational workshop, over 8-h duration for all midwives who worked in the labor ward. The experience of participants ranged from 3 to 10 years. Three years later, when the assessment was repeated, the staffing situation was virtually the same with only two new staff added to the team in that time. The topics for the workshop were selected based on the literature and input from experienced midwives and educators.

The sessions focused on teaching participant midwives specific caring behaviors that were identified as the preferred and required behaviors by most women in labor as these have been recommended in previous studies.[8,23-25] These behaviors were aggregated around the following workshop topics; listening to women, respecting women, be a courageous professional, use

positive language, know when to be silent and be engaged and humane [Table 1]. The course was taught by two experienced midwives and one experienced maternity health educator. Teaching methods were mostly based on PowerPoint presentations, and subsequent role-plays of scenarios and situations related to caring, and noncaring behaviors and analysis of these situations explained in the PowerPoint presentation [Table 2]. Watson's caring theory and elements of an effective team were introduced, and

Table 1: Description of the educational program

Topics	Teaching contents	Methods of preparation
Caring behaviors		
Listen to women	Be patient and calm when listening to women Try to understand the reasons behind their hopes, plans, concerns, or fears	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Respect women	Be supportive to women's needs and be prepared to work with them from where and who they are: No discrimination Polite manners Put emphasis on woman complaints Protect woman privacy	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Be a courageous professional	Be a professional friend for women, someone who: Has the knowledge, skills and courage to provide information and advice based on the needs of the individual woman Can make clinical decisions in her own right rather than blindly follow protocols Has the ability and courage to stand up to criticism of herself and/or others Challenge unacceptable protocols, speak out when they witness poor practice, and follow women's individual needs	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Use positive language	Use encouraging words rather than discouraging words such as "well done," "you are so strong," "you are amazing"	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Know when to be silent	Be sensitive to women's individual differences. Some women need a great deal of active encouragement, others need silence. Often women need both at different times, therefore they need midwives who are: Confident and comfortable to do little but to be discretely watchful and attentive when appropriate Midwives who understand that sometimes there is a necessity and value in "being" rather than "doing," and in silence rather than talking, and to know which is needed when	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Be engaged and humane	Help women proactively when you find them in need instead of help them only when they call you	Role plays of scenarios and situations related to caring behaviors and analysis of these situations
Uncaring behaviours		
Lack of effective communication skills	Speak very fast, too loud, or too low Have no patience to listen to woman complaints	Role plays of scenarios and situations related to noncaring behaviors and analysis of these situations
Insufficient professional knowledge	Having no professional answers to woman's inquiries and questions about her health condition Referring answering all questions to doctors Mechanical implementation of the doctor order	Role plays of scenarios and situations related to noncaring behaviors and analysis of these situations
Poor maintenance of ward environment and short supply of resources	Allow visitors to enter and exit as they want Not to maintain calm Do not provide a clean and quiet environment Lack of necessary needs such as bed sheets or changing when dirty	Role plays of scenarios and situations related to noncaring behaviors and analysis of these situations

Table 2: Example scenario and role play of caring behaviors

Scenario 1	What midwife might do
You are a midwife who arrives for duty in the labor ward. As you take over duty from the previous midwife, you are told that one of the women in labor Mrs. Salma is 19 years old, G1P0, full term, in labor for 8 h, and admitted to the hospital 4 h ago. You are told that she is difficult to examine because she keeps her legs together and cries. You observe the woman lying on the bed with only a sheet covering her. You know that the labor ward does not have curtains between beds and you know that the midwife who is reporting to you usually takes the sheet off when examining someone and has been seen to force a woman's legs apart when she decides to do an examination. She usually communicates little with women in labor except to tell them to "be silent" or "shut up." The other midwife leaves and you take over the care of Mrs. Salama. As always, you have many women in labor at this time. What might you do to provide respectful maternity care to Mrs. Salma?	Approach her with a smile and introduce self. Ask her how she is, and listen to her response attentively. Patiently recognize that her resistance to a vaginal examination may have many causes: Sociocultural beliefs, fear, shyness, and experience of gender-based violence. Kindly touch her or wipe her forehead with a cool cloth. Spend some time with her providing comfort measures. When it is time to examine her: Explain what you are going to do and why you are going to do it. Be sure, she is appropriately covered with the sheet while doing the examination. Kindly ask for her help by separating her legs so that you can examine her to help both of them know how she and the baby are doing. Explain the findings of the examination and their meaning. Assure her that she only needs to call you and you will come to her bedside. Come quickly when she calls. Assure her that you will not leave her. Treat her as an individual. Provide pain relief as appropriate.
Role play of the scenario	First two expert midwives; one play the role of woman and the other play the role of the midwife. All participant midwives observe and then reflect the situation. Then every pair of participating midwives repeat the role play.

common caring and noncaring behaviors were also presented and discussed. Preferred and desired caring behaviors identified by women themselves such as "listen to woman," "respect woman," and "being truly present for woman when she needs you" were taught to midwives and they were asked to intentionally apply these caring behaviors during their work. Subsequent "follow-ups" designed to ensure applications of the desired caring behaviors and reflect on learning and its application in practice, were undertaken for midwives in the field regularly for 6 weeks. The 12 follow-up sessions consisted of small meetings with midwives during working hours and were led by assistant researchers (one experienced midwife and one experienced maternity educator). Each midwife reflected on her experience of and shared stories of caring moments and challenges she faced during the application of workshop material. The analysis of these challenges and decisions made related to overcoming challenges were debriefed and learned from in these discussions with the assistant researchers. A convenient time to conduct the initial workshop was chosen and agreed on with the collaboration of midwives and their employers.

Instruments

Sociodemographic data

A form developed by the researcher was used to gather information about the characteristics of women participating, including age, level of education, marital status, economic status, and parity.

The Caring Behaviors Inventory developed by Hegedus[26] was used to measure effect with eight items from these Caring Behaviors extracted and used. These following items were chosen (1) because they were related to the most desired caring behaviors that the literature identified were required by laboring women, (2) were the focus of the educational workshop[23,25] and (3) they were easy and quick to answer by women. These consisted of the following: (1) the midwives treat me as an individual; (2) the midwives respect my rights; (3) the midwives are always honest with me; (4) the midwives provide soothing reassurance through their touch; (5) when I am fearful, the midwives try to relieve my fears; (6) the midwives make me feel important; (7) when I am sad and cry, the midwives stay with me; and (8) the midwives comfort me by their silent presence. To make it simple for women to answer, each question was rated on a 3-point scale: 1 (not sure

or disagree), 2 (agree), and 3 (strongly agree). Therefore, the total scores could range from 8 to 24. The items had been translated into Arabic and back into English. The face validity of the set of questions used was found to be high in preliminary testing. Data from the 120 women in the study confirmed that the eight items have strong internal consistency ($\alpha = 0.910$).

The birth satisfaction scale-revised

The birth satisfaction scale-revised (BSS-R) is a 10-item, validated self-report scale that was reduced from the original 30-item BSS.[27] It assesses women's perceptions and satisfaction with their birth experience.[27-29] The BSS-R is a Likert type scale asking participants to rate their level of agreement with each item (4 = Strongly Agree, 3 = Agree, 2 = Neither Agree or Disagree; 1 = Disagree; and 0 = Strongly Disagree). Therefore, the total score could range from 0 to 40. Four of the items are reverse-coded (e.g., "I found giving birth a distressing experience"). Items were organized on three subscales including: stress experienced during labor, women's personal attributes, and quality of care provision. Data from the 120 women in the initial evaluation confirmed that the scale has very good internal consistency with $\alpha = 0.88$. The same instruments were used after the initial training and 3 years later.

The instruments were translated from English into Arabic using the blind-back translation method for ensuring the semantic and technical equivalence.[30] To assess the content validity of the Arabic version, three academic experts in the field of maternal and child health nursing reviewed the items to determine whether they were understandable and suitable for the Jordanian culture. Another test was undertaken with 10 women completing the scales to assess the face validity. Scales items were easily understood by all women (100%). Data were collected in three phases. The first phase, pretest data were collected before the training was instituted using the demographic questionnaire, the Caring Behaviors Inventory, and the BSS-R. All were completed individually by women. In the second phase (6-week postintervention) and the third phase (3-year postintervention), to assess the maintenance of learning and caring behaviors, data were collected using the same instruments.

Ethical considerations

Approval to conduct the study was obtained from the Ethics Committee at Faculty of Nursing at Mutah University and the Ministry of Health (Ethics No. 4385). Participants (women and midwives) were informed about the study and verbal and written consent for the agreement were obtained from each participant. Participants were assured that participation was voluntary and they could withdraw from the study at any time without giving any reason. Participants were assured that their information would not be recognized in any products of this research.

Data analysis

The SPSS (v. 17.0, SPSS Inc., Chicago, IL, US) was used for statistical analysis. The normality of data was tested using the Kolmogorov–Smirnov test. Descriptive statistics were used to describe women's demographic characteristics. Pearson's correlation coefficients were used to analyze the relationship between midwives caring behaviors and women satisfaction. Analysis of variance was used to determine the effects of the educational workshop according to the results from the Caring Behaviors Inventory and the BSS-R. A significance level of <0.05 was used.

Results

A total of 560 eligible women were admitted to the labor ward in the selected hospital during the preintervention, 6-week postintervention, and 3-year postintervention periods. A total of 410 women were enrolled, 120 of them were enrolled during preintervention, 180 during the 6-week postintervention, and 110 during the long-term evaluation, 3-year postintervention. A total of 150 women refused to take part mostly due to no interest. The mean age of the participated women was 29 years, 99.8% were married, 58.5% had university education, 80.2% had a monthly income of 400 Jordanian dinars and more and 61.2% were multiparous [Table 3]. A total of 20 midwives had participated in the original educational workshop. All these midwives were still working in the labor ward when long-term evaluation was conducted. Two new midwives were employed during the year before our extended assessment of the impact of the intervention 3 years later. Midwives' caring behaviors and women satisfaction were positively correlated on the pretest ($r = 0.501$, $P < 0.05$), 6-week posttest ($r = 0.880$, $P < 0.05$), and 3-year postintervention ($r = 0.602$, $P < 0.05$). Women who rated midwives' caring behaviors higher reported greater satisfaction; thus, there was a positive correlation between midwives caring behaviors and women satisfaction.

A significant increase in the overall score of midwives caring behaviors at 6-week and 3-year postintervention was observed compared to the preintervention period. After the intervention, women perceived midwives to be more caring than did women admitted before the intervention ($F = 114.78$, $P = 0.001$). Significant changes were observed from the preintervention scores to 6-week postintervention and 3-year postintervention in all items of the caring behavior scale, except for

the item "the midwives respect my rights" [Table 4]. Moreover, significant changes were found in the women's satisfaction scores on the three subscales from the preintervention to 6-week and 3-year postintervention [Table 5]. The Tukey's *post hoc* test showed significant differences in the women's perceptions of the midwives' caring behaviors between the preintervention group and 6-week postintervention group ($P < 0.05$). However, the 3-year postintervention did not significantly differ from the preintervention group and the 6-week postintervention ($P > 0.05$). The Tukey's *post hoc* showed a significant differences in the women's satisfaction between the three groups ($P < 0.05$).

Table 3: Sociodemographic characteristics of women (*n*=410)

Characteristics	*n* (%)
Age (years)	
20-29	254 (62.0)
30-39	114 (27.8)
≥40	42 (10.2)
Marital status	
Married	409 (99.8)
Divorced	1 (0.2)
Level of education	
Primary	78 (19.0)
Secondary	56 (13.6)
College	36 (8.9)
University	240 (58.5)
Monthly income (Jordanian Dinar)	
<200	20 (04.9)
200-399	61 (14.9)
400-499	184 (44.9)
500-599	96 (23.4)
600-699	37 (09.0)
≥700	12 (02.9)
Parity	
Primiparous	159 (38.8)
Multiparous	251 (61.2)

Discussion

Results of this study showed that midwives caring behaviors and women's satisfaction were positively correlated. The positive effect of the educational intervention was also maintained with the midwives caring behaviors and women's satisfaction at 6-week and 3-year postintervention. These findings indicate that a "one-off" educational workshop was effective in improving midwives' caring behaviors and also enhanced women's satisfaction. A number of earlier studies also have reported that educational interventions can enhance nurses'[21] and midwives'[22] communication skills[31] and caring behaviors[32] which in turn ensure that women are receiving quality care, thereby enhancing their satisfaction. Our results also correspond with previous studies where nurses[32] and midwives[22] who are more caring employ more client-centered caring skills in clinical practice, and clients-women in this care-feel more cared for and satisfied with the care they received.[22]

The long-term evaluation shows small but not statistically significant sustained effect of the educational workshop. These results may be explained by the fact that after 3 years, when the assessment was repeated, the staffing situation was virtually the same with only two new staff added to the team in that time; therefore, almost all the team had undertaken the training. This indicates that

Table 4: Comparison of caring behaviors scores between the three phases preintervention, 6-week postintervention, and 3-year postintervention (score range from 1 to 3)

Caring behaviors	Group[a]			*F* (df)	*P*
	G1	G2	G3		
The midwives treat me as an individual	2.25 ± 0.160	2.30 ± 0.80	2.24 ± 0.50	14.075 (2)	<0.001
The midwives respect my rights	2.25 ± 0.160	2.26 ± 0.85	2.28 ± 0.49	2.369 (2)	0.095
The midwives are always honest with me	2.19 ± 0.162	2.29 ± 0.82	2.20 ± 0.51	40.664 (2)	<0.001
The midwives provide soothing reassurance through their touch	2.29 ± 0.158	2.35 ± 0.79	2.31 ± 0.44	13.245 (2)	<0.001
When I am fearful, the midwives try to relieve my fears	2.31 ± 0.150	2.39 ± 0.76	2.24 ± 0.50	51.183 (2)	<0.001
The midwives make me feel important	1.97 ± 0.168	2.11 ± 0.87	2.19 ± 0.58	128.474 (2)	<0.001
When I'm sad and cry, the midwives stay with me	1.89 ± 0.171	2.12 ± 0.87	2.14 ± 0.56	141.448 (2)	<0.001
The midwives comfort me by their silent presence	2.29 ± 0.158	2.37 ± 0.78	2.29 ± 0.48	30.507 (2)	<0.001
Total score (score range from 3 to 24)	17.44 ± 1.4	18.91 ± 1.4	17.89 ± 1.4	86.430 (2)	<0.001
Post hoc test				Tukey test	
G1 versus G2				1.4834	<0.001
G1 versus G3				1.2137	0.059
G2 versus G3				0.2697	0.061

[a]Data presented as mean ± SD. G1: Preintervention (*n*=120), G2: 6-week postintervention (*n*=180), G3: 3-year postintervention (*n*=110), SD: Standard deviation

Table 5: Comparison of women's satisfaction scores between the three phases preintervention, 6-week postintervention, and 3-year postintervention

Satisfaction subscales	Group[a]			*F* (df)	*P*
	G1	G2	G3		
Stress experienced during labor (score range between 0 and 16)	12.88 ± 1.13	14.08 ± 0.80	13.08 ± 0.50	86.900 (2)	<0.001
Women's personal attributes (score range between 0 and 8)	6.44 ± 1.60	7.04 ± 0.85	6.54 ± 0.49	13.87 (2)	<0.001
Quality of care provision (score range between 0 and 16)	12.90 ± 1.11	14.10 ± 0.82	13.10 ± 0.51	86.43 (2)	<0.001
Total score (score range from 0 to 40)	32.22 ± 2.3	35.22 ± 2.3	32.75.7 ± 2.3	86.63 (2)	<0.0001
Post hoc test				Tukey test	
G1 versus G2				1.5834	<0.001
G1 versus G3				1.3372	<0.050
G2 versus G3				1.2697	<0.050

[a]Data presented as mean ± SD. G1: Preintervention (*n*=120), G2: 6-week postintervention (*n*=180), G3: 3-year postintervention (*n*=110), SD: Standard deviation

the training helped improve their caring practices. While results of the long-term evaluation of the effectiveness of the educational workshop showed a decline in women's ratings of the caring behaviors of midwives and women satisfaction compared with short-term evaluation results, they were still in a positive direction. These results are consistent with previous studies and the challenges of achieving the persistent effect of educational programs which need to be addressed through conducting refreshing workshops.[22,31] The results show that the effects of a well-designed and well administered educational workshop on good caring behavior can continue for at least 3 years. The program that was developed can well be used with some modification, as a part of midwifery students' educational program or as an in-service program with employed midwives. This small study suggests offering of such workshops from time to time can maintain the desired effect in a stable team of staff.

This study adopted an in-service education program approach targeting caring behaviors as a strategy to help midwives in Jordan increase their caring behaviors during their interaction with women in labor. Somewhat surprisingly and gratifyingly, the goal of acquiring these behaviors from the workshop would persist 3 years later as personal qualities in midwives future practice. Our findings also show what women expect midwives and other health-care professionals. This study also suggests that teaching suitable caring theories such as Watson's theory of human caring science and using effective educational strategies to convey the basic messages of such caring theories can sustainably improve the health-care professionals caring behaviors. This study does not address the fact that midwives themselves were likely to find such caring behaviors very satisfying and rewarding personally and this could also affect the enduring positive result.

The study limitations were obvious in the sampling and methodology by sampling and resampling women who were admitted to labor ward at one hospital in Southern Jordan. Another possible limitation was that caring behavior and women's satisfaction was measured subjectively, which might create a reporting bias.

Conclusion

This current study can inform midwifery educators on the importance of teaching and learning of caring behaviors to future midwives in their preservice preparation. The program that was developed could well be used, with some modification, as part of a midwifery student educational program.

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Conflicts of interest

There are no conflicts of interest.

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