Mothers’ and Midwives’ and Nurses’ Perception of Caring Behaviors During Childbirth: A Comparative Study

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Abstract
Understanding mothers’ caring preferences during childbirth and midwives’ and nurses’ perception of mothers’ caring needs may enhance more satisfying birth experiences and positive health outcomes. The purpose of this descriptive comparative study was to identify the important caring behaviors provided during childbirth as perceived by mothers and midwives and nurses and the congruence of these perceptions between the two groups. A convenient sample of 100 postpartum mothers and 109 midwives and nurses was recruited from maternity settings in public hospitals in Jordan. This study demonstrated a statistically significant difference in the perceptions of caring behaviors between mothers and midwives and nurses. Mothers rated the need for spiritual caring behaviors as essential, while midwives and nurses did not perceive spiritual caring as a necessary part of their caregiving role. To design effective interventions that support a woman’s experience, midwives and nurses must identify and prioritize behaviors that convey caring to women during the intrapartum period.

Keywords
caring, childbirth, mother, midwives’ and nurses’ perception

Introduction
Caring is the essence of midwifery and nursing practice. Effective caring promotes healing, health, individual and family growth, sense of wholeness, and inner peace that transcends the crisis and fear of disease, traumas, or life changes (Watson & Nelson, 2012). Care during childbirth is frequently described as “being with” the woman and defined as providing emotional, physical, spiritual, and psychological support by a midwife and nurse as preferred by the laboring woman (Hunter, 2009). Assessing a mother’s expectations during childbirth helps midwives and nurses provide high-quality care to childbearing women (Iravani et al., 2015). International policies and programs recommend individualized and mother-centered labor and childbirth to ensure effective maternity services that achieve better physical, emotional, and psychological outcomes (Oladapo et al., 2018). Respecting mothers’ preferences and choices and meeting their needs and their expectations may help mothers to achieve satisfying births, and thus, improve their health and well-being (Conesa Ferrer et al., 2016; Preis et al., 2018). A recent Cochrane review concluded that labor support improves maternal and neonatal outcomes, such as shortened duration of labor, decreased cesarean and instrumental births, decreased analgesia, improved Apgar score, and enhance maternal satisfaction (Bohren et al., 2017).

The Hashemite Kingdom of Jordan is a politically stable, middle-income country. It is constitutional, guided by Islamic law and the majority (95%) of the population are Muslims. In Jordan, almost all women (98%) receive prenatal care, and nearly all births (99.1%) occur in hospitals and by physicians (96%) (Department of Statistics & ICF International, 2013, 2018). Currently, all birth practices, including normal vaginal deliveries, are managed and conducted by obstetricians (Department of Statistics & ICF International, 2013). In Jordan, midwifery is not recognized as a separate profession (Shaban et al., 2012). Midwifery practice in Jordan is not independent of nursing practice. Nurses and midwives have a common Nursing and Midwifery Syndicate and a
common council, the Jordanian Nursing Council. These two bodies act to regulate the professional practice and to set policies for midwifery and nursing education and health care (Jordanian Nursing Council, 2020; Jordan Nurses and Midwives Council, 2020). The absence of professional recognition of midwifery and inadequate understanding of the midwife’s role result from a lack of recognition of midwifery’s benefits and the high level of nursing and medical dominance of midwifery practice. This restricts midwives’ practice, reduces their autonomy in decision-making, and negatively affects their ability to provide care in antenatal, intrapartum, and postpartum settings. The absence of job descriptions for midwives leads to confusion in their professional roles. Midwives cannot effectively undertake independent roles because of the burden of nonmidwifery duties, unreasonable workloads, and inflexibility in practice (Shaban et al., 2012).

Based on these practice restrictions, midwives’ and nurses’ work in Jordan is very similar in labor and postpartum wards. Even with these overlapping roles, there are critical shortages of skilled and competent midwives and nurses, further impacting the quality of care provided to women in childbirth wards (Khader et al., 2018). For example, it is common for laboring women to be left alone and unattended for a long time during the first stage of labor. In addition, they cannot have a companion, a husband, mother, or friend, to be with them during labor and birth (Khresheh, 2009). These factors create an environment whereby midwives and nurses need to identify and integrate behaviors that convey caring to women during childbirth to make them feel cared for and promote a positive birth experience (Nikula et al., 2015). Disrespectful and abusive treatment for mothers during childbirth in health care facilities such as physical abuse, nonconsented care, nonconfidential care, nondignified care, stigma, and discrimination based on specific patient attributes and abandonment of care and negligence have been widely reported globally by mothers in low-, middle-, and high-income countries (Bohren et al., 2015; Miller & Lalonde, 2015). This abuse can contribute to negative childbirth experience and dissatisfaction of care (Bohren et al., 2015) and even poor maternal and newborn health outcomes (Miller & Lalonde, 2015). Similarly, several reports indicate that Jordanian women considered their childbirth experience as dehumanized and expressed their dissatisfaction with the care provided, lack of support, and abuse (Al- et al., 2020; Alzyoud et al., 2018; Hatamleh et al., 2013; Mohammad et al., 2014). They experience high levels of unnecessary interventions, such as augmentation, excessive vaginal examinations, and routine episiotomies (Department of Statistics & ICF International, 2013, 2018; Shaban et al., 2011), and sometimes, these interventions were conducted without a woman’s consent (Al-Maharma et al., 2020). Mothers reported feeling frightened, humiliated, ignored, and disrespected (Khresheh et al., 2019).

Midwives’ and nurses’ caring behaviors are positively associated with mothers’ satisfaction about their childbirth experience (Khresheh & Barclay, 2019). Caring is a transpersonal relationship that involves the conscious intention of “doing” for another and “being” with another in need while practicing and honoring the wholeness of mind–body–spirit in oneself and the other. Watson’s Theory of Human Caring was used to guide this work because it can embrace the nursing approaches in childbirth settings to deal with women holistically (Watson, 2007). Watson placed special emphasis on 10 carative factors/caritas processes, which are defined as healing factors to guide professional practice. These factors include the following: (a) adopting humanistic–altruistic values, and approaching one’s self and others with love, kindness, and compassion, (b) belief in the individual and enabling faith and hope, (c) being sensitive to one’s self and others by recognizing and feeling one’s feelings, (d) developing and sustaining a helping, trusting, and caring relationship, (e) promoting and accepting the expression of positive and negative feelings by truly listening to the histories of people, (f) engaging in creative, individualized, problem-solving to make care decisions, (g) engaging in genuine teaching–learning experiences suitable for the individual’s needs and way of understanding, (h) creating a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment, (i) assisting with gratification of basic physical, emotional, and spiritual needs, and (j) opening and attending to spiritual–mysterious, unknown existential dimensions of life–death to allow miraculous cures and healings (Watson & Nelson, 2012). When Watson’s theory is applied in clinical practice, it promotes a harmonious, healing environment that preserves human dignity (Kormusky & Karakashian, 2018).

Few researchers have addressed mothers’ perceptions of midwives’ and nurses’ caring behaviors in childbirth settings. In some studies, mothers reported that nurse behaviors that involved attending to human physical needs and demonstrating competency (technical nursing skills) were the most important caring behaviors (Potter & Fogel, 2013; Potter et al., 2012). In others, they reported that emotional assistance, such as praising, individualized care, answering questions truthfully (Khresheh et al., 2019; Nikula et al., 2015), and being emotionally and physically present by providing support until the end of the childbirth process, as the most preferred caring behaviors (Khresheh et al., 2019). Moreover, some studies found that integrating women’s spirituality in midwives’ and nurses’ caring behaviors can convey and sustain caring for women during pregnancy and childbirth (Callister & Khalaf, 2010; Mutmainnah & Afiyanti, 2019). It was pointed out that spirituality enhances women’s self-confidence, motivation, and persistence during pregnancy and childbirth. It is a way of self-control to overcome anxiety and labor pains during labor and delivery (Mutmainnah & Afiyanti, 2019).
Little is known about midwives’ and nurses’ perceptions of behaviors necessary to convey caring for childbearing women and the congruence of these caring behaviors perceptions between nurses and midwives and mothers. The discrepancy in caring behavior perceptions between midwives and nurses and patients is believed to be a contributing factor to dissatisfaction with care (Papastavrou et al., 2011), affecting patient outcomes particularly in childbirth (Preis et al., 2018). This study explored the hypothesis that there is a difference in the perception of caring behavior between mothers and nurses and midwives. Therefore, this study aims to (a) explore the perceptions of mothers and midwives and nurses regarding the preferred or most important caring behaviors in childbirth and (b) compare mothers’ and midwives’ and nurses’ perceptions of caring behaviors and congruence of these perceptions.

**Method**

**Design**

This is a cross-sectional study using a descriptive comparative design. The data were collected using self-report questionnaires from hospitalized postpartum mothers and maternity midwives and nurses during the immediate postpartum period.

**Sample and Setting**

A convenience sample of mothers and midwives and nurses were recruited from maternity units in four public hospitals in Jordan from June 2017 to June 2018. Hospitals were selected randomly from 31 public hospitals in Jordan (Ministry of Health, 2017). A power analysis using a .05 two-tailed level of significance, an effect size = .30 (medium), and a power = .80 using the mean difference test required a sample of 70 mothers and 70 midwives and nurses (Cohen, 1992). The postpartum mothers’ inclusion criteria were (a) women who had an uncomplicated normal vaginal birth, (b) had given birth to a healthy full-term newborn, and (c) had not had narcotics in the last 4 hours before the interview. The midwives and nurses’ inclusion criteria included all registered midwives and nurses with a minimum of 6 months of clinical experience in labor and delivery.

**Instrument**

The Caring Behavior Assessment (CBA) scale was developed by Cronin and Harrison (1988). The CBA listed 63 nursing behaviors that are congruent with Watson’s 10 Carative factors. The CBA is ordered in seven subscales including (a) humanism/faith-hope/sensitivity, (b) helping/trust, (c) expression of positive/negative feelings, (d) teaching/learning, (e) supportive/protective/corrective environment, (f) human needs assistance, and (g) existential/phenomenological/spiritual forces. The Cronbach’s alpha for the seven subscales demonstrated acceptable reliability ranging from .66 to .90 (Cronin and Harrison, 1988). According to Cronin and Harrison (1988), the face validity and content validity of the CBA were established by a panel of four content specialists familiar with Watson’s conceptual model. In addition, the congruency of each behavior with its given subscale was rated by the panel, and all items showed interrater reliabilities of ≥ .75.

Permission to use the Arabic version of the CBA was obtained from Suliman and colleagues. They reported Cronbach’s alpha values for the CBA scale is .958. The seven subscales’ alpha coefficient in their study demonstrated acceptable reliability (with a Cronbach’s alpha ranging from .66 to .90 (Suliman et al., 2009)).

Owing to sampling variation, a pilot study that included 10 mothers and 10 midwives and nurses was conducted to determine the tools’ reliability using Cronbach’s alpha reliability coefficient, any difficulties in understanding, and the time required to complete the questionnaire. Mothers and midwives and nurses were asked to indicate the degree to which each behavior communicated a caring behavior using a Likert-type scale ranging from 1 to 5, with 5 denoting the most important caring behavior and 1 the least important caring behavior. After conducting the pilot study, 62 of the 63 items of the CBA scale were used. Item 28, the midwives and nurses “encourage me to talk about how I feel” behavior was deleted to enhance the Cronbach’s alpha value for the expression of positive/negative feelings subscale from .50 to .60. For mothers, the Cronbach’s alpha values for the CBA scale was .91. The alpha coefficient for the CBA subscales in this study for mothers ranged from .60 to .80. The alpha coefficients of the total CBA scale for midwives and nurses was .95, and the Cronbach’s alpha values for its subscales ranged from .71 to .84.

**Data Collection and Ethical Considerations**

Before conducting the study, ethical approval was obtained from the institutional review board. The mothers were informed about the study’s purpose and procedures, about their rights to voluntary participation, confidentiality, and the right to decline or withdraw from the study without consequential penalty. They were informed that no harm would be inflicted on them and consequently invited to sign a consent form and given a copy of this form that includes the research team’s contact number for future reference.

**Analysis**

Statistical analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 20.0 for Windows (SPSS Inc. Chicago, IL, USA). Descriptive statistics were calculated for the demographic data, the overall CBA scale, the subscales, and the scale items. Mothers’ and
midwives’ and nurses’ perceptions of caring behaviors during childbirth were compared using independent sample t-test. The level of significance for this study was set at $p \leq .05$ to detect significant differences between groups. All study variables of interest had less than 5% of missing data and were treated as a pairwise deletion (Schafer, 1999).

**Results**

**Mothers’ Characteristics**

One hundred and ten eligible mothers were approached, of whom 100 voluntarily consented to participate in the study (response rate: 90.8%). All midwives and nurses had working experience in labor and postpartum wards from 6 months to 34 years with a mean of 4 years. The mean age of midwives and nurses was 31.04 ($SD = 8.97$) years, ranging from 20 to 60 years. Their family monthly income in Jordanian dinar (JOD) ranged from 250 to 1,200 JOD with a mean of 585.33 ($SD = 197.96$), (825 USD, 733 Euro), reflective of the low salaries of midwives and nurses in Jordan.

**Perceptions of Mothers Toward Midwives and Nurses Caring Behaviors in Childbirth Settings**

To enhance the clarity of the results’ presentation, only the mothers rating the overall CBA scale and its subscales as important “4” or very important “5” are included in the percentage calculation. The subscales that were rated as the most important caring behavior by mothers were human needs assistance (99%), supportive/protective/corrective environment (98%), and existential/phenomenological/spiritual forces (97%). The Helping-trust subscale (61%) was rated as the least important caring behavior by mothers. The mothers’ mean scores for each item in the CBA scale ranged from 2.56 to 4.96. The 10 most important caring behaviors and the 10 least important caring behaviors as perceived by mothers are listed in Table 1.

| Rank | Item                                                                 | M     | SD   |
|------|----------------------------------------------------------------------|-------|------|
| 1    | Know how to handle equipment (e.g., monitors)                       | 4.96  | 0.20 |
| 2    | Check with me before leaving the room to be sure I have everything I need within reach | 4.96  | 0.20 |
| 3    | Are kind and considerate                                           | 4.93  | 0.26 |
| 4    | Reassure me                                                        | 4.93  | 0.29 |
| 5    | Check my condition very closely                                    | 4.91  | 0.32 |
| 6    | Are cheerful                                                       | 4.90  | 0.33 |
| 7    | Give my pain medication when I need it                             | 4.90  | 0.52 |
| 8    | Encourage me to ask questions about my illness and treatment       | 4.90  | 0.41 |
| 9    | Keep my family informed of my progress                             | 4.89  | 0.42 |
| 10   | Ask me what I like to be called                                    | 4.88  | 0.48 |

| Rank | Item                                                                 | M     | SD   |
|------|----------------------------------------------------------------------|-------|------|
| 1    | Accept my feelings without judging them                              | 2.56  | 1.59 |
| 2    | Come into my room just to check on me                               | 2.77  | 1.63 |
| 3    | Answer quickly when I call for them                                 | 3.79  | 1.47 |
| 4    | Talk to me about my life outside the hospital                       | 3.81  | 1.46 |
| 5    | Treat me as an individual                                           | 4.27  | 1.22 |
| 6    | Try to see things from my point of view                             | 4.27  | 1.19 |
| 7    | Ask me how I like things done                                       | 4.29  | 1.09 |
| 8    | Ask me what I want to know about my health/illness                   | 4.30  | 1.13 |
| 9    | Touch me when I need it for comfort                                 | 4.37  | 0.99 |
| 10   | Ask me questions to be sure I understand                            | 4.42  | 1.03 |

**Midwives’ and Nurses’ Characteristics**

One hundred and twenty eligible midwives and nurses were approached, of whom 109 voluntarily consented to participate in the study (response rate: 90.1%). Their age ranged from 17 to 40 years, with a mean of 26.72 ($SD = 6.07$). The monthly income of families in Jordanian dinar (JOD) ranged from 60 to 850 JOD with a mean of 337.40 ($SD = 130.20$) (475 UDS, 422 Euro). Most mothers (86%) had a high school degree or less and were unemployed (97%). The majority of the mothers (76%) were multipara, one-fourth (24%) were primipara, and 18% were grand multipara (a woman who has given birth five or more times). Nearly two-thirds (65%) of the mothers did not have any form of health insurance.
the midwives and nurses “accept my feelings without judging them” (M = 2.56), “come into my room just to check on me” (M = 2.77), “answer quickly when I call for them” (M = 3.79), “talk with me about my life outside the hospital” (M = 4.37) indicating the lower value of those behaviors for mother in labor and birth.

### Perceptions of Midwives and Nurses Regarding Caring Behaviors in Childbirth Settings

After including only, the midwives and nurses who rated the overall CBA scale and its subscales as important “4” or very important “5,” the most important caring behavior subscales were human needs assistance (94.5%), supportive/protective/corrective environment (93.6%) and humanism/faith-hope/sensitivity (89%). The least important caring behavior subscales were helping/trust (60.6%), teaching/learning (67.9), and existential/phenomenological/spiritual forces (79.8%). The midwives and nurses’ mean scores for each item in the CBA scale ranged from 2.77 and 4.83. The ten most important caring behaviors and the ten least important caring behaviors as perceived by midwives and nurses are listed in Table 2.

Four of the 10 least important caring behaviors for midwives and nurses belong to the helping/trust subscale. These items are the midwives and nurses “accept my feelings without judging them,” “answer quickly when I call for them,” “come into my room just to check on me,” and “do what they say they will do,” with mean scores of 2.77, 2.94, 3.28, and 4.07, respectively. Four of the 10 least important behaviors correspond to the teaching/learning subscale. They include the midwives and nurses “help me set realistic goals for my health” (M = 3.70), “help me plan for my discharge from the hospital” (M = 3.94), “ask me what I want to know about my health/illness” (M = 3.98), and “help me plan ways to meet those goals” (M = 4.07).

### Comparison Between Mothers’ and Midwives’ and Nurses’ Perceptions Regarding Caring Behaviors in Childbirth Settings

Independent-sample *t*-test was used to assess the significant differences in caring behaviors between mothers and midwives and nurses. As shown in Table 3, the results indicate a significant difference in the overall caring behaviors in terms of importance (*p* < .001) in favor of mothers and in terms of all caring behavior subscales except for the helping/trust subscale, which shows no significant difference.

Of the 62 caring behaviors, mothers ranked 52 items as very important (the mean above 4.5/5), while the midwives and nurses ranked only 26 items as very important. Mothers and midwives and nurses shared four caring behaviors of the top-10 most important behaviors. These caring behaviors are “Know how to handle equipment (e.g., monitors),” “Give

#### Table 2. Rank of Importance Assigned by Midwives and Nurses to Caring Behaviors (n = 109).

| Rank | Item                                                                 | M    | SD   |
|------|---------------------------------------------------------------------|------|------|
| The most important caring behaviors as perceived by midwives and nurses |
| 1    | Know how to handle equipment (e.g., monitors)                       | 4.83 | 0.37 |
| 2    | Give my pain medication when I need it                              | 4.83 | 0.42 |
| 3    | Give my treatments and medications on time                         | 4.83 | 0.41 |
| 4    | Help me with my care until I’m able to do it for myself            | 4.81 | 0.42 |
| 5    | Are cheerful                                                       | 4.78 | 0.48 |
| 6    | Know what they’re doing                                           | 4.77 | 0.46 |
| 7    | Know when it’s necessary to call the doctor                        | 4.75 | 0.47 |
| 8    | Treat me as an individual                                         | 4.72 | 0.51 |
| 9    | Reassure me                                                        | 4.69 | 0.52 |
| 10   | Check with me before leaving the room to be sure I have everything I need within reach | 4.65 | 0.53 |
| The least important care behaviors as perceived by midwives and nurses |
| 1    | Accept my feelings without judging them                            | 2.77 | 1.35 |
| 2    | Answer quickly when I call for them                                | 2.94 | 1.38 |
| 3    | Come into my room just to check on me                              | 3.28 | 1.32 |
| 4    | Help me set realistic goals for my health                          | 3.70 | 1.22 |
| 5    | Help me plan for my discharge from the hospital.                   | 3.94 | 0.87 |
| 6    | Ask me what I want to know about my health/illness                 | 3.98 | 0.82 |
| 7    | Let my family visit as much as possible                            | 4.03 | 0.91 |
| 8    | Ask me how I like things done                                      | 4.07 | 0.74 |
| 9    | Do what they say they will do                                      | 4.07 | 0.97 |
| 10   | Help me plan ways to meet those goals                              | 4.07 | 0.90 |
my pain medication when I need it," "Are cheerful," and "Reassure me." Both mothers and midwives and nurses ranked "Know how to handle equipment (e.g., monitors)" as their number one important behavior.

Mothers and midwives and nurses shared the same top three least important behaviors. Overall, they shared five of the top 10 least important behaviors, indicating strong congruence in the least important caring behaviors. Of the 10 most important caring behaviors reported by midwives and nurses, six behaviors do not coincide with important behaviors identified by childbearing women. Three of the six behaviors are related to the human needs assistance subscale, including “Give my treatments and medications on time,” “Help me with my care until I’m able to do it for myself,” and “Know when it’s necessary to call the doctor.”

### Discussion

This study’s findings demonstrate that mothers perceive the overall caring behaviors and each subscale as being more important than midwives and nurses reported. This study’s findings supported the results of previous studies showing that there is some incongruence between midwives’ and nurses’ and patients’ perceptions of which behaviors are considered caring (Papastavrou et al., 2011). Midwives and nurses should provide mother-centered care that is respectful of and responsive to individual mothers’ preferences and needs, ensuring that mothers’ needs and expectations guide all nursing caring behaviors. Mother-centered care is a cornerstone for achieving a high degree of mothers’ satisfaction during their childbirth experience. The World Health Organization (2018) considers this to be an essential criterion for delivering quality health services. These findings are significant in light of current practice in Jordan of mothers laboring without a companion at their side (Shaban et al., 2011). Changing this practice to allow a trusted relative to give some support and comfort might alleviate some degree of dissatisfaction with the care that does not provide enough of the deeply personal emotional and spiritual needs that may accompany childbirth.

In this study, mothers ranked the human needs assistance subscale as the highest in importance in demonstrating caring, followed by the supportive/protective/corrective environment subscale, with the existential/phenomenological/spiritual forces subscale ranking third. The midwives and nurses ranked the human needs assistance subscale highest in importance in demonstrating caring, followed by the supportive/protective/corrective environment subscale with the humanism/faith-hope/sensitivity subscale ranking third. The midwives and nurses ranked the existential/phenomenological/spiritual forces among the least important caring behaviors. This incongruence in perception between midwives and nurses and mothers can result in providing care that is not a priority to mothers, thus contributing to their dissatisfaction (Papastavrou et al., 2011; Preis et al., 2018).

Previous studies reported that fulfilling the mothers’ physical needs and providing nursing skills professionally and competently were essential indicators of caring (Potter & Fogel, 2013; Potter et al., 2012). Consistently, both mothers and midwives and nurses in this study rated the human needs assistance subscale as the first and most important caring behavior during childbirth. This can be understood by Maslow’s hierarchy of needs in which the lower-order needs, for example, physiological and safety needs, must be satisfied
before individuals can attend to higher-order needs, for example, self-actualization needs (Taormina & Gao, 2013).

Mothers’ ranking the need for supportive/protective/corrective environment as second important behaviors indicating the importance of giving mothers control over their childbirth by creating a safe birth environment that allows them to be active participants in their childbirth experience with minimal routine medical interventions (World Health Organization, 2018). This will offer better obstetrical outcomes and mothers’ satisfaction during labor, birth, and the immediate postnatal period (Conesa Ferrer et al., 2016; Preis et al., 2018). Similarly, in this study, midwives and nurses ranked the supportive/protective/corrective environment subscale as the second most important caring behavior. Midwives and nurses can protect and support childbearing women by creating a healing environment that involves comfort, privacy, safety, and clean and aesthetic surroundings. A recent Cochrane review emphasizes the importance of repatterning the environment to improve women’s sense of control and increase the positive emotional experience of labor (Smith et al., 2018).

In this study, mothers perceived the existential/phenomenological/spiritual forces as the third most important caring behaviors, while midwives and nurses considered it one of the least important behaviors. Callister and Khalaf (2010) found that mothers from diverse cultures espousing Christianity, Judaism, and Islam perceived their childbirth as a time of strong relationship with God. They used their religious beliefs and accompanying rituals, such as prayer, as a coping mechanism to seek higher power to influence their birth outcomes. However, it may be impractical for the full weight of meeting mothers’ expectation of having all their needs, for example, receiving spiritual support during childbirth, to fall solely on midwives and nurses. Much of this kind of support might be provided by family members if a family member was with the mother during labor and delivery.

Surprisingly, both the midwives and nurses and the mothers considered the helping-trust subscale to be the least important caring behaviors, demonstrating no significant difference between mothers and midwives and nurses. This subscale requires midwives and nurses to provide care with nonjudgmental attitudes and engage in effective, supportive, constructive, and respectful verbal and nonverbal communications. Perhaps, midwives and nurses in understaffed and busy maternity wards in Jordan viewed communication skills as less important than their clinical skills, and thus mothers should expect only the professional support from midwives and nurses (Omari et al., 2013). Possibly, for the same reason, midwives and nurses in this study considered the teaching/learning subscale among the least important caring behaviors.

**Conclusions**

One of this study’s unique contributions is having the self-reports of both mothers and midwives and nurses on their perceptions of caring during childbirth. Although there were areas of agreement on identified caring behaviors, there were also substantial areas where mothers’ and nurses’ perceptions of caring diverged. Midwives and nurses should re-evaluate their practices to be responsive to mothers’ perceived caring behaviors to promote a positive childbirth experience. In addition, midwives and nurses have a duty to advocate for mothers to receive family support during labor to help them more fully address their caring needs.

Limitation of this study include (a) stratified sampling technique could be used in future studies to enhance the sample’s representativeness for both mothers and midwives and nurses to study the effect of parity on mothers perception and to assess if there is a difference in perception between midwives and nurses (b) most of the mothers in this study were multiparas, and their caring needs may vary by parity status and previous experiences, (c) collected data did not investigate the impact of some potential influencing variables such as birth experience, parity, quality of antenatal visits, length of labor, type of delivery, disrespectful and abusive treatment, presence of unnecessary obstetric interventions on mothers’ perception of caring behaviors by midwives and nurses, and (d) the length of the CBA scale which required prolonged time for mothers and midwives and nurses to complete.

**Relevance for Practice, Education, and Research**

Midwives and nurses can use the findings of this study to encourage more mother-centered care. Health care facilities can adopt caring theory to guide midwifery and nursing practices, whether from Watson or another theorist, to meet mothers’ expectations efficiently. Mothers’ satisfaction surveys can be developed to help in the regular evaluation of mothers’ satisfaction and monitoring of midwifery and nursing caring behaviors. Midwife and nurse administrators are encouraged to provide continuing education for midwives and nurses, mainly newly employed ones, to prepare them for caring practices that are more mother centered. A caring theory should be integrated into midwifery and nursing education curricula to prepare students for providing holistic care and not only the technical competencies at the bedside. Further research could investigate the impact of the birth experience, parity, quality of antenatal visits, length of labor, type of delivery, disrespectful and abusive treatment, and unnecessary obstetric interventions on the mother’s perception of caring behaviors. Further research is needed to examine the effect of adopting mother-centered care on mothers’ outcomes during childbirth.

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**References**

Al-Maharma, D. Y., Khalaf, I. A., Abu-Moghibi, F., & Alhammy, S. (2020). “Save my baby”: The lived experience of hospitalized pregnant women with a threat of preterm birth. *Qualitative Report, 25*(4), 1042–1059. https://www.scopus.com/inward/record.uri?eid=2-s2.0-85083436800&partnerID=40&md5=a5c278fc6a07f5c6490af6714a4bea7ef

Alzyoud, F., Khoshnood, K., Alnatour, A., & Oweis, A. (2018). *Exposure to verbal abuse and neglect during childbirth among Jordanian women*. *Midwifery, 38*, 71–76. https://doi.org/10.1016/j.midw.2017.12.008

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD003766.pub6

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., . . . Gulmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLOS Medicine, 12*(6), Article e1001847. https://doi.org/10.1371/journal.pmed.1001847

Callister, L. C., & Khalaf, I. (2010). Spirituality in childbirth among women. *The Journal of Perinatal Education, 19*(2), 16–24. https://doi.org/10.1624/105812410X495514

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155–159.

Conesa Ferrer, M. B., Canteras Jordana, M., Ballesteros Meseguer, C., Carrillo Garcia, C., & Martinez Roche, M. E. (2016). Comparative study analysing women’s childbirth satisfaction and obstetric outcomes across two different models of maternity care. *BMJ Open, 6*(8), Article e011362. https://doi.org/10.1136/bmjopen-2016-011362

Cronin, S., & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. *Heart & Lung: The Journal of Critical Care, 17*(4), 374–380.

Department of Statistics, & ICF International. (2013). *Jordan population and family health survey 2012*. https://dhsprogram.com/pubs/pdf/FR282/FR282.pdf

Department of Statistics, & ICF International. (2018). *Jordan population and family health survey 2017-18: Key indicators*. https://dhsprogram.com/pubs/pdf/PR106/PR106.pdf

Hatamleh, R., Shaban, I. A., & Homer, C. (2013). Evaluating the experience of Jordanian women with maternity care services. *Health Care for Women International, 34*(6), 499–512. https://doi.org/10.1080/07399332.2012.680996

Hunter, L. P. (2009). A descriptive study of “being with woman” during labor and birth. *Journal of Midwifery & Women’s Health, 54*(2), 111–118. https://doi.org/10.1016/j.jmwh.2008.10.006

Irvani, M., Zarean, E., Janghorbani, M., & Bahrami, M. (2015). Women’s needs and expectations during normal labor and delivery. *Journal of Education and Health Promotion, 4*, Article 6. https://doi.org/10.4103/2277-9531.151885

Jordan Nurses and Midwives Council. (2020). *Jordan nurses and midwives council vision and mission*. http://jnmc.jo/index.php/about-us-7/

Jordanian Nursing Council. (2020). *Jordanian Nursing Council: Vision, mission and values*. http://www.jnc.gov.jo/en/about/pages/Vision-Mission.aspx

Khader, Y. S., Alyahya, M., Al-Sheyab, N., Shattanawi, K., Saquer, H. R., & Batieha, A. (2018). Evaluation of maternal and newborn health services in Jordan. *Journal of Multidisciplinary Healthcare, 11*, 439–456. https://doi.org/10.2147/jmddl.s171982

Khresheh, R. (2009). Support in the first stage of labour from a female relative: The first step in improving the quality of maternity services. *Midwifery, 26*(6), e21–e24.

Khresheh, R., & Barclay, L. (2019). Assessing the effectiveness of an educational workshop designed to improve caring behaviors of Midwives at Public Hospitals in Jordan. *Nursing and Midwifery Studies, 8*(2), 70–77. https://doi.org/10.4103/nms.nms_4_19

Khresheh, R., Barclay, L., & Shoqirat, N. (2019). Caring behaviours by midwives: Jordanian women’s perceptions during childbirth. *Midwifery, 74*, 1–5. https://doi.org/10.1016/j.midw.2019.03.006

Kornusky, J., & Karakashian, A. L. (2018). *Watson’s theory of caring: Integration into practice*. http://0f10wlrfn.y.http.content.ebscohost.com.proxy.elm.jo/ContentServer.asp?EbscoConten
t=dGlyMNHR7ESexlI4y9SOC25msIeip655r6y486%2BWyXWSX&ContentCustomer=dGlyMOzpsE2yrbNuePfIgyx43zx1%2B6B&T=P&P=AN&S=L&D=nup&K=T707730

Miller, S., & Lalonde, A. (2015). The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO’s mother–baby friendly birthing facilities initiative. *International Journal of Gynecology & Obstetrics, 131*, S49–S52. https://doi.org/10.1016/j.ijgo.2015.02.005

Ministry of Health. (2017). *Number of hospitals according to health sectors in Jordan*. http://www.moh.gov.jo/Pages/view-page.aspx?pageID=171

Mohammad, K. I., Alafi, K. K., Mohammad, A. I., Gamble, J., & Creedy, D. (2014). Jordanian women’s dissatisfaction with childbirth care. *International Nursing Review, 61*(2), 278–284. https://doi.org/10.1111/inr.12102

Mutmainnah, M., & Afiyanti, Y. (2019). The experiences of spirituality during pregnancy and child birth in Indonesian muslim women. *Enfermeria Clinica, 29*, 495–499. https://doi.org/10.1016/j.enfcli.2019.04.074

Nikula, P., Laukkanla, H., & Pöllki, T. (2015). Mothers’ perceptions of labor support. *MCN: The American Journal of Maternal/child Nursing, 40*(6), 373–380.
Oladapo, O., Tunçalp, Ö., Bonet, M., Lawrie, T., Portela, A., Downe, S., & Gülmezoglu, A. (2018). WHO model of intrapartum care for a positive childbirth experience: Transforming care of women and babies for improved health and wellbeing. *BJOG: An International Journal of Obstetrics & Gynaecology, 125*(8), 918–922. https://doi.org/10.1111/1471-0528.15237

Omari, F. H., AbuAlRub, R., & Ayasreh, I. R. (2013). Perceptions of patients and nurses towards nurse caring behaviors in coronary care units in Jordan. *Journal of Clinical Nursing, 22*(21–22), 3183–3191.

Papastavrou, E., Efthathiou, G., & Charalambous, A. (2011). Nurses’ and patients’ perceptions of caring behaviours: Quantitative systematic review of comparative studies. *Journal of Advanced Nursing, 67*(6), 1191–1205. https://doi.org/10.1111/j.1365-2648.2010.05580.x

Potter, D. R., Condon, E. H., Montgomery, A. J., Muhammad, T. S., & McGee, Z. T. (2012). Selected African American first-time teenage mothers’ perceptions of nurse caring behaviors during the postpartum period. *International Journal of Advanced Nursing Studies, 1*(1), 1–21.

Potter, D. R., & Fogel, J. (2013). Nurse caring: A review of the literature. *International Journal of Advanced Nursing Studies, 2*(1), 40.

Preis, H., Lobel, M., & Benyamini, Y. (2018). Between expectancy and experience: Testing a model of childbirth satisfaction. *Psychology of Women Quarterly, 43*(1), 105–117. https://doi.org/10.1177/0361684317779537

Schäfer, J. L. (1999). Multiple imputation: A primer. *Statistical Methods in Medical Research, 8*(1), 3–15. https://doi.org/10.1177/09622290900800102

Shaban, I., Barclay, L., Lock, L., & Homer, C. (2012). Barriers to developing midwifery as a primary healthcare strategy: A Jordanian study. *Midwifery, 28*(1), 106–111. https://doi.org/10.1016/j.midw.2010.11.012

Shaban, I., Hatamleh, R., Khresheh, R., & Homer, C. (2011). Childbirth practices in Jordanian public hospitals: Consistency with evidence-based maternity care? *International Journal of Evidence-Based Healthcare, 9*(1), 25–31. https://doi.org/10.1111/j.1744-1609.2010.00197.x

Smith, C. A., Levett, K. M., Collins, C. T., Armour, M., Dahlen, H. G., & Sugučumana, M. (2018). Relaxation techniques for pain management in labour. *Cochrane Database of Systematic Reviews, 3*(3), Article CD009514. https://doi.org/10.1002/14651858.CD009514.pub2

Suliman, W. A., Welmann, E., Omer, T., & Thomas, L. (2009). Applying Watson’s nursing theory to assess patient perceptions of being cared for in a multicultural environment. *Journal of Nursing Research, 17*(4), 293–300.

Taormina, R. J., & Gao, J. H. (2013). Maslow and the motivation hierarchy: Measuring satisfaction of the needs. *The American Journal of Psychology, 126*(2), 155–177. https://doi.org/10.5406/amerjpsyc.126.2.0155

Watson, J. (2007). Watson’s theory of human caring and subjective living experiences: Carative factors/caritas processes as a disciplinary guide to the professional nursing practice. *Texto & Contexto—Enfermagem, 16*, 129–135. http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-070720000100016&nrm=iso

Watson, J., & Nelson, J. (2012). *Measuring caring: International research on caritas as healing.* Springer.

World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience.* http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf