Building capacity of midwives for result-oriented client education and friendly service

Article · May 2013

CITATIONS
0

READS
178

2 authors:

Bridget Akin-Otiko
University of Medical Sciences, Ondo City, Nigeria
8 PUBLICATIONS **5** CITATIONS
SEE PROFILE

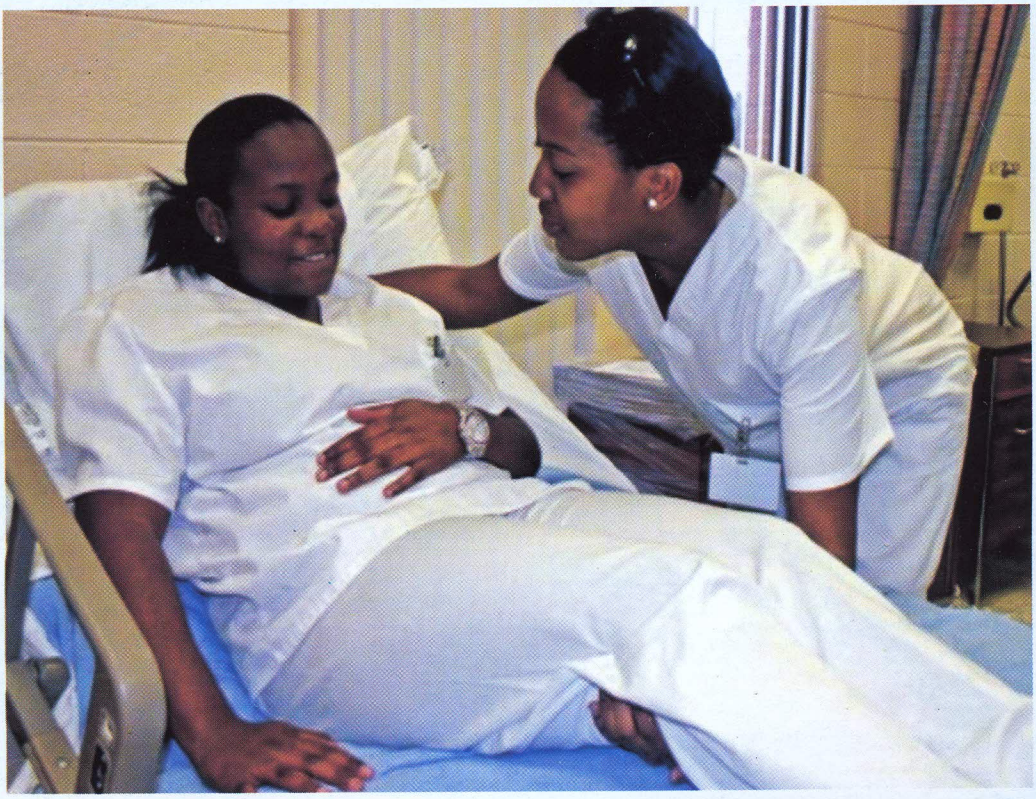
Busisiwe Rosemary Bhengu
University of KwaZulu-Natal
18 PUBLICATIONS **164** CITATIONS
SEE PROFILE

ISSN 1117-9689

WEST AFRICAN JOURNAL OF NURSING

Published by West African College of Nursing

Vol. 24 No. 1 May 2013



TECHNOLOGY AND DECLINING NURSING CARE

An Agency of West African Health Organisation.

₦500

WEST AFRICAN JOURNAL OF NURSING
Published by WEST AFRICAN COLLEGE OF NURSING
This leading peer reviewed Journal promotes excellence in Research, Education and Health Care Practice.

TECHNOLOGY AND DECLINING NURSING CARE

Contents

Education Papers:

BUILDING CAPACITY OF MIDWIVES FOR RESULT-ORIENTED CLIENT EDUCATION AND FRIENDLY SERVICE

AKIN-OTIKO, *BridgetOmowumi[1] RN, RM, RNT, FWACN, BSc Nursing., MPH., PhD.*
Nursing Services Division, Federal Ministry of Health, Abuja - Nigeria
wumiakinotiko@yahoo.com., Phone: +234 80 37213522; +234 81 91246675

BHENGU, *BusisiweRosemary[2] RN, RM, RNE, RNA Gen. Int Care IntNsgSc, Dip AdvNsgSc (Admin) Dipl,B Cur Hons; M. Cur., PhD.*
School of Nursing, University of KwaZulu-Natal, Durban, 4041, South Africa
bhengub2@ukzn.ac.za, Phone: +27 (0) 31 260 1134., Fax: 031 260 1543

Abstract

Introduction: Literature is replete with evidences of midwives' lack of the required interpersonal communication skills for client education. Client education is a major responsibility of midwives and provides opportunity to promote both the positive health behaviours of clients and the image of the midwives.

Purpose: The study explored an interpersonal communication and counselling (IPCC) capacity building approach to empowering midwives for result-oriented client education and friendly service at first level of midwifery practice.

Methods: Fifteen midwives at first level maternal and child care facilities across Kaduna State participated in the preliminary need assessment and design of the consequent capacity building programme. After the 3-day interactive training, midwives' hands-on practice using the observation checklist, and the implementation of their action plans were supervised for three months. Baseline data on the knowledge and skills of the midwives were taken at the capacity building programme and repeated at the end of the three months of supervision at site.

Findings: Respect for the midwives' preferences sustained their interest throughout the empowerment process. Their knowledge and skills increased significantly. Some of the midwives trained their colleagues to serve as peer assessors.

Implication for Practice: Midwives require IPCC workshops, however, contextual relevance enhances the empowerment process.

Key words: Capacity Building, Client Education, Behaviour Change Communication, Kaduna State, Nigeria, Training.

Statement of Problem The maternal and child mortality rates in Nigeria are among the highest in the world. Critical to the attainment of the maternal and child health-related Millennium Development Goals (MDGs) in Nigeria are the availability of essential obstetric care, the provision of friendly service by health workers, and the access by consumers to appropriate information to guide their decision-making and utilization of services. Nigeria's health sector reform project, the country's programme to accelerate the attainment of the maternal and child-related MDGs, and the behaviour change communication plan for Nigeria, identified training of health care providers on interpersonal communication / counselling (IPCC) and enhancing their skills to promote friendly service and utilization of services, as critical. Similarly, in 2007, at a multi-agency stakeholders' forum to improve midwifery education and practice in Nigeria, it was resolved that workshops on interpersonal relationship (IPR) should be organized frequently for midwives. This was to further empower midwives to provide friendly services and encourage desired behaviour change in their clients. There were no such IPR workshops for midwives at the time. Interpersonal communication and counselling (IPCC) skills training was only an adjunct topic to some staff development programmes such as the Life Saving Skills (LSS) and Family Planning. Studies, however, show that such

adjunct approach was usually ineffective as greater emphasis was placed on the technical components of the programmes[6]. As in previous studies[6], at the preliminary need assessment phase of this project, the midwives also indicated that interacting with clients was difficult for them. There was, therefore, the need to find out how midwives could be empowered for effective relationship with their clients.

Aimof the Study was toexplore an interpersonal communication and counselling (IPCC) capacity building approach to empowering midwives for friendly service and result-oriented client education at first level of midwifery practice.

Significance of the Study The Kaduna State health policy milestones indicated that, the knowledge, attitude and practices (KAP) of clients and communities on priority health issues, were expected to have increased by sixty percent by 2011[7]. With the poor access to electronic media and about four-fifths of the women in the rural areas of the north west zone being unable to read or write[8], the performance of midwives' client education functions as frontline prototype providers of maternal, newborn and child care at the first level[9]is critical to achieving the government policy milestones by 2011. The study was expected to empower midwives to offer friendly services and to provide appropriate information to their clients, for the latter to gain confidence in the midwives and utilize available services; thus, contributing to the achievement of the Federal and Kaduna State Government's goals. Moreover, literature is replete with the recognition of fewer related studies in developing countries than in the developed world, and thus calls for further studies in the area of provider-client interaction for improved professional performance and better client health outcomes[10-13]. de Negri, Brown, Hernández et al.[14] noted that researchers were usually afraid of possible failure or lack of interest by professionals in such studies. This study would, therefore, contribute to the body of knowledge in promoting maternal, newborn and child health through midwife-led behaviour change communication. Similarly, the collaborative nature of the research approach could narrow the gap between research and practice, making utilization of findings feasible.

Review of literature

Studies over the years show that the voice of the respected health worker is the most powerful in promoting desired behaviour in clients[6, 15]. Midwives consider client education as one of their priority duties, however, it has become more challenging for them do it effectively[13]. According to Boyd and Shaw[6], interaction with mothers is not as easy as the technical aspect of the midwives' work. An ethnographic study of encounters between midwives and breastfeeding mothers showed that midwives delivered client education as a routine under pressure of time, without considering whether or not their clients understood the information[16]. Shortage of staff and heavy workloads shorten client education sessions during antenatal care (ANC) with midwives focusing more on services and jeopardizing counselling and provision of information[17, 18]. Al-Motlaq et al.[19]also reported that client education activities by nurses were unplanned because of heavy workloads. According to Haruna et al.[20], nurse-midwives admitted having difficulties finding effective ways to advise women on lifestyle related issues because they were not adequately prepared in school and the textbooks did not provide what they needed for their daily experiences with women. Other documented hindrance to effective client

education included the lack of appropriate job aids and guidelines[13, 20], thus limiting midwives' counsel to only their personal experiences[20]. Some studies however, reported that despite the challenges, some midwives were committed, giving their clients the attention, information and support required[13, 16].

Midwives, therefore, being more of traditional 'health educationalists' than 'health promotionalists'[21], need to be empowered to perform their client education functions in a result-oriented manner. To change the behaviour of mothers for favourable maternal, newborn and child health (MNCH) outcomes, the knowledge, attitude and skills of the midwives must change first[6] because, there would be no behaviour change by consumers, especially at the grassroots, without effective communication by providers[22]. The behaviour change communication strategic approach at the health system level in Nigeria is both service oriented and interpersonal communication focused[4]. The service oriented strategy includes 'improving the image of the service providers for increased client confidence; holding health talks or sessions at the clinics; and creating opportunities for integrated service approach.'[4:64] The interpersonal communication focused strategy involves 'training the health workers to enhance their skills on IPCC and patronage; as well as developing and producing job aids for them.'[4:65]. Interpersonal communication channel is favoured by researchers because the most influential way of communicating is through a trusted individual with a valued opinion[6] .

Most IPCC capacity building programmes are usually designed by the initiators or engaged experts in alignment with the country's national MNCH policies, guidelines and protocols[23]. According to Turan et al.[24], purposefully planned learning activities promote acquisition of clinical communication skills. A competency-based curriculum to guide training is required for effective skills development[25]. Studies have shown that there is no magic curriculum or absolute training manual that fits all categories of learners in every country of the world, and so where there is an existing curriculum, there is the need to adapt it creatively for information, cultural and contextual relevance[14, 23, 26]. Interventions must be appropriate to the specific needs of both the midwives and their clients[17]. Parry[11] noted in the review of studies on communication skills training, that interventions were more effective when tailored to specific communication needs in specific clinical areas based on evidence. Need assessment to identify the gaps in the objectives of the training programme and the existing knowledge, attitudes, skills and practices of prospective participants must be conducted to arrive at the content of the curriculum[27, 28]. Need assessment surveys in previous studies revealed both strengths and weaknesses of professionals with respect to their communication skills[14, 29] and revealed clients' preferences[30]. Doyle et al.[31] observed that teaching communication skills in natural settings was essential while Subramanian et al.[32] demonstrated the enormous value of whole-site training. To acquire and sustain essential competencies, practice must be repeated and objectively assessed[33]. Students in Licqurish and Seibold's[34] study, learnt best by hands-on practice with the support of helpful midwife preceptors and real life opportunities for critical thinking and practice.

An enabling environment encourages desired behaviour in both the midwives and their clients[4]. According to de Negri et al.[14], clients cannot effect

lifestyle changes or comply with treatment if they cannot access drugs and essential supplies. In previous studies, providers suggested reorganization of clinics, provision of equipment, and improved facilities, in addition to interpersonal communication training[14]. Midwives emphasized the significant role of supportive supervision in reinforcing learning and motivating them, especially in rural areas where midwives worked alone[23]. Smith[35]also recommended complementing training with evidence-based guidelines and action plans on how to implement the gains of the training. Where professionals were provided with context relevant[35] job aids or guides[15, 36], they were used and seen as useful reminders in improving their interaction with the clients[14, 15].

Theoretical frame work

The overarching framework[37] which guided and was reflected at every stage of the entire project was Michie et al.'s[38] *integrative framework for studying the implementation of evidence based practice.* The framework is made up of twelve theoretical domains of behaviour change: knowledge; skills; social/professional role and identity; beliefs about capabilities; beliefs about consequences; motivation and goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; behavioural regulation; and nature of the behaviours[38]. By deciding to use this integrative framework, the researcher ***assumed*** that: the twelve domains would reveal the strengths and weakness related to midwives' behaviour change communication for MNCH in the facilities; that clear and comprehensive identification of the weaknesses using the twelve domains would simplify the process of identifying appropriate strategies to address hindrances to BCC activities in health facilities; and that if the weaknesses are correctly identified and the suggested solutions are appropriate then the intervention would be successful.

Methods:

Ethical clearance to undertake the study was obtained from the Humanities and Social Sciences Ethics Committee of the University of KwaZulu-Natal, South Africa. Written permission to carry out the study in Kaduna State among the midwives was secured from the Ministry of Health and Ministry for Local Government, Kaduna State, Nigeria. Permission was also obtained in writing to adapt theDavid & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs' interpersonal communication and counselling (IPCC) skills training manual, focussed on adolescent sexuality[39], to the maternal, newborn and child health (MNCH) focus of the study.

Action Research, with concurrent transformative mixed method data collection strategy[37] was employed for the project. The maximum variation sampling technique[40] was used to recruit midwives from health facilities in rural, urban, and urban slum communities, in eight of the twenty-three local government areas of Kaduna State, north west Nigeria. Authors advocate small class size for effective collaborative learning[41, 42]. Twenty-two (66.7%) of the thirty-three qualified midwives in all the nine selected facilities at the timeexpressed their interest and gave their consent in writing, to participate in the study. Fifteen (68%) of the twenty-two recruited midwives continued to the final phase of the project, due to, withdrawal by some midwives on the grounds of ill-health, transfer from Kaduna State, and heavy workload. Prior to

the training, at an earlier 3-day search conference[43] held on 27th – 29th January 2010, the midwives reviewed data from: personal data questionnaire of the twenty-two midwives, the in-depth interviews with nine of the midwives, and the focus group discussions with sixty-five women in communities where the midwives worked. The review was to identify the needs of the midwives for capacity building and of the women regarding their experiences and expectations from client education sessions[6]. Empowering the midwives (the training) was the intervention phase of the three-phased action research oriented project.

The three-day capacity building workshop was designed in line with the midwives' preferences agreed on at the search conference. The date and duration of the programme was decided by the midwives, taking into consideration their work schedules. The midwives were involved in determining the content of the curriculum for the capacity building programme[6, 44]. The capacity building workshop was designed by a committee with one of the midwives as a member. The committee developed the capacity building training manual; pre- and post-test questionnaire having forty questions based on the training manual; and the observation checklists to assess the process of interaction between the midwives and their clients[45, 46]. The midwife-client interaction observation checklist was an adaptation of the interpersonal communication sender-receiver-feedback model in most Federal Ministry of Health's training manuals[47, 48]. The training materials were reviewed by a staff of the safe motherhood branch of the Federal Ministry of Health, Nigeria and a professor in the School of Nursing, University of KwaZulu-Natal.

The three-day capacity building workshop was held on 3rd – 5th March 2010. As adult and professional learners, stimulating participatory approaches[49] such as, demonstrations, group work, and individual presentations were used to deliver the sessions at the workshop.In their groups, participants exchanged roles as clients and midwives, and used the observation checklist for peer assessment. Participants were treated with respect, and their professional strengths recognized[6, 49]. The content covered during the workshop included: introduction to behaviour change process (54 minutes), introduction to integrated maternal, newborn and child health and review of primary health care (98 minutes), marketing of MNCH services using client-centred / customer service approach (76 minutes), review of communication / IPCC skills and discussion of the checklist (90 minutes), counselling and individual demonstration (138 minutes), use of information, education and communication (IEC) materials and individual demonstration (116 minutes), community mobilization (54 minutes), values clarification and review of core MNCH messages (53 minutes), and group work on the IPCC process, using the checklist (60 minutes). Pre- and Post-tests were taken before and after exposure to the content respectively.

A special interactive session captioned *Challenges of Rural Midwifery Practice / Networking* was held by the midwives with top government officials of the State Ministry of Health and the Ministry for Local Government, as requested by the midwives. The session was well attended and key issues related to the welfare of the midwives and the conditions of the health facilities were discussed. This afforded the midwives an opportunity to interact with their employers and discuss their concerns in an unthreatened atmosphere. The special interactive session lasted 93 minutes. Supervisory visits were

paid monthly for three months post capacity building workshop. The visits were to assist the midwives with their hands-on practice of the IPCC skills using the checklist and the core messages provided in the training manual. At the third (last) visit, the same simulated client[50] with specific counselling needs[46] was engaged to assess all the participants at their respective workplaces. The midwife-client interactions were personally assessed by B. O. (first author) using the observation checklist. At the end of each interaction, the client, the midwife and B.O. had a discussion on the interaction. The knowledge of the midwives was also reassessed at three months using the pre- and post-test questionnaire. The study was strictly guided by general ethical principles ensuring confidentiality, openness, respect, and the rights of the midwives to differ, negotiate access, and verify the reports[51]. Attrition was minimized by recruiting interested participants directly and not by employer nomination[52, 53]. Similarly, a sense of ownership of the project by all was encouraged, through active participation and professional co-learning[49].

Both qualitative and quantitative data were collected concurrently[43]using the pre- and post-test questionnaire, the IPCC observation checklist, and various data sheets[54]such as, registration forms, attendance register, individual assessment form, and the workshop evaluation form. Information requested on the open-ended individual assessment form included: the most important things learned; the skills or abilities developed; what to improve; and what to start doing. The workshop evaluation form was used to capture the views of the midwives about the various activities during the workshop. Data from all these data sources were analyzed using the SPSS 15.0 for Windows. Open ended responses in the questionnaires / data sheets were coded before analysis. Findings were presented to the midwives for discussion / validation at a debriefing session held on 29th July 2010.

Findings: The fifteen midwives were aged between 32 – 59 years and had 4 to 30 years experience as midwives. Four of them had only the midwifery qualification, while the others had additional nursing / health qualifications. Five, had not taken part in any professional development programme since qualifying. The midwives' knowledge of the content areas covered during the training increased significantly immediately after training, and remained significantly improved at three months as shown in Table 1.

Table 1: Comparison of the Pre-, Post- and Repeat Post-Test Scores

Statistics	Pre-Test Scores	Post-Test Scores	Repeat Post-Test Scores (after 3 months)	Remarks
Minimum	5	15	10	
Maximum	24	35	40	
Median	12	27	26	
Chi-Square	19.9966			Friedman Test (Significant at the **0.05** level)
Degree of freedom	2			
Asymptotic Significance (2-tailed)	**.000**			

The duration of the midwife-client interactions and the midwives' interpersonal communication (IPC) skills also improved significantly at three months as presented in Table 2.

Table 2:*Comparison of theDuration and OverallInterpersonal Communication (IPC) Skills Scores in First and Second Assessments Using the Observation Checklist*

Variable	Statistics	First IPC Skills Assessment	Second IPC Skills Assessment	Remarks
Duration of Interaction	Minimum	84	162	
	Maximum	225	452	
	Median	200	236	
	Z - Statistics	-2.841 (Based on negative ranks)		Wilcoxon Signed Ranks Test (Significant at the **0.05** level)
	Asymptotic Significance (2-tailed)	**.004**		
Overall IPC Scores (Maximum Obtainable Score is 23)	Minimum	5	12	
	Maximum	21	23	
	Median	18	21	
	Z - Statistics	-2.200 (Based on negative ranks)		Wilcoxon Signed Ranks Test (Significant at the **0.05** level)
	Asymptotic Significance	**.028**		

Further analysis of the improvement in the IPC skills revealed that the improvement was significant for verbal communication skills, client participation, and feedback, but, not for the reception, non-verbal comunication skills, and the message (see details in Table 3).

SHARING

There isn't much that I can do, but I can share my bread with you, and sometimes share the sorrow, too.
There isn't much that I can do, but I can sit an hour with you, and I can share a joke with you, and sometimes share reverses, too
There isn't much that I can do, but I can share my flowers with you, and I can share my books with you and sometimes share your burdens, too
There isn't much that I can do, but I can share my songs with you, and I can share my mirth with you, and sometimes come and laugh with you
There isn't much that I can do, but I can share my hopes with you, and I can share my fears with you, and sometimes shed some tears with you
There isn't much that I can do, but I can share my friends with you, and I can share my life with you, and oftentimes share a prayer with you.

Table 3:*Item Analysis of Interpersonal Communication (IPC) Skills - First and Second Assessments Using the Observation Checklist*

Variables	**1st Assessment Scores (At workshop)**	**2nd Assessment Scores (At three months)**	**Z- Statistics Asymptotic Significance (2-tailed)****
Reception: Midwife welcomed client to clinic, introduced herself and maintained same level with the client (language, pace, position) **(Maximum Score 3)**	4(26.7%) scored 2; 11(73.3%) scored 3	6(40%) scored 2; 9(60%) scored 3	Based on positive ranks Z -1.000 Asymp. Sig. .317
Midwife's Verbal Communication Skills using the C-L-E-A-R and the **KISS Model:** Midwife was Clear and audible, Listened, was patient and did not interrupt, Encouraged client on desired behaviour, Acknowledged client's responses, Repeated / Reflected on what said, and Kept It Simple and Sensible (KISS); the client did not say she did not understand or could not hear frequently **(Maximum Score 6)**	1(6.7%) scored zero; 1 (6.7%) scored 2; 2(13.3%) scored 3; 4(26.7%) scored 4; 6(40%) scored 5; 1(6.7%) scored 6	1(6.7%) scored 2; 2(13.3%) scored 4; 4(26.7%) scored 5; 8(53.3%) scored 6	Based on negative ranks Z -2.311 Asymp. Sig. **.021****
Midwife's Non-verbal Communication Skills using the R-O-L-E-S Model: Midwife was Relaxed (not hurriedly conducted, not anxious), Opened up and approachable, Leaned forward tolerably, Eye Contact was maintained tolerably, she Sat squarely (and Smiled tolerably) **(Maximum Score 5)**	1 (6.7%)scored zero; 2(13.3%) scored 4; 12 (80%) scored 5	1(6.7%) scored 3; 14(93.3%) Scored 5	Based on negative ranks Z -.736 Asymp. Sig. .461
Message(s) Presented by the Midwife: Appropriate for client / group, Correct (In line with developed messages), Should / Could be done / adopted by client **(Maximum Score 3)**	1(6.7%) scored zero; 1(6.7%) scored 1; 3(20%) scored 2; 10(66.7%) scored 3	2(13.3%) scored 1; 3(20%) scored 2; 10(66.7%) scored 3	Based on negative ranks Z -.183 Asymp. Sig. .855
Client Participation: Requested for information, responded to and/or asked questions freely (comfortable / relaxed), Attentive **(Maximum Score 2)**	2(13.3%) scored zero; 3(20%) scored 1; 10(66.7%) scored 2	15(100%) scored 2	Based on negative ranks Z -2.070 Asymp. Sig. **.038****
Feedback: Midwife allowed client(s) to respond/ask questions. Answered client's question(s). Client(s) expressed satisfaction / understanding, and Midwife Assured client(s) of readiness to assist always **(Maximum Score 4)**	3(20%) scored zero; 2(13.3%) scored 1; 5(33.3%) each scored 2 and 3 respectively	1(6.7%) Scored 1; 5(33.3%) scored 2; 3(20%) scored 3; 6(40%) scored 4	Based on negative ranks Z -2.818 Asymp. Sig. **.005****

*** Wilcoxon Signed Ranks Test (Significant at the **0.05** level)*

None of the midwives documented their interactions with the clients at the first assessment but seven of them did at three months.

Themost important things the midwives indicated they learned at the capacity building workshop included: the behaviour change process and how it varies from one person to another, effective communication, the proper way to give health talks and counsel clients, clients' rights and respect for clients' values. The IPCCskills acquired included: introducing self to the client, courage to face the client, proper counselling and health talks, as well as proper use of IEC materials.Some of themidwivesindicated that they still needed to improve in the areas of verbal communication and counselling, helping clients to open up, self introduction, and the use of IEC materials. The midwives indicated that they would be more tolerant and start attending to their clients always, even if the latter came late. They would also work in the fear of God and be more committed to their work despite discouragements from the poor work environment. In terms of personal and professional development, they expressed the desire to read more, attend more workshops, train their colleagues and create awareness on friendly service in their facilities. The interactive session with the employers saw the employers pledging their support and looking into the concerns of the midwives. Evaluating the workshop, the midwives generally described the workshop as excellent and relevant,

with the workshop duration adequate, and the venue, transportation, refreshment, materials adequate. They were grateful to be part of it and looked forward to more of such workshops.

At the end of the three months of hands-on practice, the midwives were more confident in talking to their clients, and were able to manage allegedly annoying or insultingclients. Their preparation and delivery of health talks and counselling of the clients improved, with impressive feedback during health talks. There was improvement also, in promoting MNCH services available in the facilities and making the services available on request outside scheduled times. The clients and their relatives freely approached the midwives for assistance and sometimes the midwives had to close late after attending to clients in need. The midwives worked more because of: their improved interaction with the clients, the clients' preference for the midwives (participants) in the facilities, and midwives' attending to pregnant women at all time. The midwives and clients were happier. Some of the midwives trained their colleagues and / or supporting staff. The changes initiated by the midwives especially attending to clients outside scheduled time was resisted by some supporting staff, however, the midwives overcame such resistance. The two major issues unresolved as at the debriefing forum were, the problems of staff shortage and the lack of confidence by midwives in their employers' promise to attend to their concerns about personnel, equipment, drugs and supplies. The midwives pleaded to be exposed to more workshops to help them, and recommended that student midwives should be involved in similar workshops to 'get more children and women going to the clinic' - (F83 – rural hospital). The midwives found the training manual, the observation checklist and the core messages very useful. The supportive monthly visits also encouraged the midwives to continue practising what they learnt. Networking with other government and non-governemental agencies to improve their services as in their action plans was exciting to the midwives.

Discussion on the findings: As in previous studies, the active participation of the midwives promoted their sense of identity with the project[55]. Earlier studies have also documented significant improvements in midwives' knowledge post-intervention[56, 57], and the immediate improvements in communication skills were also reportedly sustained during subsequent assessments[14, 32, 58]. Greetings and warm welcome is a rich part of Nigerian culture and this was probably why there was no significant change post intervention, however, self-introduction to clients was motivated in this study to enhance accountability and promote consumer's rights[59], and the clients were happy to know the midwives' names. The confidence to face clients, gained by the midwives, was probably because of the increased knowledge and repeated practice[33]. Studies show that after similar capacity building programs focused on one communication message, the information provided by providers was adequate[32]. This study did not document significant difference in the messages. This was probably because the messages varied at each assessment. Midwives have more than one message from pregnancy to the care of the child, to assist clients with, hence, the need for professional development and regularly updated job aids[4]on the core messages. The improved client participation and feedbackskills support findings in other studies that, practitioners significantly became less authoritarian post-intervention[60, 61]. Assuring clients of midwives' availability and readiness to assist always, was uncommon to the midwives, probably with further practice more of the midwives would do it

regularly[33], because the midwives who used their checklist frequently, seemed to have better interactions with their clients[62]. Improved duration of interaction post-intervention was also observed in literature[57] and the time was adequate[46]. The inadequate midwife: client ratio in many facilities[63] posed a threat to satisfactory interaction where there was only one midwife in the facility. The gross staff shortage was worse in the rural areas[27], and affected hands-on practice where there was only a midwife in the facility. The midwives' indication that they acquired new knowledge and skills, and would utilize these, supported previous observations that health workers respond positively to well planned training[14, 64]. The sustained improvement after three months affirmed the importance of contextual relevance[6, 25], hands-on practice, and corrective feedback in skills development[31, 34, 36]. Implementation of the action plans brought the gains of the workshop closer *home* and encouraged innovation[65, 66].

Peer assessment and transfer of knowledge and skills thrived where there were more than one midwife in the facility, and it helped them to strengthen their gains[36]. Despite widely acknowledged benefits of self assessment[14, 67], most of the midwives in this study preferred peer-evaluation to self-evaluation. Most of the primary health care facilities in this study operated the solo-midwife approach discouraged by authors [27]. This made peer assessment of IPCC skills practice, using the checklist, impossible for those who insisted they could not assess themselves. Through peer assessment, professionals understood that others had weaknesses similar to theirs, and learned together, strengthening one another [67]. This means that in spite of the manuals and checklist, it is essential to have supportive, non-judgmental, and purposeful supervisory visits to reinforce learning and motivate midwives in the field [14, 23, 32,36]. This study also demonstrated the importance of an enabling environment for midwives to provide what would be perceived by clients as friendly service, and promote clients' adoption of desired health behaviour[14, 33].

Conclusion:

Midwives are willing to acquire essential IPCC skills and improve their image. A successful capacity building package helps midwives to understand themselves and their clients, and produces positive changes in day-to-day midwifery practice. Improved preparation of health talks makes midwives confident, and the consequent improved delivery of the health talks increases client participation and interest, encourages clients' voluntary request for more information and assistance when necessary, and could increase utilization of MNCH services. Midwives' attending to clients outside scheduled service hours and days promotes utilization of MNCH services in the facilities. Midwives' lack of trust in the Government to attend to the environmental factors poses a serious threat to the midwives' job satisfaction and delivery of friendly service.

Implication for practice: Midwives must be involved at every stage of any programme aimed at assisting them develop essential skills for effective client educationand the skills must be practised and supervised on site, to attain competency levels.

References:

1. United Nations. The Millenium Development Goals Report 2008 – End Poverty 2015 make it happen. United Nations; 2008.
2. F.M.O.H, WHO. Road Ma for Accelerating the Attainment of the MDGs Related to Maternal

and Newborn Health in Nigeria. Abuja, Nigeria: Federal Ministry of Health/ Yaliam Press Ltd; 2005.

3. F.M.O.H. Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and a Plan of Action, 2004 – 2007. Abuja, Nigeria: Federal Ministry of Health; 2004.
4. F.M.O.H; WHO., PATHS, UNFPA, UNICEF, DFID. Behaviour Change Communication Strategy for the National Reproductive Health Policy and Framework Nigeria 2005 – 2008. Abuja, Nigeria: Federal Ministry of Health 2005.
5. N&MCN. Communique Issued At The End Of One-Day Stakeholders Meeting On Improving Midwifery Education And Practice In Nigeria For The reduction of Maternal Morbidity and Mortality. Stakeholders Meeting On Improvinf Midewifery Education And Practice In Nigeria For The Reduction of Maternal Morbidity and Motality; 2007; Reiz Continental Hotel, Abuja, Nigeria. Thursday 29th March, 2007. Nursing & Midwifery Council of Nigeria; 2007. P.1-4.
6. Boyd BL, Shaw WD. Unlocking Health Worker Potential: Some Creative Strategies from the Field. Washinton, DC: AED – Academy for Educational Development Social Development Social Development Division; 1995.
7. Kaduna State Govrnment. KADSEEDS II 2008 – 2011 (Health Component) KADSEED II Final Version. Kaduna: Kaduna State Government; 2008.
8. NPC, ICF Macro. Nigeria Demographic Health Survey 2008. Abuja, Niggeria: National Population Commission (NPC) [Nigeria] and ICF macro Calverton, Maryland, USA; 2009.
9. WHO. The World health report: 2005: make every mother and child count. Geneva, Switzerland: World Health Organization; 2005.
10. Labhardt ND, Schiess K, manga E, langewitz W. Provider-patient intraction in rural Cameroon-How it relates to the patient's understanding of diagnosis and prescribed drugs, he patient's concept of illness, and access therapy. Patient Education and Councelling. 2009; 76:196-201.
11. Parry R. are interventions to enhance communication performance in allied health professionals effective and how should they be delivered? Direct and indirect evidence. Patient Education and Counselling. 2008; 73:186-95.
12. Jewkes R, Abrahams N, Mvo Z. Why Do Nurses Abuse Patients? Reflections From South African Obsteric services. Soc Sci Med. 1998;47(11):178-95.
13. Freda MC. Issues in Patient Education. J Midwifery Womens Health. 2004;49:203-9.
14. De Negri, B. Brown LD, Hernandez O, Rosenbaum J, Roter D. Improving Interpersonal Commuication Between Health Care Providers and Clients – Quality Assurance Methodology Refinement Series. Bethesda: Quality Assurance Retrieved 4th March, 2010 from http//www.globalhealthcommunication.org/tool_docs/47/gap_improving_interpersona_communication 2005.
15. Devine SG, Harrison SL, Buettner PG. Building capacity of maternity staff to discourage the use of sunlight theraphy in the post-partum period and infancy. Women and Birth 2008; 21:107-11.
16. Dykes F.A: Critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England. Midwifery. 2005;21:241-52.
17. Couillet M, Serhier Z, Tachfouti N, Elrhazi K, Nejjari C, Peerez F. The use of antenatal services in health centres of Fe's, Morocco. Journal of Obstetrics and Gynaecology. 2007;27(7):688-94.

18. Seidel R. Behaviour Change Perspectives and Communication Guidelines on Six Child Survival interventions Academy for Educational Development, the Johns Hopkins Boomberg School of Public Health/ Center for Communication Programs and the United Nations Children's Fund; 2005.
19. Al-Motlaq M, Mills J, Birks M, Franscis K. How nurses address the burden of disease in remote or isolated areas in Queensland. Intenational Journal of Nursing Practice. 2010;166:472-7.
20. Haruna M, Yeo S, Watanabe E, Matsuzaki M, Ota E, Nakayama K et al. Perceptions of women and health-care providers in Tokyo of appropriate weight gain during pregnancy. Nursing and Health Sciences. 2010; 12:21-6.
21. Whitehead D. Health education, behavioural change and social psychology: nursing's contribution to health promotion? Journal of Advanced Nursing. 2001;34(6):822-32.
22. Kalita A. Maternal behaviour change for child health and nutrition. Mumbai: Social Initiatives Group ICICI Bank; 2006.
23. WHO. A handbook for building skills Counselling for Maternal and Newborn Health Adaptation Guide. Geneva, Switzerland: The Department of Making Pregnancy Safer (MPS), World Health Organization; 2008.
24. Turan S, Elcin M, Uner S, Odaasi O, Sayek I, Senemoglu N. The impact of clinical visits on communication skills training. Patient Education and Counselling. 2009;77:42-7.
25. WHO. Information, education and communication – lessons from the past; perspectives for the future. Geneva, Switzerland Department of Reproductive Health and Research, World Health Organization WHO/RHR/01.22 2001.
26. Visser A, Wysmans M. Improving patient education by an in-service communication training for health care providers at a cancer ward: Communication climate, patient satisfaction and the need of lasting implementation. Patient Education and Counselling. 2010;78:402-8.
27. Koblinsky M, Mathews Z, Hussein J, Mavalankar D, Mridha MK, Anwar I et al, Going to scale with professional skilled care. Lancet. 2006;368:1377-86.
28. Roberts A Pareja R, Shaw W, Boyd B, Booth E, Mata JI. A Tool Box for Building Health Communication Capacity Washington, D.C: Academy for Educational Development; 1995.
29. Jangland E, Gunningberg L, Carlsson M. Patients' and relatives' complaints about ncounters and communication in health care: Evidence for quality improvement. Patient Education and Counselling. 2009;75:199-204.
30. Novick G. Women's Experience of Prenatal Care: An Integrative Review. Journal of Midwifery & Women's Health. 2009;54(3):226-37.
31. Doyle D, Copeland HL, Bush D, Stein L, Thompson S. A course for nurses to handle difficult communication situations. A randomized controlled trial of impact on self-efficacy and performance. Patient Education and Counselling. 2011;82(1):100-9.
32. Subramanian L, Cisek C, Kanlisi N, Pile JM. The Ghana vasectomy initiative: Facilitating client-provider communication on no-scalpel vasectomy. Paient Education and Counselling. 2010;81(3):374-80.
33. UNFPA, ICM. Investing in midwives and others with midwifery skills to save the lives of mothers and newborns and improve their health – Policy and programme guidance for countries seeking to scale up midwifery services, especially at the

community level UNFPA-ICM Joint Initiative to support the call for a Decade for Action for Human Resources for Health made at World Health Assembly 2006.

34. Licquirsh S, Seibold C. Bachelor of Midwifery students' experiences of achieving competencies: The role of the midwife preceptor. Midwifery. 2008;24:480-9.
35. Smith WR. Evidence for the Effectiveness of Techniques To Change Physicial Behaviour. Chest 2000. 2000;118:8S-17S.
36. The LINKAGES Project. Training of Trainers for Negotiating Sustainable Behaviour Change. Washington, DC: LINKAGES, Academy for Educational Development; 2004.
37. Creswell JW. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 3rd ed. California: SAGE Publications, Inc.; 2009.
38. Michie S, Johnston M, Abraham C, Lawton R, Parker D, Walker A, et al. Making psychological theory useful for implementing evidence based practice: a consensus approach. QualSaf Health Care. 2005;14:26-33.
39. The David & Lucile Packard Foundation, John Hopkins Bloomberg School of Public Health centre for Communication Programs. An Interpersonal Communication and Counseling (IPC/C) Skills Training Manual for Health care Providers – Participant's Manual. FIRST KLASS, Ku Saurara!; 2006.
40. Miles MB, Huberman AM. An Expanded Sourcebook Qualitative Data Analysis 2nd ed. London: SAGE Publications International Educational and Professional Publisher; 1994.
41. Davis BG. Collaborative Learning: Group Work and Study Teams Tools for Teaching (1993). San Francisco: Jossey-Bass Publishers Retrieved 14th August 2010 from http://teaching.berkeley.edu/bgd/collaborative.html 2002.
42. Euliano TY. Small group teaching: Clinical correlation with a human patient simulator. AdvPhysiol Educ. 2001;25:36-43.
43. O'Brien R. An Overview of the Methodological Approach of Action Research 2001: Retrieved 2nd April from http://www.webnet/~robien/papers/arfinal.html
44. CHANGE. Maternal Survival: Improving Access to Skilled Care A Behavior Change Approach. Washington DC: CHANGE/Manoff group; 2005.
45. Donabedian A. Criteria, Norms and Standards of Quality: What Do They Mean? Am J Public Health. 1981;71:409-12.
46. Mesquita AR, LyraJr DP, Brito GC, Balisa-Rocha BJ, Aguiar PM, de Almeida Neto AC. Developing communication skills in pharmacy: A systematic review of the use of simulated patient methods. Patient Education and Counseling. 2010;78:143-8.
47. F.M.O.H. Family Planning Training for Physicians and Nurses/Midwives – National Training Manual Abuja, Nigeria: COMPASS Project, USAID, and VISION Project; 2005.
48. F.M.O.H, PATHS, DFID, WHO. Training Manual on Life Saving Skills for Nurses/Midwives Abuja, Nigeria: PATHS & Federal Ministry of Health, Nigeria; 2005.
49. McNiff J. Action research for professional development Concise advice for new action researchers: Copy AR booklet for web site. Retrieved 9th April 2009 for http://jeanmcniff.com/booklet1.html 2009.
50. Amin S, Das J, Goldstein M, (Eldrs.) Are you being served? New Tools for Measuring Service Delivery. Washington DC The International Bank

forReconstruction and Development/ The World Bank; 2008.

51. McBride R, Schosak J. Chapter 3: Researching action and change. Retrieved 2nd April from http://www.equirylearning.net/ELU/Issues/Research/Res1Ch3.html; 2009.
52. Lie K. Validity & Reliability In Quantitative Research. Study Notes 2009; 3: retrieved 9th April from http:qmu.ac.uk/psych/RTrek/study_notes/web/sn3.htm.
53. Bradley J, Lynam PF, Dwyer JC, Wambwa GE. Whole-Site Training: A New Approach to the Organization of Training AVSC Working Paper New York: Engender Health. 1998;11 (August).
54. Cano V. Reliability & Validity in Qualitative Research Retrieved 9th April 2009 from http://www.qmuack/psych/RTrek/study_notes/web/sn5htm 2009.
55. Ajayi IO, Oladepo O, Falade CO, Bamgboye EA, Kale O. The development of a treatment guideline for childhood malaria in rural Southwest Nigeria using participatory approach. Patient Education and Counseling. 2009;75:227-37.
56. Harvey SA, Blandon YCW, McCaw-Binns A, Sandino I, Urbina L, Rodriguez C, et al, Are skilled birth attendants really skilled? A measurement method, some disturbing results and a potential way forward. Bull World Health Organ 2007;85(10):783-90.
57. Lamiani G, Furey A. Teaching nurses how to teach: An evaluation of a workshop on patient education. Patient Education and Counseling. 2009;75:270-3.
58. Helitzer DL, LaNoue M, Wilson B, de Hernandez BU, Warner T, Roter D. A randomized controlled trial of communication training with primary care providers to improve patient-centeredness and health risk communication. Patient Education and Counseling 2011;82(1):21-9.
59. CRR, WARDC. Broken Promises: Human Rights, Accountability, and Maternal Death in Nigeria. United States: Center for Reproductive Rights/Women Advocates Research and Documentation Centre; 2008.
60. Boscart VM. A communication intervention for nursing staff in chronic care. Journal of Advances Nursing. 2009;65(9):1823-32.
61. Griffin SJ, Kinmonth A-L, Veltman MWM, Gillard S, Grant J, Stewart M. Effect on Health-Related Outcomes of Interventions to Alter the Interaction Between Patients and Practitioners: A Systematic Review of Trials. Annals of Family Medicine. 2004 NOVEMBER/DECEMBER 2004;2(6):595-608
62. Kriebs JM, Shannon M. HIV Counseling and Testing in Pregnancy. Journal of Midwifery & Women's Health. 2008;53(3):265-7.
63. UNICEF. Child Survival – The state of the world's children 2008. New York: United Nations Children's Fund (UNICEF). 2008.
64. Ratanawongsa N, Wright SM, Vargo EM, Carrese JA. Challenges in primary care relationships: Seeing it from both sides. Patient Education and Counseling. 2011;85(1):40-5.
65. Knoll J, Van Linge, R. Innovative behavior: the effect of structural and psychological empowerment on nurses. Journal of Advanced Nursing. 2009;65(2):359-70.
66. Petterson KO, Johansson E, Pelembe MDM, Dgedge C, Christensson K. Mozambican Midwives' Views on Barriers to Quality Perinatal Care. Health Care for Women International. 2006;27:145-68.
67. The World Bank. Communicating the Impact of Communication for Development Recent Trends in Empirical Research World Bank Working Paper No. 120. Washington, DC: The InternationalBank for Reconstruction and Development/ The World Bank; 2007.

Acknowledgement:

Supported by the University of KwaZulu-Natal (UKZN) in form of a Doctoral Research Grant Award received by the first author in the course of the project. There is no conflict of interest.