NWU®

The characteristics of kind and compassionate care during childbirth according to midwives

SS Krause

orcid.org 0000-0001-8363-1040

Dissertation submitted in partial fulfilment of the requirements for the degree *Master in Nursing Science* at the North-West University

Supervisor: Prof CS Minnie

Co-supervisor: Prof SK Coetzee

Graduation October 2018

Student number: 20357842

PREFACE

Report outline

This report was compiled using the North West University (NWU) Manual for Master's and Doctoral Studies (NWU, 2016:22) article format. In accordance with the guidelines, one manuscript was formulated following the instructions of the Bio Med Central (BMC) Pregnancy and Childbirth Journal. Resultantly, repetition of sections is inevitable, with some sections repeated verbatim.

The following structure will be followed:

Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Article manuscript: **The characteristics of kind and compassionate care during childbirth according to midwives**

Chapter 4: Evaluation of the study, limitations and recommendations for future midwifery practice, research, education and policy.

The study was carried out, and written by the researcher – Samantha Salome Krausé, Open Researcher and Contributor Identification Number (ORCID), 0000-0001-8363-1040, under the supervision of the principle study leader, Professor C.S. Minnie and Professor S.K. Coetzee.

The referencing style used was the NWU Harvard style, as in The North-West University Guide (NWU: 2012), with the exception of Chapter three, where the author guidelines of the BMC Pregnancy and Childbirth Journal was followed.

ACKNOWLEDGEMENTS

I would like to express my deep gratitude and appreciation to the following people:

- To my husband, Damien Krausé, thank you for your never-ending love, support and encouragement. You are both my anchor and compass. “Love and compassion are necessities, not luxuries. Without them humanity cannot survive.” (Dalai Lama)

- To my son, Judah Krausé, thank you for being my joy and light. “Spread love everywhere you go, let no one ever come to you without leaving happier.” (Mother Theresa)

- To my Mom and Dad, Annelie and Gerhard Naus, thank you for always making sure I had the best in life and for providing me with privileges that I am still reaping the rewards from. “Kindness in words creates confidence. Kindness in thinking creates profoundness. Kindness in giving creates love.” (Lao Tzu)

- To my in-laws, Lindy and Rob Krausé, thank you for your continuous support and making the impossible possible. “A single act of kindness throws out roots in all directions, and the roots spring up and make new trees.” (Amelia Earhart).

- To my brothers Matthew and Gerard Naus (as well as my sister in-law Nadine Naus), thank you for your encouragement and love. “No act of kindness, however small, is ever wasted.” (Aesop)

- To one of my oldest and dearest friends, Stacey Viljoen, thank you for your unceasing interest and praise. “Compassion is not a relationship between the healer and the wounded. It’s a relationship between equals. Only when we know our own darkness well can we be present with the darkness in others. Compassion becomes real when we recognize our shared humanity.” (Pema Chodron)

- To my study leader, Professor Siedine K. Coetzee, thank you for your patience and reassurance. You are an inspiration. “Educating the mind without educating the heart is no education at all.”(Aristotle)

- To the designer and principle investigator of the full study (to which mine was a sub-study) Professor C.S. Minnie, thank you for your motivation in getting this leg of the project done. “My wish for you is that you continue. Continue to be who you are, to astonish a mean world with your acts of kindness.” (Maya Angelou)

- To the ladies whom I share an office as well as a piece of my heart with – Dibolelo Lesao; Johandi Neethling; Kgomotso Mathope, Olivia Ngami and Stephani Botha, thank you for all the laughs and upliftment. “Kindness is a language that the deaf can hear and the blind can see.” (Mark Twain)

- To my colleagues at the School of Nursing Science, thank you for always teaching me something new. You are a woman amongst woman. “Everyone you meet is fighting a battle you know nothing about. Be kind. Always.”

- To the PLUME FUNDISA/NRF grant for the project: *“Improving quality of midwifery care through implementation of evidence-based strategies – Promoting kind and compassionate care during childbirth* of CS Minnie”. Thank you for carrying the study financially.

ABSTRACT

Background

Although compassion is considered to be of prime importance in nursing and midwifery care, there is no clear understanding of what compassionate care in childbirth entails, and how midwives' perceive compassionate care is largely unknown. This study accordingly seeks to explore and describe the characteristics, as perceived by midwives, of kind and compassionate care during childbirth.

Methods

A qualitative descriptive inquiry was undertaken by means of a voluntary online survey, where participants were recruited via snowball sampling on the social networking site Facebook. The participants were midwives, and the unit of analysis was the received response. Participants gave written responses reporting on instances of kind and compassionate care during childbirth. The data was thematically analysed using Tesch's eight steps to identify common themes.

Results

Ninety-eight responses from participants were analysed and three themes and 11 sub-themes emerged as dominant characteristics. Themes and sub-themes were as follows: making meaningful connections with patients (displaying good interpersonal skills, conduct based on dignity and respect, establishing trust); initiating individualised understanding of each patient (showing empathy, being patient, permitting maternal choice, promotion of advocacy, non-judgemental attitude) and action through care and support (providing emotional support, assistance through instrumental support, continuous informational support).

Conclusion

In seeking to determine what characterises compassionate care, a pivotal consideration is relationship based on trust involving a distinctive understanding of the individual patient and her individual needs. Unique to this study was the finding that participants regarded advocacy as a characteristic of compassionate midwifery care. There was also an emphasis on not judging the labouring woman, as it hindered the connected relationship created. By acting on the information gathered through connections and shared

understandings the midwife provides compassionate emotional, instrumental and informational care and support. Better understanding of how midwives perceive compassionate care could potentially improve the quality of care midwives offer during childbirth.

Keywords

Attributes, kindness, compassion, labour, birth, midwifery, perception, understanding, thematic analysis

LIST OF ABBREVIATIONS

BMC	Bio Med Central
FUNDISA	Forum of University Deans of South Africa
HREC	Health Research Ethics Committee
ICM	International Confederation of Midwives
NRF	National Research Foundation
NWU	North West University
ORCID	Open Researcher and Contributor Identification Number
POPI	Protection of Personal Information
SANC	South African Nursing Council
SNS	Social Networking Site
UN	United Nations
WHO	World Health Organisation

TABLE OF CONTENTS

PREFACE .... **I**

ACKNOWLEDGEMENTS .... **II**

ABSTRACT .... **IV**

LIST OF ABBREVIATIONS .... **VI**

CHAPTER 1: OVERVIEW OF THE STUDY **1**

1.1 Introduction **1**

1.2 Background and rationale for the study **1**

1.3 Problem statement **5**

1.4 Research aim and objective **5**

1.5 Central theoretical argument **6**

1.6 Research design **6**

1.7 Research methods **6**

1.7.1 Population 6

1.7.2 Sampling method 6

1.7.3 Sample 7

1.7.4 Data collection 8

1.7.5 Data analysis 9

1.7.6 Trustworthiness 10

1.7.7 Ethical considerations 11

1.8 Conclusion **12**

CHAPTER 2: LITERATURE REVIEW 13
2.1 Introduction 13
2.2 Search strategy 14
2.3 Sympathy, empathy and compassion 14
2.4 Kindness and compassion 16
2.5 Characteristics of compassion 16
2.6 The process of compassion 17
2.7 Research on compassion in nursing fields 19
2.7.1 Elderly care 20
2.7.2 Medical-surgical care 21
2.7.3 Emergency care 21
2.8 Compassion in midwifery 22
2.9 The "good midwife" 24
2.10 Conclusion 26

CHAPTER 3: ARTICLE MANUSCRIPT 27
3.1 Chapter three outline 27
3.2 Section I 27
3.3 Section II 38
3.4 Section III 39

CHAPTER 4: EVALUATION, LIMITATIONS AND RECOMMENDATIONS 69
4.1 Introduction 69

4.2 Evaluation of the study **69**

4.3 Limitations of the study **70**

4.4 Recommendations **70**

4.4.1 Recommendations for midwifery practice 70

4.4.2 Recommendations for midwifery research 71

4.4.3 Recommendations for midwifery education 72

4.4.4 Recommendations for policy 72

4.4.5 Recommendations for management 72

4.5 Conclusion **73**

REFERENCE LIST **74**

APPENDIX A – SURVEY QUESTIONS **84**

APPENDIX B – INTRODUCTION PAGE AND INFORMED CONSENT **86**

APPENDIX C – ETHICS APPROVAL FROM NORTH-WEST UNIVERSITY **88**

APPENDIX D – LANGUAGE EDITING REPORT **89**

ADDENDUM A - PROMOTING KIND AND COMPASSIONATE CARE FACEBOOK PAGE SCREENSHOT **90**

ADDENDUM B – EXAMPLE OF POST ON FACEBOOK PAGE INVITING POTENTIAL PARTICIPANTS TO PARTAKE IN THE STUDY **91**

LIST OF TABLES

Table 1-1: Inclusion & exclusion criteria with rationale 8

CHAPTER 1:
OVERVIEW OF THE STUDY

1.1 Introduction

This is a sub-study of a larger study titled "Promoting kind and compassionate care during childbirth". The larger study is led by the principal investigator Prof CS Minnie as part of the PLUME program of the Forum of University Deans of South Africa (FUNDISA) and funded by the National Research Foundation (NRF). The findings of this sub-study will contribute towards the overall larger study goal of promoting kind and compassionate care during childbirth and improving the quality of midwifery care through implementation of evidence-based strategies.

This chapter outlines the background and problem statement and identifies the research question, aim and objective. A general overview of the study is presented through explanation of the research design and method and indication of applicable ethical considerations.

1.2 Background and rationale for the study

Midwives are often the main caregivers caring for healthy women during childbirth (Brodie, 2013:1075; Feijen-de Jong *et al.,* 2017:157; ICM, 2013:19) and have been referred to as the "backbone" of maternal and newborn care (Brodie, 2013:1075). How the midwife cares for the woman during childbirth is associated with deep personal and cultural significance for the woman herself and for her family (White Ribbon Alliance, 2011:1). Recently, however, there have been an alarming number of reports of disrespect and abuse during childbirth (Bowser & Hill, 2010:6; Freedman & Kruk, 2014:1; Goer, 2010:33-35; Honikman *et al.,* 2015:284; Human Rights Watch, 2011; Kruger & Schoombee, 2009:84-85; White Ribbon Alliance, 2011:1-2). This has been noted by the World Health Organization (WHO) as a serious problem that needs urgent attention (WHO, 2014).

Every women has the right to the highest attainable standard of health, which includes the right to dignified, respectful care (WHO:2016), and a recent WHO advisory on positive childbirth experience makes recommendations on how to manage and minimise

disrespect and abuse by providing compassionate care to all women (WHO, 2018:19-21, 23, 25, 32, 93, 96, 157).

Compassion is referred to in the literature in terms of adding quality to patient care (Sinclair *et al.,* 2016a:1, 8, 10; Sinclair *et al.,* 2016b:193). To confront the problem of disrespect, a "culture of compassionate care" has therefore been encouraged globally in nursing and midwifery care. One of the first countries to implement this on a national basis has been the United Kingdom. The guiding principles are the so-called "6 C's": care, compassion, courage, communication, commitment and competence (Cummings & Bennett, 2012:10, 13), originally devised for general nurses in an attempt to improve the quality of care delivered, but subsequently sifting through to midwifery practice. Largely unknown, however, is how midwives perceive compassionate care during childbirth (Ménage *et al.,* 2017:558-560).

The term *midwife* signifies "a person trained to assist at childbirth" (The Pocket Oxford Dictionary, 2000:562). In the fuller internationally accepted definition pioneered by the International Confederation of Midwives (ICM) in collaboration with the WHO and the United Nations (UN), a midwife is

> *a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title "midwife"; and who demonstrates competency in the practice of midwifery. (ICM, 2011:1)*

As defined by the South African Nursing Council (SANC), midwifery is

> *a caring profession practised by persons registered under this Act [Nursing Act 2005], which supports and assists the health care user and in particular the mother and baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium. (Nursing Act, 2005:5)*

Globally, the ICM guides midwifery associations and their governments on the essential competencies for basic midwifery practice (ICM, 2013:1). Once deemed competent, the midwife may practice in whichever context is applicable: the home, the community, hospitals, clinics or health units (ICM, 2013:2). The competent midwife then works

together with women, taking full responsibility and liability for their pregnancy, labour and puerperium care (ICM, 2011:1).

The ICM (2013:19) defines competence for midwives as “a combination of knowledge, professional behaviour and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and practice.” Seven basic obligatory competencies are set out and explained in terms of key knowledge and skills needed to be considered competent.

The seven basic competencies are in each case competency in

- social, epidemiologic and cultural context of maternal and newborn care
- pre-pregnancy care and family planning
- care during pregnancy
- care during labour and birth
- care during the postpartum period
- postnatal care of the newborn
- facilitation of abortion-related care (ICM, 2013:3-18).

The focus in the international and the national definitions of a midwife, and also the focus of midwifery associations, is clearly on the minimum cognitive and psychomotor competencies required of a midwife (Byrom & Downe: 2010:127; Fraser, 1999:105-106; ICM, 2011:1; ICM, 2013:3-18; McCourt & Pearce, 2000:149-151; Nicholls & Webb, 2006:415; Nursing Act, 2005:5). However, in the last decade midwifery has also started to focus on the affective domain in addition to the cognitive and psychomotor competencies required of a midwife (Byrom & Downe, 2010:127). A “good midwife”, so termed, is one who is competent in the cognitive, psychomotor and affective domains (Borrelli 2014, 3-5; Byrom & Downe, 2010:126; Nicholls & Webb, 2006:427). Competency in the affective domain has been described as use of soft skills such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 130, 135; Masala-Chokwe

& Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427), of which compassion is considered to be of prime importance (Sinclair *et al.,* 2016b:194).

The term *compassion* stems from the Latin *com*, meaning together with and *pati*, meaning to suffer (Shantz, 2007:48). In this study, the definition of compassion by Sinclair *et al*., (2016a:6) as "a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action" will be adopted. Actions taken to alleviate suffering and needs of a person, along with deeds of kindness, will be understood as the action component in compassion (Sinclair *et al*., 2016a:2-3, 8, 10). Deeds of kindness will be understood as actions taken beyond the normal or routine ambit of the midwife's care: supererogatory deeds, expressed in metaphorical terms as "going the extra mile" or "going above and beyond" (Sinclair *et al*., 2016a:8). Thus, *compassion and kindness* will be regarded as a single term, and in mention of compassion kindness is simultaneously assumed.

Compassion tends to be referred to in the literature along with deeds of kindness (Goetz *et al.,* 2010:352, 354, 364; McCaffrey & McConnell, 2015:3010; McConnell, 2015:96-98) which are not obligatory and not rewarded financially (Sinclair *et al.,* 2016a:1, 3, 6, 8). These deeds are seen as acts performed that are not usually considered part of the midwife's regular care (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair *et al.,* 2016a:8) – described by Sinclair *et al.* (2016a:8) as "going above and beyond".

In a conceptual analysis conducted by Ménage *et al.* (2017:559) no account was found in the current body of knowledge of how compassion is perceived by midwives. Compassion was discussed as a process in midwifery care and expressed in a model based primarily on studies related to nursing and health care. The process begins with acknowledgement of suffering that stimulates emotions experienced by the midwife, motivating him/her to relieve the suffering through subsequent deeds (Ménage *et al.,* 2017:558-560, 563).

Compassion is thus undeniably sought for in nursing and midwifery care (Burnell, 2013:180; Crawford *et al*., 2014:3589; Graber & Mitcham, 2004:87-88; Hall, 2013:269; Strauss *et al*., 2016:15). Nonetheless, there is no agreed-upon definition of compassion in the literature (Dewar *et al*., 2014:1738, Goetz *et al*., 2010:351, Sinclair *et al*., 2016 a:1, Strauss *et al*., 2016:15, Way & Tracy, 2012:292) nor is there a clear understanding of

compassion in midwifery (Ménage *et al.,* 2017:558-559). This study accordingly sought to explore and describe the characteristics of what midwives regard as kind and compassionate care during childbirth.

1.3 Problem statement

Midwives work together with women during their pregnancy, labour and puerperium stages, and global standards have been set for the minimum cognitive and psychomotor competencies required of a midwife (ICM, 2013:3-18). However, recent literature has seen new focus on the notion of the *good midwife*, which includes affective competencies. Competency in the affective domain has been described as the use of emotions and feelings such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 135; Masala-Chokwe & Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427) of which compassion is considered to be of prime importance (Sinclair *et al.,* 2016b:194) and pivotal to quality nursing and midwifery care (Shantz, 2007:48; Ménage *et al.,* 2017:558). Although researchers are exploring the term compassion in nursing (Blomberg *et al.,* 2016:137; Downs, 2013:53; Ellis-Hill, 2011:6; Goetz *et al.*, 2010:351; Graber & Mitcham, 2004:87; Halifax, 2011:146; McConnell, 2015:96-97; Shantz, 2007:48; Sinclair *et al.*, 2016a:1; Sinclair *et al.*, 2016b:193, Strauss *et al.*, 2016:15), little is known about what constitutes compassion in midwifery (Ménage *et al.,* 2017:558) – compassion which authors consider to be essential for improvement of midwifery care (Byrom & Downe, 2010:126, 135; Ménage *et al.,* 2017:558-559; Nicholls & Webb, 2006:414, 427) and for reducing the incidence of disrespect and abuse (Freedman & Kruk, 2014:1-2).

From this problem statement the following research question arises:

What are the characteristics of kind and compassionate care during childbirth as perceived by midwives?

1.4 Research aim and objective

Aim of the study

To create awareness amongst midwives in regard to kind and compassionate care and contribute to promote kind and compassionate care by midwives during childbirth, for ultimate improvement of the quality of care rendered.

Research objective

To explore and describe how midwives perceive the characteristics of kind and compassionate care during childbirth.

1.5 Central theoretical argument

The central theoretical argument of this study is that exploring and describing the characteristics of kind and compassionate care during childbirth as perceived by midwives will create awareness and contribute to promote kind and compassionate caregiving by midwives during childbirth, thereby improving the quality of care and reducing the incidence of disrespect and abuse during childbirth.

1.6 Research design

A qualitative descriptive research design was chosen as best fitting the research problem of deficit in the understanding of what constitutes kind and compassionate care in midwifery, calling therefore for exploration and description (Creswell, 2009:18). This type of design suits description of accounts from practice to develop meaningful understanding of an ill-explored concept (Sandelowski, 1997:128).

1.7 Research methods

The research methods for this study as briefly outlined below include population and sampling, data collection, data analysis and ethical considerations.

1.7.1 Population

The target population was midwives practicing in South Africa and elsewhere. The units of analysis were the responses from each midwife, not the midwives themselves.

1.7.2 Sampling method

Snowball sampling was done via Facebook groups. Facebook was chosen as the social networking site (SNS) best suited for recruitment of potential participants in view of its size, features, intensive use, and continuing growth (Bhutta, 2012:57). SNS's offer new ways for researchers to conduct studies quickly and cost-effectively, particularly in constructing snowball samples for exploratory work (Bhutta, 2012:59; Murray & Fisher, 2002:10).

A Facebook page was created and named “Promoting kind and compassionate care during childbirth” (see Addendum A). The target population was recruited through midwife-based groups and pages on Facebook using the search words “midwife” and “childbirth”.

A notice addressed to interested midwives was posted on group pages identified as midwife-based, inviting them to participate in the proposed study via a link to the study’s Facebook page (see Addendum B). Typically, each Facebook user has their own network of friends, family and Facebook groups (virtual communities linking people with common interests). Interested midwives were invited to like and share the study’s Facebook page; this increased the likelihood of other midwives taking cognizance of the study, thereby propelling the snowball sampling process.

1.7.3 Sample

The participant units in the study were completed responses from midwives who met the inclusion criteria set out in Table 1-1. The researcher considered a response as completed when all 10 of the questions were answered without any having been skipped. As the objective of this study was explore and describe how midwives perceive the characteristics of kind and compassionate care during childbirth, no limit was placed on the number of responses received. If there were more than one incident midwives wished to report, they were invited to do so, since any incident profound enough to make an impact on the midwife was deemed relevant. There were no exclusion criteria. Unrelated and incomplete responses and where participants did not answer the open-ended question were cleaned before data analysis.

The researcher could not predict a specific sample size due to the exploratory nature of the research question and the unpredictability of the number of replies. Hill (1998:4) indicates a wide range of possibilities (from 30 to 500) for recommended sample size in an online survey. It was accordingly estimated that the sample size would be around 100, in view of the qualitative nature of the study. Number of completed responses ultimately received was 98. In an online survey reported by Bhutta (2012:67-68), the majority of the responses were received within the first few days following the survey launch. However, in this study less than 50 responses were received within the first month and a second invitation was therefore posted on the Facebook page. A further 48 responses were then

received in the subsequent two months. As previously explained, no limit was placed on the number of responses that could be submitted by each participant.

Table 1-1: Inclusion & exclusion criteria with rationale

Inclusion criteria	Rationale
Midwives who have experience in assisting women during childbirth	No time limit is placed on experience, as any life event that has made an impression on the midwife will be relevant.
Midwives who have internet access	Recruitment through Facebook group.
Exclusion criteria	**Rationale**
None applied	

1.7.4 Data collection

The survey was open for 3 months for data collection from 13 December 2016 to 13 March 2017. The Facebook page contained a direct link to the SurveyMonkey electronic platform used for the self-administered survey was hosted. SurveyMonkey was chosen as the online site to collect and store data in view of favourable features it offers such as affordability, easy format and possibility to set up the survey as desired (Survey Monkey, 2018:online). Electronic surveys have been reported as equivalent to paper-based surveys in terms of internal reliability and completion rates (Denscombe, 2006:246; Joubert & Kriek, 2009:78). The benefits of online surveys are that they save time, are cost-effective, and can be accessed quickly by people with shared characteristics from widely separated geographical locations (Callegaro *et al.,* 2015:18-23; Wright, 2005).

The self-administered survey consisted of a demographic section with five closed-ended questions and three open-ended questions (see Appendix A). The closed-ended questions (with the options for choice of one standard answer indicated in brackets) were as follows:

- What is your gender? (male or female)
- Where do you practice midwifery? (rural area or urban area)

- In which facility do you practice midwifery? (state hospital, private hospital, community health centre, private practice that is midwife-lead or other)
- How many years' experience do you have working as a midwife? (1-5 years, 5-10 years, 10-20 years, 20-30 years or 30 plus years)
- Is this the first time you are answering the survey? (yes or no).

Concise instructions were given, followed by the three open-ended questions. Two were explicitly phrased:

- Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth.
- List five words that you associate with kind and compassionate maternity care.

The third made provision for participants to contribute any additional comments. Once the survey was complete, the participant was asked to click on the "submit" button.

According to Callegaro *et al.,* (2015:69), an advantage of open-ended questions is that participants have an opportunity to re-tell a life event that made an impact on them in as much detail as needed, thereby revealing how the concept is perceived (in this case, by the midwife). Closed-ended questions, on the other hand, do not provide much insight. The disadvantage of open-ended questions is that it might be a cognitive strain to answer them; they were accordingly kept to a minimum in this study (Callegaro *et al.,* 2015:69).

1.7.5 Data analysis

Thematic analysis was the most appropriate means to analyse this data set, as the objective of the study was to explore and describe the characteristics of a specific concept. Braun and Clarke (2006:79) explain that thematic analysis is "a method of identifying, analysing and reporting patterns within data." Patterns can also be referred to as themes. This makes it possible to identify a common train of thought in the responses received from the participants (Morse & Field, 1995:139, Vaismoradi *et al.*, 2013:400).

The data analysis took place as follows: the data were transferred to an Excel spreadsheet and then imported into the qualitative research program Atlas.ti 8, which was

used to process the large amount of data into a smaller set of easily readable interpreted themes (Burns & Grove, 2009). The data were managed and arranged by numbers according to the sequence in which responses were received. As this was an anonymous survey, there were no other identifiable data.

Thematic analysis was carried out according to Tesch's eight steps as explained by Creswell (2009:186). The data set was read over to obtain a general idea of what was said. Next, it was looked at in greater detail to begin the coding process. Coding is defined by Creswell (2009:186) as the process of taking a large amount of data and breaking up into smaller sections before attaching meaning to it. These smaller sections were named following the open coding process of giving labels or renaming sections of the data set to find and categorise shared meanings (Morse & Field, 1995:140). The data set was read through again to get an idea of what participants had to say. A handful of the most interesting responses from participants were identified and read through several times to determine their fundamental meaning. A list of topics surfaced that had been brought up several times by different participants. New categories originated from reading through the responses from the participants again. These were then refined and grouped according to similar meanings, resulting in a list of final categories – labelled as themes – which had come to light (Creswell, 2009:186).

1.7.6 Trustworthiness

The four fundamental epistemological standards listed by Lincoln and Guba (1985) were applied to ensure the trustworthiness of this qualitative study. Theoretical validity was provided by conceptualisation of the central concepts described in the study (Botes, 2003).

Prolonged engagement in the field of midwifery and in the collection and analysis of data, and peer debriefing with the principle investigator and co-supervisor, enhanced the credibility of the study findings. Transferability was strengthened by providing a thorough account of the research process applied in the study and by analysing all data entries even after data saturation was reached. The dependability of the study was enhanced through review, approval and monitoring from the applicable scientific committees and study leaders associated with this study. A co-coder (a Honours Psychology student) was assigned to thematically analyse the data set. The codes were subsequently worked on

individually. The researcher and the co-coder obtained inter-coder agreement regarding the open codes (Creswell, 2009:187). The researcher declares a non-biased approach to the study, increasing the confirmability of the results.

1.7.7 Ethical considerations

Ethical approval was granted by the INSINQ Scientific Committee and the Health Research Ethics Committee (HREC) of North-West University (NWU) for the overall project: Promoting kind and compassionate care during childbirth. This sub-study addresses the second objective, namely: “To explore and describe characteristics of kind and compassionate care according to midwives” (NWU-00072-16-A1 – see Appendix C). As the study took place online, no further legal authorization or goodwill consent was necessary.

1.7.7.1 Informed consent

The link to SurveyMonkey took potential participants to an introduction page which was simultaneously utilized as the informed consent (see Appendix B). The introductory page stipulated the criteria that the participants should meet, what was expected from the participants, the questions that the participant was expected to answer, the risks and benefits of the study, the fact that participants may withdraw from the study at any time, and ended with a statement that multiple submissions will be accepted. The participant could withdraw from the study at any time by exiting the SurveyMonkey page. Potential participant who agreed with the above-stated conditions were requested to click on a specified button to complete the online survey.

1.7.7.2 Anonymity and confidentiality

Anonymity was ensured as no names or contact details were requested. Theoretically, through a default option in SurveyMonkey (2018:online), the computer from which the survey was completed could however be identified by the IP address; to prevent this, the anonymous response option was activated. The completed surveys were identified in the sequence in which participants submitted them. Anonymity and confidentiality was thus not compromised (Buchanan & Hvizdak, 2009:43).

1.7.7.3 Risks and benefits

The estimated level of risk for the participants was estimated to be minimal, as the focus of the study was on positive experiences. A low risk of psychological discomfort was identified, as the participant might be reminded of their own or witnessed negative childbirth experiences. In this instance, the participant was encouraged to contact the researcher via email, and psychological support would be arranged by the researcher. Such an incident did not occur.

The survey was not time-consuming, as the expected completion time was 15 to 30 minutes. There was no direct benefit for the participant; benefit was indirect in ultimately contributing to the improvement of practice. There was no remuneration or reimbursement for the participant.

1.7.7.4 Data management and security

The researcher, the supervisor's and the co-coder were the only people that had access to the anonymous data set. The researcher ensured that the electronic data would remain confidential (Protection of Personal Information [POPI] Act 4 of 2013) by password protecting all electronic equipment storing the data set. The electronic copies of the data will be stored on an external storage device post data analysis, in a locked cupboard in the principle investigator's office. This includes any hard copies of the data set. The electronic and hard copies will be destroyed after five years.

1.8 Conclusion

This concludes the overview and introduction for the study "The characteristics of kind and compassionate care during childbirth according to midwives". The background and problem statement were discussed, the research question, aims and objectives were identified, the research design, method and analysis were described, and the applicable trustworthiness and ethical considerations were highlighted.

CHAPTER 2:
LITERATURE REVIEW

2.1 Introduction

Chapter one presented an overview of the study providing background and rationale, identified the research aim and objective, discussed the research design and method and identified the ethical considerations.

In this chapter, a literature review is provided to indicate what is currently known about the characteristics of kind and compassionate care during childbirth as perceived to midwives. As stated by Botma *et al.* (2010:63-64), the aim of a literature review is to assess what is presently known about a phenomenon and present a frame of reference that shows how the findings of the study will contribute towards the existing body of knowledge.

A disturbing phenomenon noted in Chapter one is the occurrence of disrespect and abuse during childbirth (Bowser & Hill, 2010:6; Freedman & Kruk, 2014:1; Goer, 2010:33-35; Honikman *et al.*, 2015:284; Human Rights Watch, 2011; Kruger & Schoombee, 2009:84-85; White Ribbon Alliance, 2011:1-2). Documenting this as a pressing problem, the WHO stresses that every women has the right to the highest attainable standard of health (WHO:2016), including the right to dignified, respectful care and advises that providing compassionate care to all women should ultimately reduce the incidence of disrespect and abuse (WHO, 2018:19-21, 23, 25, 32, 93, 96, 157).

As highlighted in Chapter one, international standards have been set for the minimum cognitive and psychomotor competencies required of a midwife (ICM, 2013:3-18). The recent focus in the literature on the concept of the "good midwife", brings in the issue of affective competencies. Competency in the affective domain has been reported to include the effects of emotions and feelings such as compassion, kindness, empathy and support (Byrom & Downe, 2010:126, 135; Masala-Chokwe & Ramukumba, 2015:1; Nicholls & Webb, 2006:414,427) of which compassion is considered of prime importance (Sinclair *et al.,* 2016b:194) and pivotal to quality nursing and midwifery care (Ménage *et al.,* 2017:558; Shantz, 2007:48).

Although researchers have been exploring the significance of compassion in nursing (Blomberg *et al.,* 2016:137; Downs, 2013:53; Ellis-Hill, 2011:6; Goetz *et al.*, 2010:351; Graber & Mitcham, 2004:87; Halifax, 2011:146; McConnell, 2015:96-97; Shantz, 2007:48; Sinclair *et al.*, 2016a:1; Sinclair *et al.*, 2016b:193, Strauss *et al.*, 2016:15), little is known about what constitutes compassion in midwifery (Ménage *et al.,* 2017:558), which is regarded as a crucial factor in improving midwifery care (Byrom & Downe, 2010:126, 135; Ménage *et al.,* 2017:558-559; Nicholls & Webb, 2006:414, 427) and in reducing the prevalence of disrespect and abuse (Freedman & Kruk, 2014:1-2).

2.2 Search strategy

To find relevant literature addressing the research problem, the following electronic databases was searched: EBSCO Host; Academic Search Premier; CINAHL; ERIC; Health Source: Nursing/Academic Edition; MasterFile Premier; MEDLINE; Pre-CINAHL; PsychINFO; Cochrane Library; SociINDEX with Full Text; Humanities International Complete; Academic Search Complete; Education Research Complete; Science Direct; SAePublications and PubMed Central. Google and Google Scholar were also searched using the advanced option.

Working in conjunction with the subject librarian at the NWU Potchefstroom Campus, the following search words were identified: (midwife* OR maternity care OR nurs*) AND (childbirth OR labour OR care); AND (characteristics OR attributes); AND (kind* OR compassion*). Synonyms for compassion were also searched, such as empathy and sympathy.

2.3 Sympathy, empathy and compassion

Nursing and midwifery literature frequently refers indistinguishably to sympathy, empathy and compassion (Goberna-Tricas *et al.,* 2011:231; Goetz *et al.,* 2010:360; von Dietze & Orb, 2000:116; Shantz, 2007:49) despite these being three distinct concepts (Beaumont & Hollins Martin, 2016:784; Blomberg *et al.,* 2016:138; Sinclair *et al.*, 2016a:1-2; Sinclair *et al.,* 2016b:193; Way & Tracy, 2012:308).

In the reviewed literature, sympathy was collectively defined as feeling for another (Beaumont & Hollins Martin, 2016:784; Ménage *et al.,* 2017:562; Sinclair *et al.,* 2016b:193). Empathy was jointly defined as feeling with another (Beaumont & Hollins

Martin, 2016:784; Goetz *et al.,* 2010:351), and as understanding the feelings of another (Ménage *et al.,* 2017:562). Compassion was defined as feeling together (Dewar, 2013:61; Maben *et al.,* 2009:9), feeling with another (McCaffery & McConnell, 2015:3010), and subsequently performing a deed or deeds (Beaumont & Hollins Martin, 2016:783) to provide relief for suffering or pain (Goetz *et al.,* 2010:351; McCaffery & McConnell, 2015:3010; Ménage *et al.,* 2017:562).

Sinclair *et al.* (2016a:6) set out to define sympathy, empathy and compassion based on the way in which the patient perceived the nurse's reaction to their discomfort. Sympathy was described as being a sorrowful reaction, empathy was found to be an emotional reaction (Sinclair *et al.,* 2016a:6), and compassion was explained as a "virtuous" reaction towards another's anguish (Sinclair *et al.,* 2016b:193). It was further pointed out that sympathy is undesirable and non-beneficial to patients due to minimal insight (Sinclair *et al.,* 2016a:4, 6, 9; Way & Tracy, 2012:307-308) and understanding as to what matters to the patient (Dewar *et al.,* 2014:1743-1744).

Empathy is thought of as the basis for compassion (McCaffery & McConnell, 2015:3012), as it involves feeling with another (Halifax, 2011:146; Sinclair *et al.,* 2016a:4, 9). However, it is frequently remarked that compassion differs from empathy in view of the activities carried out (Goetz *et al.,* 2010:351; McCaffery & McConnell, 2015:3009; Ménage *et al.,* 2017:562; Sinclair *et al.,* 2016a:6, 8-9; Sinclair *et al.,* 2016b:193) in an attempt to alleviate discomfort (Beaumont & Hollins Martin, 2016:783; Dewar & Nolan, 2013:2; Goetz *et al.,* 2010:351; Gustin & Wagner, 2012:2; McCaffery & McConnell, 2015:3008, 3013; Ménage *et al.,* 2017:562; Papadopoulos *et al.,* 2017:289; Shantz, 2007:51-52; Sinclair *et al.,* 2016a:1-4; Sinclair *et al.,* 2016b:193, 197; Straughair 2012a:161; Strauss *et al.,* 2016:15). Way and Tracy (2012:308) state that empathy and sympathy are feeling states. Conversely, compassion goes beyond the feeling state to an action state (Halifax, 2011:146; Sinclair *et al*., 2016a:3, 6, 8), manifested in deeds of displaying kindness (Sinclair *et al.,* 2016a:1, 3, 6, 8; Sinclair *et al*., 2016b:197). Compassion appears to be favoured amongst the three concepts (Blomberg *et al*., 2016:138; Graber & Mitcham, 2004:87; Sinclair *et al.,* 2016a:1, 8; Sinclair *et al.,* 2016b:193). This is supported by Graber and Mitcham (2004:87) along with Way and Tracy (2012:306), as compassion is believed to be preferred by patients due to the deeds of kindness performed.

2.4 Kindness and compassion

Ménage *et al.* (2017:562) define *kindness* in a concept analysis as "the quality of being generous, considerate, friendly and deliberately doing good to others". As stated in Chapter one, compassion tends to be referred to in the literature along with deeds of kindness (Goetz *et al.,* 2010:352, 354, 364; McCaffrey & McConnell, 2015:3010; McConnell, 2015:96-98) that are not compulsory or monetarily remunerated (Sinclair *et al.,* 2016a:1, 3, 6, 8). The deeds are considered to be based on a kind nature, as the acts performed are not usually reckoned as part of the midwife's regular care (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair *et al.,* 2016a:8; Sinclair *et al.,* 2016b:197). The two terms will therefore be merged in this study with *kind and compassionate* regarded as a single concept.

2.5 Characteristics of compassion

Compassion has been cited as possibly the most highly valued attribute in nursing and midwifery care (Burnell, 2009:319; McCaffery & McConnell, 2015:3013; Shantz, 2007:48) and is widely recognised as its core element (Dewar & Christley, 2013:46; Maben *et al.,* 2009:9; McCaffery & McConnell, 2015:3006, 3012, 3013; Strauss *et al.,* 2016:15; von Dietze & Orb, 2000:116; Waugh *et al.,* 2014:1190). Yet how compassion manifests itself when providing care is poorly understood (Brown *et al.,* 2014:384, 387; Dewar *et al.,* 2014:1739; Fry *et al.,* 2013:1; Graber & Mitcham, 2004:88; McCaffery & McConnell, 2015:3006, 3014; Sinclair *et al.,* 2016b:194; von Dietze & Orb, 2000:116; Waugh & Donaldson, 2016:22).

Burnell (2013:180) describes compassion as a constituent of nursing excellence. Moreover, compassion is seen as a vital component for achieving quality nursing and midwifery care (Black, 2008:70; Blomberg *et al.,* 2016:138; Brown *et al.,* 2014:384; Cleary *et al.,* 2015:536; Cummings & Bennett, 2012:13; Fry *et al.,* 2013: 1; Larson *et al.,* 2015:1; Sinclair *et al.*, 2016b:193; Straughair, 2012a:160; Sturgeon, 2010:1047,1050) and it has is furthermore been proposed that more compassion is needed among its practitioners (Crawford *et al.,* 2014:3589, 3590; Dewar & Christley, 2013:47; Ellis-Hill, 2011:6; McCaffery & McConnell, 2015:3012; Taylor, 2015:352).

Nurses and midwives perform a challenging job, generally, moreover, in difficult situations (Sturgeon, 2008:43; Sturgeon, 2010:1050). According to Sinclair *et al.* (2016b:202), the

characteristics of kind and compassionate care will differ, depending on the specific individuals in practice and the practice setting. This is argued as being due to the subjective character of kind and compassionate care (Dewar, 2013:61; Goetz *et al.,* 2010:351; Straughair, 2012b:239; Papadopoulos *et al.,* 2017:291). Way and Tracy (2012:309) affirm that “compassion is in your heart, not your head.” McCaffery and McConnell (2015:3007) aver, in metaphoric terms, that compassion is the genuine heart of nursing. Identifying the exact characteristics of compassion is thus a challenge. Ménage *et al.* (2017:559) have noted that no studies on what compassion means in midwifery care are to be found in the literature.

2.6 The process of compassion

Compassion is described in the literature as a process. Authors agree that compassion usually consists of three phases, beginning with recognising discomfort in others (Dewar, 2013:61; McCaffery & McConnell, 2015:3009; Strauss *et al.,* 2016:15; Way & Tracy, 2012:300), followed by a desire to ease it (Beaumont & Hollins Martin, 2016:784; Dewar & Nolan, 2013:2-3; McCaffery & McConnell, 2015: 3012-3013, 3010; Strauss *et al.,* 2016:15) and concluding with a functional response or action (Strauss *et al.,* 2016:15; Way & Tracy, 2012:300) – the action being constituted by deeds of a kind nature (Sinclair *et al.,* 2016a:1, 3, 6, 8; Sinclair *et al.,* 2016b:197).

In an empirical research study, Sinclair *et al.* (2016b) identify seven phases in the process of compassion. The first phase they refer to as *virtues*, in which the practitioner is described as kind and caring (Sinclair *et al.,* 2016b:197, 199). Similarly, Curtis (2013:746, 748) makes reference to there being a goodness about the practitioner. Blomberg *et al.* (2016:139) link compassion with displaying wisdom, humanity, love and empathy, echoing the description of virtues by Sinclair *et al.,* (2016b:197, 199). Straughair (2012a:160-161) observes that the concept of compassion is based on devout ideals similar to those documented in the Christian and Buddhist religions. This righteous nature of compassion is based on principles of integrity, honesty and purity (McCaffery & McConnell, 2015:3006 - 3008, 3010 - 3011, 3013; von Dietze & Orb, 2000:116).

The second phase, *relational space*, relates to active involvement in caring, shown by understanding and recognising each patient (Sinclair *et al.,* 2016b:199, 202). This is supported by Dewar *et al.* (2014:1741-1742, 1744-1745) and referred to as “relationship

centred care" (Dewar *et al.* 2014:1741). Burnell (2009:319) makes reference to a real connection between the practitioner and the patient. This, according to Gustin and Wagner (2012:8), takes place when the patient and the practitioner make themselves equally subject to feeling vulnerable.

The third phase, *virtuous response*, signifies intentionally becoming accustomed to the patient and recognising matters of great importance to each individual (Sinclair *et al.,* 2016a:8-9; Sinclair *et al.*, 2016b:193, 195-197). This is done through display of genuineness, love, openness, honest, authenticity, care, understanding, tolerance, and acceptance (Sinclair *et al.,* 2016b:197). Ideal care should protect from harm and result in successful recovery.

The fourth phase, *seeking understanding*, is described as searching for insight into the patient and his or her key requirements (Sinclair *et al.,* 2016a:1-4, 6-9; Sinclair *et al.,* 2016b:193-196, 198, 200, 202). Graber and Mitcham (2004:88) state that correct regard of the patient and his or her current situation generates compassion. McCaffery and McConnell (2015:3011) refer to the circumstantial nature of compassion in which each situation presents possibility to apply a unique approach; hence the importance of searching for individualised understanding for each patient.

The fifth phase, *relational communicating*, is described as being demonstrated by deeds (displayed through real actions that are kind), affective nature (expressed through emotions and mindful approach), attitude (revealed through non-verbal body language, and tone used) and participation (shown by listening, two-way communication that is courteous and encouraging) (Sinclair *et al.,* 2016b:196-199, 200, 202). Compassion implies having an affective nature and a deeds-based character (Beaumont & Hollins Martin, 2016:783; Cleary *et al.,* 2015:563; Goetz *et al.*, 2010:351; McCaffery & McConnell, 2015:3008-3009, 3013; McConnell, 2015:96), shown by deeds of kindness to others (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair *et al.,* 2016a:8; Sinclair *et al.,* 2016b:196-197) and to oneself (Beaumont & Hollins Martin, 2016:785). Way and Tracy (2012:310) support the notion that compassion is an assembly of deeds that is built through communicating. Examples of such deeds put forward by Graber and Mitcham (2004:89) are facial expressions such as a smile, and a warm manner of speaking. Cummings and Bennett (2012:13) and Black (2008:71) also emphasize the

importance of listening. Black (2008:71) advises practitioners not to rush when they speak to their patients, as this helps to create a trusting relationship.

The sixth phase, *attending to needs*, is outlined as efforts to meet the requests of the patient promptly, with no hesitation shown (Sinclair *et al.,* 2016b:197-200). Responses or activities carried out in an attempt to alleviate discomfort show the deeds-based character of compassion (Beaumont & Hollins Martin, 2016:783; Dewar & Nolan, 2013:2; Goetz *et al.,* 2010:351; Gustin & Wagner, 2012:2; McCaffery & McConnell, 2015:3008, 3013; Ménage *et al.,* 2017:562; Papadopoulos *et al.,* 2017: 289; Shantz, 2007:51-52; Sinclair *et al.,* 2016a:6-9; Sinclair *et al.,* 2016b:193, 195-199, 200, 202; Straughair 2012a:161; Strauss *et al.,* 2016:15). Sinclair *et al.* (2016a:1, 3, 6, 8, 10) add the qualification that such deeds of kindness are not obligatory and not rewarded financially. Way and Tracy, (2012:306) refer to a further type of compassionate deed not previously noted in the literature which they refer to as *strategic inaction* – when the practitioner takes a moment to stand back and do nothing, simply allowing leeway to just be.

The seventh phase, *patient-reported outcomes*, relates to easing of anguish and promotion of comfort and care (Sinclair *et al.,* 2016a:3, 6, 10; Sinclair *et al.,* 2016b:197, 201-202). Compassion is known to improve patient satisfaction and outcomes (Downs, 2013:53-54; Graber & Mitcham, 2004:87-88; McCaffrey & McConnell, 2015:3006-3007; MacCulloch, 2007:825, 827).

2.7 Research on compassion in nursing fields

Most of the research investigating compassion has been done in the context of nursing fields and an outline will be given here of what is known from these studies

A recent international online survey study undertaken by Papadopoulos *et al.* (2017:286) explored differences and similarities in the perception and display of compassion in nursing praxis. The survey spanned 15 countries with a total population of 1,323 nurses. A range of questions were asked relating to compassion in nursing practice. The data uncovered several themes in relation to the “conscious and intentional nature of compassion”. This was described as spending time with patients and with their families by “going the extra mile” or “giving of oneself”. Examples were given of nursing staff working beyond contracted hours to provide compassionate care (Papadopoulos *et al.,* 2017:289-290). The nurses’ presence was also emphasized, with particular reference to

the intentional nature of the presence (Papadopoulos *et al.,* 2017:291, 293). Compassionate care was also noted as being based on “individuality/personalisation” with some participants referring to being non-judgemental when providing compassionate care (Gustin & Wagner, 2012:8).

Crawford *et al.* (2014:3591) conducted a narrative review to investigate compassion in health care from an organisational perspective, based on the rise in demand for compassionate care. A “compassionate mentality” was understood to be gentle, warm, loving, affectionate, caring, sensitive, helpful, considerate, sympathetic, comforting, reassuring, calming, open, concerned, empathetic, friendly, tolerant, patient, supportive, encouraging, non-judgemental, understanding, giving, soothing, validating, respectful and attentive (Crawford *et al.,* 2014:3592).

The next sections discuss the study of compassion in specific nursing specialisations.

2.7.1 Elderly care

Dewar and Nolan (2013:1) conducted a study outlining compassion in the conditions of acute care for the elderly. The study established that compassion is considered to be of prime importance in quality care for patients. Three paramount characteristics emerged, involving concepts such as emotional support, empathy and exceptional communication with the patient and the family. It was emphasised that empathy was fundamental in creating connections (Dewar & Nolan, 2013:2-3). Similarly, Dewar *et al.*, (2014:1742-1743) found that forging emotional connections and being appreciative were seen as vital elements in providing compassionate care to patients. Burnell (2013:180) adds that these connections need to be significant to have positive impact. This enables individualised understanding of the patient and their accompanying support system (Dewar & Nolan, 2013:2-3).

A qualitative study by van der Cingel (2001:672-685) concentrated on understanding the benefits of compassion in long-term care for the elderly. Seven dimensions of compassion emerged: attentiveness, listening, confronting, involvement, helping, presence, and understanding (van der Cingel, 2011:676). Furthermore, it was pointed out that the family should form part of the decision-making process.

Dewar *et al*. (2014:1738-1747) also focused on elderly care using an appreciative inquiry to identify good compassionate care in ward settings with a focus on emotional connections. Seven C's were summarised as a model of compassionate relationship-centred care: compromising, courageous, considerate, curious, celebratory, collaborative and connecting.

2.7.2 Medical-surgical care

A qualitative descriptive study by Kret (2011:29-36) explored the qualities that a compassionate nurse should possess, according to medical-surgical patients. It was found that attentiveness and caring were the qualities most sought after from a kind and compassionate nurse.

Graber and Mitcham (2004:87) used a phenomenological approach to explore the relationship between kind and compassionate practitioners and patients admitted to hospital. Twenty-four hospital clinicians were interviewed to determine what compassionate practitioners do to form relationship with their patients. It was found that compassionate practitioners develop close, affectionate relationships with patients (Graber & Mitcham, 2004:87).

2.7.3 Emergency care

Fry *et al*. (2013:1) conducted an investigation in Australia among emergency care nurses who had a post-basic speciality qualification on what is needed to provide patients with compassionate care. It was found that nurses who were able to quickly build a therapeutic relationship with their patients effortlessly displayed compassionate caring. Communication by verbal and non-verbal means is essential in showing kind and compassionate caring (Fry *et al.,* 2013:14, Graber & Mitcham, 2004:89). Verbal communication was specifically found to be simple communication employing basic etiquettes such as introducing themselves (Graber & Mitcham, 2004:89). Non-verbal communication was identified as smiling, touch, and eye contact (Fry *et al*., 2013:14). The study concluded that compassionate caring involves an intricate mix between clinical skills and good interpersonal relationships (Fry *et al*., 2013:17).

2.8 Compassion in midwifery

Ménage *et al.* (2017:559) argue that although nursing and midwifery bear many similarities, they are essentially divided by registration and practice within the profession at large. Scientific exploration of compassion within the field of midwifery is lacking (Ménage *et al.,* 2017:559).

Little is known about what constitutes compassion in midwifery (Ménage *et al.,* 2017:558-562), which, according to various authors, is essential for improvement in midwifery care (Byrom & Downe, 2010:126, 135; Ménage *et al.,* 2017:558-559; Nicholls & Webb, 2006:414, 427). To date, few studies have focused on the characteristics of compassion in practice as perceived by midwives.

It is clear that the international, national and nursing association definitions of a midwife focus worldwide on the minimum cognitive and psychomotor competencies required of a midwife (Byrom & Downe: 2010:127; Fraser, 1999:105-106; ICM, 2011:1; ICM, 2013:3-18; McCourt & Pearce, 2000:149-151; Nicholls & Webb, 2006:415; Nursing Act, 2005:5). There is very little mention of the affective competencies required of a midwife.

Compassion in midwifery is a relatively new concept (Goberna-Tricas *et al.,* 2011:31; Hall, 2013:269; Ménage *et al.*, 2017:558, 560) as opposed to compassion in nursing (Burnell, 2013:180; Crawford *et al.,* 2014:2589; Dewar *et al.,* 2014:1739; Goetz *et al.,* 2010:351; Papadopoulos *et al.,* 2017:286; McCaffery & McConnell, 2015:3007, 3013; Shantz, 2007:48; Strauss *et al.,* 2016:15; Sturgeon, 2008:43; Taylor, 2015:352; van der Cingel, 2011: 672; Waugh & Donaldson, 2016:22). There is wide consensus that compassion is needed in midwifery (Butler *et al.,* 2008:260; Byrom & Downe, 2010:126-127, 130; Feijen-de Jong *et al.,* 2017:160; Masala-Chokwe & Ramukumba, 2015:7; Ménage *et al.,* 2017:559; Nicholls & Webb, 2006:427; Waugh *et al.*, 2014:1190-1195), but no accounts of how it is exhibited (Goberna-Tricas *et al.,* 2011:31; Hall, 2013:269; Ménage *et al.,* 2017:558-559).

A conceptual analysis by Ménage *et al.* (2017:559) reported that nothing is to be found in the body of knowledge indicating how compassion is perceived in midwifery. The study conclusively defined compassion as a process in midwifery care, following a model predominantly based on nursing and health care related studies. This process begins with the cognisance of suffering, prompting emotions experienced by the midwife that

motivates him/her to relieve the suffering through deeds (Ménage *et al.,* 2017:558-560, 563) based on kindness (Beaumont & Hollins Martin, 2016:783; Carolan, 2013:115; Sinclair *et al.,* 2016a:8; Sinclair *et al.,* 2016b:197). The affective nature of compassion is highlighted by Ménage *et al.* (2017:558), who note in addition the importance of kinship and connectedness established in the practitioner/patient relationship, coupled with determination to support and encourage women.

Currently there is little mention of compassion in international instructional documentation on midwifery (ICM, 2011:1; ICM, 2013:1-2). It has been suggested that compassion be added as a core competency in nursing and midwifery care (Butler *et al.,* 2008:260; Cummings & Bennett, 2012:13; Dewar & Nolan, 2013:9; Sinclair *et al.,* 2016b:194). The absence in contemporary documents of discussion on compassion as a concept is attributed by Straughair (2012a:163) to the progressive focus in recent decades on cognitive and psychomotor skills, with minimal attention to affective and attitudinal aspects.

Although compassion is not explicitly mentioned in the core documents of the International Confederation of Midwives (ICM), it is implied in the documents like the philosophy and model of care (ICM, 2014), the definition of a midwife (ICM, 2011) and the code of ethics (ICM, 2008). The essential competencies of basic midwifery practice (ICM, 2013) include aspects such as partnership with women to promote self-care, respect for human dignity and advocacy for women so that their voices are heard.

Butler *et al.* (2008:268) stress that essential competencies in midwifery should incorporate the particular characteristics required of a midwife. Butler *et al.* (2008:260) add that compassion as an essential competency should include positive attitude, shown by being caring and kind as the affective component. Masala-Chokwe and Ramukumba, (2015:1, 2, 7) concur, pointing out that compassion in the absence of competence is futile. Larson *et al.* (2015:2, 4), support the notion that midwives need to be competent as well as being kind and compassionate.

The WHO (2015:48) states that all women have the right to favourable and good care, with practitioners treating all women with kindness and compassion (WHO, 2018:25, 32); terms such as *courtesy*, *respect*, *understanding* and *preservation of dignity* feature in the statement. In the latest recommendations (WHO, 2018:25) compassion is discussed in

the context of effective communication skills and companionship during childbirth for creating a positive birth experience. Good quality care is provided through a mix of the best skills and affective component (Larson *et al.,* 2015:2; Masala-Chokwe & Ramukumba, 2015:1; Straughair 2012a:160, 162), specifically in the attitude of the practitioner (Tunçalp *et al.,* 2015:1046-1047), shown by kindness and compassion (Ménage *et al.,* 2017:559).

It is known that midwives practice under high levels of stress (Beaumont & Hollins Martin, 2016:784). This creates a problem when attempting to maintain compassion over long periods of time (Beaumont & Hollins Martin, 2016:777). Midwives are the primary practitioners that care for women during childbirth (Brodie, 2013:1075; Feijen-de Jong *et al.,* 2017:157; ICM, 2013:19). Globally sought after (Brodie, 2013:1075) they need nonetheless, in addition to meeting the minimum requirements of competency, also to be "good midwives" who practice with kindness and compassion (Brodie, 2013:1075; Byrom & Downe, 2010:126-137; Nicholls & Webb, 2006:427).

2.9 The "good midwife"

As discussed in Chapter one, "good midwife" is a term often applied to a midwife who is competent within the cognitive, psychomotor and affective domain (Borrelli 2014: 3-5; Byrom & Downe, 2010:126; Feijen-de Jong *et al.,* 2017:160; Nicholls & Webb, 2006:414). A "good midwife" strives for a physiological approach to birth (Feijen-de Jong *et al.,* 2017:157-158, 160-161), while childbirth itself is typically seen as series of orderly actions that results in a transformative experience (Jacinto & Buckey, 2013:11, Ménage *et al.,* 2017:559).

A "good midwife" meets the essential competencies required in terms of cognitive and psychomotor skills, in addition to displaying a well-developed affective component (Carolan, 2011:503; Carolan, 2013:115). In the literature the cognitive competencies are synonymous with intellectual competencies (Byrom & Downe, 2010:127) and possessing adequate knowledge (Nicholls & Webb, 2006:414). The psychomotor competencies are described in terms of the skill needed to practice as a midwife (Nicholls & Webb, 2006:414) and are collectively referred to as "skilled competence" by Byrom and Downe (2010:129).

The affective competency is explained by Byrom and Downe (2010:126, 130-131,135) as "emotional intelligence" and is believed to promote excellence (Borrelli, 2014:4). This refers to personality traits shown in the midwife, with specific mention of being "approachable" and "adaptable" (Byrom & Downe, 2010:132). Caring personality required of a midwife was explained in terms such as "supportive", "enthusiastic", "understanding", "approachable" and "good leader" (Byrom & Downe, 2010:133). Nicholls and Webb (2006:425) describe caring characteristics as being "pleasant" and "friendly". Terms used in relation to significant personality traits of a "good midwife" as reported by Feijen-de Jong *et al.* (2017:157, 159-161) were "unique", "spontaneous", "having life experience", "working hard", "independent" and "smart". Borrelli (2014:3-5, 7, 9) mentions the importance of specific personal qualities needed in a "good midwife" but does not expand on what these are considered to be.

Affective component and attitude are mentioned synonymously in the midwifery literature (Byrom & Downe, 2010:126, 130; Nicholls & Webb, 2006:414, 422). A caring attitude is specifically noted as an important requirement of a "good midwife" (Byrom & Downe, 2010:135; Feijen-de Jong *et al.,* 2017:159; Nicholls & Webb, 2006:424-425). Support emerged as an essential requirement in the affective component of a "good midwife" (Nicholls & Webb, 2006:414, 422; Feijen-de Jong *et al.,* 2017:159), displayed in the midwife's capacity to give the labouring woman choice, continuity and control (Nicholls & Webb, 2006:422,424,427). A supportive relationship is built through communication skills that ultimately empower the labouring woman and ensures that the relationship is built on trust (Byrom & Downe, 2010:129; Feijen-de Jong *et al.,* 2017:159-160; Nicholls & Webb, 2006:424). To be truly effective, the relationship should be established quickly (Byrom & Downe, 2010:127), confirming the importance of strong communication skills. A positive attitude is also considered to be vital (Feijen-de Jong *et al.,* 2017:160; Nicholls & Webb, 2006:422). The general attitude sought after in a "good midwife" was described in terms such as "warmth", "fairness", "empathy", "kindness" and "friendly" (Byrom & Downe, 2010:135).

"Good midwives" make their patients feel safe because they are always "present" (Feijen-de Jong *et al.,* 2017:158; Masala-Chokwe & Ramukumba, 2015:6; Ménage *et al.,* 2017:558; Nicholls & Webb, 2006:427). This involves both physical and emotional

presence, regarded as demonstrating compassion in action (Feijen-de Jong *et al.,* 2017:160).

To create better birthing experiences, kindness and compassion are needed, yet little is known about what midwives perceive this in midwifery practice**.**

2.10 Conclusion

Chapter two began with an introductory reminder of the issues discussed in Chapter one. Details were then given of the search strategy. Key distinctions were explained between sympathy, empathy and compassion; explanation was given of kindness and compassion; the characteristics of compassion were outlined; the process of compassion was discussed; research on compassion in nursing fields were identified, including specific focus on elderly care, medical-surgical care and emergency care; and a discussion was presented of compassion in midwifery, ending with an explanation of the "good midwife" concept. This concludes Chapter two, the literature review.

CHAPTER 3:
ARTICLE MANUSCRIPT

3.1 Chapter three outline

This chapter was written according to the article format as stated in the NWU Manual for Master's and Doctoral studies concerning submitting a dissertation. One manuscript was written following the instructions for authors as per the BMC Pregnancy and Childbirth Journal, hence repetition – in some instances verbatim of what was written in Chapter one and Chapter two. The references were recorded according to the reference style as indicated in the instructions for authors for the BMC Pregnancy and Childbirth Journal.

The chapter outline is as follows:

Section I: Article instructions for authors

Section II: Cover letter to the Editor-in-Chief of the BMC Pregnancy and Childbirth Journal

Section III: Article manuscript for submission to the BMC Pregnancy and Childbirth Journal

3.2 Section I

Instructions for authors according to the BMC Pregnancy and Childbirth Journal to follow:

Instructions for authors

Research articles

Criteria | Submission process | Preparing main manuscript text | Preparing illustrations and figures | Preparing tables | Preparing additional files | Style and language

Assistance with the process of manuscript preparation and submission is available from BioMed Central customer support team. See 'About this journal' for information about policies and the refereeing process. We also provide a collection of links to useful tools and resources for scientific authors on our page.

Criteria

Research articles should report on original primary research, but may report on systematic reviews of published research provided they adhere to the appropriate reporting guidelines which are detailed in our Editorial Policies. Please note that non-commissioned pooled analyses of selected published research will not be considered.

Submission process

Manuscripts must be submitted by one of the authors of the manuscript, and should not be submitted by anyone on their behalf. The corresponding author takes responsibility for the article during submission and peer review.

Please note that *BMC Pregnancy and Childbirth* levies an article-processing charge on all accepted Research articles; if the corresponding author's institution is a BioMed Central member the cost of the article-processing charge may be covered by the membership (see About page for detail). Please note that the membership is only automatically recognised on submission if the corresponding author is based at the member institution.

To facilitate rapid publication and to minimize administrative costs, *BMC Pregnancy and Childbirth*prefers online submission.

Files can be submitted as a batch, or one by one. The submission process can be interrupted at any time; when users return to the site, they can carry on where they left off.

See below for examples of word processor and graphics file formats that can be accepted for the main manuscript document by the online submission system. Additional files of any type, such as movies, animations, or original data files, can also be submitted as part of the manuscript.

During submission you will be asked to provide a cover letter. Use this to explain why your manuscript should be published in the journal, to elaborate on any issues relating to our editorial policies in the 'About *BMC Pregnancy and Childbirth*' page, and to declare any potential competing interests.

Assistance with the process of manuscript preparation and submission is available from BioMed Central customer support team.

We also provide a collection of links to useful tools and resources for scientific authors on our Useful Tools page.

File formats

The following word processor file formats are acceptable for the main manuscript document:

- Microsoft word (DOC, DOCX)
- Rich text format (RTF)
- Portable document format (PDF)
- TeX/LaTeX (use BioMed Central's TeX template)
- DeVice Independent format (DVI)

TeX/LaTeX users: Please use BioMed Central's TeX template and BibTeX stylefile if you use TeX format. During the TeX submission process, please submit your TeX file as the main manuscript file and your bib/bbl file as a dependent file. Please also convert your TeX file into a PDF and submit this PDF as an additional file with the name 'Reference PDF'. This PDF will be used by internal staff as a reference point to check the layout of the article as the author intended. Please also note that all figures must be coded at the end of the TeX file and not inline.

If you have used another template for your manuscript, or if you do not wish to use BibTeX, then please submit your manuscript as a DVI file. We do not recommend converting to RTF.

For all TeX submissions, all relevant editable source must be submitted during the submission process. Failing to submit these source files will cause unnecessary delays in the publication procedures.

Publishing Datasets

Through a special arrangement with LabArchives, LLC, authors submitting manuscripts to BMC Pregnancy and Childbirth can obtain a complimentary subscription to LabArchives with an allotment of 100MB of storage. LabArchives is an Electronic Laboratory Notebook which will enable scientists to share and publish data files in situ; you can then link your paper to these data. Data files linked to published articles are assigned digital object identifiers (DOIs) and will remain available in perpetuity. Use of LabArchives or similar data publishing services does not replace preexisting data deposition requirements, such as for nucleic acid sequences, protein sequences and atomic coordinates.

Instructions on assigning DOIs to datasets, so they can be permanently linked to publications, can be found on the LabArchives website. Use of LabArchives’ software has no influence on the editorial decision to accept or reject a manuscript.

Authors linking datasets to their publications should include an Availability of supporting data section in their manuscript and cite the dataset in their reference list.

Preparing main manuscript text

General guidelines of the journal's style and language are given below.

Overview of manuscript sections for Research articles

Manuscripts for Research articles submitted to *BMC Pregnancy and Childbirth* should be divided into the following sections (in this order):

- Title page
- Abstract
- Keywords
- Background
- Methods
- Results and discussion
- Conclusions
- List of abbreviations used (if any)
- Competing interests
- Authors' contributions
- Authors' information
- Acknowledgements
- Endnotes
- References
- Illustrations and figures (if any)
- Tables and captions
- Preparing additional files

The **Accession Numbers** of any nucleic acid sequences, protein sequences or atomic coordinates cited in the manuscript should be provided, in square brackets and include the corresponding database name; for example, [EMBL:AB026295, EMBL:AC137000, DDBJ:AE000812, GenBank:U49845, PDB:1BFM, Swiss-Prot:Q96KQ7, PIR:S66116].

The databases for which we can provide direct links are: EMBL Nucleotide Sequence Database (EMBL), DNA Data Bank of Japan (DDBJ), GenBank at the NCBI (GenBank), Protein Data Bank (PDB), Protein Information Resource (PIR) and the Swiss-Prot Protein Database (Swiss-Prot).

For reporting standards please see the information in the About section.

Title page

The title page should:

- provide the title of the article
- list the full names, institutional addresses and email addresses for all authors
- indicate the corresponding author

Please note:

- the title should include the study design, for example "A versus B in the treatment of C: a randomized controlled trial X is a risk factor for Y: a case control study"
- abbreviations within the title should be avoided
- if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the

"acknowledgements" section in accordance with the instructions below. Please note that the individual names may not be included in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

Abstract

The Abstract of the manuscript should not exceed 350 words and must be structured into separate sections: **Background,** the context and purpose of the study; **Methods**, how the study was performed and statistical tests used; **Results**, the main findings; **Conclusions**, brief summary and potential implications. Please minimize the use of abbreviations and do not cite references in the abstract. **Trial registration**, if your research article reports the results of a controlled health care intervention, please list your trial registry, along with the unique identifying number (e.g. **Trial registration**: Current Controlled Trials ISRCTN73824458). Please note that there should be no space between the letters and numbers of your trial registration number. We recommend manuscripts that report randomized controlled trials follow the CONSORT extension for abstracts.

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should be written in a way that is accessible to researchers without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the background to the research and its aims. Reports of clinical research should, where appropriate, include a summary of a search of the literature to indicate why this study was necessary and what it aimed to contribute to the field. The section should end with a brief statement of what is being reported in the article.

Methods

The methods section should include the design of the study, the setting, the type of participants or materials involved, a clear description of all interventions and comparisons, and the type of analysis used, including a power calculation if appropriate. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses in the Methods section.

For studies involving human participants a statement detailing ethical approval and consent should be included in the methods section. For further details of the journal's editorial policies and ethical guidelines see 'About this journal'.

For further details of the journal's data-release policy, see the policy section in 'About this journal'.

Results and discussion

The Results and discussion may be combined into a single section or presented separately. Results of statistical analysis should include, where appropriate, relative and absolute risks or risk reductions, and confidence intervals. The Results and discussion sections may also be broken into subsections with short, informative headings.

Conclusions

This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance. Summary illustrations may be included.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations can be provided, which should precede the competing interests and authors' contributions.

Competing interests

A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organizations. Authors must disclose any

financial competing interests; they should also reveal any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript.

Authors are required to complete a declaration of competing interests. All competing interests that are declared will be listed at the end of published articles. Where an author gives no competing interests, the listing will read 'The author(s) declare that they have no competing interests'.

When completing your declaration, please consider the following questions:

Financial competing interests

- In the past three years have you received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? Is such an organization financing this manuscript (including the article-processing charge)? If so, please specify.
- Do you hold any stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? If so, please specify.
- Do you hold or are you currently applying for any patents relating to the content of the manuscript? Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript? If so, please specify.
- Do you have any other financial competing interests? If so, please specify.

Non-financial competing interests

Are there any non-financial competing interests (political, personal, religious, ideological, academic, intellectual, commercial or any other) to declare in relation to this manuscript? If so, please specify.

If you are unsure as to whether you, or one your co-authors, has a competing interest please discuss it with the editorial office.

Authors' contributions

In order to give appropriate credit to each author of a paper, the individual contributions of authors to the manuscript should be specified in this section.

According to ICMJE guidelines, An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. To qualify as an author one should 1) have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) have been involved in drafting the manuscript or revising it critically for important intellectual content; 3) have given final approval of the version to be published; and 4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship.

We suggest the following kind of format (please use initials to refer to each author's contribution): AB carried out the molecular genetic studies, participated in the sequence alignment and drafted the manuscript. JY carried out the immunoassays. MT participated in the sequence alignment. ES participated in the design of the study and performed the statistical analysis. FG conceived of the study, and participated in its design and coordination and helped to draft the manuscript. All authors read and approved the final manuscript.

All contributors who do not meet the criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, a department chair who provided only general support, or those who contributed as part of a large collaboration group.

Authors' information

You may choose to use this section to include any relevant information about the author(s) that may aid the reader's interpretation of the article, and understand the standpoint of the author(s). This may include details about the authors' qualifications, current positions they hold at institutions or societies, or any other relevant background information. Please refer to authors using their initials. Note this section should not be used to describe any competing interests.

Acknowledgements

Please acknowledge anyone who contributed towards the article by making substantial contributions to conception, design, acquisition of data, or analysis and interpretation of data, or who was involved in drafting the manuscript or revising it critically for important intellectual content, but who does not meet the criteria for authorship. Please also include the source(s) of funding for each author, and for the manuscript preparation. Authors must describe the role of the funding body, if any, in design, in the collection, analysis, and interpretation of data; in the writing of the manuscript; and in the decision to submit the manuscript for publication. Please also acknowledge anyone who contributed materials essential for the study. If a language editor has made significant revision of the manuscript, we recommend that you acknowledge the editor by name, where possible.

The role of a scientific (medical) writer must be included in the acknowledgements section, including their source(s) of funding. We suggest wording such as 'We thank Jane Doe who provided medical writing services on behalf of XYZ Pharmaceuticals Ltd.'

If you would like the names of the individual members of a collaboration Group to be searchable through their individual PubMed records, please ensure that the title of the collaboration Group is included on the title page and in the submission system and also include collaborating author names as the last paragraph of the "acknowledgements" section. Please add authors in the format First Name, Middle initial(s) (optional), Last Name. You can add institution or country information for each author if you wish, but this should be consistent across all authors.

Please note that individual names may not be present in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

Authors should obtain permission to acknowledge from all those mentioned in the Acknowledgements section.

Endnotes

Endnotes should be designated within the text using a superscript lowercase letter and all notes (along with their corresponding letter) should be included in the Endnotes section. Please format this section in a paragraph rather than a list.

References

All references, including URLs, must be numbered consecutively, in square brackets, in the order in which they are cited in the text, followed by any in tables or legends. Each reference must have an individual reference number. Please avoid excessive referencing. If automatic numbering systems are used, the reference numbers must be finalized and the bibliography must be fully formatted before submission.

Only articles, clinical trial registration records and abstracts that have been published or are in press, or are available through public e-print/preprint servers, may be cited; unpublished abstracts, unpublished data and personal communications should not be included in the reference list, but may be included in the text and referred to as "unpublished observations" or "personal communications" giving the names of the involved researchers. Obtaining permission to quote personal communications and unpublished data from the cited colleagues is the responsibility of the author. Footnotes are not allowed, but endnotes are permitted. Journal abbreviations follow Index Medicus/MEDLINE. Citations in the reference list should include all named authors, up to the first six before adding 'et al.'..

Any *in press* articles cited within the references and necessary for the reviewers' assessment of the manuscript should be made available if requested by the editorial office.

An Endnote style file is available.

Examples of the *BMC Pregnancy and Childbirth* reference style are shown below. Please ensure that the reference style is followed precisely; if the references are not in the correct style they may have to be retyped and carefully proofread.

All web links and URLs, including links to the authors' own websites, should be given a reference number and included in the reference list rather than within the text of the manuscript. They should be provided in full, including both the title of the site and the URL, as well as the date the site was accessed, in the following format: The Mouse Tumor Biology Database. http://tumor.informatics.jax.org/mtbwi/index.do. Accessed 20 May 2013. If an author or group of authors can clearly be associated with a web link, such as for weblogs, then they should be included in the reference.

Authors may wish to make use of reference management software to ensure that reference lists are correctly formatted. An example of such software is Papers, which is part of Springer Science+Business Media.

Examples of the *BMC Pregnancy and Childbirth* reference style

Article within a journal
Smith JJ. The world of science. Am J Sci. 1999;36:234-5.

Article within a journal (no page numbers)
Rohrmann S, Overvad K, Bueno-de-Mesquita HB, Jakobsen MU, Egeberg R, Tjønneland A, et al. Meat consumption and mortality - results from the European Prospective Investigation into Cancer and Nutrition. BMC Medicine. 2013;11:63.

Article within a journal by DOI
Slifka MK, Whitton JL. Clinical implications of dysregulated cytokine production. Dig J Mol Med. 2000; doi:10.1007/s801090000086.

Article within a journal supplement
Frumin AM, Nussbaum J, Esposito M. Functional asplenia: demonstration of splenic activity by bone marrow scan. Blood 1979;59 Suppl 1:26-32.

Book chapter, or an article within a book
Wyllie AH, Kerr JFR, Currie AR. Cell death: the significance of apoptosis. In: Bourne GH, Danielli JF, Jeon KW, editors. International review of cytology. London: Academic; 1980. p. 251-306.

OnlineFirst chapter in a series (without a volume designation but with a DOI)
Saito Y, Hyuga H. Rate equation approaches to amplification of enantiomeric excess and chiral symmetry breaking. Top Curr Chem. 2007. doi:10.1007/128_2006_108.

Complete book, authored
Blenkinsopp A, Paxton P. Symptoms in the pharmacy: a guide to the management of common illness. 3rd ed. Oxford: Blackwell Science; 1998.

Online document
Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. http://www.rsc.org/dose/title of subordinate document. Accessed 15 Jan 1999.

Online database
Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. http://www.healthwise.org. Accessed 21 Sept 1998.

Supplementary material/private homepage
Doe J. Title of supplementary material. 2000. http://www.privatehomepage.com. Accessed 22 Feb 2000.

University site
Doe, J: Title of preprint. http://www.uni-heidelberg.de/mydata.html (1999). Accessed 25 Dec 1999.

FTP site
Doe, J: Trivial HTTP, RFC2169. ftp://ftp.isi.edu/in-notes/rfc2169.txt (1999). Accessed 12 Nov 1999.

Organization site
ISSN International Centre: The ISSN register. http://www.issn.org (2006). Accessed 20 Feb 2007.

Dataset with persistent identifier
Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (Sorghum bicolor). GigaScience Database. 2011. http://dx.doi.org/10.5524/100012.

Preparing illustrations and figures

Illustrations should be provided as separate files, not embedded in the text file. Each figure should include a single illustration and should fit on a single page in portrait format. If a figure consists of separate parts, it is important that a single composite illustration file be submitted which contains all parts of the figure. There is no charge for the use of color figures.

Please read our figure preparation guidelines for detailed instructions on maximising the quality of your figures.

Formats

The following file formats can be accepted:

- PDF (preferred format for diagrams)
- DOCX/DOC (single page only)
- PPTX/PPT (single slide only)
- EPS
- PNG (preferred format for photos or images)
- TIFF
- JPEG
- BMP

Figure legends

The legends should be included in the main manuscript text file at the end of the document, rather than being a part of the figure file. For each figure, the following information should be provided: Figure number (in sequence, using Arabic numerals - i.e. Figure 1, 2, 3 etc); short title of figure (maximum 15 words); detailed legend, up to 300 words.

Please note that it is the responsibility of the author(s) to obtain permission from the copyright holder to reproduce figures or tables that have previously been published elsewhere.

Preparing tables

Each table should be numbered and cited in sequence using Arabic numerals (i.e. Table 1, 2, 3 etc.). Tables should also have a title (above the table) that summarizes the whole table; it should be no longer than 15

words. Detailed legends may then follow, but they should be concise. Tables should always be cited in text in consecutive numerical order.

Smaller tables considered to be integral to the manuscript can be pasted into the end of the document text file, in A4 portrait or landscape format. These will be typeset and displayed in the final published form of the article. Such tables should be formatted using the 'Table object' in a word processing program to ensure that columns of data are kept aligned when the file is sent electronically for review; this will not always be the case if columns are generated by simply using tabs to separate text. Columns and rows of data should be made visibly distinct by ensuring that the borders of each cell display as black lines. Commas should not be used to indicate numerical values. Color and shading may not be used; parts of the table can be highlighted using symbols or bold text, the meaning of which should be explained in a table legend. Tables should not be embedded as figures or spreadsheet files.

Larger datasets or tables too wide for a portrait page can be uploaded separately as additional files. Additional files will not be displayed in the final, laid-out PDF of the article, but a link will be provided to the files as supplied by the author.

Tabular data provided as additional files can be uploaded as an Excel spreadsheet (.xls) or comma separated values (.csv). As with all files, please use the standard file extensions.

Preparing additional files

Although *BMC Pregnancy and Childbirth* does not restrict the length and quantity of data included in an article, we encourage authors to provide datasets, tables, movies, or other information as additional files.

Please note: All Additional files **will be published** along with the article. Do not include files such as patient consent forms, certificates of language editing, or revised versions of the main manuscript document with tracked changes. Such files should be sent by email to editorial@biomedcentral.com, quoting the Manuscript ID number.

Results that would otherwise be indicated as "data not shown" can and should be included as additional files. Since many weblinks and URLs rapidly become broken, *BMC Pregnancy and Childbirth* requires that supporting data are included as additional files, or deposited in a recognized repository. Please do not link to data on a personal/departmental website. The maximum file size for additional files is 20 MB each, and files will be virus-scanned on submission.

Additional files can be in any format, and will be downloadable from the final published article as supplied by the author. We recommend CSV rather than PDF for tabular data.

Certain supported files formats are recognized and can be displayed to the user in the browser. These include most movie formats (for users with the Quicktime plugin), mini-websites prepared according to our guidelines, chemical structure files (MOL, PDB), geographic data files (KML).

If additional material is provided, please list the following information in a separate section of the manuscript text:

- File name (e.g. Additional file 1)
- File format including the correct file extension for example .pdf, .xls, .txt, .pptx (including name and a URL of an appropriate viewer if format is unusual)
- Title of data
- Description of data

Additional files should be named "Additional file 1" and so on and should be referenced explicitly by file name within the body of the article, e.g. 'An additional movie file shows this in more detail [see Additional file 1]'.

Additional file formats

Ideally, file formats for additional files should not be platform-specific, and should be viewable using free or widely available tools. The following are examples of suitable formats.

- Additional documentation
  - PDF (Adode Acrobat)
- Animations
  - SWF (Shockwave Flash)
- Movies
  - MP4 (MPEG 4)
  - MOV (Quicktime)
- Tabular data
  - XLS, XLSX (Excel Spreadsheet)
  - CSV (Comma separated values)

As with figure files, files should be given the standard file extensions.

Mini-websites

Small self-contained websites can be submitted as additional files, in such a way that they will be browsable from within the full text HTML version of the article. In order to do this, please follow these instructions:

1. Create a folder containing a starting file called index.html (or index.htm) in the root.
2. Put all files necessary for viewing the mini-website within the folder, or sub-folders.
3. Ensure that all links are relative (ie "images/picture.jpg" rather than "/images/picture.jpg" or "http://yourdomain.net/images/picture.jpg" or "C:\Documents and Settings\username\My Documents\mini-website\images\picture.jpg") and no link is longer than 255 characters.
4. Access the index.html file and browse around the mini-website, to ensure that the most commonly used browsers (Internet Explorer and Firefox) are able to view all parts of the mini-website without problems, it is ideal to check this on a different machine.
5. Compress the folder into a ZIP, check the file size is under 20 MB, ensure that index.html is in the root of the ZIP, and that the file has .zip extension, then submit as an additional file with your article.

Style and language

General

Currently, *BMC Pregnancy and Childbirth* can only accept manuscripts written in English. Spelling should be US English or British English, but not a mixture.

There is no explicit limit on the length of articles submitted, but authors are encouraged to be concise.

BMC Pregnancy and Childbirth will not edit submitted manuscripts for style or language; reviewers may advise rejection of a manuscript if it is compromised by grammatical errors. Authors are advised to write clearly and simply, and to have their article checked by colleagues before submission. In-house copyediting will be minimal. Non-native speakers of English may choose to make use of a copyediting service.

Language editing

For authors who wish to have the language in their manuscript edited by a native-English speaker with scientific expertise, BioMed Central recommends Edanz. BioMed Central has arranged a 10% discount to the fee charged to BioMed Central authors by Edanz. Use of an editing service is neither a requirement nor a

guarantee of acceptance for publication. Please contact Edanz directly to make arrangements for editing, and for pricing and payment details.

Help and advice on scientific writing

The abstract is one of the most important parts of a manuscript. For guidance, please visit our page on Writing titles and abstracts for scientific articles.

Tim Albert has produced for BioMed Central a list of tips for writing a scientific manuscript. American Scientist also provides a list of resources for science writing. For more detailed guidance on preparing a manuscript and writing in English, please visit the BioMed Central author academy.

Abbreviations

Abbreviations should be used as sparingly as possible. They should be defined when first used and a list of abbreviations can be provided following the main manuscript text.

Typography

- Please use double line spacing.
- Type the text unjustified, without hyphenating words at line breaks.
- Use hard returns only to end headings and paragraphs, not to rearrange lines.
- Capitalize only the first word, and proper nouns, in the title.
- All lines and pages should be numbered. Authors are asked to ensure that line numbering is included in the main text file of their manuscript at the time of submission to facilitate peer-review. Once a manuscript has been accepted, line numbering should be removed from the manuscript before publication. For authors submitting their manuscript in Microsoft Word please do not insert page breaks in your manuscript to ensure page numbering is consistent between your text file and the PDF generated from your submission and used in the review process.
- Use the *BMC Pregnancy and Childbirth* reference format.
- Footnotes are not allowed, but endnotes are permitted.
- Please do not format the text in multiple columns.
- Greek and other special characters may be included. If you are unable to reproduce a particular special character, please type out the name of the symbol in full. **Please ensure that all special characters used are embedded in the text, otherwise they will be lost during conversion to PDF.**

Units

SI units should be used throughout (liter and molar are permitted, however).

© 2016 BioMed Central Ltd unless otherwise stated. Part of Springer Science+Business Media.

From: http://old.biomedcentral.com/bmcpregnancychildbirth/authors/instructions/researcharticle

3.3 Section II

Cover letter to the Editor-in-Chief of the BMC Pregnancy and Childbirth Journal:

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Fax: 018 299-4910
Web: http://www.nwu.ac.za

Editor-in-Chief

BMC Pregnancy and Childbirth Journal

RE: ARTICLE FOR SUBMISSION

The article titled: “The characteristics of kind and compassionate care during childbirth according to midwives: a qualitative descriptive inquiry” is hereby submitted.

The article was not submitted to any other journal. Please note, that the article was approved for submission by contributing authors. Ethical approval was obtained from the North-West University (NWU) (Certificate number: NWU-00072-16-A1) in order to conduct the empirical study. The study was funded by the principle investigator through the PLUME researcher development program of the Forum of University Nursing Deans of South Africa (FUNDISA) and the National Research Foundation (NRF) after peer review. The researcher declares a NWU post-graduate bursary for part-time students as well as staff discount, as the researcher is employed on a fixed term contract for the School of Nursing Science as a Clinical Preceptor. No conflict of interest is declared.

Thank you for considering this manuscript for publication.

Kind regards,

S.S. Krausé

3.4 Section III

Article manuscript as prepared for submission

The characteristics of kind and compassionate care during childbirth according to midwives: a qualitative descriptive inquiry.

Samantha Salome Krausé

North-West University

Private Bag x6001

Potchefstroom

South Africa

2520

Samantha.Krause@nwu.ac.za

Catarina Susanna Minnie (Corresponding author)

NuMIQ Research Focus Area

North-West University

Private Bag x6001

Potchefstroom

South Africa

2520

Karin.Minnie@nwu.ac.za

Siedine Knobloch Coetzee

North-West University

Private Bag x6001

Potchefstroom

South Africa

2520

siedine.knobloch@nwu.ac.za

Abstract

Background

Although compassion is considered to be of prime importance in nursing and midwifery care, there is no clear understanding of what compassionate care in childbirth entails, and how midwives' perceive compassionate care is largely unknown. This study accordingly seeks to explore and describe the characteristics, as perceived by midwives, of kind and compassionate care during childbirth.

Methods

A qualitative descriptive inquiry was undertaken by means of a voluntary online survey, where participants were recruited via snowball sampling on the social networking site Facebook. The participants were midwives, and the unit of analysis was the received response. Participants gave written responses reporting on instances of kind and compassionate care during childbirth. The data was thematically analysed using Tesch's eight steps to identify common themes.

Results

Ninety-eight responses from participants were analysed and three themes and 11 sub-themes emerged as dominant characteristics. Themes and sub-themes were as follows: making meaningful connections with patients (displaying good interpersonal skills, conduct based on dignity and respect, establishing trust); initiating individualised understanding of each patient (showing empathy, being patient, permitting maternal choice, promotion of advocacy, non-judgemental attitude) and action through care and support (providing emotional support, assistance through instrumental support, continuous informational support).

Conclusion

The characteristics of kind and compassionate care were identified as follows: (i) making meaningful connections with patients by displaying good interpersonal skills and showing dignity and respect, and establishing trust; (ii) initiating individualised understanding of each patient the midwife comes into contact with by showing empathy, being patient, permitting maternal choice, promotion of advocacy and having a non-judgmental attitude; and (iii) acting to provide care and support in the form of emotional support, instrumental support assistance, and continuous informational support. In seeking to determine what

characterises compassionate care, a pivotal consideration is relationship based on trust involving a distinctive understanding of the individual patient and her individual needs. Unique to this study was the finding that participants regarded advocacy as a characteristic of compassionate midwifery care. There was also an emphasis on not judging the labouring woman, as it hindered the connected relationship created. By acting on the information gathered through connections and shared understandings the midwife provides compassionate emotional, instrumental and informational care and support. Better understanding of how midwives perceive compassionate care could potentially improve the quality of care midwives offer during childbirth.

Keywords

Attributes, kindness, compassion, labour, birth, midwifery, perception, understanding, thematic analysis

Introduction

Midwives work together with women during their pregnancy, labour and puerperium stages and global standards have been set for the minimum cognitive and psychomotor competencies required of a midwife [1]. In the midwifery literature, a recent shift has increased attention to affective competencies with particular focus on the notion of the "good midwife". Competency in the affective domain has been described as the use of emotions and feelings such as compassion, kindness, empathy and support [2-4] of which compassion is considered of prime importance [5] and pivotal to quality nursing and midwifery care [6-7]. Although researchers are exploring the term compassion in nursing [5-6], little is known about what constitutes compassionate care in midwifery [7], which according to the authors is essential to improve midwifery care [2, 4, 7] and decrease the incidence of disrespect and abuse [8].

Background

Midwives are often the main caregivers for healthy women during childbirth [9-11] and have been referred to as the "backbone" of maternal and newborn care [9]. Globally, the ICM guides midwifery associations and their governments on the minimum cognitive and psychomotor competencies required of a midwife [1-2, 4, 11]. Once deemed competent, the midwife may practice in whichever context is applicable: the home; the community; hospitals; clinics or health units [1]. The competent midwife then works together with women, taking full responsibility and liability for their pregnancy, labour and puerperium care [11].

How the midwife cares for the woman during childbirth is associated with deep personal and cultural significance for the woman herself and for her family [12]. Hence the focus, as noted above, on the affective domain in midwifery, in addition to cognitive and psychomotor competencies [2]. A "good midwife" so termed, is one who is competent in the cognitive, psychomotor and affective domains [2, 4, 13]. Competency in the affective domain has been described as use of soft skills, such as compassion, kindness, empathy and support [2-4]. Compassion is considered to be so important in the affective competencies of a registered midwife that suggestions have been made to add it as a core competency in midwifery care [14-16].

Recently, there have been an alarming number of reports of disrespect and abuse during childbirth [8, 12, 17-21]. This has been noted by the World Health Organization (WHO) as a serious problem that needs urgent attention [22]. Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful care [23]. A recent WHO advisory on positive childbirth experience makes recommendations on how to manage and minimise disrespect and abuse by providing compassionate care to all women [24].

Compassion is defined in the literature as feeling together [25], feeling with another [26], and subsequently taking action or performing deeds of kindness [27] to provide relief for suffering or pain [7, 26, 28]. In this study, deeds of kindness are understood as action taken beyond the normal or routine ambit of the midwife's care: supererogatory deeds – expressed in metaphorical terms as "going the extra mile" or "going above and beyond" [29]. C*ompassion and kindness* are accordingly regarded in this study as a single concept, and mention of compassion includes the assumption of kindness.

Compassion has been cited as possibly the most highly valued attribute in nursing and midwifery care [6, 26, 30] and is widely recognised as its core element [25-26, 31-34]. Compassion is described as a constituent of nursing excellence [30] and as a vital component for achieving quality nursing and midwifery care [5, 15, 35-38].

Compassion is thus undeniably sought for in nursing and midwifery care [30, 32]. Yet how compassion manifests itself in provision of care is poorly understood, as it differs from practitioner to practitioner and from practice setting to practice setting [5, 26, 33, 37, 39]. Ménage et al. [7] note that there is no clear understanding of what compassionate care in childbirth entails and midwives' perceptions of compassionate care is largely unknown. This study was accordingly undertaken to explore and describe midwives' perceptions of kindness and compassion in caregiving for women in childbirth.

Methods

In this study, a qualitative descriptive research design was chosen in response to deficit in the understanding of the concept of compassionate care in midwifery [40]. A descriptive design is suitable when describing accounts from practice to develop a meaningful understanding of an ill-explored concept [41].

Data were collected through a voluntary, anonymous online survey. Electronic surveys have been reported as equivalent to paper-based surveys in terms of internal reliability and completion rates [42-43]. The benefits of online surveys are that they save time, are cost-effective, and can be accessed quickly by people with shared characteristics from widely separated geographical locations [44-45].

A Facebook page was created entitled "Promoting kind and compassionate care during childbirth." The target population was recruited using a snowball sampling technique via midwife-based groups and pages on Facebook using the search words "midwife" and "childbirth". Typically, each Facebook user has their own network of friends, family and Facebook groups (i.e., virtual communities linking people with common interests). Interested midwives were invited to like and share the study's Facebook page (with the link to the online survey); this increased the likelihood of other midwives taking cognizance of the study, thereby propelling the snowball sampling process.

Facebook was chosen as the social networking site (SNS) for recruiting participants as it is reportedly the largest online community [46]. SNS's offer new ways for researchers to conduct studies quickly and cost-effectively, particularly in constructing snowball samples for descriptive work [46-48].

The Facebook page contained a link to the SurveyMonkey electronic platform used for the self-administered survey. SurveyMonkey was chosen as the online site to collect and store data in view of favourable features it offers such as affordability, easy format and possibility to set up surveys as desired [49]. An invitation to participate in the proposed study was posted on the Facebook page.

Population and sample

The target population was midwives practicing in South Africa and elsewhere. The units of analysis were the responses from each midwife, not the midwives themselves. Inclusion criteria for midwives were experience in assisting women during childbirth and having internet access (more specifically a Facebook account following a midwife-orientated group). As the aim of the study was to gain understanding about kind and compassionate care in midwifery, no limit was placed on the number of responses received. If there was more than one incident midwives wished to report, they were invited

to do so, since any incident profound enough to make an impact on the midwife was deemed relevant. For this same reason, there were no exclusion criteria.

The researcher could not predict a specific sample size due to the descriptive nature of the research problem and the unpredictability of the number of replies. Hill [50] indicates a wide range of possibilities (from 30 to 500) for recommended sample size in an online survey, with a small sample size being more economical while a larger sample adds reliability and representativeness [50]. This study fell somewhere in the lower end of the sample size, with 98 completed responses received. This was considered to be sufficient as data saturation took place. Data saturation occurred once similar themes repetitively stood out.

The survey was open for three months for data collection from the 13th of December 2016 to the 13th of March 2017. In an online survey reported by Bhutta [46], the majority of the responses were received within the first few days following the survey launch [46]. However, in this study less than 50 responses were received within the first month. A second invitation was therefore posted on the Facebook page, and a further 48 responses were then received over the subsequent two months.

Data analysis

Thematic analysis was carried out according to Tesch's eight steps as explained by Creswell [40]. Thematic analysis was the most appropriate means to analyse this data set, as the objective of the study was to explore and describe the characteristics of a specific concept [40]. Braun and Clarke [51] explain that thematic analysis is "a method of identifying, analysing and reporting patterns within data." Patterns can also be referred to as themes [51]. This makes it possible to identify a common train of thought in the responses received from the participants [52].

The data analysis took place as follows: the data was transferred to an Excel spreadsheet, thereafter imported into the qualitative research program Atlas.ti 8, which was used to process the large amount of data into a smaller set of easily readable interpreted themes [53]. The data were managed and arranged by numbers according to the sequence in which responses were received. As this was an anonymous survey, no other identifying criteria were available.

Tesch's eight steps as explained by Creswell [40] were carried out as follows in the thematic analysis: the data set was read over to obtain a general idea of what was said. Next, it was looked at in greater detail to begin the coding process. Coding is defined by Creswell [40] as the process of taking a large amount of data and breaking up into smaller sections before attaching meaning to it. These smaller sections were named following the to open coding process of giving labels or renaming sections of the data set to find and categorise shared meanings. The data set was read through several times to get an idea of what the participants had to say. The most interesting responses from participants were identified and explored to determine their fundamental meaning. A list of topics surfaced that had been brought up several times by different participants. New categories originated from reading through the responses from the participants again. These were then refined and grouped according to similar meanings, resulting in a list of final categories – labelled as themes– which had come to light [40].

Ethical considerations

The link to SurveyMonkey took potential participants to an introduction page which was simultaneously utilized as electronic informed consent. On this page the participants were formally invited to participate in the research project, with a statement declaring the research question and aim, and the inclusion criteria for the voluntary study were specified. The open-ended questions were stated so as to prepare the participants for the expectations of the low-risk study so that they understood it would not have any direct benefit for participants. Participants were encouraged to contact the researcher should there be any level of psychological distress experienced for assistance or referral. Password protection of data gave participants assurance of the confidentiality and anonymity of the study. Participants were asked to confirm that they were 18 years or older; understood the information stated and wanted to complete the survey by clicking on the accept button.

Anonymity was ensured as no names or contact details were requested. The completed surveys were identified in the sequence that the participants submitted. Anonymity and confidentiality was thus not compromised.

Ethical approval was granted by the Health Research Ethics Committee (HREC) of North-West University [certificate number: NWU-00072-16-A1]. As the study took place online, no further legal authorization or goodwill consent was necessary.

Trustworthiness

The four fundamental epistemological standards listed by Lincoln and Guba [54] were applied to ensure the trustworthiness of this qualitative study. Theoretical validity was provided by conceptualisation of the central concepts described in the study [55].

Prolonged engagement in the field of midwifery and in the collection and analysis of data, and peer debriefing with the principle investigator and co-supervisor, enhanced the credibility of the study findings. Transferability was strengthened by providing a thorough account of the research process applied in the study and by analysing all data entries even after data saturation was reached. The dependability of the study was enhanced through review, approval and monitoring from the applicable scientific committees and study leaders associated with this study. A co-coder was assigned to thematically analyse the data set. The codes were subsequently worked on individually. The researcher and the co-coder obtained inter-coder agreement regarding the open codes [40]. The researcher declares a non-biased approach to the study, increasing the confirmability of the results.

Findings

The self-administered survey consisted of a demographic section with five closed-ended questions and three open-ended questions. According to Callegaro et al. [44], an advantage of open-ended questions is that participants have an opportunity to re-tell a life event that made an impact on them in as much detail as needed, thereby revealing how the concept is perceived (in this case, by the midwife). Closed-ended questions, on the other hand, do not provide much insight. The disadvantage of open-ended questions is that it might be a cognitive strain to answer them; they were accordingly kept to a minimum in this study [44]. The survey was not time-consuming, as the expected completion time was 15 to 30 minutes.

The closed-ended questions (with the options for choice of one standard answer indicated in brackets) were as follows:

- What is your gender? (male or female)
- Where do you practice midwifery? (rural area or urban area)
- In which facility do you practice midwifery? (state hospital, private hospital, community health centre, private practice that is midwife-lead or other)
- How many years' experience do you have working as a midwife? (1-5 years, 6-10 years, 11-20 years, 21-30 years or 30 plus years)
- Is this the first time you are answering the survey? (yes or no).

Concise instructions were given, followed by the three open-ended questions. Two were explicitly phrased:

- Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth.
- List five words that you associate with kind and compassionate maternity care.

The third made provision for participants to contribute any additional comments. Once the survey was complete, the participant was asked to click on the "submit" button.

There were 98 completed responses to the online survey, of which 10 participants repeated the survey. A response was considered to be completed when all 10 of the questions were answered without any questions having been skipped. Only female midwives responded to the online invitation. The majority of participants indicated practicing in urban midwife-led facilities and had on average 1 to 5 years of midwifery experience. See Table 1 for the collected demographic data of the participants.

PREFERRED PLACEMENT OF TABLE 1

Table 2 sets out the reported instances of kind and compassionate care during childbirth in relation to three main themes and 11 subthemes.

PREFERRED PLACEMENT OF TABLE 2

Theme 1: MAKING MEANINGFUL CONNECTIONS WITH PATIENTS

Participants felt that the midwife typically connects with the mother in labour by becoming in tune with her and creating a bond. This connection flows when the midwife and the labouring mother actively collaborate with one another through interpersonal skills, dignity and respect, and establishing trust.

Displaying good interpersonal skills

Interpersonal skills is a broad term indicating capacity to communicate with others through combined verbal and non-verbal communication and active listening. Participants emphasised the importance of using positive, affirming language when communicating with their patients and speaking softly and calmly. Examples were given of basic communication skills such as introducing yourself and more complex skills such as connecting with a patient in tragic situations. The importance was also highlighted of listening and using non-verbal cues such as facial expression, tone of voice and touch.

Participants made explicit reference to listening and the importance of being a good listener for good communication.

Participant 93:

> *When the client is listened to, when her feelings are taken note of...*

Non-verbal communication was frequently mentioned, with references to smiles, eye contact and touch.

Participant 73:

> *… A glance a look from a woman can be interpreted by a midwife and reassurance given from a look.*

Conduct based on dignity and respect

Participants discussed experiences where the midwife overtly displayed respect and maintained an overall framework of respect, particularly respect for bodily autonomy. This reinforced the connection between the midwife and the labouring woman, and was described as an essential part of compassionate care.

Participant 39:

> *… Simple gestures of covering her body to respect her dignity; acknowledging and respecting her wishes…*

Participant 47:

> *… I attended a home birth… She is a modest woman so we kept her lap covered with a towel during the birth which helped her feel more comfortable. We also did not perform any vaginal examinations for this particular client and instead we watched her contraction pattern and trusted her with what she was feeling. The birth was perfect and healthy, and all appropriate customs were performed with minimal interference and with great respect from the midwives…*

Establishing trust

In relation to the subtheme *establishing trust*, two features stood out: establishing partnership between the midwife and the labouring mother, and creating a strong sense of safety. Trust should be established quickly, with many participants using terms such as honesty, integrity and maintaining privacy and confidentiality to describe how the meaningful connection is strengthened.

Participant 64:

> *Caring for a hardened criminal who did not want to engage, by being kind, gentle, inclusive and treating the couple as equals, trust was created and they engaged. They were very thankful and said they have never been treated so kindly by health professionals.*

Participants mentioned strong focus on relationships between the midwife and mother in labour. There was an emphasis on relational building and on being partners or teammates during delivery, with partnerships being non-authoritarian.

Participant 76:

> *… It is hard to put into words as it is intangible and it does not differ from being 'kind'. Many practitioners are 'kind' but compassionate care is fuller and involves more equality in the relationship.*

Participants referred to feeling a sense of safety and trust when kind and compassionate care was practised.

Participant 83:

> *In a homebirth situation, where the couple had got to know their midwife through the antenatal period and were therefore able to be in a place of safety, feeling trust in their carer.*

Theme 2: INTIATING INDIVIDUALISED UNDERSTANDING OF EVERY PATIENT

Participants described compassionate care as personal, referring to the women they are caring for in labour as “my women”. Compassion in caring for labouring woman made it seem as if the midwife was caring for her own family. Participants often made the point that each labouring woman is unique and should be seen as an individual, not just someone you had a duty to give compassionate care to; everyone has their own individual needs and wishes. Participants recounted numerous instances where the essence of compassion was shown in the midwife’s empathy, in being patient at all times, respecting maternal choice, and, in extreme circumstances, speaking on behalf of the labouring woman when she was not able to speak for herself.

Showing empathy

Participants recounted numerous incidents where the midwife showed how much she cared through expressions and gestures such as crying with the labouring women in moments of great sorrow and pain.

Participant 15:

> *I was working in a busy labour and delivery unit. One afternoon, (it was extremely busy that day and at the end of the shift: we were all so tired), I heard the most horrific scream from the room (unlike what we heard from our patients in this particular unit), I went in and saw the Gynaecologist examine and hurt the patient. With the patient was a midwife I had the world’s respect for! She was holding the patient and crying with her, as if she herself felt this excruciating pain…*

Participant 29:

> *When the midwife left the room, I went and sat next to the mom and held her hand. I understood something that day that I’m carrying with me*

> *today still… for you it may seem like just another patient having a baby. But for this mother it was her first baby. After holding her hand and wiping her face for a while, the mom appeared calmer…*

Patience

Patience came through as an intrinsic element of kind and compassionate care during childbirth. Patience meant being unhurried and not setting time limits. Words such as *warmth*, *gentle* and *love* were used in accounts indicating patience shown by midwives.

Participant 26:

> *A birth I witnessed at our private birthing facility in which the midwife conducting the birth was patient with the mom. It took long to push baby out. She never got frustrated or upset, or used abusive language.*

Participant 66:

> *…But the midwife present at that delivery, stood by her and comforted her for the whole 8 hours, even though the patient was not pleasant. She handled the patient with so much love. After the delivery that women was so grateful and named her baby after the midwife.*

Examples of not being rushed and not setting time limits came out in accounts of midwives taking extra time and allowing the mother all the time she needed.

Participant 49:

> *Every time someone takes the time to know the woman, know her history, understand her concerns, her fears and her desires and then creates a plan; whatever that may be....*

Prioritising maternal choice

In relation to the *choice* sub-theme participants discussed the importance of the labouring woman being able to make an informed choice between alternative options. They stressed that maternal choice should be given priority and that the mother should have the biggest say in the management of the delivery.

Participant 81:

> *… The midwife made it clear my client had choices, that they were going to be led by her...*

Participant 92:

> *On a regular basis just providing choices to women and families and offering personalized care that is tailored to each unique birth and life circumstance.*

Promotion of advocacy

Participants felt that everyone deserves kind and compassionate care during childbirth. In instances where this was not the case, participants described experiences where the midwife was an advocate for the patient and spoke on behalf of the patient when this was called for.

Participant 15:

> *The midwife very calmly and professionally told the Doctor that she did not approve of her behaviour. This will stay with me forever. ——* is such a frail, tiny, humble human being with the biggest heart: exceptional compassion for her fellow human beings and patients and the lion's-courage to stand up against bullies. She is my hero.*
>
> * Name omitted to preserve anonymity

Participant 50:

> *A midwife standing up for a woman's birth plan in a way which shielded the woman from the negative bullying process.*

Non-judgemental attitude

Participants spoke of situations where the midwife refused to make negative judgements about the patient, but instead focused on being objective and understanding.

Participant 79:

> *…she had the most amazing experience because the midwife trusted in her and stood by her side without judgement...*

Participant 88:

> *The biggest challenge I ever had was providing care to a 9 month pregnant prostitute who admitted to drinking half a gallon of vodka a day. The whole of the nursing staff were so angry at this patient. But she was labouring and in pain, and it took everything to stay kind.*

Theme 3: ACTION THROUGH CARE AND SUPPORT

Participants explained how compassion can be shown through emotional, instrumental and informational care and support. In emphasising the importance of giving support and encouragement there were some accounts that referred to allowing the woman to follow her instincts and lead her own birth uninterrupted, providing only what is needed and wanted. Supervision and encouragement were seen as emotional support; physical interventions to provide relief were seen as instrumental support and instruction and advice were seen as informational support.

Providing emotional support

Participants recounted numerous experiences where the midwife used encouraging words to support the patient emotionally. They also described instances where it was the midwife’s presence that gave emotional support to the patient, such as the midwife going beyond the call of duty by staying on after the end of her shift to continue that support.

Participant 17:

> *…in the end the midwife stayed with the patient until she delivered, even after the midwife was done with her shift.*

Participants also referred to instances where midwives offered calm reassurance to assist and comfort labouring women.

Participant 91:

> *When the midwife reassuring the mother to hold on through labour stages, managing pain and giving her support, and reminding the mother that it will be worth it when she holds her baby in her hands.*

Participants stated that they felt empowered by the midwife's care and support, as in the following participant's comments.

Participant 32:

> *Kind and compassionate care happens when a midwife and team comes around a woman and empower her to have the best birthing experience she can ever have. I see it all the time as I am doing woman centred care, allowing women to be in charge of their birth…. I see it when women can move freely during their labour and birth, never have to be by themselves and are coached and encouraged right through. Where there is no room for fear and anxiety.*

Assistance through instrumental support

Participants spoke of action-oriented support and care shown by midwives in assistance to relieve discomfort or pain, such as administration of analgesia or physical intervention such as a massage, judged according to the patient's need.

Participant 27:

> *Wiping the brow between contractions and gently whispering how strong she is.*

Instances were also mentioned where tangible aid was given as an act of kindness and compassion.

Participant 51:

> *Providing the birthing woman with eggs after she had given birth and she had no food in the house.*

Participant 96:

> *I was delivering someone's baby and that mother didn't have any clothes for the baby so as midwives we donated money and clothing for the baby.*

Continuous informational support

Participants related stories of midwives providing care and support to the labouring woman by giving her information in the form of advice, useful instructions, helpful suggestions and guidance. There was also emphasis on the importance of giving positive feedback.

Participant 81:

> *She was greeted warmly by our allocated midwife and having checked the fetal heart rate remained normal, took time to explain what was going to happen next, and gave her opportunity to ask questions.*

Participant 21:

> *A midwife was explaining the death of the parent's unborn child to them with so much love and compassion that they were feeling a lot more peaceful about letting their child go. An awesome experience I will remember for the rest of my life.*

Discussion

This study sought to identify what midwives regarded as characterising kind and compassionate care during childbirth. What the participants described were experiences of kind and compassionate care displayed through creation of a meaningful connection with the patient, followed by individualized understanding of each patient and leading to appropriate action taken in the giving of care and support. This is similar to the process of compassion outlined by Ménage et al. [7] in their concept analysis [7]. Broadly, the process of compassion has been described as originating in recognition of discomfort in others, accompanied by a desire to ease it [7, 16, 26, 32] which is subsequently manifested in meeting the identified need.

The participants' descriptions of the connection created resemble what has been reported in literature [16, 39] and was seen as crucial for provision of compassionate care. When

compassionate care is practiced, an authentic bond is created between the practitioner and the patient, described by Byrom and Downe [2] as “this unseen thing”. Establishing connectedness in the practitioner–patient relationship is a highly affective process [7] in which the practitioner intentionally becomes accustomed to the patient [5, 29, 56], resulting in a close and meaningful relationship [57]. Compassionate practice enables therapeutic relationships to be created through interpersonal skills [37], particularly through verbal communication such as introducing oneself [57], through non-verbal communication such as eye contact, smiling and touch [37] and through being a good listener [34, 58]. Respect has been highlighted as an important characteristic of compassion [3] and of being considerate and willing to compromise [39]. Cummings and Bennett [15] also found that a relationship based on dignity and respect results in compassionate care, seen as the foundational principle in how to care for others.

In relation to midwives establishing meaningful connections, issues that participants raised included being attentive to the patient [59], focusing on the individualized understanding of the patient [16, 59] and adopting a collaborative approach [39]. This enables the midwife to be involved with, and recognize what especially matters for each individual patient [5, 29]. It has been stressed that understanding is created by looking at each patient in their current situation [57] and generating unique applications according to each particular set of circumstances [60].

When midwives have the ability to treat women as individuals [4], compassionate care can flow. Participants felt that there should be a stronger emphasis on an individualized approach to care, since women want to be understood by the practitioner caring for them [61]. Participants felt that an important aspect of compassion is seeing your patient (in the words of one participant) as an “individual and not a duty”, which is supported by authors who highlight the importance of humanizing the patient [35, 57].

The issue of empathy came up frequently in participants’ descriptions of compassion, and is supported in the literature [2-4, 7, 10, 61]. One study linked compassion with trustworthiness and patience [34], and this also came through as important characteristics of compassion in this study. Davison et al. [62] noted that labouring woman prefer midwives who give individualized attention and accommodate the particular needs of each childbearing woman; reference is also made by the authors to reaching a shared

goal [62]. Berg et al. [63] stress the importance of supporting and guiding the labouring woman according to her own terms so that she has a sense of control.

Linkage between advocacy and compassion does not appear to have been discussed in the literature and is thus considered to be a unique finding in this study. Crawford et al. [64] use the term *non-judgmental* to describe a characteristic of a "compassionate mentality".

however, applying this term as a characteristic of kind and compassionate care during childbirth appears to be a further unique finding.

Once the midwife has connected with and understood the patient, she can act in a way that matters to the labouring woman and execute the care [58]. Compassion is frequently defined as an action-oriented state [5, 29] in which activities are carried out [28, 7, 60] and the deeds-based character of compassion [36] is shown by small acts of kindness [5, 29, 57] carried out in an attempt to alleviate discomfort [32, 38, 56]. This corresponds with descriptions participants gave of emotional, instrumental and informational care and support. Compassion shown through presence of the midwife, as described by participants, is also reported in the literature [3-4, 7, 10, 59].

Characteristics of compassion found in long-term care were attentiveness, involvement and helping, and were found to be motivational in achieving agreed-upon goals [59], also emerged in the theme *action through care and support*. Midwives determination to support and encourage women reflects the affective nature of compassion [7].

Limitations of the study

Paucity of descriptions of compassion in midwifery care appeared to be a limitation in the early stages of the study but as the study progressed this became a strength, since there is a definite gap in the literature regarding midwives' perception of compassion. This empirical study is thus able to contribute to the body of knowledge, as it identified unique findings as well as providing a starting point for continued future investigations into the concept.

A limitation of the study was that only midwives with an active Facebook account were eligible for inclusion in the study. The sample may not be exactly representative, as it is not required of midwives that they have access to the internet or Facebook accounts [44].

This limitation is acknowledged, although representativeness is not pivotal in this qualitative study [48]. The sample obtained in this study represents a diverse selection of midwives, allowing multiple viewpoints to be analyzed and considered. This is seen as a strength in a qualitative study [40].

Conclusion

Overall, this study reveals that midwives view compassionate care as connecting with the patient so that they develop an individual understanding of the patient shown through action focused on care and support. Unique to this study was that midwives highlighted the importance of promoting advocacy while maintaining a non-judgemental attitude in attempting to develop an individualised understanding of the patient. It is recommended that further exploration be undertaken to develop an accepted conceptual definition of compassionate care in midwifery. The description of compassionate care as provided in this study could be used as an important starting point for future research investigating the concept in midwifery.

Abbreviations

HREC : Health Research Ethics Committee; ICM: International Confederation of Midwives; NWU: North-West University; SNS: Social Networking Site; WHO: World Health Organization

Competing interests

The authors declare no financial or any otherwise competing interests.

Authors' contributions

SSK conducted the study; thematically analysed the data and wrote the preliminary manuscript for submission. CSM planned and designed the study, managed the ethical approval, initiated the data collection and is the principle investigator in a series of studies promoting kindness and compassion during childbirth. SKC made valuable contributions regarding the background of the study, assisted with thematically analysing the data and facilitated drafting the manuscript. All authors read and were in agreement with the final manuscript.

Authors' information

SSK is a part-time M.Cur student at North-West University, Potchefstroom Campus, who conducted the study as partial fulfilment for the M.Cur in Nursing Science.

CSM is an Associate Professor of Nursing Science and the Director of the NuMIQ research focus area at North-West University.

SKC is an Associate Professor at the School of Nursing Science and NuMIQ research focus area of the North-West University.

Acknowledgements

Ms Angelina Wilson for co-coding the data set in collaboration with the researcher. Mr Francois Watson for guidance regarding the qualitative research programme Atlas.ti 8. Ms Gerda Beukman for assistance with the literature review as the subject librarian.

References

1. International Confederation of Midwives: essential competencies for basic midwifery practice. http://internationalmidwives.org/assets/uploads/ documents/ CoreDocuments/ ICM%20Essential%20Competencies%20for%20Basic%20Midwifery%20Practice%2020 10,%20revised%202013.pdf (2013). Accessed 20 Jul 2017.

2. Byrom S, Downe S. “She sort of shines”: midwives’ accounts of “good” midwifery and “good” leadership. Midwifery. 2010;26:126-37.

3. Masala-Chokwe MET, Ramukumba TS. Exploring the meaning of caring amongst student midwives, professional midwives and educators in Tshwane, South Africa. African journal of primary health care family medicine. 2015;7(1):1-8.

4. Nicholls L, Webb C. What makes a good midwife? An integrative review of methodologically-diverse research. J Adv Nurs. 2006; doi:10.1111/j.1365-2648.2006. 04026.x.

5. Sinclair S, McClement S, Raffin-Bouchal S, Hack TF, Hagen NA, McConnell S, et al. Compassion in healthcare: an empirical model. Palliat Med. 2016a; doi:10.1177/0269216316663499.

6. Shantz ML. Compassion: a concept analysis. Nursing forum. 2007;42(2):48-55.

7. Ménage D, Bailey E, Lees S, Coad J. A concept analysis of compassionate midwifery. J Adv Nurs. 2017; doi:10.111/jan.13214.

8. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. Lancet. 2014;1-2.

9. Brodie P. "Midwifing the midwives": addressing the empowerment, safety of and respect for, the world's midwives. Midwifery. 2013;29:1075-6.

10. Feijen-de Jong EI, Kool L, Peters LL, Jansen DEMC. Perceptions of nearly graduated fourth year midwifery students regarding a "good midwife" in the Netherlands. Midwifery. 2017;50:157-62.

11. International Confederation of Midwives: international definition of the midwife. http://internationalmidwives.org/assets/uploads/documents/Definition.of%20the%20Midwife%20-%202011.pdf (2011). Accessed 3 Jul 2017.

12. White Ribbon Alliance: respectful maternity care, the universal rights of childbearing women. http://whiteribbonalliance.org.s112547.gridserver.com/wp-content/uploads/2013/05/ Final_RMC_Charter.pdf (2011). Accessed 26 Jul 2017.

13. Borrelli SE. What is a good midwife? Insights from literature. Midwifery. 2014;30:3-10.

14. Butler MM, Fraser DM, Murphy RJL. What are the essential competencies required of a midwife at registration? Midwifery. 2008;24:260-9.

15. Cummings J, Bennet V. Compassion in practice: nursing, midwifery and care staff-our vision and strategy. In: NHS Commissioning Board. Department of Health. 2012. http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf. Accessed 2 Sept 2017.

16. Dewar B, Nolan M. Caring about caring: developing a model to implement compassionate relationship centred care in an older people care setting. Int J Nurs Stud. 2014; doi:10.1016/j.ijnurstu.2013.01.008.

17. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. In: Translating research into practice. USAID-

TRAction project. 2010. http://www. tractionproject.org/resources/access-skilled-care-respectful-maternal-care/exploring-evidence-disrespect-and-abuse. Accessed 18 Sept 2017.

18. Goer, H. Cruelty in maternity wards: fifty years later. Journal of Perinatal Education. 2010;19(3):33-42.

19. Honikman S, Fawcus S, Meintjies I. Abuse in South African maternity settings is a disgrace: potential solutions to the problem. S Afr Med J. 2015;105(4):284-6.

20. Human Rights Watch. “Stop making excuses”: accountability for maternal health care in South Africa. http://www.hrw.org/fr/node/100757 (2011). Accessed 25 Jul 2017.

21. Kruger L-M, Schoombee C. The other side of caring: abuse in a South African maternity ward. Journal of Reproductive and Infant Psychology. 2009;28(1):84-101.

22. World Health Organization: the prevention and elimination of disrespect and abuse during facility-based childbirth. http://who.int/reproductivehealth/topics/ maternal_ perinatal/statement_childbirth/en (2014). Accessed 2 Jan 2017.

23. World Health Organization. WHO Standards for improving quality of maternal and newborn care in health facilities. Geneva; 2016. ISBN 978 92 4 15 11216.

24. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva; 2018. ISBN 978-92-4-155021-5.

25. Maben J, Cornwell J, Sweeney K. In praise of compassion. Journal of Research in Nursing. 2010;15(1):9-13.

26. McCaffrey G, McConnell S. Compassion: a critical review of peer-reviewed nursing literature. Journal of Clinical Nursing. 2015;24:3006-15.

27. Beaumont E, Durkin M, Hollins Martin CJ, Carson, J. Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: a quantitative survey. Midwifery. 2016;34:239-44.

28. Goetz JL, Keltner D, Simon-Thomas E. Compassion: an evolutionary analysis and empirical review. Psychol Bull. 2010;136(3):351-374.

29. Sinclair S, McClement S, Raffin-Bouchal S, Hack TF, Hagen NA, McConnell S, et al. Compassion in healthcare: an empirical model. J Pain Symptom Manage. 2016b;51(2):193-203.

30. Burnell L. Compassionate care, a concept analysis. Home health care management and practice. 2009;21(5):319-24.

31. Dewar B, Christley Y. A critical analysis of compassion in practice. Nursing standard. 2013;28(10):46-50.

32. Strauss C, Taylor BL, Gu J, Kuyken W, Baer R, Jones F, et al. What is compassion and how can we measure it? Clin Psycholog Rev. 2016;47:15-27.

33. Von Dietze E, Orb A. Compassionate care: a moral dimension of nursing. Nursing inquiry. 2000;7(3):166-74.

34. Waugh A, Smith D, Horsburgh D, Gray M. Towards a values-based person specification for recruitment of compassionate nursing and midwifery candidates: a study of registered and student nurses' and midwives' perceptions of prerequisite attributes and key skills. Nurse education today. 2014; 34:1190-5.

35. Blomberg K, Griffiths P, Wenstrom Y, May C, Bridges J. Interventions for compassionate nursing care: a systematic review. Int J Nurs Stud. 2016;62:137-55.

36. Cleary M, Horsfall J, Escott P. Compassion and mental health nursing. Mental health nursing. 2015;36:536-5.

37. Fry M, MacGregor C, Ruperto K, Jarrett K, Wheeler J, Fong J, et al. Nursing praxis, compassionate caring and interpersonal relations: an observational study. Australasian emergency nursing journal. 2013;16(2):37-47.

38. Straughair C. Exploring compassion: implications for contemporary nursing: part one. British journal of nursing. 2012;21(3):160-4.

39. Dewar B, Adamson E, Smith S, Surfleet J, King L. Clarifying misconceptions about compassionate care. Journal of advanced nursing science, 2014;1738-1747. DOI:10.1111/jan.12322.

40. Creswell JW. Research design: qualitative, quantitative and mixed method approaches. 3rd ed. Los Angeles: Sage Publications Inc.; 2009.

41. Sandelowski M. “To be of use”: enhancing the utility of qualitative research. Nurs Outlook. 1997;45(3):125-32.

42. Denscombe M. Web-based questionnaires and the mode-effect: an evaluation based on completion rates and data contents of near-identical questionnaires delivered in different modes. Social science computer review. 2006; 24(2):246-54.

43. Joubert T, Kriek HJ. Psychometric comparison of paper and pencil and online personality assessments in a selection setting. South African journal of industrial psychology. 2009;35(1):78-88.

44. Callegaro M, Manfreda KL, Vehovar V. Web survey methodology. Los Angeles: Sage Publications Inc.; 2015.

45. Wright KB. Researching internet-based populations: advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. Journal of computer-mediated communication. 2005; doi:10.111/j.1083-6101.2005.tb00259.x.

46. Bhutta CB. Not by the book: Facebook as a sampling frame. Sociological methods and research. 2012;41(1):57-88.

47. Murray DM, Fisher JD. The Internet: a virtually untapped tool for research. Journal of technology in human services. 2002;19(2):5-18.

48. Whitehead LS. Methodological and ethical issues in internet-mediated research in the field of health: an integrated review of the literature. Soc Sci Med. 2007;65:782-91.

49. Survey Monkey. Features. https://www.surveymonkey.com/features (2018). Accessed 15 Apr 2018.

50. Hill R. What sample size is “enough” in Internet survey research? Interpersonal computing and technology. 1998;6(3-4):1-10.

51. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006;3(2):77-101.

52. Vaismoradi M, Turunen H, Bondas, T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nursing and Health Sciences. 2013;15:398-405.

53. Burns N, Grove SK. The practice of nursing research – appraisal, synthesis, and generation of evidence. 6th ed. New York: Saunders Elsevier; 2009.

54. Lincoln YX, Guba EA. Naturalistic inquiry. Thousand Oaks: Sage Publications Inc., 1985.

55. Botes AC. Validity, reliability and trustworthiness. In: Rossouw, D, editor. Intellectual tools: skills for the human science. 2nd ed. Pretoria: van Schaik; 2003.

56. Papadopoulos I, Taylor G, Ali S, Aagard M, Akman O, Alpers L-M, et al. Exploring nurses' meaning and experiences of compassion: an international online survey involving 15 countries. Journal of transcultural nursing. 2017; doi: 10.1177/1043659615624740.

57. Graber DR, Mitcham MD. Compassionate clinicians take patient care beyond the ordinary. Holistic nursing practice. 2004;18(2): 87-94.

58. Hall J. Developing a culture of compassionate care – the midwives voice? Midwifery. 2013;29:269-71.

59. Van der Cingel M. Compassion in care: a qualitative study of older people with a chronic disease and nurses. Nursing ethics. 2011;18(5):672-85.

60. Way D, Tracy, SJ. Conceptualising compassion as recognizing, relating and (re)acting: a qualitative study of compassionate communication at Hospice. Communication monographs. 2012; doi:10.1080/03637751.2012.697630.

61. Goberna-Tricas J, Banús-Giménez MR, Palacio-Tauste A, Linares-Sancho S. Satisfaction with pregnancy and birth services: the quality of maternity care services as experienced by women. Midwifery. 2011;27:231-7.

62. Davison C, Hauck YL, Bayes SJ, Kuliukas LJ, Wood J. The relationship is everything: women's reasons for choosing a privately practising midwife in Western Australia. Midwifery. 2015;31:772-778.

63. Berg M, Lundgren I, Hermansson E, Wahlberg V. Women's experience of the encounter with the midwife during childbirth. Midwifery. 1996;12:11-5.

64. Crawford P, Brown B, Kvangarsnes M, Gilbert P. The design of compassionate care. Journal of clinical nursing. 2014;23:3589-99.

TABLES

Table 1 Responses for demographic data

Question	Details	Total
What is your gender?	Male	0
	Female	98
Where do you practice midwifery?	Rural area	28
	Urban area	70
In which facility do you practice midwifery?	State hospital	31
	Private hospital	17
	Community health centre	7
	Private practice (midwife-led)	24
	Other	19
How many years' experience do you have working as a midwife?	1-5 years	33
	6-10 years	14
	11-20 years	22
	21-30 years	20
	30+ years	9
Is this the first time you are answering the survey?	Yes	88
	No	10

Table 2 Identified themes and subthemes in kind and compassionate midwifery care

Themes	**Subthemes**
Making meaningful connections with patients	Displaying good interpersonal skills
	Conduct based on dignity and respect
	Establishing trust
Initiating individualised understanding of each patient	Showing empathy
	Being patient
	Prioritising maternal choice
	Promotion of advocacy
	Non-judgemental attitude
Action through care and support	Providing emotional support
	Assistance through instrumental support
	Continuous informational support

CHAPTER 4:
EVALUATION, LIMITATIONS AND RECOMMENDATIONS

4.1 Introduction

In this chapter the study is evaluated, the limitations of the study are discussed and future recommendations for nursing practice, nursing research, nursing education and policy are suggested.

4.2 Evaluation of the study

The objective of this study was to explore and describe the characteristics of kind and compassionate care during childbirth as these are perceived by midwives. The objective was accomplished through identification of themes and sub-themes that materialised in thematic analysis of the data. A qualitative descriptive research design was chosen for the study as best suited to the nature of the research problem (Creswell, 2009:18), namely a gap in knowledge about what midwives regard as the characteristics of kind and compassionate care. Few other empirical studies could be found exploring this relatively new concept (Ménage *et al.,* 2017:558-562). The research design chosen also made it possible to explore and describe accounts from practice (Sandelowski, 1997:128), which was needed to develop a meaningful understanding of how midwives regard the concept of kind and compassionate care during childbirth. The characteristics of kind and compassionate care were identified as follows: (i) making meaningful connections with patients by displaying good interpersonal skills and showing dignity and respect, and establishing trust; (ii) initiating individualised understanding of each patient the midwife comes into contact with by showing empathy, being patient, permitting maternal choice, promotion of advocacy and having a non-judgmental attitude; and (iii) acting to provide care and support in the form of emotional support, instrumental support assistance, and continuous informational support.

A further aim of the study was to create awareness amongst midwives and promote kind and compassionate midwifery care during childbirth as this is believed to improve the quality of care rendered (Byrom & Downe, 2010:126, 135; Ménage *et al.,* 2017:558-559 Nicholls & Webb, 2006:414, 427). This was achieved by creating the Facebook page named “Promoting kind and compassionate care during childbirth.” The Facebook page

was shared and liked by 81 midwives, encouraging discussion and awareness of the topic. Positive feedback, encouragement and praise was received from midwives on the Facebook page.

The findings of the study will be disseminated to the international scientific community by submitting them for publication in the *BMC Pregnancy and Childbirth* journal.

4.3 Limitations of the study

Few descriptions could be found in the literature regarding compassion in midwifery care. In the early stages of the study, this appeared to be a limitation. Yet as the study progressed it became a strength, as there is a definite gap in the literature in relation to the way midwives view compassion. This empirical study is able to contribute to the body of knowledge, as unique findings were identified, and provides a starting point for continued future investigations into the concept.

A limitation of the study was that only midwives with an active Facebook account were eligible for inclusion in the study. The sample may not be representative off all midwives, as it is not required of midwives that they have access to the internet or Facebook accounts (Callegaro *et al.,* 2015:18-23). This limitation is acknowledged, although representativeness is not pivotal in this qualitative study (Whitehead, 2007:782). The sample obtained in this study represents a diverse selection of midwives, allowing multiple viewpoints to be analyzed and considered. This is seen as a strength in a qualitative study (Creswell, 2009:173). Hill (1998:4) recommends a sample size of between 30 and 500 for an online survey. 98 completed responses were received and this was considered to be sufficient as data saturation took place.

4.4 Recommendations

The following recommendations are suggested by the researcher following completion of the study.

4.4.1 Recommendations for midwifery practice

- A positive stance could be taken in practice by promoting kind and compassionate care during childbirth. This can be done by midwives starting initiatives advocating for kind and compassionate care in daily practice. For example, the unit manager of a

maternity ward could initiate and implement a ‘kind and compassionate employee of the month’ award to serve as encouragement to practice compassionately. An incentive could ultimately be offered to the overall winner after twelve consecutive months. A ceremony could be held where midwives could share stories of how they perceive kind and compassionate maternity care as this could improve understanding and awareness of kind and compassionate care during childbirth.

- The Facebook page could continue to be used as a platform for midwives to discuss kind and compassionate care during childbirth, as much encouragement and praise was received from midwives concerning the concept and initiative. If midwives who are currently practicing could improve the manner in which compassion is practiced and its incidence, the overall quality of midwifery care rendered could be improved.

- Focusing on the characteristics identified, the researcher could offer in-service training to local and other interested communities to make more midwives aware of what kind and compassionate care during childbirth is considered to be. To serve as continuous reminder to practice compassionately, posters could be put up around the ward summarising the characteristics of kind and compassionate care.

- A poster could be designed, highlighting the characteristics of kind and compassionate care during childbirth and shared electronically on the Facebook page. Midwives could be encouraged to spread the information and initiate discussions about the concept. In this way, the idea could be re-enforced in practice, as there would be an increased awareness amongst practicing midwives.

4.4.2 Recommendations for midwifery research

- The findings from this study will be incorporated into the main study by principle investigator Professor C.S. Minnie – “Promoting kind and compassionate care during childbirth” – in the development of a tool that will be used to assess kind and compassionate midwifery care in an effort to promote good midwifery care.

- More investigation is recommended into the concept of kind and compassionate care during childbirth from the midwife’s perspective to improve understanding of the concept within midwifery. Once the concept can be better defined and described, theoretical frameworks could be designed which could guide midwifery practice in

providing more compassionate care, ultimately improving the quality of midwifery care offered.

- Additional studies are needed in relation to the mother's understanding of kind and compassionate care during childbirth.

4.4.3 Recommendations for midwifery education

- It is recommended that compassion be added to and taught in the undergraduate midwifery curriculum on a theoretical and practical level. On a theoretical level, articles could be shared regarding compassionate care and discussed from the first year of training through to graduation. Assignments and debate regarding the topic are encouraged amongst lecturers and students.

- A short course could be developed for midwifery lecturers, focusing on the characteristics of kind and compassionate care during childbirth.

4.4.4 Recommendations for policy

- A strategy plan for kind and compassionate care during childbirth could be developed for hospital management, nursing forums and policy makers. The findings of this study suggest that implementing policies promoting kind and compassionate care during childbirth could improve the quality of care given by midwives. The Department of Health could be approached to become involved and implement the policy in the North West Province, maternity units, as a pilot.

4.4.5 Recommendations for management

- The management of hospitals should create awareness concerning kind and compassionate care during childbirth in order to improve the quality of care provided by midwives. This could be done by implementing an in-service training program focusing on kind and compassionate care during childbirth.

- The management of hospitals could implement a personal and professional development system where feedback could be given to midwives regarding their behaviour concerning compassionate care. This could encourage the implementation of kind and compassionate care as a gold standard.

4.5 Conclusion

In this chapter, the study was evaluated, limitations in the study were identified, and recommendations for future midwifery practice, research, education, management and policy were made. The characteristics of kind and compassionate care during childbirth as perceived by midwives were identified as follows: making meaningful connections with patients; individualized understanding of each patient cared for during childbirth, and action through giving of care and support. Better understanding of how midwives perceive the concept is a starting point for design and development of potential frameworks which could be implemented in practice and which, in time, would improve the quality of care midwives offer to women during childbirth.

REFERENCE LIST

Beaumont, E. & Hollins Martin, C.J. 2016. Heightening levels of compassion towards self and others through use of compassion mind training. *British journal of midwifery*, 24(11):777-786.

Berg, M., Lundgren, I., Hermansson, E., Wahlberg, V. 1996. Women's experience of the encounter with the midwife during childbirth. *Midwifery*, 12:11-5.

Bhutta, C.B. 2012. Not by the book: Facebook as a sampling frame. *Sociological methods and research*, 41(1):57-88.

Black, S. 2008. The power of compassion. *Nursing standard*, 23(7):70-71.

Blomberg, K., Griffiths, P., Wengstrom, Y., May, C. & Bridges, J. 2016. Interventions for compassionate nursing care: a systematic review. *International journal of nursing studies*, 62:137-155.

Borrelli, S.E. 2014. What is a good midwife? Insights from literature. *Midwifery*, 30:3-10.

Botes, A.C. 2003. Validity, reliability and trustworthiness. Found in Rossouw, D. (Editor.), Intellectual tools: skills for the human sciences, 2nd ed. Pretoria: van Schaik. p 176-184.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in Health Sciences. Heinemann: Cape Town. 370 p.

Bowser, D. & Hill, K. 2010. Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. http://www.tractionproject.org/ resources/ access-skilled-care-respectful-maternal-care/exploring-evidence-disrespect-and-abuse. Date of access: 10/01/2017.

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2):77-101.

Brodie, P. 2013. '"Midwifing the midwives"': addressing the empowerment, safety of, and respect for, the world's midwives. *Midwifery*, 29:1075-1076.

Brown, B., Crawford, P., Gilbert, P., Gilbert, J. & Gale, C. 2014. Practical compassions: repertoires of practice and compassion talk in acute mental health care. *Sociology of health & illness,* 36(3):383-399.

Buchanan, E.A. & Hvizdak, E.E. 2009. Online survey tools: ethical and methodological concerns of human Research Ethics Committees. *Journal of empirical research on human research ethics*, 4(2):37-48.

Burnell, L. 2009. Compassionate care. *Home health care & management practice,* 21(5):319-324.

Burnell, L. & Agan, D.L. 2013. Compassionate care: can it be defined and measured? The development of the compassionate care assessment tool. *International journal of caring sciences*, 6(2): 180-187.

Burns, N. & Grove, S.K. 2009. The practice of nursing research – Appraisal, synthesis, and generation of evidence. 6th ed. New York: Saunders Elsevier. 750p.

Butler, M.M., Fraser, D.M. & Murphy, R.J.L. 2008. What are the essential competencies required of a midwife at registration? *Midwifery*, 24:260-269. doi:10.1016/j.midw.2006.10.010.

Byrom, S. & Downe, S. 2010. '"She sort of shines'": midwives' accounts of '"good'" midwifery and '"good'" leadership. *Midwifery*, 26:126-137.

Callegaro, M., Manfreda, K.L. & Vehovar, V. 2015. Web survey methodology. Los Angeles: Sage. 344p.

Carolan, M. 2011. The good midwife: commencing students' views. *Midwifery*, 27:503-508.

Carolan, M. 2013. "A good midwife stands out": 3rd year midwifery student's views. *Midwifery,* 29:115-21.

Cleary, M., Horsfall, J. & Escott, P. 2015. Compassion and mental health nursing. *Mental health nursing*, 36:536-5. doi:10.3109/01612840.2015.1053771.

Crawford, P.; Brown, B.; Kvangarsnes, M. & Gilbert, P. 2014. The design of compassionate care. *Journal of clinical nursing*, 23:3589-3599.

Creswell, J.W. 2009. Research design: qualitative, quantitative and mixed method approaches. *3rd ed*. Los Angeles: Sage Publications Inc. 260p.

Cummings, J. & Bennet, V. 2012. Compassion in practice: nursing, midwifery and care staff-our vision and strategy. NHS Commissioning Board. http://www.england. nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf. Date of access: 02/09/2017.

Curtis, K. 2013. 21st Century challenged faced by nursing faculty in educating for compassionate practice: embodied interpretation of phenomenological data. *Nurse education today,* 33:746-750.

Davison, C., Hauck, Y.L., Bayes, S.J., Kuliukas, L.J. & Wood, J. 2015. The relationship is everything: women's reasons for choosing a privately practising midwife in Western Australia. *Midwifery*, 31:772-778.

Denscombe, M. 2006. Web-based questionnaires and the mode-effect: an evaluation based on completion rates and data contents of near-identical questionnaires delivered in different modes. *Social science computer review*, 24(2):246-254.

Dewar, B. & Christley, Y. 2013. A critical analysis of compassion in practice. *Nursing standard*, 28(10):46-50.

Dewar, B. & Nolan, M. 2013. Caring about caring: developing a model to implement compassionate relationship centred care in an older people care setting. *International journal of nursing studies,* 1-12. http://dx.doi.org/10.1016/j.ijnurstu.2013.01.008.

Dewar, B., Adamson, E., Smith, S., Surfleet, J. & King, L. 2014. Clarifying misconceptions about compassionate care. *Journal of advanced nursing science*, 1738-1747. DOI:10.1111/jan.12322.

Dewar, B. 2013. Compassionate care. *Nursing standard,* 28(15):61.

Downs, M. 2013. Putting people – and compassion - first: the United Kingdom's approach to person-centred care for individuals with dementia. *Journal of the American society on aging*, 37(3):53-59.

Ellis-Hill, C. 2011. Compassion and lifeworld-led care: an emerging field of study. *Journal of Australian rehabilitation nurses'*, 14(2):6-11.

Feijen-de Jong, E.I., Kool, L., Peters, L.L. & Jansen, D.E.M.C. 2017. Perceptions of nearly graduated fourth year midwifery students regarding a '"good midwife"' in the Netherlands. *Midwifery*, 50:157-62.

Fraser, D.M. 1999. Women's perceptions of midwifery care: a longitudinal study to shape curriculum development. *Birth*, 26:99-107.

Freedman, L.P. & Kruk, M.E. 2014. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet*, Online (1-2). http://dx.doi.org/10.1016/ S0140-6736(14)60859-X.

Fry, M., MacGregor, C., Ruperto, K., Jarrett, K., Wheeler, J., Fong, J., Fetchet, W. 2013. Nursing praxis, compassionate caring and interpersonal relations: an observational study. *Australasian emergency nursing journal*, 16(2):37-47.

Goberna-Tricas, J., Banús-Giménez, M.R., Palacio-Tauste, A. & Linares-Sancho, S. 2011. Satisfaction with pregnancy and birth services: the quality of maternity care services as experienced by women. *Midwifery*, 27:231-237.

Goer, H. 2010. Cruelty in maternity wards: fifty years later. *The journal of perinatal education*, 19(3):33-42.

Goetz, J.L., Keltner, D. & Simon-Thomas, E. 2010. Compassion: an evolutionary analysis and empirical review. *American psychological association*, 136(3): 351-374.

Graber, D.R. & Mitcham, M.D. 2004. Compassionate clinicians take patient care beyond the ordinary. *Holistic nursing practice*, 18(2): 87-94.

Gustin, L.W. & Wagner, L. 2012. The butterfly effect of caring – clinical nursing teachers' understanding of self-compassion as a source to compassionate care. *Scandinavian journal of caring sciences,* 1-9. DOI:10.1111/j.1471-6712.2012.01033.x.

Halifax, J. 2011. The precious necessity of compassion. *Journal of pain and symptom management*, 41(1): 146-153.

Hall, J. 2013. Developing a culture of compassionate care – the midwives voice? *Midwifery*, 29:269-271.

Hill, R. 1998. What sample size is '"enough'" in Internet survey research*? Interpersonal computing and technology*, 6(3-4):1-10.

Honikman, S., Fawcus, S. & Meintjies, I. 2015. Abuse in South African maternity settings is a disgrace: potential solutions to the problem. *South African medical journal,* 105(4):284-286.

Human Rights Watch. 2011. "Stop making excuses"- Accountability for maternal health care in South Africa. http://www.hrw.org/fr/node/100757. Date of access: 25/07/2017.

ICM (International Confederation of Midwives). 2008. International Code of Ethics for Midwives. https://internationalmidwives.org/assets/uploads/documents/CoreDocuments/CD2008_001%20V2014%20ENG%20International%20Code%20of%20Ethics%20for%20Midwives.pdf Date of access 03/07/2017.

ICM (International Confederation of Midwives). 2011. ICM International definition of the midwife. http://internationalmidwives.org/assets/uploads /documents/ Definition%20 of%20the%20Midwife%20-%202011.pdf. Date of access: 03/07/2017.

ICM (International Confederation of Midwives). 2013. ICM Essential competencies for basic midwifery practice. http://internationalmidwives.org/assets/uploads/ documents/ CoreDocuments/ICM%20Essential%20Competencies%20for%20Basic%20Midwifery%20Practice%202010,%20revised%202013.pdf. Date of access: 20/07/2017.

ICM (International Confederation of Midwives). 2014. Philosophy and model of midwifery care. http://internationalmidwives.org/assets/uploads/documents/ CoreDocuments/CD2005_001%20V2014%20ENG%20Philosophy%20and%20model%20of%20midwifery%20care.pdf

Jacinto, G. & Buckey, J.W. 2013. Birth: a rite of passage. *International journal of childbirth education,* 28(1):11-14.

Joubert, T. & Kriek, H.J. 2009. Psychometric comparison of paper and pencil and online personality assessments in a selection setting. *South African journal of industrial psychology*, 35(1):78-88.

Kret, D.D. 2011. The qualities of a compassionate nurse according to the perceptions of medical-surgical patients. *Medsurg nursing*, 20(1):29-36.

Kruger, L-M. & Schoombee, C. 2009. The other side of caring: abuse in a South African maternity ward. *Journal or reproductive and infant psychology*, 28(1):84-101.

Larson, E., Vall, D., Mbaruku, G.M., Kimweri, A., Freedman, L.P. & Kruk, M.E. 2015. Moving toward a patient-centred care in Africa: a discrete choice empowerment of preferences for delivery care among 3,003 Tanzanian women. *Public library of science one,* doi:10.1371/journal.pone.0135621.

Lavender, T., Walkinshaw, S.A. & Walton, I. 1999. A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery*, 15:40-6.

Lincoln, Y.X. & Guba, E.A. 1985. Naturalistic inquiry. Thousand oaks: Sage.

Maben, J., Cornwell, J. & Sweeney, K. 2009. In praise of compassion. *Journal of research in nursing*, 15(1):9-13.

Masala-Chokwe, M.E.T. & Ramakumba, T.S. 2015. Exploring the meaning of caring amongst student midwives, professional midwives and educators in Tshwane, South Africa. *The African journal of primary health care and family medicine*, 7(1):1-8.

MacCulloch, T. 2007. Comments, critique, and inspiration the gift of compassion. *Issues in mental health nursing,* 28:825-827.

McCaffrey, G. & McConnell, S. 2015. Compassion: a critical review of peer-reviewed nursing literature. *Journal of clinical nursing*, 24:3006-3015.

McConnell, E. 2015. Compassion starts from within: beyond the checklist. *Nursing and residential care*, 17(2):96-99.

McCourt, C. & Pearce, A. 2000. Does continuity of carer matter to women from minority ethnic groups*? Midwifery*, 16:145-154.

Ménage, D.; Bailey, E., Lees, S. & Coad, J. 2017. A concept analysis of compassionate midwifery. *Journal of advanced nursing*, 73(3): 558-573.

Morse, J.M. & Field, P.A. 1995. Qualitative research methods for health professionals. 2nd *ed*. Los Angeles: Sage Publications. 254p.

Murray, D.M. & Fisher, J.D. 2002. The Internet: a virtually untapped tool for research. The Haworth Press Inc., 5-18.

Nicholls, L. & Webb, C. 2006. What makes a good midwife? An integrative review of methodologically-diverse research. *Journal of advanced nursing*, 56(4):414-429.

Nursing Act **see** South Africa.

Papadopoulos, I., Taylor, G., Ali, S., Aagard, M., Akman, O., Alpers, L.-M., Apostolara, P., Biglete-Pangilinan, S., Biles, J., Martín García, A., Gonzάlez-Gil, T., Kouloglioti, C., Kouta, C., Krepinska, R., Nirmal Kumar, B., Lesińska-Sawicka, M., Diaz, A.L.L., Malliarou, M., Nagórska, M., Nassim, S., Nortvedt, L., Oter-Quintana, C., Ozturk, C., Papp, K., Rubiano, F.O., Diaz, M.Y.T., Tóthovά, V., Vasiliou, M. & Zorba, A. 2017. Exploring nurses' meaning and experiences of compassion: an international online survey involving 15 countries. *Journal of transcultural nursing*, 28(3):286-295.

Pocket Oxford Dictionary. 2000. 18th *ed*. Oxford: Oxford University Press. 1092 p.

Polit, D.F., Beck, C.T. & Hungler, B.P. 2001. Essentials of nursing research: methods, appraisal, and utilization. 5th ed. Philadelphia: Lippincott Wiliams & Wilkens.

Protection of Personal Information Act (POPI) **see** South Africa.

SANC (South African Nursing Council). 2005. Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act 33 of 2005. http://www.sanc.co.za/regulat/Reg-scp.htm. Date of access: 25/07/2017.

Sandelowski, M. 1997. "To be of use": enhancing the utility of qualitative research. *Nursing outlook*, 45(3):125-32.

Shantz, M.L. 2007. Compassion: a concept analysis. *Nursing forum*, 42(2): 48-55.

Sinclair, S., Beamer, K., Hack, T.F., McClement, S., Bouchal, S.R., Chochinov, H.M. & Hagen, N.A. 2016a. Sympathy, empathy and compassion: a grounded theory study of palliative care patients' understandings, experiences and preferences. *Palliative medicine journal*, 1-11. DOI: 10.1177/0269216316663499.

Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T.F., Hagen, N.A., McConnell, S. & Chochinov, H.M. 2016b. Compassion in healthcare: an empirical model. *Journal of pain and symptom management,* 51(2):193-203.

South Africa. 2005. Nursing Act 33 of 2005.

South Africa. 2013. Protection of Personal Information Act 4 of 2013.

Straughair, C. 2012a. Exploring compassion: implications for contemporary nursing, part one. *British journal of nursing*, 21(3):160-164.

Straughair, C. 2012b. Exploring compassion: implications for contemporary nursing, part two. *British journal of nursing,* 21(4):239-244.

Strauss, C., Taylor, B.L., Gu, J., Kuyken, W., Baer, R., Jones, F. & Cavanagh, K. 2016. What is compassion and how can we measure it? *Clinical psychology review*, 47:15-27.

Sturgeon, D. 2008. Measuring compassion in nursing. *Nursing standard,* 22(46):42-43.

Sturgeon, D. 2010. 'Have a nice day': consumerism, compassion and health care. *British journal of nursing*, 19(16):1047-1051.

Survey Monkey. 2018. Features. https://www.surveymonkey.com/features. Date of access: 15/04/2018.

Taylor, A. 2015. Person-centred care in practice. *British journal of midwifery*, 23(5):350-355.

The Pocket Oxford Dictionary. 2000. 18th *ed.* Oxford: Oxford University Press. 1092 p.

Tunçalp, O., Were, W.M., MacLennan, C., Oladapo, O.T., Gülmezoglu, A.M., Bahl, R., Daelmans, B., Mathai, M., Say, L., Kristensen, F., Temmerman, M. & Bustreo, F. 2015. Quality of care for pregnant women and newborns- the WHO vision. *British journal of obstetrics and gynaecology,* 122:1045-1049.

Vaismoradi, M., Turunen, H. & Bondas, T. 2013. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15:398-405.

van der Cingel, M. 2011. Compassion in care: a qualitative study of older people with a chronic disease and nurses. *Nursing ethics*, 18(5):672-685.

von Dietze, E. & Orb, A. 2000. Compassionate care: a moral dimension of nursing. *Nursing inquiry*, 7(3):166-74.

Waugh, A., Smith, D., Horsburgh, D. & Gray, M. 2014. Towards a values-based person specification for recruitment of compassionate nursing and midwifery candidates: a study of registered and student nurses' and midwives' perceptions of prerequisite attributes and key skills. *Nurse education today*, 34:1190-1195.

Way, D. & Tracy, S.J. 2012. Conceptualizing compassion as recognizing, relating and re(acting): a qualitative study of compassionate communication at Hospice. *Communication monographs*, 79(3):292-315.

White Ribbon Alliance. 2011. Respectful Maternity Care: the universal rights of childbearing women. Online: 1-6. http://whiteribbonalliance.org. s112547.gridserver. com/wp-content/uploads/2013/05/Final_RMC_Charter.pdf. Date of access: 26/07/2017.

Whitehead, L.S. 2007. Methodological and ethical issues in internet-mediated research in the field of health: an integrated review of the literature. *Social science & medicine*, 65:782-791.

WHO (World Health Organization). 2014. The prevention and elimination of disrespect and abuse during facility-based childbirth. http://who.int/reproductivehealth/ topics/maternal_perinatal/statement_childbirth/en. Date of access: 02/01/2017.

WHO (World Health Organization). 2016. Standards for improving quality of maternal and newborn care in health facilities. Geneva; Switzerland. ISBN 978 92 4 15 11216.

World Health Organization. 2018. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva; Switzerland. ISBN 978-92-4-155021-5.

Wright, K.B. 2005. Researching internet-based populations: advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of computer-mediated communication*, 10(3). DOI: 10.111/j.1083-6101.2005.tb00259.x.

APPENDIX A – SURVEY QUESTIONS

Demographic section. This information is needed to publish in Scientific Journals. All answers will be kept anonymous.

Please click the appropriate box:

How old are you?	
21-29 years old	
30-39 years old	
40-49 years old	
59-60 years old	
60 + years old	

What is your gender?	
Male	
Female	

Where do you practice midwifery?	
Rural area	
Urban area	

In which facility do you practice midwifery?	
State Hospital	
Private Hospital	
Community Health Centre	
Private Practice (Midwife lead)	
Other	

How many years experience do you have of working as a midwife?	
1-5 years	
6-10 years	
11-20 years	

21-30 years	
30+ years	

Is this the first time you are answering the survey?

Yes ☐ No ☐

Please write a paragraph about an instance in which you saw or experienced kind and compassionate care during childbirth

List five words that you associate with kind and compassionate care during childbirth

Additional comments

APPENDIX B – INTRODUCTION PAGE AND INFORMED CONSENT

Survey regarding characteristics of kind and compassionate care during childbirth according to midwives

You are hereby invited to participate in a research project to identify the characteristics of kind and compassionate maternity care according to midwives. This is part of a research project on promoting kind and compassionate care of which Prof Karin Minnie of INSINQ Research Focus Area of the North-West University is the primary investigator. This part of the project will add to the knowledge needed to identify an instrument that can be used to assess the maternity care in selected health care facilities, which can eventually contribute to the promotion of kind and compassionate maternity care.

You will be eligible to participate if you are

- a midwife who can make a contribution from your experience.

Your decision to participate or not is entirely voluntary and you can stop at any stage if you do not want to continue.

If you decide to participate you are expected to complete a few demographic questions and two survey questions on the next page. In the first question you will be asked to write a paragraph about an instance which you saw or experience that portray kind and compassionate maternity care. In the second question you are asked to list five words that you associate with kind and compassionate maternity care. You are also welcome to leave further comments. You can complete the survey more than once. The completion of the survey are not expected to take more than 15 minutes. There is no direct benefit for you in participating, but your participation can contribute to guidelines to promote kind and compassionate care provided to new mothers. This is a low risk study, but if you experience any psychological distress, you are welcome to contact the researcher at the e-mail address below for assistance or referral.

The answers to the questions cannot be accessed by anyone but the research team. The completed surveys will be kept safely on servers that are well protected with passwords and firewalls.

All the answers will be analysed together and only the combined findings will be used in the final report. You are welcome to send an e-mail to Samantha.Krause@nwu.ac.za if you would like to receive an electronic version of this report or have any questions.

Please click on the button if you are eighteen years or older. □

Please click on the button if you understand the information about the research. □

Please click on the button if you want to complete the survey. □

APPENDIX C – ETHICS APPROVAL FROM NORTH-WEST UNIVERSITY

Private Bag X6001, Potchefstroom,
South Africa, 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Institutional Research Ethics Regulatory Committee
Tel: +27 18 299 4849
Email : Ethics@nwu.ac.za

2016/09/02

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)**, after being reviewed at the meeting held on **13/07/2016**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Promoting kind and compassionate care during childbirth.

Study Leader/Supervisor: **Prof CS Minnie**
Student: -

Ethics number: N W U - 0 0 0 7 2 - 1 6 - A 1
(Institution / Study Number / Year / Status)
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study
Commencement date: 2016-08-26 **Risk:** **Minimal**

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,*
    - *the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA Du Plessis — Digitally signed by Prof LA Du Plessis Date: 2016.09.05 17:27:31 +02'00'

Prof Linda du Plessis
Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

APPENDIX D – LANGUAGE EDITING REPORT

29 May 2018

To whom it may concern

This is to certify that the Master's thesis entitled "The characteristics of kind and compassionate care during childbirth according to midwives" by Samantha Krausé has been edited by me for English grammar, idiom, orthography, punctuation and sentence structure.

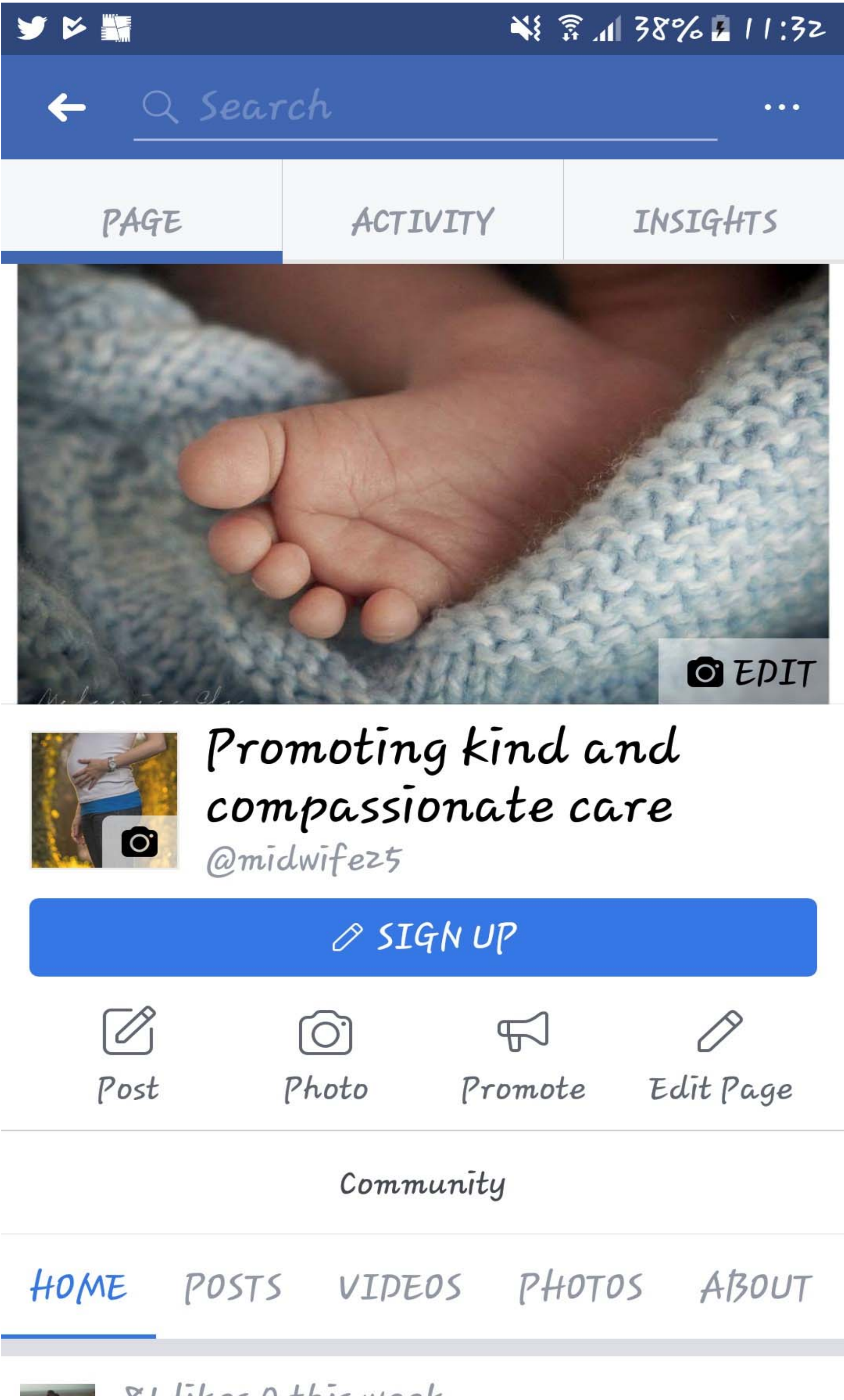
I will be happy to furnish additional information if requested.

David Newmarch BA(Hons) (Natal), M Phil (York)

Professional
EDITORS
Guild
Associate

197 Queen Elizabeth Ave, Durban 4001, South Africa
082 554 9090 (c) • 031 261 2197 (h) • grammarline@gmail.com

ADDENDUM A - PROMOTING KIND AND COMPASSIONATE CARE FACEBOOK PAGE SCREENSHOT



ADDENDUM B – EXAMPLE OF POST ON FACEBOOK PAGE INVITING POTENTIAL PARTICIPANTS TO PARTAKE IN THE STUDY