Article

Midwife-Woman Interaction as a Critical Component of Antenatal Care: Ethical Implications and Lessons to Be Learnt

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Abstract

Pregnancy and childbirth are important rites of passage for women and their families, with deep personal and cultural significance, bringing joy along with great physical and emotional vulnerability. The purpose of the study under review was to explore pregnant women's experiences of midwife-woman interaction and the extent to which it conforms to respectful ethical care. A qualitative case study design was applied. The setting was randomly selected primary health care facilities that form a first point of contact for pregnant women for antenatal care in Gauteng, South Africa. The population of the study was pregnant women of low socio-economic class receiving free antenatal care service at public primary health care facilities. Women waiting for their routine antenatal care were conveniently selected to be part of the focus group discussions (FGDs). The data was analysed thematically. Whilst a few positive aspects regarding midwife-woman interaction were shared, the participants expressed a desire for personal care; a shorter waiting time; continuity of care; enhanced communication with midwives; a greater opportunity for asking questions and receiving comprehensive answers; and a greater attention to their needs and fears. Recommendations were provided based on the study findings to enhance respectful practice by midwives.

Keywords: antenatal care; critical component; midwife-woman interaction; ethical implications; pregnancy

Introduction and Background

Most international efforts for strengthening maternal health care focus largely on preventing morbidity and mortality, but recent emphasis on the universal right of quality maternal health care has illuminated the need for examining interpersonal relationships between patients and healthcare providers (Abuya et al. 2015, 1).

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Midwives are the primary care providers for pregnant women in many countries. Good interpersonal care and effective communication have proved to empower women and increase the likelihood of a positive long-term effect on childbirth experience (Kabo et al. 2019, 3). Kozhimannil et al. (2015, 1614) state that midwifery is a care model with demonstrated effectiveness, satisfaction and lower cost and is often underused for women engagement.

Midwives are trained to be the first line management for women during pregnancy with a focus on the promotion of a healthy pregnancy and management of possible complications. As such, midwives are expected to act in the best interest of women through independent and interdependent decision making when health care needs overlap and also as based on their scope of practice (Froneman, Van Wyk and Mogale 2019, 1069). As Van Bussel, Spitz and Demyttenaere (2010, 143) state, patient satisfaction has become an important concern in health care and in obstetrics, with the focus mostly on women's experience and satisfaction with childbirth. Motherhood and pregnancy are cherished moments in a woman's life. The experience of pregnancy should be a period of great happiness and fulfilment (Johnson et al. 2019, 318), as pregnancy offers a unique opportunity to engage with women while the right support is vital (Jomeen and Redshaw 2013, 281). Therefore, the focus of the study was on midwife-woman interaction during antenatal care as most of the studies address this phenomenon in the context of childbirth.

Exploring and understanding midwife-woman interaction from the women's perspective to some extent underpins how women are perceived by midwives and is also considered the first step in improving the quality of midwife-woman interaction (Jomeen and Redshaw 2013, 281). An efficient midwife-woman interaction is fundamental to the promotion of positive childbirth experiences for women as antenatal care is the first point of contact for antenatal care. The researcher observed that both traditionally and in many contemporary contexts, including South Africa, antenatal care consists of a prescribed set of acts based around the clinical monitoring and screening of all pregnant women, which to a certain extent might compromise midwife-woman interaction.

According to Patterson, Martin and Karatzias (2019, 78), interpersonal difficulties, especially between midwives and women, being ignored and an unmet desire for support, are the strongest factors for women to develop post-traumatic stress disorder. Thompson and Downe (2010, 102) conclude their study on women's experiences of a positive birth by suggesting that "preparing women for uncertainty and providing opportunities for them to build trust in themselves and their caregivers may provide a bridge to a redemptive experience". Walburg, Friederich and Callahan (2014, 130) also highlight that ensuring a professional and respectful attitude from medical staff

that includes midwives, as well as having procedures explained, could reduce women's feelings of modesty. Midwives need to be aware of the ethical rules governing their profession with reference to the Nurses' Pledge of Service (https://www.sanc.co.za/aboutpledge.htm); the South African Nursing Council Code of Ethics (SANC 2013); and the International Council of Nurses Code of Ethics for Nurses (ICN 2012). Ethical obligations for midwives refer to the moral principles that underpin midwifery practice (McQuoid-Mason and Dada 2017, 129). Midwife-woman interaction is part of caring, which as an ethical principle, implies doing what is good and right, and identifies specific behaviours that characterise excellence in human behaviour (Pera and Van Tonder 2018, 16). The fundamental ethical principles that enhance midwife-woman interaction are autonomy, beneficence, non-maleficence and justice. Autonomy implies respect for unconditional worth of an individual, which refers to women in the context of this study. Beneficence is the obligation of doing good, while non-maleficence is the passive principle of avoiding harm. Justice, in the context of the study, implies midwives offering antenatal care that women deserve (Pera and Van Tonder 2018, 50).

Therefore, the current study was undertaken to explore midwife-woman interaction and to establish the extent to which the interaction conforms to respectful ethical maternal care as reflected in the basic ethical principles of autonomy, beneficence, non-maleficence and justice as recommended by the World Health Organization (WHO 2015): "every woman has the right to the highest attainable standard of health, including the right to dignity". Thomson and Downe (2010, 102) state that preparing women for the uncertainties of childbirth and providing opportunities for them to build trust in themselves and caregivers during antenatal care may provide a bridge to a redemptive experience.

Purpose and Objectives of the Study

The purpose of the study was to explore midwife-woman interaction and to establish the extent to which the interaction conforms to respectful ethical care and care that women expect during pregnancy. The objectives of the study were to:

- identify the care and support that women receive from midwives;
- determine if the care provided is what pregnant women expect; and
- establish the extent to which the midwife-woman interaction conforms to respectful ethical care.

Methodology

A qualitative case study design was applied to inductively describe the phenomenon of midwife-woman interaction (Christensen, Johnson and Turner 2015, 68). The midwifery-led health facilities that offer antenatal care were randomly selected in Gauteng, South Africa, as the study context. The rationale was that the settings are the first point of contact for antenatal care for the majority of low socioeconomic pregnant women and that services are widely available and offered free of charge. Four focus group discussions (FGDs) were conducted with pregnant women attending antenatal care at the selected facilities. Non-probability sampling was applied. Pregnant women waiting for their routine antenatal care were conveniently selected to be part of the FGDs. Only women who had given birth once and had attended antenatal care three or more times at the selected clinics for the current pregnancy were regarded as being able to share information about their experiences of interaction with midwives. The women's antenatal record cards were reviewed to verify that they met the criteria. Willing participants were requested to sign a consent form prior to the interview after being informed about the purpose of the study. The FGDs occurred after the women completed their routine antenatal care.

Ethical Considerations

Ethical approval was obtained from the University of the Witwatersrand Human Ethics Committee (Protocol number: M081013). Permission was obtained from the Gauteng Department of Health and the clinics where the FGDs were conducted. All the participants were informed that participation was voluntary and that they were free to withdraw at any stage. They were advised that all information obtained would be confidential and that pseudonyms would be used in any public account of the findings. In the event of the participants experiencing anxiety or distress, protocols were in place to refer them accordingly, for example, offering options for an unwanted pregnancy and referral to social services.

Trustworthiness

To ensure the process is trustworthy, the research should satisfy four criteria, namely, credibility, transferability, dependability and confirmability. These were ensured through prolonged engagement with the participants, member checking, maintaining an audit trail, and giving a thick description of the research process as outlined by Polit and Beck (2012, 331). Furthermore, prior to data collection and data analysis, the researcher reflected on her own perspectives and put them on hold. To ensure credibility, the researcher spent sufficient time interacting with the participants during discussions in order to develop a rich understanding of their experiences of interacting with midwives. Member checking was justified by reading out what was documented

to the participants and confirming if that was what they wanted to share. Probing was used to confirm that the researcher obtained their opinions correctly. A detailed description of the process, context and people in the research including the meaning and intentions of the participants' and researcher's conceptual developments was provided. To ensure transferability, the researcher provided the background information to establish the context of the study and a detailed description of the phenomenon to allow comparisons to be made. To justify dependability, the researcher maintained an audit trail in which the research design, data collection methods and analysis implemented were documented. Confirmability was authenticated through an audit trail and a thick description.

Data Collection and Analysis

The FGDs took place in a private room provided by the clinic managers. The researcher conducted the FGDs with the research assistant recording and collecting field notes. A semi-structured interview guide was used to conduct the FGDs. The interview guide was piloted with the first FGDs and adjustments were made accordingly. The question that was posed to participants as an opening question was: "Please tell me about the care and support you received from midwives during your clinic visits" and that was followed up by more questions and probing for example, "was the care you received what you expected". Eight participants were recruited for each FGD to ensure consistency of the group sizes and also as recommended by the literature for a homogenous group of 6–12 (Christensen, Johnson and Turner 2015, 73). Pregnant women were encouraged to express themselves in their preferred language if need be. Assurance regarding anonymity was communicated to women throughout the interview process. The common languages used by participants were Sesotho, IsiZulu, Xhosa and Tsonga. The researcher and assistant are competent in these languages. The participants were labelled G1P1 to G1P8 and so on for each group.

Participation of pregnant women in the FGDs offered the women an opportunity to express common feelings. Participants shared similar characteristics in that they were within the childbearing age, of similar social class and did not know one another outside of the antenatal care clinic. These factors encouraged a more honest and spontaneous expression of their views. The participants were reflexive, thoughtful, articulate and willing to engage in a discussion about their experiences of pregnancy and childbirth and appeared to be comfortable with one another, and as such engaged in a lively discussion. Each discussion lasted approximately an hour. The discussions were recorded and transcribed verbatim. The less-inhibited participants tended to encourage engagement of shy participants. Subtle group control was used by the researcher for dominant, rambling and shy participants. According to Christensen,

Johnson and Turner (2015, 73), FGDs are appropriate for groups who seem to be disempowered and who might feel reluctant to give negative feedback. This was applicable to pregnant women as a vulnerable group. Trans-group data saturation was reached with the fourth FGD. The data was analysed manually through the process of decontextualisation, recontextualisation, categorisation and compilation as described by Bengtsson (2016, 10). Data analysis began with the initial reading of the transcripts, with recontextualisation, the responses were re-read to confirm understanding. At categorisation stage, data were coded and codes were finally grouped into themes and sub-themes.

Findings

The three major themes that emerged were general care and support; clients' expectations of care; and outcomes of midwife-woman interaction. The major themes and sub-themes are reflected in Table 1, followed by the participants' verbatim responses.

Table 1: Major themes and sub-themes

Major themes	**Sub-themes**
1. General care and support offered to women	1.1 Physical care and monitoring 1.2 Attention received from midwives
2. Clients' expectations of care	2.1 Unmet expectations
3. Outcomes of midwife-woman interaction	3.1 Ineffective communication 3.2 Non-involvement 3.3 Fear 3.4 Punctuality 3.5 Arrogance 3.6 Lack of commitment 3.7 Discrimination

Theme 1: General care and Support Offered to Women

Sub-theme 1.1: Physical Care and Monitoring

A few participants had the following to say about physical care and monitoring:

> First time around they (the midwives) took proper care of me, giving me the appointment card indicating my return dates, checking various aspects such as my stomach, high blood pressure, HIV status and urine. (G4P1)

They help us first by undressing us, checking the BP level, and putting us on the scale for proper weight checks. They also provide us with iron tablets and vitamin tablets to assist in the development of the baby, free of charge. (G4P2)

Yes, I can also confirm that I got the necessary treatment … They checked my BP plus urine, and also did some tape measurements. (G4P8)

One thing I can point out is that the care they provide is mainly in the form of guidance, encouraging us to do blood tests so that in case one is HIV positive proper interventions can be initiated. (G4P6)

Yes, we do get care and support, because in the beginning they check BP levels, teach us, and do check-ups on us whilst we are lying in bed. During the check-up sessions we get the opportunity to discuss our health problems with them, and they provide medication suitable for our respective ailments. (G3P8)

I also like to add to what has been said. Sometimes you want to know more about the pregnancy condition and related aspects, only to find that the nurse (midwife) is already upset and moody, and not in an approachable state. Then you become discouraged, though there is so much we want to learn. (G3P5)

I am satisfied with some other aspects. As previously stated, when you find the sisters (midwives) in a right, welcoming mood you also become right and loosen up. (G3P6)

I can say that we do not become totally satisfied in all aspects, as we want to learn more about pregnancy-related matters. However, sometimes we are afraid to ask what is the meaning of this, or that. Although they do explain some aspects for us, nevertheless at times they do not make you comfortable to probe further. (G3P2 in an irritated tone)

Sub-theme 1.2: Attention Received from Midwives

Some participants made the following comments about the attention they received from the midwives:

You see, here even if you are feeling some physical discomfort they (midwives) will say it is normal for a pregnant woman to feel that way, even if with some intensive examination they would have discovered more on you. So you end up not informing them of some ailments, such as back-pain, because it is normal, whereas at a private institution they attend to even seemingly minor ailments. (G4P1)

They attend to almost all my needs, but sometimes you leave the clinic uncomfortable, unhappy. This is because sometimes they ask you a question on your first clinic visit, such as when last did you experience your menstrual cycle. When you are unable to

recall or you fumble a bit they shout at you, making the situation worse. It is better when they talk to you nicely, then you can explain a lot of things coherently, feeling at ease. (G3P4)

Sometimes you do not get the desired support from the sister (midwife). For instance, you tell her about the problems you encounter at home and she just ignores you, never responding, and you leave. (G3P2)

Theme 2: Clients' Expectations of Care

Sub-theme 2.1: Unmet Expectations

One participant said her expectation of care was unmet:

Not at all … not at all, ok? … Not at all, because at times one attends the clinic hoping to have a discussion (with midwives) around pregnancy staff, such as how you are feeling, are you managing, what to eat and so forth. Particularly when it is your first pregnancy. (G2A1)

Theme 3: Outcomes of Midwife-Woman Interaction

Sub-theme 3.1: Ineffective Communication

Several participants complained about the ineffective communication with the midwives:

They don't have time to listen to you, they are impatient. (G2P6)

When you go for injections, you can't even ask why the injection, she will also tell you that she does not have time. (G1P3)

The thing is, we don't understand the languages, they don't repeat" "They only help those who talk Zulu or Sotho. (G2P7)

That woman did not understand Zulu and the nurse shouted at her as if we are enjoying what she was doing to her. (G2P1)

Even if you can wait for a while, until around past four o'clock in the afternoon, she (midwife) will still tell you that they do not have sufficient time to explain issues, If you ask, they say, what are you saying? You are wasting my time. (G4P7)

Yes she says she is doing her work, she only have time to do her work? (G1P6)

Communication should be both ways. I should be able to raise issues and discuss with the midwife. (G2P4)

> Sometimes if you ask, they respond only after two hours when your time is already wasted. (G4P8)

> We don't receive the information that we need. (G1P5)

> When you ask, they don't explain to your satisfaction, they leave you hanging. (G4P4)

> They told me that the baby lies in breech, they did not explain what a breech is, just that the baby is not lying correctly. (G4P6)

> There is a lot that we would like to know and you are left without a meaning of what is happening. (G3P7)

Sub-theme 3.2: Non-Involvement

Three participants complained about the ineffective communication with the midwives:

> The nurse undress you and check you, let you lie and touch you but don't tell you what is happening, I want to know how things are. (G1P3)

> Say you have a problem and they refer you to the doctor, you expect the doctor to tell you something after sonar, but he just say go, you are finished. (G2P8)

> If you had a problem and come back for check-up, they no longer tell you how things are. (G4P2)

Sub-theme 3.3: Fear

Two participants said they experienced fear:

> They instil fear in us, you become afraid to talk to her and ask. (G4P4)

> If she is not welcoming in this regard or approachable, I will be crippled by fear. If I am afraid to talk there would not be any progress. (G3P1)

Sub-theme 3.4: Punctuality

Two participants complained about the midwives' punctuality:

> They start late to work, we arrive here at ten to six. (G4P8)

> I waited here until 12 midday without being attended, they said it was punishment because I arrived at 7. (G4P2)

Sub-theme 3.5: Arrogance

Four participants found the midwives cheeky and arrogant:

> It's ok, but they can be cheeky sometimes. (G3P1)

> If they can change their attitude, so that you can feel free to talk to them. (G3P6)

> She makes a joke of you in front of others. (G1P1)

> Like N, when you book, she cheeks you. I could not even call her aside and tell her that I have a problem that I once terminated my pregnancy because N will let everyone hear about your problem, and when you talk softly to her, she will shout and say is that how you speak to your mother, I was afraid and ended up telling her that this is my first pregnancy? (G1P3)

Sub-theme 3.6: Lack of Commitment

Two participants thought the midwives lacked commitment to their work:

> It seems like they are forced to come to work, sometimes you want to cry, you end up crying because you are hurting and that thing affects the baby. (G1P7)

> They can't even tell us that we have an urgent meeting, something like that, they just leave us here as if we are nothing. (G4P1)

Sub-theme 3.7: Discrimination

Four participants complained that the midwives showed discrimination:

> We are not of equal means. Some of us are wealthy, whilst some are poor and cannot afford opting for private clinics. However, we all deserve equal treatment, irrespective of means. (G3P3)

> One sister said they (foreigners) fall pregnant more than South Africans. (G4P1)

> One day they (the midwives) remarked that the main problem is that we foreigners generally conceive and give birth a lot. That did not go down well with me. (G1P8)

> There is one sister who said don't bring people from Zimbabwe here. (G1P4)

Discussion of Findings

The participants in all the FGDs seemed reluctant to share their negative experiences until one of them became bold enough to share and then the rest opened up.

General Care and Support Received from Midwives

The women's responses indicated that basic antenatal care services were offered. The sub-themes that emerged were physical care and monitoring and the attention received from midwives. The services included routine tests such as urine analysis, blood tests, weight measurement and abdominal palpation. Physical care seemed to be the dominant form of care received by women with, the focus on examination and assessment by the midwife. In one group, four of nine women (44%), supported physical care. Antenatal preparation should be offered to all women during pregnancy as a national policy. Screening during pregnancy is crucial, with the aim of detecting and preventing both maternal and neonatal adverse events and instituting early intervention.

The women defined the role of midwives in terms of clinical tasks carried out. While responses of good interaction were shared by some participants, which signified attention received, most felt that they were not treated well as individuals with needs. A concern about the midwife's attitude was raised by participants as midwives often seemed not to show sensitivity when interacting with them. Harassment was displayed by midwives shouting at women for no reason. Women felt intimidated by midwives. According to the National Institute for Clinical Excellence (NICE 2003), antenatal care is not an independent entity as viewed from a midwifery perspective. It is an integral part of the whole childbearing experience which marks the beginning of a journey that midwives and women will undertake. It is a time when a partnership is negotiated; roles and responsibilities are identified; information is shared; options are discussed; and choices are made.

Clients' Expectations of Care

Although the participants broadly defined their expectations, the type of care that was offered to the women seemed not to be what they expected. The factors that contributed to the women's expectations not being met were generally that the care was impersonal and hurried, leading to lack of interaction or attention. The participants felt that the care they received was not ideal as they were attending clinic at a public institution where it is free, whereas at a private clinic, care is individualised as it has to be paid for. They were also concerned about not being able to ask the midwives questions, and there were comments about intimidation and negative attitudes from some of the midwives, which probably led to the women experiencing pregnancy-specific anxiety.

In their study, Vanagienė, Žilaitienė and Vanagas (2009, 656) conclude that antenatal care-related expectations of pregnant women as described in the literature fall into four categories, namely, a wish to be provided with adequate information; emotional

support; general support with the management of their pregnancies; and professional care.

Outcomes of Midwife-Woman Interaction

The sub-themes that emerged from interaction were: ineffective communication; non-involvement of women; fear; punctuality; humiliation; lack of commitment and discrimination. Ineffective communication was justified through midwives not being responsive to the women; offering superficial or incomplete information; and language barriers.

As Kozhimannil et al. (2015, 1609) state, the midwifery model of care aligns well with the paradigm of patient centred care, a philosophy of care that includes providing women with full information, involving them in decision making about their care and individualising care to best meet the woman's needs. Constructive communication in antenatal care includes an empathetic communication style; provider willingness to respond to the woman's questions; and allowing more time to discuss the woman's concerns. Improving the delivery of essential information regarding antenatal care is deemed critical to ensure that women get the maximum benefit from the services (Gulema and Berhane 2017, 144).

There was evidence of poor communication between the midwives and pregnant women. Language barriers also limited the communication with the midwives displaying both limited listening and attentive skills. The participants displayed a need to be well-informed and to understand issues about their health status. Gross et al. (2011, 9), in an exploratory study on antenatal care in practice, remarked that the midwives' behaviour demonstrated power as they exerted a hierarchical control over pregnant women. The use of power by midwives has been reported by Froneman, Van Wyk and Mogale (2019, 1063) to be a direct result of the external control exerted on them by policy makers and management and that midwives are working under stressful circumstances without much recognition for their services. Under these circumstances, midwives often find it difficult to render quality care to women and, as such, compromise interpersonal relations.

The study found evidence of limited interaction between the midwives and pregnant women during antenatal care. The women's participation in the management of their pregnancies was limited as they passively listened to the attending midwife. They emphasised the importance of information as a matter of dialogue rather than a one-way information transfer from midwives to them. As highlighted by Patterson, Martin and Karatzias (2019, 78), the relationship between a woman and her midwife is considered distinct from other healthcare professional/client relationships as it focuses

on "caring as a gift" and engaging with one another. Interaction difficulties, especially being ignored, is considered a strong risk for a woman developing post-traumatic stress.

The midwives were often unapproachable and most women were afraid to talk to them. For example, a concern was raised regarding fear by a *primi gravida* who had so much to ask but was just afraid to do so. During the discussion this woman expressed fear "ten times". Fear has been found to often result in anxiety and inhibit communication between women and midwives and that pregnancy may give rise to anxiety due to anticipated uncertainties associated with it (Madhavanprabhakaran, D'Souza and Nairy 2015, 1; Menon, Musonda and Glazebrook 2010, 359). According to Handley (2006, 8), anxiety is a diffuse apprehension, vague in nature and associated with feelings of uncertainty and helplessness, which may occur as the woman is uncertain of her expectations or facts about her pregnancy. Negative or unsatisfactory pregnancy and childbirth experience is also associated with fear of a subsequent pregnancy with the increased likelihood of the woman not having another child (Van Bussel, Spitz and Demyttenaere 2010, 144).

Most of the respondents raised a concern about the adherence of caregivers to the appointment time as antenatal visits are mostly prolonged. Punctuality was also a concern regarding response time. This appears to interfere with personal commitments. In his comment on the uplifting of midwifery in Africa, Mhlanga (1996, 2) concludes that one way in which to facilitate a positive relationship between the woman and the midwife is through negotiation of the most convenient time for each pregnant woman to attend antenatal clinic. The working hours for staff should be adjusted as much as possible to suit women's needs.

The Antenatal Care Policy (SA 1997) as a guideline states that:

> Working hours should be convenient to pregnant women and the health care providers. Evening and weekend clinics are acceptable to the province and not only traditional weekdays. This approach allows flexibility and accommodates women who are employed or have problems in attending antenatal clinic during specific periods as set up by the institution.

There was a sense of arrogance from the midwives as evidenced, for example, by them refusing to repeat themselves if the women missed something they were communicating. The Department of Health (SA 2015) urges health workers who care for pregnant women to demonstrate respect for and genuine interest in their clients, and to avoid an arrogant, judgmental or rude attitude.

The World Health Day: Safe Motherhood initiative (WHO 1998) reported poor quality of interaction of women with health care workers stating that "women perceive health care providers as rude, patronizing and insensitive … interaction with providers can be threatening and humiliating". Women often felt pressured to make choices that conflicted with their own needs. The situation led to women being reluctant to use health care services. Most participants expressed anger and frustration. Anger was mostly associated with the insensitive care they received; midwives withholding information; and the fact that they did not have time to address the women's concerns.

While pregnancy and childbirth is a life-transforming event associated with satisfaction, self-esteem, personal growth and the assumption of the parental role, it can also be associated with negative emotions, such as grief, guilt, disappointment and anger, and these emotions are mostly influenced by the women's interaction with health care providers (Mozingo et al. 2002, 344). According to Dragonas and Christodoulou (1998, 138), most studies emphasise the desire expressed by women for personal care; shorter waiting time; continuity of care; enhanced communication with health care practitioners; a greater opportunity for asking questions and receiving comprehensive answers; and a greater attention to their needs and fears.

The aspects of care that the women were dissatisfied with within the study are similar to those reported in the literature, for example, Fawole, Okunlola and Adekunle (2008, 1056); Menon, Musonda and Glazebrook (2010, 360); Mozingo et al. (2002, 346) and Rall, James and Strumpher (2013, 154) who revealed that women's dissatisfaction was centred on long waiting times to be seen then only to be rushed, impersonal care and poor communication. Oosthuizen et al. (2017, 9) further state that interventions should address the context of respectful relationships, dignity and effective communication to improve women's childbirth experiences, thus justifying that these factors are long-standing issues that need to be resolved.

Menon, Musonda and Glazebrook (2010, 360) further highlight evidence that women are reluctant to share their concerns about pregnancy and birth with the midwives. In the study, there was a prevailing impression that the midwives were likely to be rude and outspoken, and this led to women being wary of asking questions or seeking advice.

Menon, Musonda and Glazebrook (2010, 361) further state that it is important for health professionals to ask pregnant women about their feelings related to the current pregnancy, childbirth and future motherhood, and to give any woman who expresses fear an opportunity to discuss them, paying special attention to *primi paras* and to *multi paras* with previous negative experiences of pregnancy and labour.

Discrimination was evident against foreign nationals, a concern expressed in all the FGDs. Another aspect of discrimination, mentioned by two groups, was about social status. Discrimination is addressed by the justice principle and fair treatment that aligns with the South African Constitution (1996) which emphasises the importance of promoting equality and overcoming unfair discrimination and the protection of human dignity, of which midwives have an obligation towards pregnant women (Pera and Van Tonder 2018, 103).

Reflecting on the participants' responses, the care they received compromised the ethical principles as woman versus midwife professional power relations were evident and played a central role as women were not given a right of choice related to autonomous decision making. Justice did not prevail as the health care offered was a top-down approach that led to minimal benefit for the participants. As stated by Clarke (2009, 55), beneficence as an ethical principle which requires a degree of sacrifice on the part of the moral agent, who is a midwife in this context. Furthermore, midwives should not treat women "as a means to an end" but rather treat them as ends themselves. Confidentiality was also compromised to a certain extent, which led to women not sharing all the necessary history that impacts on their wellbeing and appropriate management.

Recommendations

To support the women's voices, the following interventions are recommended, based on the general findings and as also stated by Bohren et al. (2017, 10):

- Training should be provided to midwives on how to give respectful and compassionate care to re-orientate midwives who suffer from "compassionate fatigue".

- Inservice education on the basic ethical principles should be offered to midwives and be applied to the antenatal care context.

- The training should be integrated with coping mechanisms for working in stressful environments and techniques for improving patience, tolerance and endurance.

- Facility-level redress mechanisms for women to express satisfaction or dissatisfaction with the service rendered should be put in place.

- A forum to promote engagement between women and midwives as a platform to outline expectations should be created.

Limitations of the Study

Discussions held at the clinic site might have deterred women from sharing their experience due to fear of being victimised.

Conclusion

The midwife-woman interaction was generally limited in all clinics and was basically directed by what had become the routine antenatal care process. Ineffective interaction between women and midwives compromises respectful care and ethical practice that leads to midwives being litigated. The participants' responses reflected an expectation or a desire for courtesy and caring attributed to: having effective communication; being treated with respect and allowed privacy; being involved and asked for consent; and being shown compassion and genuine interest from midwives as highlighted by Kabo et al. (2019, 3); Hallam et al. (2016, 176) and Human Rights Watch (2011). Further research on midwives to establish their honest perception of their interaction with women is recommended with the aim of developing restorative measures.

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