THE INJUSTICES OF ANTENATAL CARE: CHANGING MIDWIFERY PRACTICE FOR HUMANITY

INTRODUCTION

Maternity care is an integral component of Primary Health Care and a free Public health service for pregnant women in South Africa. The World Health Organization Maternal and Child Health Program Policy, 2016 is focused on meeting the basic needs and ensuring the wellbeing of childbearing women. Antenatal care (ANC) is the healthcare provided to women who are pregnant, for confirmation and monitoring of the progress of their pregnancy, and to promote their birth preparedness and complication readiness. The World Health Organization Policy on antenatal care for a positive pregnancy experience, envisions a world where every pregnant woman receives quality care throughout pregnancy, childbirth and the postnatal period, within the continuum of reproductive health care. Antenatal care (ANC) provides a platform for important health-care functions, including health promotion, screening and diagnosis and disease prevention. It further provides an opportunity for a midwife to communicate with and support women, families and communities at a critical time in the course of a woman's life.

The WHO antenatal care guidelines highlight the importance of midwives providing effective communication about physiological, biomedical, behavioral and sociocultural challenges and to offer support to pregnant women in a respectful way. Women's positive experiences during ANC and childbirth have proven to create a foundation for a healthy motherhood.

The scope of the WHO guideline was informed by a systematic review of women's views, which revealed that women want a positive pregnancy experience from ANC. A positive pregnancy experience is defined as maintaining physical and sociocultural normality, maintaining a healthy pregnancy by preventing or treating risks, illness and death, having an effective transition to positive labour and birth, and achieving positive motherhood that include maternal self-esteem and autonomy.

The South African Maternal, Perinatal and Neonatal Health Policy (2021) refers to physical and psychosocial preparation for childbirth and parenthood, in their definition of antenatal

care. The provision of an efficient antenatal care further responds to The United Nations 2030 Sustainable Development Goal number three, on the promotion of good health and wellbeing, aimed at the reduction of maternal mortality to below 70 per 100 000 births.

The lecture addresses the socio-political perspectives of Midwifery practice, Women's experiences reflecting the injustices they endure during antenatal care, Midwives' challenges and the possible interventions and research focus that aim to enhance humanity in the provision of antenatal care.

WHO IS A MIDWIFE?

A midwife is defined by the South African Nursing Council in Regulation 2598 of 1984 as amended, as a person who has been regularly admitted to Midwifery education and practice by means of the prescribed course of studies in a midwifery educational programme that is recognised in South Africa. In addition, has successfully acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery, has an important task in health counselling and education, not only for women but also within the family and community.
The International Council of Midwives (ICM), promotes the midwifery model of care based on respect for human dignity, compassion and the promotion of human rights for all persons, and that midwives offer care based on this philosophy.

South Africa became the first country in the world to register midwives in 1891. A Midwife, once qualified and registered, can opt to practice within a health care setting or establish a private practice. The midwife is expected to practice within regulations as stipulated by the South African Nursing Council. Midwives are the first healthcare professionals that pregnant women come into contact with, and often the only healthcare practitioner that the woman will engage with throughout pregnancy, until delivery and stretching further to postnatal care.

THE EVOLUTION OF ANTENATAL CARE

Antenatal care is about 110 years old, a national system that is based on routine visits to an obstetrician or a midwife. The first antenatal clinic was established in the Royal Adelaide hospital in 1910, from the onset it became an international movement.

The nature, development and progress of antenatal care originate from scientific, political and cultural perspectives. Factors that contributed to the shaping of antenatal care included women's pressure groups, general practitioners, obstetricians and midwives. However this joint effort, the outcome of antenatal care was directed towards the awareness, prevention and management of obstetric and medical complications and NOT on a woman as a holistic being with a body, mind, soul and with psychosocial needs. An omission that still exists in most public health facilities offering care to pregnant women.

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 pregnant women. This establishment of routine care was based on the notion that pregnancy is a state of pathology rather than normal physiology.

A question therefore arises. Is a pregnant woman a mobile pelvis?

Absolutely **NOT**, as pregnancy is not just about symphysis fundal height (SF) and the foetal heart. Pregnancy carries an emotional and psychosocial aspect where sometimes a woman just wants to be listened to and counselled. With reference to the origin of motherhood, one cannot be greater than a mother, even a King has a mother, therefore, mothers cannot be substituted. A mother is someone who acts beyond herself and not as a biological body, someone who do for others, being larger than oneself and thinking for others.

MY SUBMISSION: Injustices prevails during antenatal care as associated to the following:

- The traditional routine physiological care offered to pregnant women, not acknowledging women's psychosocial needs, impact negatively on holistic care and therefore leads to injustice in the provision of antenatal care.
- Pregnant women pose a vulnerable and desperate population as their autonomy is compromised as soon as they enter the antenatal care clinic, due to non-engagement by midwives, as supported by a study published in 2020, by Mathibe-Neke, on "*Midwife-women interaction as a critical component of Antenatal Care,*

and many more ancient and recent studies conducted on Respectful Maternal care.

- The Guidelines for Maternity Care in South Africa (2016) in its “**Pillars of Safe Motherhood**”, emphasizes physiological antenatal care and nothing on psychosocial care.
- The South African Policy Statement no. **3.1 on Respectful Maternity Care**, shares reports from women on their experiences of childbirth in health facilities which point to a deficit in respectful care, and as such trampling on women’s rights to dignity, privacy and confidentiality.
- Lack of human, material and structural resources prevailing in antenatal care facilities compromises service delivery leading to unjust care to pregnant women.

VULNERABILITY AS A SIGNIFICANT FACTOR DURING PREGNANCY

Vulnerability, according to Brugère (2019), is a profound characteristic of being human, marked by uncertainty and risks, suffering and despair that threaten human flourishing. As such, any situation leading to stress like pregnancy, compounded by limited access to resources, expose pregnant women to vulnerability. Dhai, 2012, further highlights that vulnerability carries the risk to personal integrity, whether physical, psychological, moral, or spiritual. These ideologies support the notion that vulnerability carries a prospect of one being either neglected or exploited with a potential of being wounded or open to attack. A reality for pregnant women that is morally unacceptable and a form of injustice.

Vulnerability during pregnancy is perpetuated by Intimate Partner Violence (IPV). IPV is aligned to recommendation B.1.3 of WHO as a critical factor during the assessment of a pregnant woman, which calls for routine psychosocial risk assessment. Dr Moodley from the Western Cape Health Department reported an increased number of assaults on pregnant women on 20 June 2022 and declared that 52% of the assaults are Gender-based.

Vulnerability and suffering have a potential of depriving women their internal ability to maintain dignity and to preserve self-determination, given the anxieties brought about by their interaction with midwives.

WHAT DOES JUSTICE IMPLY?

Justice as an ethics principle refers to fairness. Within antenatal care, justice simply refers to fair treatment of pregnant women. With reference to the Rights Based justice, pregnant women are entitled a right to an acceptable standard of care as outlined in the Patient's Rights Charter in chapter 2 of the Constitution of the Republic of South Africa of 1996.

I further reflect on three theories of justice:

The theory of **utilitarianism** which argues that the standard of justice depends on the principle of utility. Midwives need to, as such, maximise the utilization of antenatal care by women through an efficient service provision. Public healthcare supports this theory.
Libertarianism that implies the ability of women to pay for their care, a theory that is only applicable to private healthcare and as such, a socio-political challenge to the delivery of antenatal care in South Africa. However, **Egalitarianism** theory holds that all women should receive an equal distribution and similar antenatal care irrespective of their ability to pay.

Injustices of care during childbirth were ironically also shared by Midwives who participated in a study published during 2014 (Mathibe-Neke, 2014), regarding midwives' personal experiences of care offered during childbirth by their own colleagues. Five percent of the 178 respondents indicated that their expectations as pregnant women were not met and shared the following: ***"Because people who delivered me knew me, as I was a trained midwife, I was supported by colleagues." "A touch and go type of care, midwives were unapproachable, attitude of midwives was not good, afraid to talk to her." "They were avoiding me deliberately as they knew I was a midwife." "I insisted on talking and demanded some explanations and some services as I was a trained midwife."***

Fifty-four respondents, (30%) ignored or omitted this question. The reason could be that it was a sensitive question that probed into their personal lives, or it posed a conflict of interest against their colleagues, and also that it was a reflection on themselves as

midwives. These responses are a concern coming from the very population that should provide respectful care to pregnant women.

THE MATERNITY PARADOX

Antenatal care may be constrained by:
"Too much too soon" (TMTS) actions, where midwives intervene unnecessarily, inappropriately so or non-evidence-based".
or
"Too little too late" (TLTL) where pregnant women who need care the most are not well served", until a complication arises.

FACTORS CONTRIBUTING TO THE PARADOX

Women's perspectives	**Midwives' perspectives**
Care options either inaccessible or under-resourced	Lack of resources (human and material)
Negative experiences with previous care received	Bias or stereotyping with lack of cultural awareness and sensitivity
Avoidance of healthcare system based on distrust of midwives	Incompetency in ethical or a holistic approach to pregnancy management

SOCIO-POLITICAL PERSPECTIVES OF MIDWIFERY PRACTICE

The private health sector caters for less than 28% of the whole population in South Africa. Only about 16% of South Africans are covered by Medical Aid Schemes. The rest pay medical bills out of own pockets and rely on public institutions for hospitalisation, a principle that applies to pregnant women. The history of Midwifery training too, does reflect injustices as it took 36 years, more than a century for black women to be trained as midwives, as opposed to their white

counterparts. The social factors associated with poor experiences of maternity care include minority ethnicity, poverty, teenage pregnancy which are dominant in socio-politically under-served populations.
A Systematic review of sixteen articles by Hannah and the team in 2018 on Midwifery and Antenatal Care for Black Women, revealed that Black women are 2.3 times more likely than white women to receive delayed or no antenatal care. This review highlighted three principal areas which are: care disparities, perceptions of antenatal care and Midwifery-led care.

Disparities that have an impact on Black women's antenatal care shows that there are many factors beyond their control, such as discrimination and access to care. Discrimination is a particularly pervasive factor, as it is shown to be an issue both within the health care system on a day-to-day basis, emanating from the fact that pregnant women are mostly discriminated from participating in negotiating their care. The stress of this discrimination adds to stressful life situations that Black women are already at a higher risk of, such as intimate partner violence and lack of support systems.

Research in Midwifery practice mostly focuses on birth outcomes, provider qualities, situational life factors to name a few, and very few investigates the effects that historical underpinnings may have played in Black Women's current reception of antenatal care and the attitude of midwives.

DOES WORK OVERLOAD EXIST IN MIDWIFERY PRACTICE? IS IT ABOUT QUANTITY OR QUALITY?

A shortage of Midwives appears to be an international challenge, for example, viewpoints expressed by focus groups in a study on the Framework for Maternity Services in Scotland (2007), were that, open quote: "***You need more staff, you need more time. Midwives are key workers. If they run the busy antenatal clinic and see fifty ladies at once, they don't have the time to sit down and talk to each individual woman. If somebody's got a crisis, they do their best".*** Closed quote.

Much as there is recorded growth in the South African Nursing Council register, staff shortage is a significant factor that contributes to injustices in the provision of quality antenatal care. This is justified by the nursing manpower distribution by provinces, with a nurse-population ratio ranging between 1:322 and 1:547. Gauteng Province records 41 183 registered nurses serving a population of 15 810 387. However, the quality of midwifery care is also questionable. The concern regarding quality was alluded to by the then Minister of Health at a Nursing Summit held during 2011 in Johannesburg. A finger also points to the South African Nursing Council's Directives that does not provide an adequate framework of teaching ethics, but rather refers nurses to the Ethical code of conduct published during 2013, which is far-fetched and compromises humanistic care in a way.

CHANGING MIDWIFERY CARE FOR HUMANITY

The "Ethic of Care in Midwifery Practice" cannot be claimed whilst the current scenarios still exist regarding the injustices endured by women. These were shared by media between 2021 and 2022 on Checkpoint (eNCA) program.

Scenario 1

12 December 2021

A woman experienced a bloody vaginal discharge, she was then transferred from the clinic to Witbank hospital with a high Blood Pressure. The woman was informed that her BP is dangerously high. From 3 am to 8 am she was waiting for care. A nurse responded: ***Yes, this hospital does not want to hire and its full**, **You will have to go according to the que***. The woman continued to bleed on the bench and was only seen by a doctor at 8 am, who informed her that the baby's heartbeat was lost. The woman was induced and gave birth to a fresh stillborn at 13h40. The stillborn was left with her until the night shift staff reported on duty and the deceased baby was still on her bedside?

Scenario 2

29 May 2022

A heavily pregnant 45 year old woman who was about to go in labour in 2017, was turned away from a Maternity care facility with a Midwife claiming she was too old to be pregnant. The woman gave birth outside the clinic, assisted by her niece. The narration of her second incidence is as follows "***I reported to a hospital on 9 April 2022 at 07:45, carrying the same baby who was struggling to breath. I met a nurse at the gate who told me that the facility only attends to emergencies such as gunshots, vehicle accidents and stabbed patients. I told her that my daughter was an emergency but she send me to the main***

clinic to get a referral letter. I took a taxi to the clinic and on arrival I was told to stand in a que like anyone else. I waited for a few minutes and approached another nurse for help who checked my daughter and told me she was no more. I got shattered, I did not know what to do, my daughter died in my arms while I was standing in a que at a public health facility".

Scenario 3

2 April 2022

South Africa's Health Emergency: Pregnant and sleeping on a Hospital floor. A video of pregnant women sleeping on the floor at Raahima Moosa Mother and Child Hospital, in Johannesburg, where 16 000 babies are born annually, and most newborn babies die. An injustice to pregnant women whereby their right to a conducive and safe healthcare environment, as per the Constitution of South Africa, is compromised. Another Black African life scenario.

A CALL FOR PREGNANT WOMENS' DIGNITY WITH THE AIM OF OVERCOMING THEIR VULNERABILITY

The term 'dignity' comes from the Latin Dignitas and relates to an individual's characteristics, an intrinsic and an inter-subjective value associated with being human (Gallagher, Li, Wainwright, Jones & Lee, 2008). The inter-subjectivity stance makes human dignity a complex concept that requires partnership and mutual understanding between the midwife and a woman. Therefore, human dignity and vulnerability are related and need a goal-oriented character of midwifery care, which consists of an obligation to provide an ethically acceptable care (Gastmans, 2013). Ward and Syversen (2009), further highlights that human dignity is an influential moral concept that signifies that all human beings have intrinsic value and universal moral equality. The claim is consistent with the midwife's commitment to serving pregnant women equally irrespective of race, age, culture, or agility. Consequently, the ethics of responsibility calls for midwives to engage in a dialogue that will compel them to respond to the women's needs. It is in the realm of this dialogue, that awareness of ethical issues, ethical sensitivity to vulnerabilities, and subsequent ethical actions are warranted (Millike & Grace, 2017).

The principle of human dignity is expressed in Kant's categorical imperative, which insinuates that pregnant women need to be treated as "an end in themselves, and not as a mere means to ends".

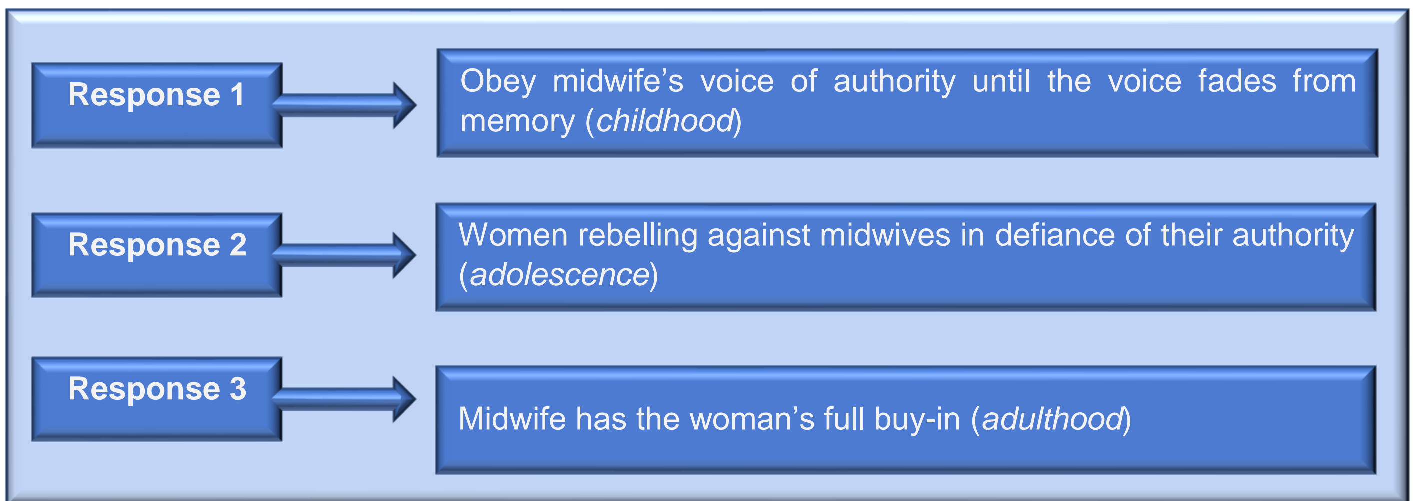
WOMEN'S RESPONSE TO AUTHORITY AS ALIGNED TO OVENSTONES' THEORY (2009)

The following illustrates the midwife-women interaction process options based on how the midwife engages the woman in the management of her pregnancy:

Response 1: An authoritative kind of interaction where the midwife takes a lead and is aligned to childhood phase (common practice in antenatal care units).

Response 2: Is aligned to an adolescent stage where women defy the authority of the midwife and might also be non-compliant to suggested antenatal care interventions.

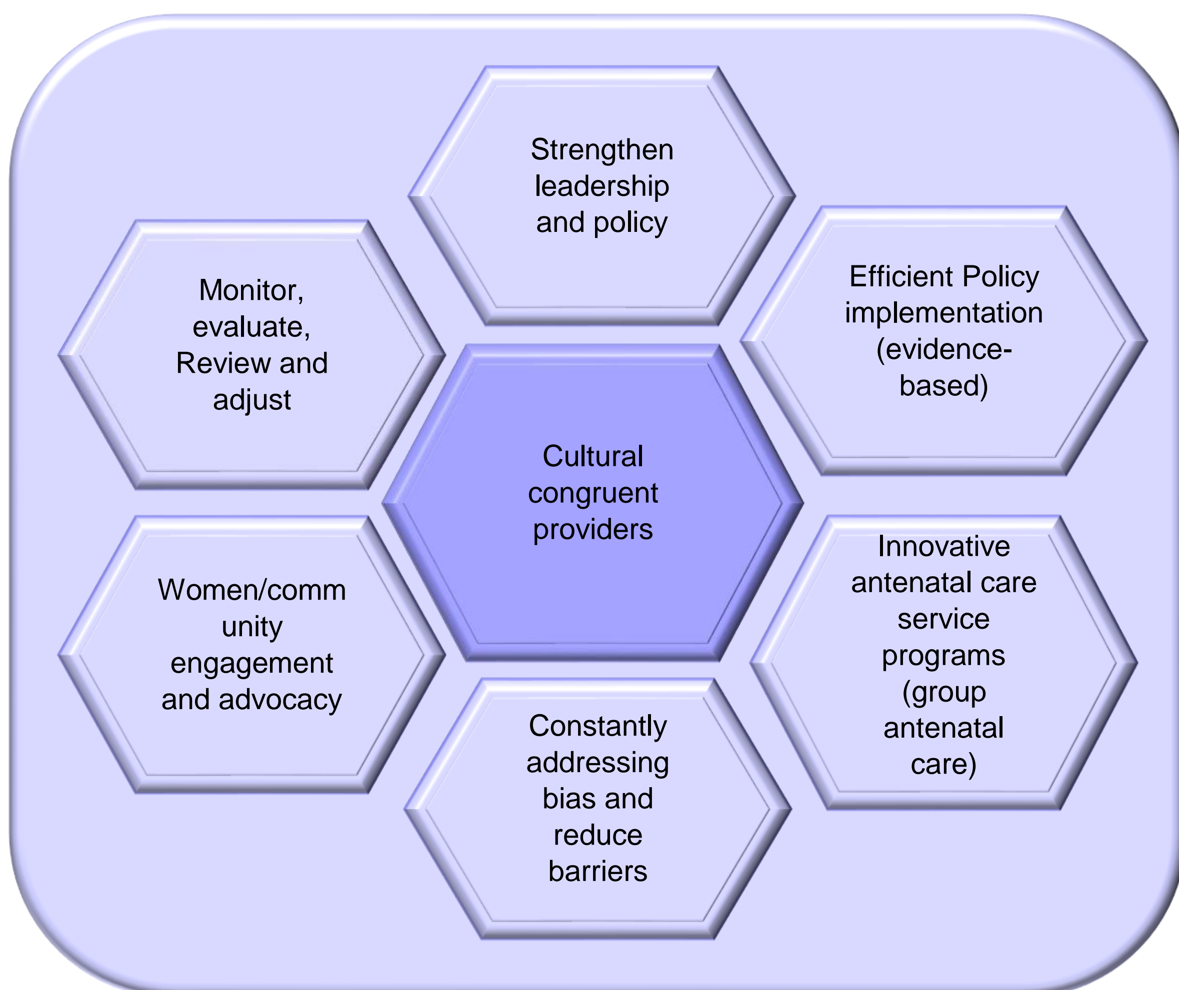
Response 3: An ideal one where midwives and women are partners in the process of healthcare that is based on the women's needs



A FRAMEWORK FOR AN IDEAL ANTENATAL CARE: GUIDING PRINCIPLES

(Ross & Perry, 2021)

The framework focuses on ideal collaborated intervention efforts that are cultural congruent through analyzing power systems, addressing intersectoral oppressions and normalizing shared decision-making, striving for evidence-based antenatal care by reflecting on specific care practices and interventions that hold potential to optimize health outcomes for pregnant women. Reviewing Antenatal care inequities and devising means to address bias and constantly monitoring the system to eradicate barriers.



QUALITY ANTENATAL CARE FRAMEWORK (Renfrew, McFadden, Bastos et al, 2014)

TOWARDS THE DECOLONIZATION OF MIDWIFERY PRACTICE

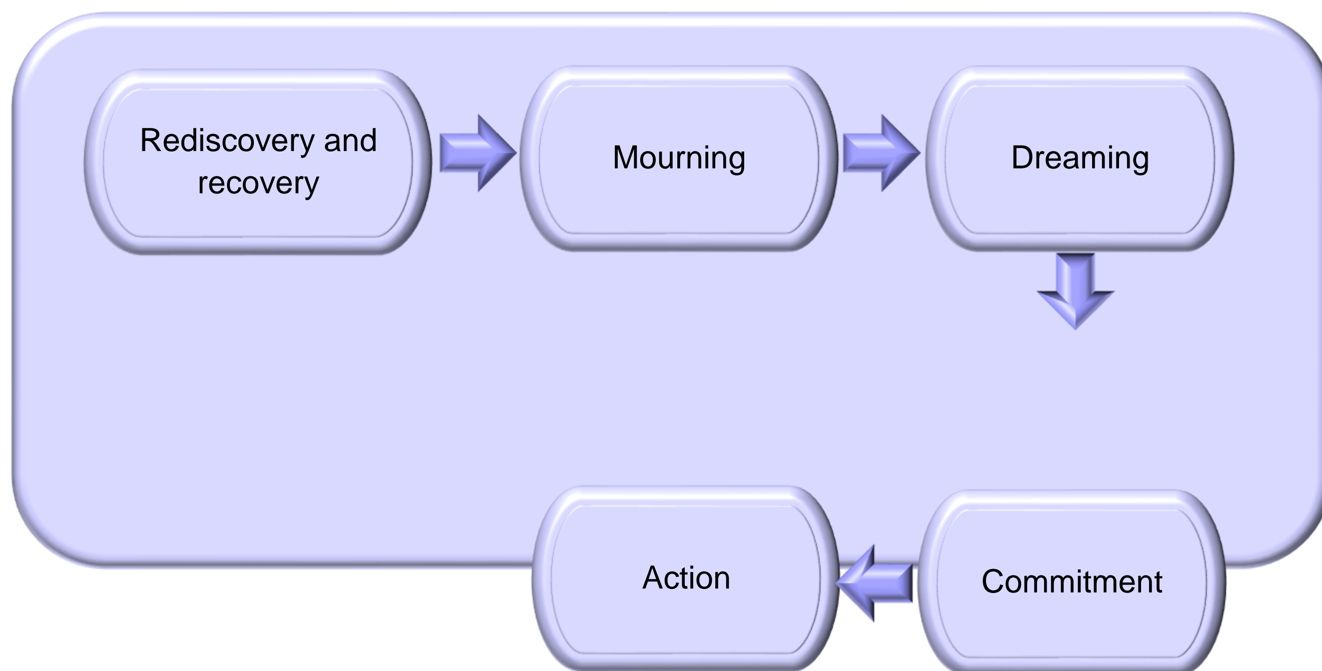
Apartheid has created a society where only one group of race mattered in an illusion and pretence than others – ignoring the fact that South Africa is in fact a multicultural space. Reflecting on the multicultural position of black pregnant women, all these groups have many intertwined social factors which influences their connection and viewpoint on necessities of life, such as health care access. How each group responds to health care access and practice is determined by the factors dominant to the group. Communities in their distinct cultures are still very much in the use of indigenous health care systems and practices in managing pregnancy,

despite the popularity of the Western centric health care systems and practices (Adekannbi et al., 2014; Arazeem, 2011; Nemutandani et al., 2017). Amongst pregnant women, those of Western-orientation would associate with Western-orientated health care services while those from the Africanist orientation would associate with African forms of health care practices. This is reflected in situations where pregnant women will use traditional herbs, for example, isihlambezo, Umqhamo wemfene and kgaba that is widely used by women to induce labour, however hiding these from the Westernized or colonised midwives.

The democratisation of antenatal care systems would not only make antenatal care service accessible by all, but would charter a way which would ensure the entrenchment of social justice in the highly polarised and divided society as a result of apartheid's disregard of other people's health care needs and preferences, as misguided by the cultural orientations of the White minority. Recognizing all women across colour and class creed will therefore put value on their respective cultures, beliefs and traditions.

THE PROCESS OF DECOLONIZATION: FUNDAMENTAL PRINCIPLES APPLIED TO A MIDWIFERY CONTEXT

(Poka Laenui, 2006)



- By rediscovery, Poka refers to a phase whereby midwives, who have undergone colonization are suffering the concepts of inferiority as a result of living under constant and overwhelming reminder of the ‘superiority’ of the colonizer or policy makers.
- The second phase being mourning is where midwives lament their victimization.
- The third phase dreaming, it is at this phase that midwives, who are colonized can explore their own cultures and express their hopes.
- The fourth phase is characterised by commitment whereby midwives come together to air their voices, breaking the layers of colonization and mapping their desired pathway.
- The fifth and last stage is where the action is taken upon and only when there is a consensus amongst stakeholders.

REFLECTING ON UBUNTU AS AN “ETHICS OF CARE” PHILOSOPHY

One cannot refer to decolonization of Midwifery practice without “Ubuntu” as a perspective of life and the practice of being humane. In the likes of Metz (2007), the ultimate goal of a human being within the African context is to exhibit Ubuntu as a virtue. At the state of accomplishment, a midwife is therefore expected to be a person who can exhibit Ubuntu, a basic principle in which one prizes relationships, by displaying a full capacity of honouring harmonious or a communal relationship between herself and the woman, also for the sake of solidarity. Solidarity in Midwifery practice represents care for the quality of life. Solidarity calls for a Midwife’s consideration of the woman and family as stakeholders in her care.

Metz further attests that the moral obligation is exemplified by a precept "**a person is a person through other persons"; "I am because we are, and since we are, therefore I am."** Loosely translated, midwives exist to serve pregnant women as a professional obligation.

SUPPORTING RESEARCH: AIMED TO PROVIDE JUST ANTENATAL CARE TO WOMEN

My shared research is in support of the The United Nations Secretary General, Ban Ki-moon’s statement. Open quote ***“To achieve the “Every Woman Every Child vision” and the Global Strategy for Women's, Children's and Adolescents' Health, we need innovative, evidence-based approaches to antenatal care”.*** Closed quote. The research

further supports the increased international moves in standardizing psychosocial care as part of routine antenatal care and providing group antenatal care as an alternative approach to traditional routine care.

Group antenatal care is a rapidly expanding alternative care delivery model. Research has shown it to be a safe and effective care model for women. Lazar, et al 2021 conducted a systematic review of nineteen published literature from nine countries that established health care professionals' experiences of facilitating group antenatal care.

Health care professionals' experience of delivering group antenatal care was positive overall as the approach offered them an opportunity to deliver high-quality antenatal care that benefits women and allows providers to strengthen their professionalism.

CURRENT PROJECT: Group ANC: A South African Perspective ((2021-2026)

Participatory antenatal care that is piloted in three facilities in Gauteng Province that offers pregnant women an opportunity to participate in their care by even monitoring their own baseline data.

The participatory antenatal care is characterized by:

- Contextual adaption reflecting on identified barriers within Antenatal care.
- Innovative interactive approach characterized by "Women-centered care".
- Woman taking a lead in sharing her experiences and expectations with a midwife.
- Woman considered an expert regarding her needs.
- Woman given opportunity to articulate what she feels is important for her care.
- Her suggestions on how to overcome her health challenges are sought.
- Interpretation of data obtained during the discussion is determined between woman and midwife.
- Focuses on a reciprocal exchange of thoughts, feelings about self and ideas.

There is a work in progress for international collaboration to apply Group antenatal care on a Provincial context in South Africa.

PREVIOUS PROJECT:

Project 1: A psychosocial assessment tool was piloted in twelve (12) facilities in Gauteng Province (2017-2019). Midwives who participated in the pilot study supported the initiative amid the challenges experienced. Their main challenges were increased workload due to overpopulation of antenatal care facilities as the service is free for everyone and foreign national women who compete for resources in South Africa, as well as limited psychosocial care referral resources. Plans to negotiate with Gauteng Maternal and Child Directorate to incorporate the tool as part of routine antenatal care were halted by covid-19 pandemic as it became a health priority.

FURTHER PLANNED RESEARCH

Development of a Teaching program for midwives on holistic antenatal care focusing on psychosocial risk assessment and Group antenatal care.
Midwives' perspectives on workload, task shifting, and the structural changes needed to support the sustainability of group antenatal care.

PUBLICATIONS ALIGNED TO HOLISTIC AND ETHICAL CARE (VISUALIZED ON POWER POINT)

CONCLUDING REMARKS

As I conclude, I raise a question to Policy makers and Midwives: Antenatal care implies WHOSE needs, WHOSE worldview, WHOSE protocols, WHOSE sensibility and WHOSE sense of justice?

The WHO Policy guideline recognizes that a woman's experience of care is key to transforming ANC and creating thriving families and communities, this guideline pose the following questions:

- What are evidence-based practices during ANC that improve outcomes and lead to a positive pregnancy experience?
- How should these practices be delivered?

In partly responding to the two questions posed by WHO:

- There is a need for due consideration of what matters for women during pregnancy.
- A service that is accessible and non-discriminatory is the one all childbearing women aspire for.
- The political undertaking in the management of pregnancy and separating health disparities from racism, recognizing disparities as inequities that lead to avoidable injustices, and not focusing on individual differences but rather on systems and structures that upholds and replicate injustice.
- Increase efforts towards an anti-racist health care system, ongoing and FOREVER.
- Ensuring an enabling working environment for midwives to maximally contribute to service delivery as guided by the National Health Workforce Account (NHWA) indicator 6-05.
- Revolutionary or radical rethinking as to how to position ourselves and not to be considered irrelevant as midwives. What are our own focal points and what are our intentions as midwives?

I further highlight that Reproductive justice, as per the Constitution of the Republic of South Africa of 1996, reserves the women's right to maintain personal bodily autonomy, and above all, to parent children in a safe, conducive and sustainable environment.

I take Bishop Tutu's position by stating that, I quote **"*If you remain silent in a situation of injustice, means you have taken the side of the oppressor*"** closed quote.

Are we, as midwives, silently hinting to pregnant women to enter at their own risk?

AND are we content with providing antenatal care upside down?

I THANK YOU ALL

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