

# The expectations of pregnant women regarding antenatal care

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From a feminist perspective, research on childbirth and women's health is a means to a positive change that is conducted in partnership with women for their benefit. A patient-led National Health System (NHS) (Hillan, 1999) also calls for consultation with patients and the wider public for shaping the current and future health services. This study was aimed at exploring and describing the expectations that pregnant women have regarding antenatal care service by the midwife practitioner. In-depth interviews were conducted in an antenatal unit of an Academic Hospital in Gauteng Province. Data saturation was reached with a sample of eighteen pregnant women who were conveniently selected. Data analysis ran concurrently with data collection. A manual content analysis as described by Tesch was used. Lincoln and Guba's method of ensuring trustworthiness was adopted (Lincoln & Guba, 1985:328)

Literature was undertaken to compare the findings of this study with those of other previous studies. Women displayed several common expectations that led to the saturation of data.

It also became apparent from the findings that each woman had varied expectations. There were also some commonalities within the women's expectations. Health care, as the major expectation and a basic human right, appeared to be basically fulfilled, with the exception of interactional characteristics such as the communication of information, guidance, involvement, the understanding and explanation of aspects, freedom of choice, punctuality, individualized care and continuity of care.

The conclusions that were reached led to recommendations for nursing practice, education, research and the formulation of guidelines for the midwife practitioner for the implementation of effective antenatal care, based on the identified expectations.

## Introduction and Background

Pregnancy is considered a phase in life that makes great demands on the women's ability to adapt and adjust physically, psychologically and socially. The antenatal period provides an opportunity for reaching out to pregnant women and providing them with care that will enhance their optimum health and the wellbeing of their unborn infants. The overall goal of antenatal care, as such, is the delivery of healthy babies born of healthy and well prepared parents. This goal can be achieved through health

supervision, supporting parents during the childbirth process and by informing and allowing women to choose what they want (Haggstrom & Hildingsson, 1999:82-90).

Client expectations as the most important influence on health care, can be conditioned by the service providers themselves or may be influenced by the available stimuli to which the client may adapt, as such, knowledge and exposure to "routine" antenatal care can also guide or influence the pregnant women's expectations (Waldenstrom, 1996:170). Constant evaluation of "routine"

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procedures and protocols and review of research findings, are necessary to ensure that the care that is provided is evidence based through involving pregnant women as stake holders (Walker, McCully & Vest, 2001:146). Research has also indicated the importance of the determination of expectations to identify the level of satisfaction with care. It further highlighted that individuals who expect a certain type of care, will be less satisfied with other forms of care than individuals with no prior expectations (Clement, Sikorski, Wilson, Das & Smeton, 1996:122).

The American Midwifery Association (AMA 2000 2 of 3) also verifies the routine antenatal care as follows:

During the first antenatal visit. your doctor or midwife will conduct the following assessment:

Obtain your medical history and your family history. Perform a physical examination to confirm that you are pregnant and evaluate your general health. Perform a vaginal examination to check the reproductive organs and to estimate the period of pregnancy. A series of blood and urine tests will be done to detect abnormalities such as anemia or diabetes and advice will be given to you on diet and exercise. You will also be warned about certain items that may harm your foetus.

During subsequent visits.

You will be weighed, blood pressure will be monitored and the size of the foetus will be checked. Ultrasound scanning will also be done to detect foetal abnormalities.

## Problem Statement

The researcher, as a midwifery lecturer, facilitated students in clinical practice in the antenatal care unit of a Gauteng Academic Hospital. She observed that routine care, as outlined by the American Midwifery Association (AMA), was rendered to pregnant women during their clinic visits. The National Collaboration Centre for Women and Children's Health (October 2003), within their Clinical guideline on antenatal care, stated that from the midwifery perspective, the term "*routine antenatal care*" is perhaps a misnomer as there is no such a thing as a "routine woman" as every pregnant woman is different and each of her pregnancies are unique. Pregnant women are mostly subjected to

a variety of prescriptions and instructions to modify their lifestyle for a healthy pregnancy and childbirth. There is usually no option of refusal and it may be that the care rendered does not fulfill the pregnant women's expectations (World Health Organization, 1998). The researcher observed women at the antenatal unit of an academic hospital in Gauteng during their antenatal care visits and noted the following:

A primigravida was referred from a satellite clinic at 34 weeks for control of hypertension. She arrives at the clinic at 06h45 as client no. 1. She then underwent weighing, urine testing and hemoglobin monitoring. History was taken. The process was completed by 07h45. The woman then waited for the obstetrician who examined her at 08h30. The woman was then given information regarding the collection of a 24 hour urine specimen as requested by the obstetrician. The woman then left the clinic at 08h50. She was then instructed to submit the urine specimen the following day.

Another client was allocated no. 7 on the list of appointments. Urinalysis and weight monitoring was done as part of routine antenatal care. She waited for the obstetrician from 07h25 to 08h45 and left the clinic at 08h55 after being examined. This research addresses this "*routine care*". Is this what pregnant women expect during her antenatal clinic visits? The researcher's view is that this routine care might be inadequate to what women expect during their antenatal care visits, based on the researcher's assumption that antenatal care is often provided in a ritualistic pattern, which is the easiest, most familiar and most comfortable for the midwife. Midwives who find comfort by providing antenatal care as a routine, may find it increasingly difficult to recognize when such care is inappropriate, or in some cases, inadequate. (Walker; McCully & Vest 2001:146).

Thompson (1999:147) stated that all women have a right to expect that they will receive sufficient care throughout pregnancy and birth to permit them to emerge unscathed.

Given the previous and present day constraints of maternity health care, it is almost certain that a maternity service that meets and fulfills every woman's expectations is an ideal setting (Ledward, 2000:156)

Vision 2000, by Kaufman (2000) also recommend that maternity services should have explicit policies to empower women as full partners in their care and to involve users in the planning, development, monitoring and auditing of service provision.

## Purpose of the Study

The overall purpose of this research was to establish the expectations of pregnant women and to develop guidelines for theory, clinical and research in antenatal care.

## Research Objectives

The research objectives were two-fold, based on the overall purpose of the research.

- To explore and describe the pregnant women's expectations of antenatal care service
- To establish guidelines to the midwife practitioner for the implementation of an effective antenatal care service based on the pregnant women's expectations

## Paradigmatic framework

### Meta-theoretical assumptions

The researcher's assumptions are based upon man being holistic in nature, and as such the service provided should offer physical, social, psychological and spiritual fulfillment. The researcher's belief is that a pregnant woman is a whole person who is a spiritual being, functioning in an integrated manner with her internal and external environment. The internal environment consists of the body, mind and spirit.

The body refers to the anatomical and psychological changes that a pregnant woman undergoes and the adjustments that she makes during pregnancy.

The mind or psyche, the second dimension, refers to the intellectual, emotional and volitional processes. The intellectual process refers to the pregnant woman's capacity to understand her situation, its process and expected outcomes, for example, the physiological and psychological changes occurring during pregnancy and the clinical implications thereof on her wellbeing. Emotions refer to feelings and affection. Does she accept the pregnancy? Is she emotionally adjusted to pregnancy? With

volition, can she make decisions about her health status or make any individual choices?

The spirit, the third dimension of the internal environment, relates to the existence of conscience in the woman to distinguish if she is able to identify right or wrong interventions regarding the management of her pregnancy. Many pregnant women follow the obstetrician or midwife's instructions without question. The spirit also relates to the woman's relationship with God. Does she believe in pregnancy as natural and as a gift from God, which indicates her morals and values.

The spiritual dimension refers to the pregnant woman's values and religious beliefs. The woman is viewed as part of the family who should also be included within the meta-theoretical assumptions, as the family's support is important during this phase, in order to effect her complete adjustment to the process of pregnancy.

#### **Theoretical assumptions**

This assumption is based upon the existing "Theory for Health Promotion in Nursing". A holistic view of a pregnant woman, as explained in the meta-theoretical assumptions by a knowledgeable, skilled and sensitive midwife practitioner, who facilitates the promotion of health through the mobilization of resources. The pregnant woman and the midwife practitioner interact in this specific context of antenatal care. This interaction should be mutual and purposeful in order to promote the wellbeing of the woman during pregnancy. (RAU, 1999)

The Patient's Rights Charter (GJTMC,1994) and The Batho Pele Principles (<http://www.kwazulunatal.gov.za/premier/bathopele/what-is.htm>) as service principles, also forms part of the researcher's theoretical assumption as it is about transforming Public Service Delivery and giving acceptable customer service to the users of government services.

#### **Research Design**

A qualitative research design was undertaken as the aim of the study was exploratory and descriptive.

This qualitative approach is based on a holistic worldview, with a belief that there is no single reality, as reality based on

perceptions, is different for each person and changes over time. What we know has meaning only within a given situation or context. As perception varies among individuals, different meanings are possible (Burns & Grove, 2007:62).

Primary data about expectations was obtained from each woman by the researcher, through structured interviews. The interview, as a flexible data collection technique, allowed the researcher to explore meaning in greater depth (Burns & Grove, 2007:377). The expectations of individual women were identified to determine individual meaning, with due consideration to changing health care needs. Data was collected through field notes and the use of a tape recorder.

The study was carried out in two phases. Phase one involved the exploration and description of pregnant women's expectations from an antenatal care service. Phase two focused on the description of guidelines for the midwife practitioner to provide an effective antenatal care service, based on the findings of phase one.

#### **Population and Sampling**

The population was pregnant women attending antenatal clinic at an Academic Hospital in Gauteng. Non-probability purposive sampling was used, which involved a conscious selection, by the researcher of certain subjects who met the criteria, to be included in the study. The sampling criteria was as follows: Willingness of the woman to share information, pregnancy to have been confirmed, the woman should have carried a minimum of two pregnancies to term with a history of regular antenatal care attendance. The woman should be able to communicate in either English, Afrikaans or Setswana.

#### **Data Gathering**

Data was collected by use of in-depth unstructured interviews, using one open-ended question. The question was asked in English, Afrikaans and Setswana:

*'Please tell me about your expectations of this antenatal care service?'* The central question was followed by a probe *'Were your expectations met during your antenatal visits?'*

A pre-testing study was conducted as a miniature trial run of the methodology in order to detect any errors and flaws in

the data gathering instrument. Pregnant women who met the criteria of the study population were selected. Every detail of the major study was applied. The findings obtained from the subject in the pre testing study were also included within the major research findings, as the responses were consistent with those of the larger sample.

Responses were recorded on an audiotape and field notes were taken. Interviews were conducted until data became saturated.

Data saturation was reached with eighteen responses.

#### **Data Analysis**

Data analysis ran simultaneously with data collection to determine direction for further data collection as evidenced by data saturation. A manual content analysis as described by Tesch (1990) was applied in the study. Data was analyzed and sub-themes were formulated. Four major themes emerged from grouping sub-themes that carried similar principles or meaning.

#### **Ethical Consideration**

Consent was obtained from both the institution and the subject on the basis of being informed. Participation was voluntary. Subjects were offered the right to refuse to participate or to withdraw without fear of recrimination. A physically, socially and interpersonally conducive context for data collection was provided. A special room within the antenatal unit was reserved for conducting interviews. No data of private nature was collected. Subjects were allowed to behave and think without interference. Subjects were kept anonymous and there was no linking of findings with individual subjects. The findings of the study were provided to the institution in a form of a bound copy and subjects were allowed access to the information.

#### **Trustworthiness**

Lincoln and Guba's model (1985:328) was applied to ensure trustworthiness. Refer table no. 1.

#### **Results**

After exploring the expectations of eighteen pregnant women, data was arranged into meaningful statements to bear the testimony of the true expectations based on obtained

**Table1: Measures used to ensure trustworthiness of the study**

STRATEGY	CRITERIA	APPLICABILITY
Credibility	Prolonged engagement	The researcher spent a month working in the unit prior to conducting the study  The researcher facilitated students in the unit for two years  The researcher spent a reasonable time with subjects before the interviews in order to establish rapport
	Pre-testing	The study was piloted
Confirmability	Authority of the researcher	Researcher has undergone training in research methodology The research was supervised by a doctor in midwifery nursing science who has experience in conducting qualitative research
	Member check	The audiotape was played back to subjects for them to confirm their responses. The subject's comments were rephrased to verify accuracy of the researcher's interpretation
	Reflexivity	Field notes were used to preserve recorded information
Dependability	Dependability audit	Personal logs and field notes were kept after use
		Use of findings from similar studies through literature control
Transferability	Structural coherence	The focus was on the expectations of pregnant women of an antenatal care service.
	Nominated sample	The results were reflected within the ' <i>Theory for Health Promotion in Nursing</i> '  The sampling method was purposive with no prior selection

responses. Coding of major themes was done through breaking down, examining, conceptualizing and categorizing data obtained from the women's comments as to what they expect from the antenatal care service. The procedure of data analysis was through manual content analysis as described by Tesch, 1990.

A consensus discussion was held between the researcher and the independent coder in order to verify data analysis. The following major themes and sub-themes emerged from data analysis. Table 2 illustrates major themes and sub themes.

**Health Care**

Health care seemed to be the overall major expectation. The focus was on examination and assessment by a doctor, the identification of any deviations from health and the resolution of presented problems, by e.g. giving of medication. One participant indicated that she wants

to be examined so that the problems that she cannot raise can be identified. Another concern was about the health of their unborn babies.

WHO (1998) also states explicitly that antenatal care is one of the most effective health interventions for the prevention of maternal mortality and morbidity. According to the National Health System (Hillan, 1999) and the Bill Of Rights (1994), health care is considered a basic human right.

A study by Morgan (1996:6) on antenatal care of African American Women, a theme related to health care stated health care as advantageous in pregnancy as it protects the mother and the baby. Hillan's response (1999:309) to '*What do women and their families need from midwives?*', is health care that is technically good and well organized.

History taking was regarded as important

for these women as one participant said "*They must ask you questions about how you feel*". History taking as part of subjective assessment, elicits from the pregnant woman those factors that may have an influence on the outcome of pregnancy (RCM 2000:224). Pregnant women felt strongly that they should be involved in the management of the pregnancy and to be guided in all activities that involves their pregnancy. Anne Thompson (1996:162) in her report on safe motherhood at risk, stated that the days of perceiving women as passive consumers of health care are passed. The involvement of women gives them a choice and allows them some control on their wellbeing as when the woman is in control of the situation, self-esteem and self-confidence increases (Berg & Dahlberg: 1998:26)

Respondents indicated that the pregnancy should be managed as unique and extra attention to be provided for

**Table2. Major Themes and sub-themes**

MAJOR THEMES	SUBTHEMES
HEALTH CARE (HC)	Physical examination History taking Involvement Individualised care Continuity of care Healthy pregnancy Guidance
COMMUNICATION (COM)	Information Explanation of aspects Understanding
FREEDOM OF CHOICE (FOC)	Choice of caregiver Choice of caring
PUNCTUALITY (PUNC)	Timing of appointments Duration of visits

primigravidas and those carrying multiple pregnancy.

To illustrate that pregnancies are not the same, the uniqueness of each pregnancy was reflected within the following response from one participant:

*"With my first baby I didn't pass water. The water passed while I was already experiencing pains and the baby came at the same time. Now I am afraid that if they want me to pass water first it means I will deliver at home"*

*"The new student nurses, ok, because they are still young and they have no experience of being pregnant, they always try and tell you what to do, but they don't even know how you feel. I can't say they don't understand, but they don't eh! Its not the same as doctors, the sympathy is very different. It seems they think that it is common in pregnancy to feel that way because that is what they study but it seems they don't really try and understand how it feels"*

The uniqueness of the expectant parents formed part of the findings of the study by Olsson, Sandman and Jansson (1996:66) which implied a means of showing willingness and pleasure in learning to know them in their specific life situations and consideration of their ability to understand and meet the challenges of pregnancy.

**Continuity of care and caregiver**

A concern was raised regarding different care givers during the woman's antenatal care. Continuity of care may be achieved

through an ongoing relationship with one or more familiar caregivers. According to Kirkham and Perkins (1997:5), continuity of caring refers to care that focuses on the pregnant woman as an individual. Continuity of caregiver reflects a philosophy of consistency of policies, practices and individualized care plans. The results of a study by Hildingsson et. Al (2002) on women's expectations on antenatal care indicated that 97% of women saw continuity of midwife caregiver during pregnancy as important.

**Healthy pregnancy**

A healthy pregnancy is not merely the absence of disease or disorders, but is rather the condition in which the pregnancy process is accomplished in a state of complete physical, mental, social and spiritual wellbeing. A healthy pregnancy is a necessity as every pregnancy faces a risk, as there is a possibility of a pregnant woman experiencing serious injury or dying because of pregnancy (WHO, 1998)

*"We should be able to get some help so that we can deliver healthy babies that are well and without problems"*

**Guidance**

Pregnant women expected to be guided in all activities that involve antenatal care as illustrated in the following statement: *"They must encourage us if they give us medicines, if they are to be taken twice or thrice, the way they are supposed to be taken. They should tell us how the*

*medicine will help us"*

**Communication (COM)**

Respondents expected an established interaction with the caregiver through verbal, non-verbal and written communication. A need for being well informed and to understand the situation was expressed as follows:

*"The doctor who did sonar said nothing to me, he did not communicate with me but just gave the file and said I should go back to the examining doctor. . . and the doctor did not talk to me, he just walked an instrument over the abdomen"*

*" They musk ask you questions about how you feel and if there is anything wrong, you can respond and tell them how you feel"*

*"They must be honest with me, not to hide anything, straight forward, the doctor please!"* (Emphasizing)

McCourt and Pearce (2000:148-149) found through a qualitative study that for effective continuity of care, good communication is extremely important to all women. They emphasized the importance of information as a matter of dialogue rather than a one way information transfer from the midwife practitioner to the woman. Kirkham & Perkins, 1997, highlighted that good communication plays a vital role in determining choices and assisting in decision-making process. In contrast, poor communication heightens uncertainty and effectively serves to conceal available options. The following issues were cited as part of effective communication: the need for information, the explanation of aspects and ensuring understanding of the conveyed message.

**Freedom of Choice (FOC)**

An expectation of freedom of choice was expressed as two-fold, i.e freedom of choice of the caregiver and freedom of choice of health care intervention. Choice was and is regarded by WHO (1993); as a central feature in health care. The Batho Pele Principles(<http://www.kwazulunatal.gov.za/premier/batho-pele/what-is.htm>) also secure the importance of informed choice through openness and transparency.

The conclusion of a report on 'what really matters to women during pregnancy',

revealed that the importance of being offered choices makes it easier for them to manage their own pregnancies. (Kirkham & Perkins, 1997:43).

### **Punctuality**

Most respondents raised a concern about the adherence of caregivers to the exact appointment time as antenatal visits are mostly prolonged. This inconveniences their own personal commitments. In his comment on the uplifting of midwifery in Africa, Doctor Mhlanga (1999:12), concluded that the facilitation of a positive relationship between the woman and the midwife, could be achieved through negotiating the most convenient time for each pregnant women to attend the antenatal clinic.

The working hours for staff should be adjusted to suite the women's needs.

### **Guidelines for Antenatal Care**

With the goal of antenatal care being to ensure the best possible healthy pregnancy and optimal growth and development for the unborn baby, the following guidelines were formulated.

### **Physical examination**

A complete physical and abdominal examination should be done to each woman during the first antenatal visit and on subsequent visits if a need arises. Routine diagnostic tests should be done as part of assessment. A detailed history should be obtained from each woman during the first antenatal visit and be reviewed on subsequent visits

### **Involvement**

The determination and agreement on the proposed plan of care should involve pregnant women as part of the decision making process. ( Maloni; Yung-Chen; Liebl & Maier, 1996:20)

### **Individualized care**

The plan of care should be acceptable and affordable to the client and directed at meeting individual needs, considering each pregnancy for each woman, whether first or subsequent, as a unique process. Every pregnant woman should be understood and respected as an individual in order to meet her needs. Midwives should be sensitive to the pregnant women's feelings.

### **Continuity of care**

Antenatal visits should be arranged in

such a way that particular midwives are on duty for particular clients appointments. (Fargutar, Camilleri, Fernate & Todd 2000: 35 – 47; Kirkham & Perkins, 1997:5; McCourt & Pearce, 2000: 148). The use of a small team of midwives that take responsibility for the majority of care seems to be working well. There is substantial evidence that midwifery-provided continuity of care has beneficial effects on the pregnancy outcome, like offering a greater sense of control and greater satisfaction with antenatal, intrapartum and postnatal care (Vision, 2000:158)

### **Healthy pregnancy**

Antenatal visits should be scheduled as outlined in the Gauteng Antenatal Care Policy Document. The midwife should encourage women to attend antenatal care as scheduled.

Targeted support should be provided for women with special needs e.g women carrying multiple pregnancy. The midwife should conduct a continuous assessment of each woman during antenatal care visits and all midwives should undertake ongoing professional development to reduce risks in midwifery practice.

### **Guidance**

Pregnant women should be continuously supervised on the proposed plan of care and skilled attendance to the women's health care program should be ensured.

### **Communication**

Adequate time to talk and listen to the woman about her health status should be provided, ensuring a two way process of interaction. The communicated information should be clearly explained at the level of the woman's understanding by using the language that the client understands and also ensuring understanding of what the client is communicating to the midwife.

### **Information**

Ensure that the information that is communicated is relevant, accurate, accessible and adequate.

### **Freedom of choice**

Inform the woman fully about the options of care available, the risk and benefits of procedures. Provide the woman with accurate, unbiased information that is based upon the best available scientific evidence to enable her to make an

informed choice. Negotiate and reach a workable agreement with the client regarding the proposed health care plan. Encourage the woman to make decisions based on her own needs and values, making her aware that she takes final responsibility for her choices. Guide and support the woman's choices.

### **Punctuality**

Provide timely and prompt attendance to women when they arrive for an antenatal visit. (Thompson, 1999:151). Scheduling of appointments should be flexible for all pregnant women to make working hours convenient for the woman, the caregivers and support services. Clinic visits may be scheduled for late afternoons or during weekends. (Antenatal Care Policy, 1998:8; Maloni et al, 1996:19)

### **Discussion**

The pregnant women's responses to the central question were clearly stated as compared to the second question where respondents either emphasized what was stated in the initial response or mentioned additional expectations. The second question enhanced responses to the central question.

Although there was no clear cut answer of either a "yes" or "no" when the respondents were asked whether their expectations were met or not, it became apparent that each woman had varied expectations. There were also some commonalities within the women's expectations. Health care, as the major expectation and a basic human right, appeared to be basically fulfilled, with the exception of interaction characteristics, such as communication of information, guidance, involvement, understanding and the explanation of aspects, punctuality, freedom of choice, individualized care and continuity of care.

The focus of health care as a major expectation included health assessment that involves physical examination and history taking or data collection, the involvement of the woman in the process of health care, continuity of care and guidance which are all interdependent and leads to a healthy pregnancy. Physical examination, data collection and technical tests are necessary as part of assessment in the nursing process, as they lead to a midwifery diagnosis and finally to the maintenance of the woman's normal health status if an appropriate

intervention is undertaken. Most women had high expectations of antenatal care in terms of an attempt to prevent foetal morbidity. Checking the baby's health was the most important aspect of health care, followed by the mother's health.

The women felt that the involvement of the woman in their health care, provision of guidance, individualized care, communication and the continuity of care fulfills them and allows them to experience a feeling of self-worth. The above four concepts also reflected within the principle of "women-centered care" (Hillan, 1999). The effectiveness of communication is based on the explanation of the information to facilitate understanding and to ensure a two-way interaction. As part of communication, record keeping in health care should also be used as a form of written communication for identification purposes, as indicated within the women's expectations.

The importance of freedom of choice of the caregiver and caring has been validated through previous studies. As the outcome of choice is based on the adequacy of information provided, the caregiver has a duty to provide information to the client. According to the Patient's Rights Charter (GJTMC, 1994), a pregnant woman should be made aware that she has a right to choose a caregiver and a health care intervention, as well a right of refusal of a caregiver or a particular intervention.

Punctuality, as applied to scheduling of antenatal visits, appointments and the duration and period of attendance to the woman during the health care delivery, indirectly contributes to the effectiveness of health care. Scheduling of appointments should also accommodate specific groups like working women. Punctuality can be maintained through the correct timing and sticking to appointments, the reduction of the waiting period during the health care process and the actual length of attendance by the midwife or the obstetrician.

The findings of this study can also be inter-grated with the following Batho Pele Principles which are consultation, service standards, courtesy, choices and transparency.

Consultation is reflected within the title of the study, which is about asking

pregnant women about the service they expect during antenatal visits and establishing how best that could be met. Service standards or guidelines were formulated based on what is regarded as important to pregnant women. Every pregnant woman should be treated with dignity and respect as an individual, this relates to the principle of courtesy. Women indicated their need to be well informed about their wellbeing in order that they can make right choices. The service should be open and honest about every aspect of health care provided.

The maintenance of a healthy pregnancy is a challenge to midwife practitioners. Midwifery legislation also enables the midwife to provide total care during pregnancy without reference to other health care professionals, unless if there is any deviation from the norm. (ANON, 2000:225; SANC, 1990). According to the National Institute for Health and Clinical Excellence (2007), reviews of women's views on antenatal care suggest that key aspects of care valued by women are respect, competence, communication, support and convenience which generally supports the findings of this study.

## Recommendations

### Nursing Practice

Comprehensive and holistic care should be provided based on the expectations of pregnant women, as identified in the study.

A special effort should be made to consider pregnant women as unique at all times by considering individual differences and preferences

### Nursing Education

Midwife practitioners should undertake continuing education to familiarize themselves with research findings, such as the findings on women's expectations, so that they can offer health care that is congruent with pregnant women's expectations. Nurse educators should use strategies such as simulations, thinking aloud techniques and reflections, as these will provide opportunities for students to use their knowledge in clinical decision making situations and to practice reasoning processes before they fully engage in clinical practice (Cioffi, 1998:14 - 15).

## Conclusion

The Changing Childbirth report by the

National Institute for Clinical Excellence on women's views on antenatal care (2007), explicitly confirmed that women should be the focus of maternity care. It also states that "care during pregnancy should enable a woman to make informed decisions, based on her needs, having discussed her needs fully with the professionals involved.

The antenatal period presents an opportunity for reaching out to pregnant women with interventions that may be vital to their health and wellbeing and the health of their unborn babies. The findings of this study calls on a midwife to be a sensitive professional, who, through an interactive process, facilitates health care for the promotion of maternal health within the perspective of the client and the nursing environment

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