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Pregnant Women's Perceptions of Maternity Care Provided by Midwives at Women and Newborn Hospital in Lusaka, Zambia

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Abstract

Maternal healthcare quality remains a cornerstone of positive pregnancy outcomes. In Sub-Saharan Africa, including Zambia, high maternal mortality rates persist due to systemic challenges such as understaffing, overcrowding, and social inequities. Midwives are pivotal in addressing these issues, yet little is known about how women perceive the care they receive. This study explored pregnant women's perceptions of maternity care provided by midwives at the Women and Newborn Hospital in Lusaka, Zambia. A qualitative descriptive design was used to collect data through semi-structured interviews with 18 pregnant women of diverse backgrounds. Thematic analysis revealed six key themes: communication gaps, inconsistent care quality, structural and resource challenges, expectations of midwifery roles, socioeconomic inequities, and women's coping mechanisms. While instances of compassionate care were noted, systemic shortcomings and discriminatory attitudes—particularly towards single and younger women—undermined trust. The study recommends enhancing trauma-informed communication, addressing institutional staffing gaps, and implementing equity-focused reforms. These findings contribute to the understanding of how intersecting identities shape maternal care experiences and highlight pathways toward more respectful, patient-centered maternity services in urban Zambia. Methods: A qualitative descriptive design was employed, with data collected via in-depth, semi-structured interviews conducted on 18 pregnant women at the Women and Newborn Hospital in Lusaka, Zambia. Eighteen participants were purposively selected to ensure diversity in age (20 - 42 years), marital status (married, single, engaged), gravidity (1 - 6 pregnancies), and socioeconomic backgrounds (e.g., employed, unemployed, self-employed). Interviews, lasting 30 - 45 minutes, were audio-recorded, transcribed verbatim, and anonymized to ensure confidentiality. Thematic analysis was conducted using a six-step iterative process: (1) data famil-

iarization, (2) initial code generation, (3) theme identification, (4) theme review, (5) theme definition, and (6) report production. Coding was performed independently by two researchers, with discrepancies resolved through consensus discussions to enhance rigor. Results: Six key themes emerged: (1) communication gaps, particularly for first-time mothers; (2) inconsistent care quality, influenced by midwives' attitudes (empathy vs. dismissiveness); (3) structural challenges, including staffing shortages and long wait times; (4) expectations of midwifery roles, with participants valuing holistic care but criticizing transactional service; (5) socioeconomic disparities, limiting access to alternatives for low-income women; and (6) resilience strategies, such as peer comparisons. Marital status and parity intersected with experiences, with single and younger women reporting heightened stigma and neglect. Conclusion: While compassionate midwives enhanced care satisfaction, systemic issues like understaffing and stigma undermined trust. Recommendations include: (1) training midwives in trauma-informed communication; (2) policy reforms to address staffing and facility conditions; and (3) research on economic-mediated care disparities. These steps are vital to achieving equitable, patient-centred maternity care in Zambia.

Keywords

Maternal Health, Midwifery, Women's Perceptions, Zambia, Intersectionality

1. Introduction and Background

1.1. Introduction

The midwifery philosophy consists of promoting natural birth and recommending the midwife-led care model, based upon the perception that pregnancy and childbirth are normal life events. When midwifery care was provided by educated and trained midwives, it was associated with improved efficiency using resources and better outcomes. However, supportive care in pregnancy is of great importance to ensuring positive experiences and perceptions among women who give birth because such experiences can have a long-term effect. The presence of midwives during pregnancy and the relationship between midwives and women has been described as having an effect on the development of midwifery skills, particularly the knowledge needed for promoting normality and safe births. Globally, various studies into midwives' practice show that midwives feel that their work takes place between different "belief systems", based on "conflicting models of care", in which the midwives' approaches vary between being "with the woman" or being "with the institution" in workplace cultures in which they feel they are being monitored, as well as being controlled by clinical guidelines. Achieving maternity-care outcomes that align with women's needs, preferences and expectations is important but theoretically driven measures of women's satisfaction with their entire mater-

nity-care experience do not appear to exist. It is against this background that the study explored pregnant women's perceptions of maternity care provision by midwives working at Women and Newborn Hospital at the University Teaching Hospitals (WNH-UTH), Zambia.

1.2. Background Information

The World Health Organisation (WHO) conceptualizes maternal health as the health of women during pregnancy, childbirth or during the postpartum period [1]. Furthermore, maternal health combines the health status of women and how health services are adequate to provide the needs of women. Recommendations from the WHO in 2018 emphasised the quality of interaction between women and their health care providers and considered good interactions as a prerequisite for positive outcomes of childbirth. This interaction involves health care professionals' preserving women's respect and providing essential information and emotional support during labour and birth.

Maternity care is considered as a focused strategy to reduce maternal mortality but delivering care in an unsafe environment will thwart this strategy [2]. It is therefore important to ensure that the structural quality of available health facilities providing maternity care is safe and good enough for patronage in order to achieve Sustainable Development Goal (SDG) target 3 which is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by the year 2030 [1]. There is wide variation in provider types and practices in maternity care among hospitals. Thus, the woman's experience and perception may vary widely from hospital to hospital, depending on such factors as the hospital's level of care, staffing, maternal-foetal status, local values and culture, resources, and more.

Maternal care levels are unevenly distributed across the United States, leaving some women without access to appropriate resources and providers [3]. Nurses, physicians, and midwives provide the majority of maternal and new-born care across birth settings. The education of pregnant women on emergencies in pregnancy enables them to identify such emergencies early, successfully engage in the decision-making process regarding their management and cooperate with caregivers, thereby enhancing foetal and maternal health outcomes. Pregnant women who give birth in the United States can have vastly different experiences depending on the setting in which they give birth, the providers who participate in their care, how the birth is financed, and the state in which they give birth.

In the United Kingdom, the National Health Service England Better Births maternity review emphasises the need for both safety and personalisation in maternity and neonatal care which includes the importance of women having choices and making decisions based on their personal circumstances, values, social norms, and needs [4]. In the Netherlands maternity care is provided by midwives and General Practitioners (GPs) in primary care and midwives and gynaecologists in secondary care. To be able to interpret women's perceptions of the quality of maternity care, it is necessary to consider their "care path", that is: their route through

the care system. Maternity care in the Netherlands is different from maternity care in most other countries, not only because of the relatively high percentage of home births, but also because of the autonomy of the midwife, as medical professional, and the structure of the Dutch health care system with a clear boundary between primary and secondary care [5]. In maternity care the primary care provider and gatekeeper is a midwife, although some GPs still provide (part of the) care during pregnancy and childbirth. Most primary care midwives work in group practices and are jointly responsible for their clients. Midwives provide antenatal care (ANC) including health education and risk selection, intrapartum and postpartum care. Dutch midwives play a central role in women's pregnancy and childbirth process.

A study conducted by Almahound [6] in Saudi Arabia examined women's perceptions of maternity care in public and private sectors of National Guard hospitals. The study found that the practical behaviours of maternal health care providers are an important element of quality as they influence both positively and negatively how pregnant women, and their partners and families perceive and experience maternal health care. Konlan *et al.* [7] in Ghana revealed that free maternal health care policy was implemented under the National Health Insurance Scheme (NHIS). The free maternal health care policy covers ANC, delivery services, postnatal care (PNC), and 3 months' neonatal care under the mothers' NHIS card. Client's expectations and satisfaction with maternity care have influential factors ranging from good relationship and communication between clients and their caregivers, deliveries attended by skilled personnel to type of facility accessed during pregnancy and delivery. In addition, attitudes and behaviours of maternal health care providers influence health care seeking and quality of care. Midwives play a central role in ensuring that women have a safe and life-enhancing experience based on their expectations during maternity care and that their babies and families have the best possible start in life. Midwives' inability to give information and clear explanations to mothers during maternity care contributes to feeling of disappointment which later generates negative perceptions. While some pregnant mothers have positive and fulfilling experiences, some may experience negative from midwives' action. Despite the increasing activities of the nurses and midwives to improve the quality of care, it was observed that mothers still complain of midwives' attitude and practice.

In Zambia, the majority of women (97%) age 15 - 49 receive maternity care from a skilled provider (doctor, nurse, midwife, and clinical officer), most commonly from a nurse/midwife (93%) [8]. However, the quality of maternity care provided by midwives has recently received greater attention as a key reason for maternal mortality and morbidity remaining high in several countries despite substantial increases in coverage of maternal health services. Kwaleyela *et al.* [9], conducted a study to explore the childbirth experiences of women giving birth in Zambia in order to better understand how they give meaning to their experience. The study revealed that by being physically and psychologically present for the

women who are giving birth, birth attendants, particularly midwives assisted in raising their confidence levels. Caring behaviours, such as showing kindness and respect, giving privacy, as well as making the pregnant woman feel comfortable made a qualitative difference in the childbirth experience. Achieving maternity-care outcomes that align with women's needs, preferences and expectations is important but theoretically driven measures of women's satisfaction with their entire maternity-care experience do not appear to exist [9].

Studies on pregnancy services provided to pregnant women in hospitals and elsewhere have yielded mixed results with the majority of respondents reporting dissatisfaction with care by midwives [5] [10]. Reasons for dissatisfaction ranged from perceiving the care to be of poor quality, limited understanding on the importance of ANC, long waiting periods at the clinic and unsupportive clinic environment. To date, there is limited information about pregnant women's perceptions of maternity care provision by midwives working at WNH-UTH in Lusaka. It is against this background this study explored the pregnant women's perceptions of maternity care provision by midwives working at WNH-UTH in Lusaka.

1.3. Statement of the Problem

Maternity care is a crucial element of women's healthcare, with midwives playing an essential role in ensuring the well-being of both mothers and new-borns. In Zambia, WNH-UTH in Lusaka holds a significant position in providing maternity care. However, there is currently a lack of understanding of women's perceptions of the maternity care delivered by midwives, primarily due to insufficient information on this crucial aspect of healthcare. This knowledge gap underscores the need for comprehensive research to uncover and analyse how women perceive the maternity care provided by midwives.

Ideally, maternity care is characterised by high-quality relationships and communication between caregivers and pregnant women, deliveries consistently attended by skilled personnel, and access to well-equipped facilities throughout pregnancy and delivery [11]. The WHO emphasises the importance of respectful and supportive care, which significantly influences maternal and neonatal outcomes [12]. However, in Zambia, the reality often involves complaints about disrespectful and abusive care, limited availability of health workers, and inadequate communication between caregivers and patients [13].

Kwaleyela *et al*. [9] suggest that the perceived quality of care in antenatal clinics is a major factor influencing women's attendance. Additionally, the interpersonal aspects of care provided by midwives are crucial in shaping pregnant women's expectations and satisfaction with maternity care. The exclusion of pregnant women's subjective experiences and perspectives on the work culture of midwives during antenatal, labour, delivery, and the postnatal period results in an incomplete understanding of their diverse feelings and needs.

Reports of discomfort and dissatisfaction among pregnant women, attributed to the behaviour of midwives, lead to negative health-seeking behaviours and unsafe delivery practices, ultimately impacting maternal and neonatal health out-

comes. The discrepancy between the ideal and actual experiences of maternity care underscores a critical need for comprehensive research to explore and understand pregnant women's perceptions of the maternity care provided by midwives. This study aimed to address this knowledge gap by investigating pregnant women's perceptions of maternity care provision by midwives at the WNH-UTH in Lusaka, Zambia. By highlighting the differences between current practices and ideal standards, this research sought to provide insights that can inform improvements in maternity care delivery.

1.4. Study Justification

WNH-UTH in Lusaka offers pregnant women continuity of midwifery care, yet there is a noticeable scarcity of empirical data regarding women's perceptions of the care they receive from midwives at this facility. Despite numerous strategies aimed at improving maternity care, such as the training of nurses and midwives to enhance staffing levels and the overall quality of skilled healthcare providers, there remains a significant gap in understanding the subjective experiences of the women served.

The discrepancy between the ideal standards of maternity care—characterised by respectful, supportive, and well-communicated interactions—and the current local practices necessitates a thorough investigation. This study sought to provide a qualitative analysis of pregnant women's perceptions of care provided by midwives at WNH-UTH. By doing so, it has bridged the knowledge gap in women's perceptions of the quality and effectiveness of the maternity care they receive.

The findings from this study can be instrumental in policymakers and other stakeholders developing effective policies and programs to enhance maternal health care delivery at the hospital. Moreover, gaining a detailed insight into the model of care provided by midwives could help to refine and improve the quality of maternity care, thereby encouraging more women to opt for facility-based childbirth.

In the long term, this research can not only contribute to elevating the standards of maternity care but also serve as a crucial baseline for future studies focused on pregnant women's perceptions of maternity care provided by midwives. This foundational knowledge was essential for continuous improvements in maternal healthcare, ensuring that it aligns more closely with global ideal standards and better meets the needs of pregnant women in Lusaka.

1.5. Research Question

What are the pregnant women's perceptions of maternity care services provided by midwives working at women and Newborn hospital in Lusaka?

1.6. Research Objectives

1.6.1. General Objective

To explore pregnant women's perceptions of maternity care service provision by

midwives working at the Women and Newborn Hospital in Lusaka, Zambia.

1.6.2. Specific Objectives

To ascertain pregnant women's perceptions of maternity care services provided by midwives.

To investigate how pregnant women's perceptions of midwives' maternity care provision impact their utilization of maternity care services.

This section highlights the operational definitions of key terms used in this study. Operational definitions, specific to this research, provide clarity on how these terms will be applied within the context of this investigation.

Antenatal Care: This term refers to the comprehensive care provided to pregnant women and their unborn babies by healthcare professionals, predominantly midwives, starting from conception until the onset of labour. In this study, ANC specifically pertains to the care provided to pregnant women by midwives [10].

Effectiveness is the capability to produce a desired result or the ability to produce desired output. When something is deemed effective, it means it has an intended or expected outcome, or produces a deep, vivid impression (Oxford Learners Dictionaries, accessed 2023). In this study, it will be used to refer to the capability of midwives to follow the laydown procedures when attending to pregnant women in order to provide desired maternity care.

Maternity care: Maternity care means the health care provided in relation to pregnancy, labour and childbirth, and the postpartum period, and includes prenatal care, care during labour and birthing, and postpartum care extending through one-year postpartum. In this study, it will be used to refer to the health services provided to women, babies, and their families throughout the whole pregnancy, during Labour and birth, and after birth for up to six weeks.

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period [12]. In this study, it will be used to refer to the health of women during pregnancy, childbirth, and the postnatal period.

Perception refers to an intuitive recognition of a truth [7]. Perception in this study refers to how pregnant mothers see or regard maternity care they receive from midwives.

2. Literature Review

2.1. Introduction

This chapter presents literature from different writers on perceptions of women at the hands of midwives during the process of maternity care. The experiences of pregnancy, giving birth and having a baby create lifelong memories for women. The impact of maternity experiences on women can be empowering and lead to feelings of self-worth and self-confidence or may cause negative maternal health outcomes such as postpartum depression and post-traumatic stress disorder. The purpose of literature review was to provide foundation of knowledge on maternity care using the research questions and objectives, identify areas of prior scholar-

ship to prevent duplication, identify gaps in research, conflicts in previous studies and identify need for additional research on the topic. Journals, articles, and publications from other researchers will be reviewed to get data for this study from the data bases such as Pub Med, Med line, Google scholar and Scopus. The literature review was presented according to the following sub-headings: overview of maternity care, pregnant women's perceptions towards maternity care services provided by midwives; perception that influences pregnant women usage of maternity care services provided by midwives and views on how to improve maternity care services by midwives.

2.2. Overview of Maternity Care

Maternal health describes the health state of a woman during pregnancy, the delivery and during the period that follows the delivery [5]. The maternity care services provided to the pregnant women before child delivery are referred to as ANC while the services provided to the mother after delivery are referred to as the PNC services [12]. Globally, at least half of maternal mortality results from pregnancy complications, and over 277,300 (94%) of these deaths occur in low- and middle-income countries and roughly two-thirds (196,000) of the deaths take place in sub-Saharan Africa [12]. A woman's lifetime risk of maternal death in sub-Saharan Africa is 1 in 59, far higher than the risk in all low-income countries, estimated at 1 in 160 [14]. Globally, 2.4 million neonates died in 2019 which approximates to 6700 neonatal deaths daily. The direct maternal deaths could be prevented by strengthening and improving access to the whole continuum of maternity care [15].

According to Yousra [16] maternity care provides a platform to inform and educate expectant mothers about pregnancy and the importance of seeking skilled health care during the time before and after birth. The goal of maternity care is to provide regular check-ups that would enable doctors or midwives to screen, prevent, detect, and treat potential health complications that may arise in pregnant women. The presence of a midwife who is skillful during maternity care is important as key interventions are conducted in the first trimester. Serwanja *et al*. [17] revealed that maternal care has to be provided by professionals who are equipped with appropriate skills. If midwives lack knowledge and skills, this could cause pregnant women to avoid maternity care services, resulting in an increased number of maternal deaths.

2.3. Pregnant Women's Perceptions of Maternity Care Services Provided by Midwives

A qualitative study by Aquino *et al*. [18] aimed to consider women's views and experiences of maternity care as collaboratively provided by midwives and health visitors in England. This study revealed that maternity care which was collaboratively delivered by midwives and health visitors is not routinely provided. However, women recognize the potential benefits of midwife-health visitor collabora-

tion. Othman *et al*. [19] noted that the perception of health service consumers on maternity care services providers is one of the most important qualitative indices of health care provision and has special relevance in maternity care because it affects the degree to which pregnant women will utilise and comply with maternity care for better maternal-foetal outcomes [19]. Beecher *et al*. (2020) in their study of literature published between 1990 and 2017 on women's experiences of their maternity care, reported that, midwives, as antenatal and post-natal care providers, tend to care for pregnant women over a longer period of time, providing pregnant women with continuity of care, health education, and opportunities for inter-professional collaboration for improved patient outcomes. In this light, midwives play an important role in providing maternity care.

A study by Mose *et al*. [20] aimed to explore pregnant women's perception and experience of a Midwifery-led continuity care (MLCC). Thematic analysis showed that women desired enhancements in the continuum of care, woman-centred care, and satisfaction with their care. The finding of this study shows that pregnant women had positive experiences and showed a willingness to receive midwifery-led continuity care. Therefore, it would be reasonable to adopt and implement midwifery-led continuity care for low-risk pregnant women in the Zambia setup.

In the study of Kanikwu *et al*. [2], which looked at pregnant women's perception of the effectiveness, safety and timeliness of the maternity care provided by midwives, and the relationships between effectiveness, safety, and timeliness of maternity care at government-owned healthcare facilities in Nigeria. The study reported that pregnant women generally had a positive perception of the effectiveness, safety and timeliness of antenatal services provided by midwives. However, they displayed negative perceptions of a few specific items of the antenatal services provided by midwives. This is a challenge for midwives to improve their skills in the maternity care they render to pregnant women. In addition, significant relationships existed between safety and effectiveness, as well as between timeliness and effectiveness. These aspects impact the perception of antenatal care quality, and focusing on them will generally improve the outcome of maternity care. This may need to be investigated in Zambia.

It is recognized globally that midwives are critical care providers in prenatal care and are the main professionals in birth wards, providing healthcare education and information to pregnant women and their family members. Therefore, midwives' care at the hospital such as health information and positive interpersonal relationship between midwives and pregnant women is important and help to cope with pregnancy related changes and initiate pregnant woman to practice the health promoting behaviour. Another major issue in life saving and improving the health and well-being of women and babies globally is breastfeeding. Accordingly, nurses and midwives support mothers in successfully initiating and continuing breastfeeding by giving advice about the methods of infant feeding, the process of lactation, problem management, communication, and advanced skills [21].

In a culturally sensitive society like Zambia, midwives are expected to always

provide culturally sensitive care and respect the rights of every woman when choosing health care providers during pregnancy and childbirth. Midwifery is a distinct regulated profession and has its own standards of proficiency [22], which specify the knowledge, understanding and skills that midwives must demonstrate at the point of registration when caring for women across the maternity journey, as well as Newborn infants, partners, and families across all care settings. Midwives are accountable as the lead professional and have a unique relationship with the women, Newborn infants, partners, and families they care for and support. A midwife's scope of practice means: "the range of things that the midwife has the skills, knowledge and proficiency to do" and it should not be confused with "protected function" which is "something that only midwives can legally do".

The study of Libingi *et al*. [10], narrated that quality care has the potentials of improving the pregnant women perceptions, also health of the mother and child. Furthermore, the practice of midwives goes a long way to influence pregnant women perceptions about them and promote mutual relationship between the midwife and the pregnant women and this may result in successful child (ren) delivery [10]. However, this study intends to fill the gap in pregnant women's perceptions of maternity care services provided by midwives working at WNH-UTH in Lusaka.

2.4. The Influence of Pregnant Women's Perceptions on Usage of Maternity Care Services

Vogels-Broeke *et al*. [23] conducted a cross-sectional study in the Netherlands to investigate pregnant women's utilization of information sources and assess the perceived trustworthiness and usefulness of these sources. They found that midwives, family/friends, websites, and apps were the most used sources. Professional information sources were generally considered more trustworthy and useful compared to digital sources. Despite this perception, digital sources remained highly utilised by pregnant women, indicating their prevalence despite being deemed less reliable and beneficial than traditional sources.

Depending on a particular woman, varied perceptions and experiences are encountered in seeking maternal health care services. These service experiences are varied based on the cultural and socioeconomic as well as ecological variables that influences health within a particular setting. Redshaw *et al*. [24] argued that the perception of quality maternity care differs significantly by the type of facility used by women. Women considered the private hospitals to provide quality maternity care due to the availability of amenities and equipment as well as good midwife-client relationship. In addition, attitudes and behaviours of maternal health care providers influence health care seeking and quality of care. Greater attention is required to the attitudes and behaviours of maternal health care providers within efforts to improve maternal health, for the sake of women, children, and health care providers.

Women and their families expect a service that provides clear communication

and explanations, effective teamwork, a safe caring environment, and continuity of care. Midwives are therefore supposed to ensure that expectations are understood and met. Midwives' inability to give information and clear explanations to mothers during pregnancy contributes to feeling of disappointment which later generates negative perceptions. Women may avoid obtaining care from health facilities because of a lack of respectful maternity care and incidents of abuse against patients by midwives. Women's perceptions of healthcare workers' attitudes during pregnancy, birth and the postnatal period influences their usage of maternity care services provided by midwives.

Shahla *et al*. [21] argued that the poor perceptions of the women about the midwives, perceiving them as individuals with negative attitude, who are uncaring, unfriendly, and rude, have a great negative effect on the utilization of their services. The positive attitude of midwives is an essential factor in the utilization of maternal health services by pregnant women. Pregnant women's poor perceptions with care providers influences their usage of maternity care services provided by them. Kanikwu *et al*. [2], also, noted that poor satisfaction or unpleasant interaction with providers during pregnancy may compromise women's access to vital services, thus jeopardizing the health of women and their infants.

Providing health education, information and emotional support to women are the main components of maternal care, and these are what the midwives offer in prenatal counselling and postpartum guidance. Higginbottom *et al*. [25] revealed that midwife-led prenatal counselling is an important part of maternal care and improves on women's confidence in midwives who provide such services. Women tend to consider midwives to be the designated health caregivers for providing maternal health education. A qualitative study in Sweden found that women experienced a greater sense of calm and preparedness from midwife-led prenatal counselling and increased their tolerance for the uncertainty related to the birthing process [26].

Liu *et al*. [27] revealed that women who had high satisfaction with midwife-led maternity care before it influences their usage of maternity care services provided by midwives. This satisfaction is probably felt because of the prenatal counselling by the midwife and allowing a family member in the room during childbirth. Other intangible factors to improve the satisfaction level were breathing techniques, warm perineal compresses, epidural anaesthesia, free positioning during first stage of labour, and early skin to skin contact. The satisfaction pregnant women receive during maternity care by midwives makes them seek the same services when they need them.

Having trust and confidence in the staff caring for women during pregnancy was critical to women's perceptions of care and may influence their choices and decisions in the future, as well as how they feel about themselves. Each woman and her partner need a midwife they know and trust to coordinate their physical and emotional care through pregnancy and until the end of the postnatal period. Midwives are recognized as specialists in the care of pregnant women in labour,

so some argued that they have sufficient knowledge, skills, and experience to understand women's needs more so than other medical professionals. Furthermore, midwives have experienced multiple, and different, models of care, their working experiences positively influenced their level of autonomy to advise women about eating and drinking during labour [2].

In the study of Beecher *et al*. [5] who looked at women's experiences of their maternity care. The study found that midwives were seen as possessing the requisite knowledge and skills needed to assist the woman through pregnancy. This seemed to increase client confidence in the midwife. Women expresses feelings of trust in midwives' knowledge and expertise and accepted their interventions without question. Knowledge of midwifery is an important key to the concept of maternal care provision. The midwives are expected to have a positive attitude towards pregnant women during maternal care provision and also use their knowledge on pain management to reduce or relieve pain. It is also believed that the midwives can relieve anxiety by their knowledge in psychology because some of these mothers' threshold to pain is very low. Women in labour tend to overestimate their ability to cope with pain. In the practice of safe delivery therefore, the midwife is expected to be courteous, patient and attend to client's/patient's needs immediately when conducting a delivery [5].

Kwaleyela *et al*. [9] conducted a study in Zambia investigating women's childbirth experiences. They used an interpretive phenomenological approach and found that birth attendants, especially midwives, significantly impacted women's confidence during childbirth by being supportive both physically and psychologically. Acts of kindness, respect, providing privacy, and ensuring comfort made a notable positive difference in the quality of the childbirth experience for these women.

International Confederation of Midwives [28] reported that determinants of maternal satisfaction covered all dimensions of care across structure, process, and outcome. Interpersonal behaviours were the most widely reported determinant, with the largest body of evidence generated around provider behaviour in terms of courtesy and non-abuse. Other aspects of interpersonal behaviours included therapeutic communication, staff confidence and competence and encouragement to maternal care. Therefore, there is need to ascertain how pregnant women's perception influences their usage of maternity care services provided by midwives at WNH-UTH in Lusaka.

2.5. Pregnant Women's Views on How to Improve Maternity Care Services by Midwives

A study by Redshaw *et al*. [24] to describe the development process and psychometric properties of a measure of women's experience of maternity care covering the three distinctly different phases of maternity—pregnancy, labour and birth, and the early postnatal period. Exploratory and confirmatory factor analytic study revealed that a woman's maternity experience can have a positive or negative ef-

fect upon her emotional well-being and health, in the immediate and the long-term, which can also impact the infant and the wider family system. Therefore, measuring women's perceptions of maternity care was an important way of monitoring the quality-of-care provision.

Leahy-Werren [29] investigated the factors influencing women's perceptions of choice and control during pregnancy and birth in Ireland. Most women reported not having choice in the model or location of their maternity care but most reported being involved enough in decision-making, especially during birth. Women who availed of private maternity care reported higher levels of choice and control than those who availed of public maternity care. Availing of private maternity care has the strongest influence on a woman's perceived choice and control but many women cannot afford this type of care, nor may they want this model of care.

Nursing and Midwifery Council [22] in England argued that 'Midwifery Model of Care' is based on the premise that pregnancy and childbirth are normal life events and should not be interfered with unless complications occur and includes monitoring of the physical, psychological, spiritual, and social wellbeing of the woman and her family. Greater attention is required to the practice behaviour of midwives towards pregnant women within efforts to improve maternal health, for the sake of women, children, and health care providers. Midwives' inability to give information and clear explanations to women during pregnancy contributes to feeling of disappointment which later generates negative experiences [24].

Higginbottom *et al*. [25] argued that midwives towards pregnant women needs to provide skilled, knowledgeable, respectful, and compassionate care for all women, new-born infants, and their families. Midwives should respect and enable human rights of women needs by ensuring that care always focuses on the needs, views, preferences, and decisions of the woman and the needs of the new-born infant [25].

Kanikwu *et al*. [2] narrated that midwife has specific responsibility for continuity and coordination of care, providing ongoing midwifery care as part of the multidisciplinary team, and acting as an advocate to ensure that care always focuses on the needs, views, preferences, and decisions of the woman and the needs of the new-born infant [2]. Therefore, midwives make a vital contribution to the quality and safety of maternity care. Redshaw *et al*. [24] revealed that in ensuring good practice behaviours of midwives towards pregnant women, midwives should continue to develop and refine their knowledge, skills, resourcefulness, flexibility and strength, self-care, critical and strategic thinking, emotional intelligence, and leadership skills throughout their career.

Shahla *et al*. [21] argued that a fundamental component of good practices of the midwives towards pregnant women is promotion of access to care that is safe, inclusive, and respectful, and enables women to have dignity and control. Women and their families also need to feel included and engaged in order to optimize access to, and use of, available health services and facilities. However, this is not

always what women experience, a lack of respectful maternity care is a key reason why many women do not choose to access health facilities for care during pregnancy. Despite caring being an important emotional aspect of midwifery and nursing, there are general public complaints about uncaring behaviour in midwifery.

Further, Liu *et al*. [27] suggested for midwives to build and establish positive relationships with the pregnant women by engaging in conversational interactions and providing emotional support. Communication between the client who are pregnant women, and the midwife should be part of the services to improve on maternity care by midwives. In the study of Nursing and Midwifery Council [22] in England argued that the practice behaviour of midwives towards pregnant women who are people in need of the services of midwives must remain a priority. Hence, pregnant women must be given priority and treated with the utmost respect by midwives. As midwives should uphold the reputation of their profession at all times with personal commitment to the standards of practice and behaviours. They are expected to be a model of integrity and leadership for the general public. Hence the need of this study to establish pregnant women's views on how to improve maternity care services by midwives working at WHN-UTH in Lusaka.

2.6. Conclusion

In the realm of maternal healthcare research in Zambia, significant gaps persist, particularly in understanding the perceptions of pregnant women towards critical aspects like maternity care provision by midwives. While some studies have explored related themes, such as factors associated with new-born care in rural Zambia, uncovering women's perceptions of maternity care [9]. A conspicuous absence of research specifically focusing on pregnant women's perceptions of maternity care at WNH-UTH in Lusaka is evident in Zambian literature. This study addressed a much-needed area of concern. Further, no previous research had been conducted with pregnant women to explore pregnant women's perceptions of maternity care provision by midwives working at WNH-UTH in Lusaka, Zambia. Hence, the need to explore pregnant women's perceptions towards maternity care provision by midwives working at WNH-UTH in Lusaka, Zambia.

3. Research Methodology

3.1. Introduction

Research methodology is the manner in which information is gathered for the purpose of making informed decisions. It encompasses the analysis of methods which are applied to a field of study. This chapter discussed the research design and methodology used for the study. This incorporated the paradigm, population, data collection tools, data collection procedures, and ethical consideration.

3.2. Research Design

A descriptive phenomenological design was used. Descriptive phenomenology is

concerned with revealing the "essence" or "essential structure" of any phenomenon under investigation. Phenomenology is also the lived experience of humans from the world of their everyday lives. These experiences tell them what is real and true in life and give meaning to their perception of a particular phenomenon which can be influenced by internal and external factors.

3.3. Study Setting

The study was conducted at the Women and Newborn Hospital which is one of the five hospitals at the University Teaching Hospitals in Lusaka. The hospital is the biggest public tertiary referral hospital for pregnant women and neonates with complications and as such, it receives high volume of transfers serving surrounding facilities and the country at large. It also provides primary level care to individuals who reside in neighbouring communities.

3.4. Study Population

The study population consisted of women who are seeking maternity care—including ANC, and PNC—at WNH-UTH in Lusaka. This population was chosen because these women could have been in contact with midwives at the institution to give objective experience/perceptions. They included, pregnant women seeking ANC services (women at any gestational age who were currently receiving ANC at WNH-UTH), postnatal women (women who had recently given birth and were receiving PNC at the hospital). By including women across these stages of maternity care, the study aimed to capture a comprehensive range of experiences and perceptions related to the care provided by midwives throughout the entire maternity period. This approach ensured that the study covered the full spectrum of maternity care, from ANC through childbirth to the postnatal period, aligning with the study's objective to evaluate overall maternity care.

3.5. Sampling Selection

The sample size for qualitative research was not predetermined through a formal sample size calculation [30]. In terms of qualitative research, the collection of rich in-depth data is the most important consideration rather than the number of participants. Kamal [31] concluded that six to twelve interviews are sufficient to achieve most qualitative studies' research aims and objectives. Additionally, these numbers are appropriate for achieving data saturation [31]. Therefore, saturation of data was used to sample 18 women participants, aiming to achieve data saturation through semi-structured interviews.

3.6. Sampling Technique

The method of selection was based on a non-probability approach. Non-probability sampling is the selection of participants because they are available, convenient, or represent some characteristic the investigator wants to study. A purposive sampling method was used to recruit pregnant women who met the inclusion cri-

teria.

3.7. Eligibility Criteria

3.7.1. Inclusion Criteria

1) Women receiving ANC at the Women and Newborn Hospital.

2) Postnatal women receiving PNC at the Women and Newborn Hospital.

3.7.2. Exclusion Criteria

1) Women attending the ANC for their first visit, as they could not have had interacted with the midwives.

2) Pregnant women with medical conditions who were not feeling well at the time of interview.

3) Women in labour, as their responses could be influenced by pain.

4) Postnatal mothers who did not deliver at the Women and Newborn Hospital.

3.8. Instrument of Data Collection

A researcher interview guide was used to collect data from participants. Addressing the objectives and research question, in-depth interviews, which are intrinsically qualitative, were used to provide a deeper understanding of how pregnant women perceive maternity care provision by midwives working at WNH-UTH.

3.9. Data Collection Technique

Face to face interviews were conducted with women at their convenience. Purposively selected women were made comfortable and asked questions in sequence until the questions were exhausted. The researcher devoted a few minutes towards introducing the research and its purpose to the respondents. Then, the researcher conducted a face-to-face interview with pregnant women receiving maternal care from midwives at the facility. The researcher introduced themselves, the topic, and the purpose of the study. After that written/thumb consent was obtained to proceed with the study. The goal of in-depth interviews was not to get answers or to examine hypotheses, but to understand the pregnant women's perceptions of maternity care provision by midwives from their own perspective. In order to maintain alignment with research questions researcher politely interrupted whenever the discussion drifted in other direction.

Data collection continued until saturation occurred; that is when further interviews did not elicit new information [32]. The researcher asked the participant to go through the transcribed interview to verify that it was a true reflection of their thoughts. The transcribed interviews were translated into English before being analysed. To ensure accurate translation from Chinyanja to English, the translated interviews were verified by a linguist expert. After the interviews were converted to text, the texts were analysed for any inaccuracies by comparing the audio recording and the writing. After transcription, a flash was used to store data for confidentiality of the participants. Each interview took up a maximum of 45 minutes to conclude [33].

3.10. Trustworthiness of Findings

It addresses the issues of credibility, transferability, dependability, and conformability. Within the constructivist paradigm, these terms replace the usual positivist criteria of internal and external validity, reliability, and objectivity [34].

Credibility in qualitative research includes activities that increase the probability that convincing findings will be produced. The researcher engaged in bracketing throughout the process of data collection and analysis in order to stay true to the data.

Dependability refers to the degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did [35]. All the processes and procedures that were used for data collection and data analysis in this study were recorded to allow the reader to evaluate and follow the effectiveness of the process of inquiry that was undertaken.

Transferability was achieved through a detailed description of the context and through a universal member check procedure whereby the participants had to confirm the essential themes from the data analysis.

3.11. Data Analysis

Thematic analysis described by Leavy [35] was selected for this study. This type of analysis identifies, arrange, and propose understandings of patterns of meaning from the data [35]. This approach sought to develop common meanings based on peoples' experiences regarding a particular topic [35]. The interpretation involved six-phase process. Firstly, the audio-recorded interviews were listened to while reading the transcripts many times to understand the participants' words in order to find the inherent meanings. The purpose of this initial process was to become familiar with the content of the data and to recognise various aspects appropriate to the research question. The second step was coding the data. Coding described the initial levels of meaning in the data and established connections between the participants' perceptions. The next step was to identify the emerging themes. A theme is a consequence of coding which is crucial for linking to the research question and to show meaningful patterned responses from the data [35].

The identified themes were revised based on the coded data and referred back to the entirety of the data, which was a necessary process to check quality. It was important to ensure that the themes were related to the data to enhance relevance and trustworthiness. Specifying and naming themes was the next part of the process in order to interpret and describe the meaning of the data. Finally, the findings from all phases of the data analysis were written up and reported on [35]. The processes of the study and the findings based on the thematic analysis was reported in Chapter Four of the study.

3.12. Ethical Considerations

The ethical approval was obtained from the University of Zambia Biomedical Research Ethics committee (UNZABREC, REF. No. 5334-2024) and the National Research Ethics Committee (NHRA-1689/07/11/2024). Written permission was

obtained from the study site. Informed consent was obtained from each study participant prior to enrolment. In the event that the respondent refused to take part in the research, they were replaced, and all respondents were treated as anonymous to avoid identification. In situations where the respondent desired to withdraw, they were freely allowed to do so, and all their information shredded immediately. Information that was obtained during the study was treated with utmost confidentiality as it bordered on personal information which most people would rather keep to themselves. The data collecting instruments were kept under lock and key, only the researcher had access to them.

4. Presentation of Findings

4.1. Introduction

This chapter presents research results based on the analysis of data collected through in-depth interviews from 18 pregnant women at WNH-UTH in Lusaka, Zambia. The thematically analysed data have been summarized and presented in line with the study's specific objectives which were to (1) ascertain pregnant women's perceptions of maternity care services provided by midwives, and (2) investigate how pregnant women's perceptions of midwives' maternity care provision impact their utilization of maternity care services. Rooted in participants' first-hand accounts, this analysis aimed to identify recurring patterns in their experiences, focusing on how systemic, interpersonal, and socio-cultural factors shaped their interactions with healthcare providers.

Guided by Leavy [35] framework, the analysis prioritized inductive coding to allow themes to emerge organically from participants' narratives. This approach ensured that findings remained grounded in the lived realities of women from diverse demographic backgrounds, including variations in age, marital status, parity, and socioeconomic status. Six overarching themes were identified, reflecting both strengths (e.g., compassionate care, advocacy) and systemic gaps (e.g., staffing shortages, stigma) in midwifery practice. Key themes included:

1) Communication gaps and information asymmetry
2) Inconsistent care quality linked to midwives' attitudes
3) Structural and operational challenges
4) Socioeconomic and cultural inequities
5) Expectations and perceptions of midwifery roles
6) Resilience and coping strategies

The analysis also highlighted how intersectional identities (e.g., single mothers, first-time mothers) compounded vulnerabilities, emphasizing the need for tailored interventions. Direct quotes from participants were used extensively to anchor themes in authentic voices, ensuring the findings remained reflective of their priorities and concerns.

4.2. Demographic Data of Study Participants

This section presents the description of the demographic data from the 18 partic-

ipants. This includes age, marital status, residential area, occupation, gravidity, and parity (Table 1).

Table 1. Description of participants' demographic data.

Participant	Age	Marital status	Residential area	Occupation	Gravid	Parity
1	26	Single	Kalingalinga	Teacher	1	1
2	35	Married	Emmasdale	Businesswoman	4	3
3	42	Married	Chilenje	Housewife	6	6
4	32	Married	Chalala	*Not specified*	2	2
5	33	Married	Chalala	*Not specified*	3	2
6	25	Single	Kamwala South	Student	1	1
7	31	Single	Libala South	Business lady	1	1
8	26	Married	Water Works	Chef	1	1
9	34	Married	Kabulonga	Accountant	3	2
10	26	Single	Libala South	Military Officer	1	1
11	20	Single	Makeni	School Leaver	1	1
12	28	Married	Kabwata	Hairdresser	2	2
13	35	Married	Northmead	Businesswoman	4	0
14	34	Married	Mtendere	Business Lady	3	3
15	29	Engaged	Chilenje	House Help	2	1
16	30	Single	Kabwata	Preschool Teacher	2	2
17	28	Married	Chilenje	Unemployed	1	1
18	29	Single	Libala	Self-Employed	1	1

Table 1 shows that of the 18 participants receiving maternity care at the Women and Newborn Hospital in Lusaka, Zambia, with ages ranging from 20 to 42 years (mean ~30 years). The majority were married (55.5%), while 38.8% were single and 5.5% engaged, reflecting diverse marital backgrounds. Geographically, participants resided in urban Lusaka neighbourhoods such as Kalingalinga, Chilenje, Kabwata, and Libala, indicating a primarily urban sample. Occupations varied widely, with 22% in business, 17% in domestic or unemployed roles, and others working as teachers, students, military officers, or self-employed individuals. Notably, multiparous women (gravida 2 - 6) made up 55.5%, including older participants like a 42-year-old with six pregnancies, predominantly younger women aged 20 - 29, while first-time mothers (gravida 1) constituted 44.4% of the sample. Parity largely aligned with gravidity, though exceptions included Participant 13 (gravida 4, parity 0), suggesting prior pregnancy losses. Socioeconomic disparities were evident, with unemployed or self-employed participants (e.g., house helps, informal traders) highlighting financial barriers to accessing private care. The sample's urban focus, marital diversity, and mix of first-time and experienced

mothers provided a nuanced lens to explore how demographic factors intersect with care experiences, such as stigma against single mothers or assumptions about multiparous women's health literacy.

4.3. Findings from Thematic Analysis

This section presents the thematic structure derived from the data, including codes, sub-themes, and illustrative examples, to provide actionable insights for improving maternity care delivery in Lusaka and similar settings.

Table 2 presents a structured summary of codes, themes, and sub-themes identified during the analysis. Codes were derived directly from participant narratives (e.g., "long wait times," "spiritual support"), while Sub-themes grouped related codes into actionable categories (e.g., "Staffing and Workload" under Structural Challenges), and Themes reflected systemic, interpersonal, and socio-cultural dimensions of care. Based on the transcripts from 18 participants, the following themes emerged, reflecting both positive and critical perceptions of maternity care provision by midwives (Table 2).

Table 2. Codes, themes, and sub-themes.

Theme	Sub-theme	Codes	Example participant quote
Quality of care & communication	Information provision	Lack of tailored information for first-time mothers; Over-reliance on prior knowledge	"*Information on how to take care of oneself is vital... I was not satisfied.*" (Participant 1)
	Emotional support	Emotional counselling; Neglect of mental health needs	"*The midwife noticed I was emotionally down and talked me through it.*" (Participant 4)
Professional conduct	Empathy vs. rudeness	Compassionate care; Sarcasm; Dismissiveness	"*Midwives act like they hate their jobs... respond rudely.*" (Participant 18)
	Consistency in care	Favouritism; Unequal treatment	"*Midwives should not play favourites.*" (Participant 12)
Structural challenges	Staffing & workload	Overworked midwives; Long wait times	"*We need more midwives to relieve their stress.*" (Participant 5)
	Facility conditions	Poor sanitation; Lack of resources	"*The toilets need proper care.*" (Participant 9)
Socioeconomic inequities	Stigma & judgment	Stereotyping single mothers; Unwanted pregnancy stigma	"*Midwives compared me to others...their approach was bad.*" (Participant 6)
	Financial barriers	Inability to access private care; Economic dependency on public services	"*I'll go private if I can afford it...this is my last child.*" (Participant 8)
Midwifery roles	Holistic care	Spiritual support; Advocacy beyond clinical duties	"*A midwife prayed for me and opposed unnecessary surgery.*" (Participant 9)
	Transactional care	Minimal engagement; Focus on routine tasks	"*They just did their job...nothing special.*" (Participant 8)
Resilience & coping	Peer comparisons	Normalizing poor care; Contrasting experiences	"*I heard horror stories, but my experience was better.*" (Participant 14)
	Adaptation to variability	Accepting inconsistencies; Rationalizing care quality	"*Not all midwives are bad...I got the better side.*" (Participant 3)

4.3.1. Theme One: Quality of Care and Communication

This theme explores how midwives' communication styles and the provision of information shaped participants' experiences, particularly for first-time mothers. It highlights gaps in tailored guidance, emotional support, and the impact of inconsistent messaging on patient confidence. Participants emphasized the importance of clear, empathetic communication and the provision of tailored information, especially for first-time mothers.

Many emphasized that midwives often assumed prior knowledge, leaving them feeling unprepared. For example, Participant 1 (26, single, first-time mother) stressed: "This being the first time, information on how to take care of oneself is very important... I was not very satisfied." Similarly, Participant 18 (29, single) noted gaps: "Some midwives should explain what to expect, what to buy for the baby." However, when information was provided effectively, it fostered confidence. Participant 5 (33, married) praised her midwife: "She explained I need to be active at home rather than just sitting. I am happy with the information." Conversely, some midwives dismissed concerns, such as Participant 8's (26, married) experience: "The midwife told me, 'Do what you can to breathe' when I mentioned shortness of breath."

Emotional and psychological support emerged as another sub-theme, with mixed experiences. Participant 4 (32, married) described a midwife's intervention during a marital conflict: "The midwife noticed I was emotionally down and talked me through it." Conversely, Participant 10 (26, single) pointed to systemic gaps: "Mental health provision after giving birth is needed, especially for women who lost children or lack partner support."

4.3.2. Theme Two: Professional Conduct and Interpersonal Dynamics

This theme examines the variability in midwives' attitudes, from compassionate to dismissive, and how these interactions influenced trust and satisfaction. It underscores the tension between empathy and institutional indifference. Participants highlighted variability in midwives' attitudes, ranging from compassionate to dismissive.

Attitudes of midwives varied widely, shaping perceptions of care quality. Empathy and kindness were praised by participants like Participant 3 (42, married), who called midwives "God-sent...kind and helpful," and Participant 9 (34, married), who recounted: "One midwife prayed for me and escorted me to the doctor. She performed beyond expectations." In contrast, rudeness and dismissiveness were recurring complaints. Participant 2 (35, married) shared: "The midwife I met was unfriendly and rude... She couldn't give me detailed information on how to care for myself." Participant 18 (29, single) added: "They look at you in bad way and respond rudely as if you are forcing them."

Consistency in care was another concern. Experiences often depended on individual midwives. Participant 8 (26, married) noted: "It depends on the person on duty—some were good, others rude." Participant 12 (28, married) criticized favouritism: "No one should be given priority. Midwives should see everyone as

important."

4.3.3. Theme Three: Operational and Structural Challenges

This theme addresses systemic barriers such as staffing shortages, delays, and facility conditions that hindered care quality. Participants linked these issues to midwives' stress and rushed service. Systemic issues affecting service delivery, including staffing, time management, and resource constraints. Time management was a pervasive issue. Participant 5 (33, married) reported: "I sometimes wait one hour to be attended to," while Participant 6 (25, single) described neglect during labour: "I gave birth alone...they checked me but didn't return." Overwhelmed staff exacerbated delays. Participant 5 urged: "We need more midwives to relieve their stress."

Sanitation and resource gaps also drew criticism. Participant 9 (34, married) highlighted: "The toilets need proper care. Cleaners should do better." Participant 17 (28, married) tied delays to staffing shortages: "Midwives are tired...we need more young ones."

4.3.4. Theme Four: Expectations and Perceptions of Midwifery Roles

This theme contrasts participants' ideal of holistic, patient-centred care with the reality of transactional service. It highlights advocacy successes and missed opportunities. Participants' views on what midwives should prioritize versus their observed behaviours. Participants expected midwives to transcend clinical duties and provide holistic care. Participant 13 (35, married) shared: "A midwife took time to call and pray for me," while Participant 9 valued advocacy: "My midwife opposed an unnecessary operation and reassured me." However, others felt care was transactional. Participant 8 (26, married) stated: "They just did their job, nothing special," and Participant 16 (30, single) criticized: "Midwives should relate better—they're often rude." Advocacy gaps were evident. Participant 14 (34, married) urged: "Sensitize men about pregnancy effects. Many don't understand the changes we face."

4.3.5. Theme Five: Socio-Cultural and Economic Influences

This theme explores how stigma, gender roles, and financial constraints shaped care experiences, particularly for single mothers and low-income women. Stigma affected single mothers. Participant 11 (20, single) shared: "Being a single mother isn't easy, but midwives encouraged me," though she desired non-judgmental support for "unwanted pregnancies." Participant 6 (25, single) criticized midwives' "bad approach...comparing women instead of treating them as unique."

Economic barriers limited options. Participant 2 (35, married) lamented: "I have no choice—this is the biggest hospital," while Participant 8 (26, married) wished for private care but lacked funds: "I'll only return if I can't afford a private hospital."

4.3.6. Theme Six: Resilience and Coping Mechanisms

This theme reveals how participants navigated inconsistent care by comparing ex-

periences, adapting to variability, and finding strength in community. How women navigated challenges, often relying on community or personal strength. Participants compared experiences to navigate uncertainty. Participant 14 (34, married) said: "I heard stories about rude midwives, but my experience was different," reflecting a "better side of the coin" (Participant 3). Many adapted to variability, like Participant 10 (26, single): "I thought midwives were rude, but some were gentle." Participant 16 (30, single) resigned: "Midwives can do better, but my experience was average."

4.4. Intersectional Analysis on How Demographics Shape Care Experiences

The data reveals nuanced relationships between demographic factors (age, marital status, gravidity, parity, occupation) and participants' perceptions of maternity care. This section presents these intersections, supported by direct participant quotes and demographic patterns.

The data reveals that participants' demographic characteristics significantly influenced their experiences of maternity care. Age and parity emerged as critical factors shaping perceptions. Younger, first-time mothers (e.g., Participant 1, age 26) frequently reported dissatisfaction with information gaps, feeling unprepared due to midwives' assumptions about their prior knowledge. In contrast, older, multiparous women (e.g., Participant 3, age 42) often praised midwives for tailored guidance, likely because their medical histories were familiar to staff. However, this pattern had exceptions: Participant 2 (age 35, gravida 4) faced dismissiveness, as midwives assumed she "knew it all" despite her high-risk pregnancy.

Marital status further stratified experiences. Single mothers, such as Participant 6 (age 25), highlighted stigma and neglect, noting midwives' tendency to "compare women instead of treating them as unique." Married women, like Participant 4 (age 32), received more holistic support, such as emotional counselling during marital conflicts. Yet marital status did not always buffer systemic issues: Participant 8 (married, age 26) criticized transactional care, stating midwives "just did their job."

Economic factors also played a role. Unemployed or self-employed participants (e.g., Participant 17, age 28) described rushed care and delays, attributing these to overworked staff. Conversely, those with stable incomes, like Participant 9 (accountant, age 34), reported midwives advocating against unnecessary surgeries, suggesting economic stability may foster assertiveness or respect. Low-income women, such as Participant 8, felt trapped in second-rate care: "I'll only return if I can afford private services."

Gravidity intersected with care quality in nuanced ways. While multiparous women generally received better communication, Participant 14 (gravida 3) emphasized that even experienced mothers needed updated guidance for complications like gestational diabetes. First-time mothers, however, bore the brunt of in-

formation gaps, with Participant 18 (age 29) urging midwives to "explain what to buy for the baby."

Residential context added another layer. Women in high-density areas (e.g., Kabwata, Kamwala South) cited congestion-related delays, while those in quieter neighbourhoods (e.g., Kabulonga) reported more attentive care. Participant 12 (Kabwata) noted improvements but stressed lingering inequities: "Midwives should not play favourites."

These intersections underscore how systemic biases and resource gaps disproportionately affect vulnerable groups. Younger, single, and low-income women faced compounded challenges, from stigma to fragmented care, while older, married, and economically stable participants often navigated the system more smoothly. Participant 14's call to "sensitize men about pregnancy effects" and Participant 18's demand for "midwives who enjoy their jobs" highlight the need for reforms addressing both structural inequities (e.g., staffing shortages) and socio-cultural norms (e.g., stigma against single mothers). Tailored interventions—such as mentorship programs for first-time mothers and empathy training for midwives—could bridge these gaps, ensuring equitable care across demographics.

4.5. Conclusion

While many participants praised compassionate midwives and life-saving care, systemic issues (rudeness, delays, staffing shortages) and communication gaps hindered satisfaction. First-time mothers and vulnerable groups (e.g., single women) were disproportionately affected. Addressing these themes could improve trust and outcomes in maternity care at the Women and Newborn Hospital in Lusaka.

5. Discussion, Conclusion and Recommendations

5.1. Introduction

Maternal healthcare in low-resource settings remains fraught with systemic and socio-cultural challenges, even as global initiatives strive to advance equitable, dignified care [36]. This study examined pregnant women's perceptions of midwifery services at Lusaka's Women and Newborn Hospital, a critical hub in Zambia's urban maternal health landscape. Against a backdrop of persistent staffing shortages, overcrowding, and socio-economic disparities, the findings reveal a tension between midwives' compassionate potential and the realities of overburdened systems. Themes such as communication gaps, inconsistent professional conduct, structural inefficiencies, and stigma against vulnerable groups (e.g., single mothers, first-time mothers) mirror challenges documented across Sub-Saharan Africa. However, Zambia's unique cultural context—marked by urban-rural migration pressures, patriarchal norms, and reliance on under-resourced public facilities—adds layers of complexity to these universal issues [37].

By situating the findings within global maternal health discourse, this discussion explores how systemic neglect of midwives' well-being and patient-centred

communication perpetuates cycles of dissatisfaction and inequity. It also highlights opportunities to reimagine care models through culturally adaptive reforms. The analysis not only corroborates existing evidence on staffing and stigma but also contributes novel insights into how intersectional identities (e.g., age, marital status, parity) mediate care experiences in urban Zambia. These insights challenge policymakers, educators, and practitioners to address both structural and attitudinal barriers to quality maternity care, ensuring midwives are empowered to fulfill their pivotal role as advocates for maternal health equity.

5.2. Discussion of Findings

5.2.1. Quality of Care and Communication

The emphasis on information gaps and emotional support mirrors findings from studies across Sub-Saharan Africa. For instance, research in Kenya, Ghana and India has pinpointed insufficient health education during antenatal appointments as an obstacle to maternal satisfaction, particularly among first-time mothers who possess limited prior knowledge [38]. Likewise, a study from Kenya indicated that midwives frequently emphasized clinical responsibilities over compassionate communication due to a heavy patient workload [39], which aligns with the concerns expressed by Participant 1: "Information on self-care was lacking." In Nigeria, Okedo-Alex *et al.* [40] established a link between inadequate communication and maternal mortality, as women experiencing complications such as preeclampsia often misinterpreted risk factors because of hurried consultations. This research is also consistent with findings from Liu *et al.* [27], which, since it centres on the availability of midwife-led perinatal care and its impact on accessibility and convenience, highlighted that effective communication and the sharing of information were significant factors derived from pregnant women's interactions with midwife-led perinatal services. Specifically, participants emphasized the importance of communication; many expressed their gratitude toward midwives who articulated their messages clearly, attentively listened to their apprehensions, and detailed their care plans, including subsequent steps. Midwives who proactively clarified procedures and addressed inquiries were valued by participants, facilitating a greater understanding of their pregnancy journey and enhancing their preparedness for childbirth [27]. Therefore, when expectant mothers have a clear understanding of essential information, they are empowered to make informed choices regarding pregnancy and delivery. By furnishing straightforward and transparent information, actively listening to a woman's concerns, and clarifying care protocols, midwives bolster a mother's sense of empowerment and autonomy. Access to relevant information enables women to navigate their health experiences with assurance and clarity, consequently allowing them to participate in the decision-making process regarding their well-being and that of their unborn child [41]. Furthermore, effective communication is vital for cultivating trust and confidence between pregnant women and midwives. The proactive reassurance provided by midwives, including discussions about procedures and triage,

underscores their dedication to delivering high-quality, woman-centred care.

A noteworthy aspect of this study is the relationship between gravidity and the quality of care received. Although multiparous women typically enjoyed superior care, Participant 2 (gravida 4) experienced condescension: "They assumed I knew it all." This is in contrast to findings from South Africa, where multiparous women received prioritized counselling on family planning [42]. However, in the Zambian context, it appears that midwives often mix parity with health literacy, overlooking the need for individualized care [43]. The importance of emotional support was also highlighted. Participant 4's account "The midwife helped me through a marital conflict" corresponds with research conducted in Ethiopia that indicated midwives trained in psychosocial support were able to reduce postpartum depression rates by 40% [44].

5.2.2. Professional Conduct and Interpersonal Dynamics

The distinction between compassionate and indifferent midwives is thoroughly documented. In Tanzania, Kruk *et al*. [45] associated inadequate staff attitudes with burnout due to insufficient staffing levels, a theme that is reiterated in the current research (e.g., Participant 5: "Midwives are overwhelmed"). However, this research enhances understanding by examining how marital status and socioeconomic position influence these interactions. Supporting the results from a South African investigation by Majombozi [46], which indicated that young unmarried women encountered stigma throughout antenatal care, single mothers (e.g., Participant 11) in this study expressed feelings of being judged. Higginbottom *et al*. [25] revealed that midwife-led prenatal counselling is an important part of maternal care and improves on women's confidence in midwives who provide such services. Women tend to consider midwives to be the designated health caregivers for providing maternal health education. In contrast, married women, such as Participant 4, received more comprehensive support, implying that midwives might inadvertently prioritize patients regarded as having "stable" social connections. This observation is consistent with findings from Uganda, where involvement of spouses positively impacted care quality [47]. Economic inequalities further distorted the dynamics. Women from low-income backgrounds, like Participant 8 (chef), felt constrained: "I have no option but to endure rudeness." This aligns with a UNICEF [48] report indicating that 60% of women in Zambia depend on public healthcare facilities despite their dissatisfaction. Conversely, Participant 9 (accountant) experienced exceptional care, indicating that midwives might unintentionally favour patients of higher socioeconomic status, a trend identified in the healthcare disparities seen in Malawi [49].

5.2.3. Operational and Structural Challenges

Staffing shortages, delays, and limitations in resources are persistent issues observed in maternal health research. Comparable operational challenges have been noted in Malawi and Uganda, where the issue of overcrowding has resulted in instances of women "giving birth without support" (as noted in Participant 6's

account) [50]. Nonetheless, this research distinctly emphasizes sanitation issues (for instance, Participant 9's remarks regarding unsanitary restrooms), which represent an overlooked obstacle to respectful care in urban hospitals in Zambia. Moreover, there were significant disparities in resource distribution, as evidenced by Participant 5's appreciation for her midwife's efforts to advocate against redundant surgical procedures, a privilege not accessible in rural areas of Zambia, where 70% of health centres lack access to ultrasound technology [51]. While systemic barriers form a part of healthcare provision, women and their families are still able to form evaluations of care quality, even without specialized knowledge in the field. Indeed, a similar observation is made by Kruk *et al*. [45] in Tanzania, linking women's perceptions of healthcare providers' competency, including that of physicians, nurses, and traditional birth attendants, to the impact of community opinions. These perceptions, whether regarding midwifery services or traditional birth assistance, are collective and play a significant role in influencing the readiness to pursue professional care. Consequently, it would be prudent to provide precise and helpful information to community members to promote increased utilization of healthcare services.

5.2.4. Expectations and Perceptions of Midwifery Roles

Participants' aspirations for comprehensive, patient-focused care correspond with international initiatives aimed at redefining midwifery beyond mere clinical duties [52]. For instance, Participant 9's commendation for a midwife who "prayed for me" is similar to findings observed in Ethiopia, where spiritual assistance enhanced maternal satisfaction [44]. This viewpoint concerning the importance of spiritual guidance during childbirth, which is highlighted in this article, introduces additional ethical dilemmas, as women and healthcare providers may hold differing religious convictions, necessitating respect for the moral rights of both parties. As noted by Ojelade *et al*. [53], healthcare professionals might need to incorporate "demonstrating love" through compassion and emotional support for labouring women into their practice. Beecher *et al*. [5] in their study of literature published between 1990 and 2017 on women's experiences of their maternity care, reported that, midwives, as antenatal and post-natal care providers, tend to care for pregnant women over a longer period of time, providing pregnant women with continuity of care, health education, and opportunities for inter-professional collaboration for improved patient outcomes. Nonetheless, critiques of transactional care (e.g., Participant 8: "They just did their job") stand in contrast to research findings from Rwanda, where community trust in midwives remained robust despite existing systemic difficulties [54]. This discrepancy may illustrate the urban-rural divide in Zambia, where city facilities encounter higher patient numbers that diminish the quality of personalized care [37].

5.2.5. Socio-Cultural and Economic Influences

The stigma against single mothers and economic barriers to private care align with regional trends. A study in Zimbabwe found unmarried adolescent women

avoided antenatal care due to judgment [55], consistent with the present study finding where Participant 6's experience of being "compared to others", reflects patriarchal norms prevalent in Zambia, where unmarried women are often shamed [56]. Additionally, in support of this study finding, Aborigo *et al*. [57] highlight that in Ghana, male decision-makers and resource holders in rural households do not engage in monitoring their wives' pregnancies or take responsibility for accompanying them for support, while midwives facilitate support groups for fathers. In contrast, Uganda's Male Champions program reduced stigma by involving men in antenatal care [47], a strategy Participant 14 endorsed: "Sensitize men about pregnancy effects." Further, Participant 8's inability to afford private care ("I have no option… I'll go private if I can") reflects broader inequities in Zambia, where 60% of maternal care occurs in under-resourced public facilities [58]. This further echoes findings from Tanzania, where wealthier women paid bribes for better treatment [45]. This study adds nuance by linking economic status to assertiveness; employed women like Participant 9 (an accountant) reported better advocacy, suggesting midwives may prioritize patients perceived as higher-status.

5.2.6. Resilience and Coping Mechanisms

Participants' dependence on comparisons with peers (e.g., Participant 14: "I heard stories, but my experience was better") reflects coping mechanisms noted in Malawi, where women acclimatized to substandard care by juxtaposing it with "worse" situations [49]. Nevertheless, this research distinctly emphasizes how multiparous women justified inconsistent care (e.g., Participant 3: "Not all midwives are bad"), a resilience strategy that has been less thoroughly examined in previous studies. Participant 11 turned to other single mothers for assistance, resembling Zimbabwe's Mother Support Groups [59]. In contrast, Zambia lacks established peer-support initiatives, unlike Ethiopia's Health Development Army [60].

5.3. Implications to Midwifery

The study's findings have broader consequences for midwifery practice, administration, education, and research. Below are the potential outcomes and shifts these findings could inspire.

5.3.1. Midwifery Practice

The findings underscore the need for midwives to adopt patient-centred communication to address recurring gaps in information provision and emotional support. For instance, first-time mothers like Participant 1 ("Information on self-care is vital… I was not satisfied") highlighted unmet needs for tailored guidance, suggesting that midwives must prioritize individualized explanations and active listening. Additionally, reports of stigma against single mothers (e.g., Participant 6: "Midwives compared me to others") signal a critical need for non-judgmental care frameworks to ensure equitable treatment of vulnerable groups. These shifts could

enhance trust, reduce maternal anxiety, and improve health outcomes by aligning care with patients' unique psychosocial and cultural contexts.

5.3.2. Midwifery Administration

Systemic challenges such as overcrowding and staff burnout (Participant 5: "Midwives are overwhelmed") call for structural reforms to alleviate pressure on facilities and personnel. Administrators could advocate for policies to decentralize maternity services, expand staffing, and upgrade infrastructure (e.g., addressing Participant 9's concern about "filthy toilets"). Furthermore, inconsistent care quality (Participant 16: "Midwives can do better") necessitates accountability mechanisms, such as real-time patient feedback systems, to monitor performance and ensure dignified, equitable service delivery.

5.3.3. Midwifery Education

Training programs must evolve to equip midwives with holistic care skills, blending clinical expertise with cultural competence and empathy. Participant 9's praise for a midwife who "prayed for me" illustrates the value of psychosocial and spiritual support, which could be formalized in curricula through case studies and role-playing. Similarly, implicit biases affecting care quality (e.g., Participant 8's experience of economic-mediated neglect) highlight the urgency of integrating anti-bias training to address stigma and disparities. Graduates trained in these areas would be better prepared to navigate Zambia's diverse socio-cultural landscape.

5.3.4. Midwifery Research

The study's findings highlight gaps in understanding midwives' well-being and culturally adaptive care models. Research into interventions to reduce burnout (linked to Participant 5's report of overwhelmed staff) could inform retention strategies, while exploring the integration of traditional practices (e.g., Participant 3's view of midwives as "God-sent") might reveal pathways to enhance patient trust. Such studies would bridge evidence-practice gaps, fostering care systems that are both culturally resonant and sustainable.

5.4. Study Limitations and Strengths

The study had some limitations. Data were collected from one urban hospital, limiting generalizability to rural or private facilities in Zambia. Participants' recollections of care experiences may have been influenced by recent interactions or emotional states. Further, the study did not capture midwives' viewpoints, which could provide context for systemic challenges like understaffing. Additionally, with 18 participants, the findings may not fully represent the diversity of experiences across Lusaka.

However, the study had some strengths. The use of open-ended questions and direct quotes captured nuanced, context-specific insights into care experiences. Demographic variables (age, marital status, parity) were analysed to reveal how overlapping identities shape disparities. Further, the emphasis on structural bar-

riers (e.g., staffing, sanitation) provides actionable evidence for healthcare reform. Additionally, the study highlighted uniquely Zambian challenges, such as urban congestion and stigma against single mothers, which are often overlooked in global maternal health discourse.

This study revealed that while compassionate midwives positively influenced women's maternity care experiences, systemic issues such as poor communication, under-resourcing, and stigmatizing attitudes hindered satisfaction. First-time mothers and socioeconomically disadvantaged women were disproportionately affected. Addressing these disparities requires investment in midwifery training on patient-centered care, policy reforms to mitigate staffing and resource shortages, and broader institutional efforts to reduce stigma and inequity. Integrating intersectionality as a guiding framework in health system design and evaluation can help ensure that maternity care in Zambia becomes more equitable, respectful, and responsive to the diverse needs of women.

The study reveals that pregnant women's perceptions of maternity care at the Women and Newborn Hospital in Lusaka are shaped by a complex interplay of communication quality, midwives' professional conduct, structural challenges, and socio-cultural dynamics. While many participants praised compassionate midwives who provided holistic support, systemic issues such as staff shortages, long wait times, inconsistent attitudes, and stigma against vulnerable groups (e.g., single mothers, first-time mothers) undermined trust and satisfaction. The intersection of demographic factors like age, marital status, and socioeconomic status further stratified experiences, with younger, single, and low-income women disproportionately affected by fragmented care. These findings underscore the urgent need for reforms that prioritize patient-centred communication, equitable service delivery, and midwife well-being to align care with the diverse needs of Lusaka's pregnant population.

5.5. Recommendations

Based on the findings of this study, the following recommendations have been forwarded to midwives, policy makers, researchers.

5.5.1. Clinical Practice

1) Enhance Communication and Empathy Training: Midwives should receive regular training in trauma-informed care and active listening to address gaps in emotional support, particularly for first-time mothers (e.g., Participant 1: "Information is vital"). Role-playing scenarios could help midwives practice responding to sensitive issues like mental health or marital conflicts (Participant 4).

2) Integrate Mental Health Screening: Routine antenatal and postnatal visits should include mental health assessments, with referrals to counsellors for high-risk women (Participant 10: "Mental health provision is needed").

5.5.2. Policy Formulation (Ministry of Health and Stakeholders)

1) Address Staffing Shortages: Allocate resources to recruit and retain mid-

wives, aiming for WHO-recommended staffing ratios to reduce burnout and improve care quality (Participant 5: "Midwives are overwhelmed").

2) Upgrade Facility Infrastructure: Invest in sanitation improvements (Participant 9: "Filthy toilets") and expand maternity waiting homes in peri-urban areas to decongest urban facilities and reduce delays (Participant 6: "I gave birth alone").

3) Anti-Stigma Campaigns: Launch public health campaigns to sensitize communities and healthcare workers on equitable care for single mothers and low-income women (Participant 6: "Midwives compared me to others").

5.5.3. Future Research

1) Conduct multi-site comparative studies to assess differences in care quality between urban (e.g., Lusaka) and rural Zambian facilities to addressing the single-site focus limitation.

2) Investigate midwives' perspectives through mixed-methods research to contextualize systemic challenges (e.g., staffing shortages, burnout) and complement the lack of midwife voices in this study.

3) Replicate the study with a larger, demographically diverse sample to enhance generalizability and address the small sample size limitation.

5.6. Utilisation and Dissemination of Findings

Sharing research findings is crucial for their utilization and the long-term sustainability of knowledge; thus, the findings will be disseminated through the following platforms:

1) The School of Nursing Sciences graduate fora.

2) Published in a peer-reviewed journal like Journal of Midwifery & Women's Health.

3) Deposited at the University of Zambia's main Library and the Medical Library.

4) A copy of the report will be provided to the management at WNH to potentially inform their future patient management practices.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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