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Women's Perspectives on Cultural Sensitivity of Midwives During Intrapartum Care at a Maternity Ward in a National Referral Hospital in Zimbabwe

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Abstract

Introduction: Midwives attend intrapartum women of diverse ethnic backgrounds who each bring their cultural beliefs into the labor and delivery rooms. The International Confederation of Midwives has recommended providing culturally appropriate maternity care in its quest to increase skilled birth attendance and subsequently improve maternal and newborn health.
Objective: This study aimed to examine midwives' cultural sensitivity during intrapartum care from women's perspectives, and how this relates to women's satisfaction with maternity care services.
Methods: A qualitative phenomenological design was employed. Two focus group discussions were conducted with 16 women who had delivered in the labor ward of the selected national referral maternity unit. An interpretive phenomenological approach was used to analyze the data.
Results: This study revealed ineffective midwife–woman collaboration that excludes the incorporation of women's cultural beliefs in the design of maternity care plans. Emotional, physical, and informational support in the care provided to women during labor and childbirth was found to be incompetent. This suggests that midwives are not sensitive to cultural norms and do not provide woman-centered intrapartum care.
Conclusion: Various factors implying midwives' lack of cultural sensitivity in their provision of intrapartum care were identified. Resultantly, women's expectations of labor are not met and this could negatively affect future maternity care-seeking behaviors. This study's findings provide policy makers, midwifery program managers and implementers with better insights for developing targeted interventions to improve cultural sensitivity for the delivery of respectful maternity care. Identifying factors that affect the implementation of culture-sensitive care by midwives could guide the adjustments required in midwifery education and practice.

Keywords

intrapartum care, labor and delivery, culture-sensitive care, midwives, women

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Background

Cultural sensitivity is a set of skills that allow understanding and learning about people whose cultural background is different from one's own, and the ability to modify behavior to accommodate other people's cultural beliefs (Hamidzay, 2018). The International Confederation of Midwives (ICM) advocates that midwives provide high-quality, culture-sensitive care during labor, conduct a clean and safe delivery,

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and handle selected emergencies to optimize the health of women and their newborn babies (International Confederation of Midwives, 2019).

A core component of high-quality health care is ensuring that services are people-centered and that providers incorporate the preferences and aspirations of individual service users and the culture of their community (Hodin, 2017). Consequently, midwives should know and understand the culture, religious beliefs, gender roles, and traditional and modern health practices of the communities they serve. In addition, midwives need to accord women respect for their culture and customs regardless of their status, ethnicity, or religious beliefs (International Confederation of Midwives, 2019). Such practice could enhance their knowledge of various cultural norms and practices surrounding childbirth and promote the application of culture-sensitive care during maternity care encounters with women.

Cultural differences limit women's access to maternity care services worldwide and midwives need to acknowledge that a culture-sensitive approach to maternal care increases the utilization of maternal and child health services (Adatara et al., 2019). This contributes to reductions in maternal and perinatal morbidity and mortality associated with home deliveries (Selbana et al., 2020). Culture-sensitive care also creates a more rewarding relationship between the woman and the midwife (Shahid & Anwar, 2015).

Every woman and newborn need skilled care at birth, delivered in a humane and supportive environment in alignment with evidence-based practice (Tuncalp et al., 2015). Midwives should, therefore, provide maternity care for childbearing families with respect for cultural diversity while also being mindful of working toward eliminating some harmful practices within those same cultures (International Confederation of Midwives, 2019).

Four factors are considered important in determining women's satisfaction with their labor and delivery experiences (Funai & Norwitz, 2017). These are personal expectations, the amount of support received, the quality of the midwife–woman relationship, and the woman's involvement in decision-making related to her care which incorporates obtaining informed culture-sensitive consent for all procedures performed (Funai & Norwitz, 2017). This study assessed midwives' cultural sensitivity toward women while providing maternity care against these variables that all have a bearing on culture-sensitive care.

Review of Literature

Globally, more than 810 women die every day from problems related to pregnancy and childbirth and 94% of these deaths occur in low and lower- and middle-income countries (World Health Organization, 2019). Hemorrhage and infections which both mostly occur after delivery, hypertensive disorders of pregnancy, complications from delivery, and unsafe abortions are the major complications that account for 75% of all maternal deaths (World Health Organization, 2019). However, it has been noted that most of these deaths are preventable through evidence-based interventions before, during, and after childbirth even in low-income settings (Shennan et al., 2022; World Health Organization, 2019). It is unfortunate that the main factors that prevent women from seeking or accessing care are cultural beliefs and practices, poverty, lack of knowledge, distance from health facilities, and inadequate and poor quality maternity services, most of which can be addressed (World Health Organization, 2019).

Women's previous experiences and perception of ill-treatment, low expectations of care provided at health facilities and facilities' poor culture-sensitive reputations have eroded women's trust in health facilities for successive deliveries (Gebremichael et al., 2018). Accordingly, this has resulted in women considering delivery at health facilities as a last resort, prioritizing the culturally appropriate and supportive care they receive from traditional providers in their homes (Dodzo & Mhloyi, 2017). Cultural and religious beliefs and practices contribute greatly to women's reservations about seeking professionally assisted deliveries in health institutions, resulting in increased maternal and perinatal mortality and morbidity (Adatara et al., 2019). Conversely, skilled prenatal, antenatal, intrapartum, perinatal, and postnatal care can significantly save the lives of women and their newborns (World Health Organization Regional Office for Africa, 2021).

Global initiatives on intercultural processes for improving maternal health among populations through incorporating culture-sensitive care during labor and delivery have been instituted (Jones et al., 2017). This is because the World Health Organization (WHO) supports "culturally-appropriate" maternity care services to improve maternal and newborn health (Jones et al., 2017).

The Peruvian Ministry of Health, for example, introduced an intercultural birthing policy in 2005 that promotes a partnership birth care model grounded on mutual cultural respect and understanding between the birthing woman and the midwife (Guerra-Reyes, 2016). The policy was developed to accommodate the cultural beliefs and values of people with different backgrounds in the quest to reduce maternal and perinatal mortality and morbidity. Despite these efforts to promote culture-sensitive care, women's dissatisfaction with maternity care due to negative midwives' attitudes remains high in some settings.

Before launching the enabling intercultural birth policy in Peru, women shunned institutional deliveries because their cultural beliefs were not being accommodated. Midwives did not allow women to perform rituals such as keeping the placenta for disposal at home according to their culture, given that the placenta is perceived to be connected to the mother and baby's health after delivery and could cause illnesses if disposed of improperly (Guerra-Reyes, 2016). Conversely, an overall increase in health facility births was

noted with the implementation of the policy, increasing from 57.9% in 2000 to 88.2% in 2014, evidence of the positive decisions associated with culture-sensitive intrapartum care (Guerra-Reyes, 2016).

Somali women immigrants in the United States of America have also reported midwives' insensitivity to cultural practices. Women experience disrespect and insensitivity from health care providers based on their female genital circumcision (Agbemenu et al., 2021). Their right to privacy is reportedly breached by health care professionals who photograph them and bring in students and colleagues against their will or without their knowledge (Agbemenu et al., 2021). Consequently, the women feel disrespected, viewed with curiosity, and being put on display (Agbemenu et al., 2021). Women also report a lack of involvement by health practitioners in decisions about their care such as mode of delivery. Most of these women prefer a normal delivery as they believe cesarean sections are harmful to the mother's health and impair their future fertility. However, when admitted to hospital, cesarean sections are performed so quickly without waiting for labor to continue as expected by the women (Agbemenu et al., 2021). Such culture-insensitive attitudes by maternity caregivers potentiate women's decisions to delay coming to the hospital despite understanding the potential consequences of such action, a practice associated with increased risks of complications and subsequent loss of maternal and newborn lives (Agbemenu et al., 2021).

Ogbuabor and Okoronkwo (2021) underscore midwives' deficiencies in providing women with adequate and person-centered care. The findings of this Nigerian study highlight the low involvement of women in decision-making about their care and choice of birth position, and restriction of birth companions, all of which have a bearing on women's culture. Midwives have attributed this lack of providing supportive woman-centered care to restrictive policies on birth companions and poor working conditions (Ogbuabor & Okoronkwo, 2021).

A systematic review conducted in Australia, Peru, the United States, and the United Kingdom examined how interventions to provide culturally appropriate maternal health services, particularly related to patients' ethnicity, language, and religion, affected the utilization of skilled maternity care services (Jones et al., 2017). The findings of the review revealed that interventions to provide culturally appropriate maternity care have largely improved women's use of skilled maternity services.

Muwema et al. (2019) also report negative findings from a study conducted in Uganda on midwives' self-reported practices regarding cultural assessment. These include midwives' refusal of women's requests to pray during labor, only allowing delivery on a bed, not seeking women's wishes around the disposal of the placenta, and not agreeing to incorporate cultural considerations in the practice.

Similarly, a study conducted in South Africa revealed that midwives lack an understanding of the cultural competence concept although they are willing to learn means of providing culturally sensitive and appropriate maternity care (Daphney et al., 2022). Evidence of this is the midwives' inability to provide support to women in labor, not explaining procedures to patients, and not allowing a labor and birthing companion. Barriers associated with cultural incompetence and insensitivity as indicated by the midwives were lack of interpreters in light of linguistic differences, secretiveness of patients about their cultures, infrastructural limitations that make it impossible to accommodate different cultural practices, staff shortages that limit time to explain procedures, and lack of policies on culturally competent care (Daphney et al., 2022).

There is a dearth of studies that have directly considered the cultural sensitivity of midwives during labor and childbirth in Zimbabwe. One study that looked into the factors influencing women in rural settings to deliver in the community gathered many reasons including obligations to meet their cultural needs (Dodzo & Mhloyi, 2017). The mentioned study conducted in five rural districts revealed that the practices of community-based practitioners are premised on cultural beliefs which many women prefer (Dodzo & Mhloyi, 2017).

Women's autonomy in cultural and religious aspects deserves due attention. This calls for midwives to work in collaboration with women in the creative design of care plans that support positive birth outcomes while operating within acceptable midwifery practice according to midwifery standards (International Confederation of Midwives, 2019). In order to increase maternity care service utilization and boost service-user's satisfaction, cultural practices should be accepted in health facilities except for those that are harmful to the woman or her baby (Withers et al., 2018).

This study explores women's perspectives on the cultural sensitivity of midwives during intrapartum care in a Zimbabwean national maternity referral unit where no data exists. The maternity care facility attends to women from all ten provinces of the country, thus providing a sample of women with a wide range of cultures. It is hoped, therefore, that the current study will bridge this gap and integrate the views of women with varied cultural backgrounds on the extent to which midwives render culture-sensitive maternity care to childbearing women. The study is also a response to the WHO's call for greater research, action, advocacy, and dialogue on culture-sensitive care to ensure safe, timeous, and respectful maternity care for all women (World Health Organization, 2018).

Theoretical Framework

Leininger's culture care diversity theory (McFarland & Wehbe-Alamah, 2019), which focuses on providing culturally congruent midwifery care through cognitively based

assistive, supportive, facilitative or enabling actions and decisions, underpin this study. These are designed to correspond with individuals and communities' cultural beliefs and ways of life in examining a wide range of elements that affect the provision of culture-sensitive care.

According to Leininger (1995) cited in McFarland and Wehbe-Alamah (2019), the culture care decisions and modes are:

- Culture care preservation and/or maintenance refers to those assistive, supporting, facilitative, or enabling professional acts or decisions that aid cultures in reserving their beneficial care beliefs and values, for example; using the squatting birthing position.
- Culture care accommodation and/or negotiation referring to assistive, accommodating, facilitative, or enabling creative midwife's care actions or decisions which help women to adapt or negotiate with women for culturally congruent, safe, and effective care for their health, well-being, and delivery. An example of this is smearing herbs on the neonate's fontanelle. Although this practice is not harmful and can be accommodated by the midwife, it can also be sensitively discouraged as it has no scientific foundation.
- Culture care repatterning and/or restructuring is the enabling of professional actions and mutual decisions that would help women to reorder, change, modify, or restructure their ways of life and delivery for beneficial health care patterns, practices, or outcomes. Some cultures, for example, prescribe herbs for women to either drink or apply to the vagina to accelerate labor. This is a harmful practice that should be discouraged as it could cause uterine rupture or precipitate labor, resulting in complications for the woman or her baby. Rather, mothers could be encouraged to walk around during early labor to enhance head descent.

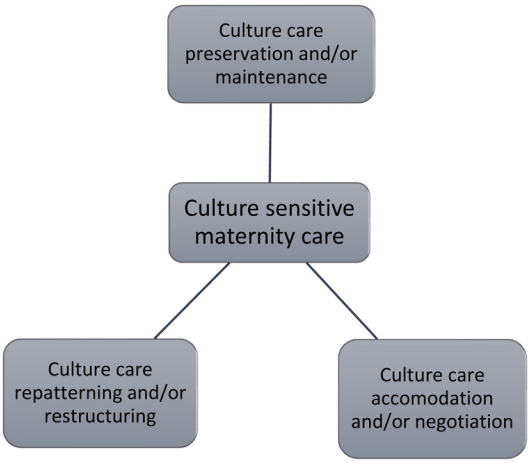

Figure 1. Culture care diversity theory (Adapted from Leininger, 1995).

This framework illustrated in Figure 1 is meant to guide midwives in providing culturally congruent and holistic maternity care known to, and used by different cultures over time while eliminating harmful practices.

Methods

Study Design

A phenomenological approach of qualitative inquiry was used in this study. Creswell (2014) defines phenomenological research as a design of inquiry in which a researcher describes the lived experiences of individuals about a phenomenon as described by the participants. The Case Study, Grounded Theory, and Ethnography qualitative designs were considered and found not suitable to address the research question of the current study (Creswell, 2014). The phenomenological research design was selected because of its ability to capture women's lived experiences during labor and delivery to better understand if and how midwives practiced cultural sensitivity in their provision of intrapartum care (Creswell, 2014). This design was also appropriate for exploring and understanding the cultural sensitivity of midwives while providing intrapartum care at Zimbabwe's public health institutions where little research has been done (Creswell, 2014).

Research Question

What are the perceptions of women who deliver at a national referral maternity unit in Zimbabwe on midwives' cultural sensitivity during intrapartum care?

Study Setting

This qualitative study was conducted between October and December 2016 in Harare Central Hospital, Zimbabwe, located in the country's capital city. The research site is the largest referral maternity unit in the country which caters to women of diverse cultural and national backgrounds referred from all of the country's 10 provinces. The institution serves as a training center for medical students, general nurses, midwives, and other allied health professionals. The maternity unit has an establishment of 242 qualified midwives with 43 working in the labor ward.

Inclusion/Exclusion Criteria

Postnatal women of all age groups, parity, and educational attainment who had given birth normally at Harare Maternity Hospital labor ward and were willing to participate were eligible to participate in the study. Mentally challenged women unable to provide informed consent, women still in labor and not yet delivered, and women who had given birth to live babies but developed severe obstetric

complications, such as eclampsia or severe hemorrhage were excluded from the study.

Sampling Procedures

Convenience sampling was used to recruit women into the study. This is a nonprobability sampling technique that uses participants that are available at the right time and willing to participate in the study (Creswell, 2014). The limitation of this sampling technique, however, is that it does not offer potential participants' equal opportunity of being included since selection is based on convenience and availability (Creswell, 2014). Although convenience sampling was applied in the selection of participants, the sampling procedure was also considered as purposive. This is based on the unique cultural values possessed by each individual that could provide meaningful insights into what they consider as culture-sensitive care (Etikan et al., 2016).

Women who deliver normally at this institution are discharged after 24 hours if they do not develop complications (Harare Central Hospital, 2017). The fourth author, therefore, allowed adequate rest for the postnatal mothers before approaching and informing them about the study, giving them the opportunity to decide on whether or not to participate.

Data Collection

Two focus group discussions (FGDs) each comprising eight participants were used for the collection of data. This method was found most suitable because it yields rich, detailed information and provides greater insights into collective community thoughts and opinions to answer the research question (Roller & Lavrakas, 2015). An FGD question guide was developed informed by a wide literature review, the research objectives and conceptual framework to ensure that all important areas of the experience were covered (Bawadi & Al-Hamdan, 2016).

The FGD guide was first pretested on five prospective participants in the postnatal ward to ensure clarity and appropriateness of the questions (Hurst et al., 2015). The women found the questions clear and relevant for addressing the research question. However, a suggestion was made on adding a question on aspects of cultural appropriateness that women anticipated the midwives to provide for a positive intrapartum experience.

The FGD guide used for the main study after adjustments solicited information on; women's experiences with midwives concerning culture-sensitive care, midwives' practices on culture-sensitive care, midwives' attitudes on culture-sensitive care during the intrapartum period, and some midwifery care aspects women anticipated the midwives to incorporate for the achievement of satisfaction with the provided services. Probes were applied based on the theoretical framework to guide the data collection.

Written informed consent was obtained from those who agreed to participate after eligible individuals were informed about the voluntary nature of participation and that they had the freedom to withdraw from the discussion without any need to give a reason.

The discussions were facilitated by the fourth author and were held in a suitable private environment, an eight-bedded postnatal ward that comfortably accommodated the women and their babies. An audio recorder was used for verbatim capture of the discussion between the researcher and the participants to preserve an accurate account of the discussion which could be replayed for analytic purposes (Khan, 2014). A summary form was used to capture the participants' nonverbal communication. The FGDs were conducted in the local Shona language and lasted between 60 and 70 minutes.

Data Analysis

An interpretive phenomenological data analysis approach was used. This method offers insights into how individuals in a given context make sense of a situation and assign meanings to their experiences (Noon, 2018).

Data analysis was performed following (Braun et al., 2014) six-step process. First, the audio recordings of the two focus groups were transcribed verbatim. They were then replayed repeatedly and compared with the transcripts to ensure that none of the information from the discussions was missed (Tessier, 2012). The fourth author who is fluent in both languages subsequently translated the transcriptions from the local language into English. These were then read several times by the first and third authors to familiarize themselves with the data and derive an in-depth understanding of the narratives (Noon, 2018). Words or phrases for sections of similar data were then assigned labels representing the main ideas from the FGDs. This identified a range of prevalent themes associated with women's lived experiences on midwives' cultural insensitivity during intrapartum care examined in this study.

Three major themes were consequently identified from the narratives on a group of codes that were thematically related to each other. Furthermore, certain groups of codes answering the major themes were identified as subthemes. The emergent themes were reviewed for their relevance to the study and to ensure that no significant data were missed.

The analysis was reviewed by all research team members and coordinated by the second author, a phenomenologist. Interpretation of the themes was done in the context of women's lived experiences related to midwives' intrapartum cultural-(in)sensitivity to provide answers to the research question.

Ethical Considerations

The authors sought permission from the Ministry of Health and Child Care to conduct the study. Written "consent"

was sought from the participants for participation in the FGD and for voice recording of the discussion. Information sheets were provided for participants to read and sign if they agreed to be part of the study. This research was conducted following the Nuremberg code and principles stated in the Helsinki Declaration for studies involving human participants.

Results

Sample Characteristics

Sixteen women participated in the study. Their ages ranged from 14 to 52 years given that only high-risk women are referred to the central maternity hospital for delivery or further management of complications. The number of children participants had following the current delivery ranged from one to seven. Table 1 presents the descriptive characteristics of the study sample.

Research Question Results

From the data analysis, three themes and nine subthemes that describe culture-related experiences of women during labor and delivery emerged. The themes presented in Table 2; *Lack of midwife–woman collaboration in the design of care plans, ineffective midwife–women relationships,* and *lack of relevant support from midwives* suggest the insensitivity of midwives in the provision of culture-centered intrapartum care.

Lack of Midwife–Woman Collaboration in the Design of Care Plans. Although women from different backgrounds bring into the labor and delivery rooms different cultural beliefs and values which they expect midwives to efficiently manage in recognition of the rights they have to make choices about their care, results from this study indicate no demonstration of such expectations being met.

No Consultation on Cultural and Religious Preferences. Women concurred that midwives did not incorporate culture-sensitive care into their midwifery practice as evidenced by the following quotes:

> I was never given any chance to make choices about my care. I had to wait to hear from the midwife (Participant 3).

Participants 1 and 6 nodded in agreement with Participant 3's observation. With further probing, women revealed that midwives never offered them a chance to give any input on their preferred methods of intrapartum care. Participant 7 added that:

> They do not ask you if you have any cultural or religious preferences. If this was practiced, many women would have their own care choices.

Participant 9 laughed stating that:

> Sometimes it is not easy to talk about cultural preferences because of the midwives' attitudes.

Participants 13 and 15 supported this sentiment, indicating that midwives do not engage women in discussions concerning their cultural and religious beliefs when planning care.

Institutional way of Doing Things. Furthermore, they also exhibit negative attitudes that prevent women from making any related inquiries. The general feeling was that if they opted for hospital delivery, women should just forget about

Table 1. Participants' Descriptive Information.

Participant	FGD number	Age	Parity
1	1	52	6
2	1	38	5
3	1	40	6
4	1	16	1
5	1	28	1
6	1	42	7
7	1	19	1
8	1	34	5
9	2	41	1
10	2	28	4
11	2	14	1
12	2	46	5
13	2	30	1
14	2	17	1
15	2	42	5
16	2	24	4

Table 2. Themes and subthemes.

Theme	Subthemes
1. Lack of midwife–woman collaboration in the design of care plans	1.1. No consultation on cultural and religious preferences
	1.2. Institutional way of doing things
2. Ineffective midwife–woman relationships	2.1. One-way communication
	2.2. Mostly no consent obtained for procedures
	2.3. Addressing women inappropriately
	2.4. Belittling of women by midwives
3. Lack of relevant support from midwives	3.1. Lack of informational and emotional support
	3.2. Accusations of using traditional herbs
	3.3. No provision for physical needs

their cultural and religious beliefs because according to Participant 10;

> They have their way of doing things, so you cannot talk of culture once you come to the hospital.

> Those interested in performing cultural or religious practices choose home deliveries to accommodate their rituals but not for a hospital delivery (Participant 12).

In congruence with the culture care model of the theoretical framework which talks to care repatterning or restructuring for the application of beneficial health practices, Participant 10 pointed out that midwives are intolerant of cultural practices because some of them are not safe for the mother and fetus and this may be a way of instigating women to discard these unsafe practices.

> Some of the herbs we like to use are destructive so if it is discouraged, it helps save women from their in-laws who give them.

This observation is consistent with the ICM statement that childbirth is a significant social event not just for the woman, but for her family and perhaps even the whole community (International Confederation of Midwives, 2013).

Therefore, extensive social needs in the woman's environment should be considered, while strategies are devised to eliminate harmful practices within those cultures.

Ineffective Midwife–Woman Relationships. Respect for women by midwives for enabling relationships is rooted in the traditional culture of acknowledging the beings that bring life into existence. Midwives are expected to have a cordial relationship with women and can connect and effectively collaborate with them for the shared goal of achieving positive birth outcomes. However, it was evident from the FGDs that the relationships between midwives and women were not conducive to the application of culturally sensitive care and communication was one way with inadequate information given to mothers.

One-Way Communication. At times you do not have information about what is expected of you although hurried instructions may be given when they want you to do something (Participant 7).

In response, Participant 1 reiterated that in such cases, it would appear to the midwives as if women do not want to cooperate yet the issue is that they are not well informed.

Mostly No Consent Obtained for Procedures. It also emerged that apart from the midwives' lack of providing information and adapting communication to the needs of each woman, consent for performing procedures was not obtained from women by some midwives. Participant 4 who had experienced labor for the first time, bemoaned the insensitivity displayed during her vaginal examination as no explanation of the procedure was given, nor was any consent sought from her by the midwives who performed the vaginal examinations.

> I just did not like the idea of someone inserting fingers into my private parts or understand why she was doing that.

Addressing Women Inappropriately. Participants also stated that midwives call them by terms indicating that they have no authority and simply have to follow instructions. Referring to women in this manner makes them feel powerless and not in control of the situation.

> They call you 'muzukuru' (a local term for niece) and do not even care that the person I am talking to is older than me (Participant 5).

Belittling of Women by Midwives. Participant 15 emphasized that if one displayed to the midwives that they know what is expected to be done, they would say:

> *Ndizvozvinonetsera vakambozvara* (those that have given birth before are a problem).

This attitude disputes the mandate of midwives who are expected to empower women to speak for themselves on issues affecting their health within their cultural norms.

Lack of Relevant Support from Midwives. As expected with the physiology of labor, women experience intense pain which ends with the expulsion of the products of conception. During FGDs, women concurred that they most needed the midwives' support throughout the birthing process such as analgesia to manage labor pain or information on ways of coping with the pain. Other forms of support expected from midwives were emotional, physical, and informational to meet their needs during labor and delivery.

Lack of Informational and Emotional Support from Midwives. Women stated that they continuously called for help due to anxiety and the fear of being 'too late' for their babies. Participant 4 described how she thought the baby was coming from the pain she was experiencing, but was sternly informed that she was still far:

> I screamed at the top of my voice, I could feel the baby coming, maybe if I had been kept informed of the labour progress it would have given me strength to soldier on.

Participant 14 in the same manner kept calling for help and shouting out:

> Ambuya (meaning 'midwife'), my baby is coming out……I really needed support and an explanation on my labour progress.

Accusation of Using Traditional Herbs. Women alluded to experiencing severe pain during labor and expressed bitterness at being accused by midwives of using herbal concoctions instead of being reassured.

> I was accused of using traditional herbs because I had severe pain yet I did not use herbs (Participant 16).

No Provision for Physical Needs. From both focus groups, the consensus was that women feel exhausted and hungry after giving birth and expect to receive a hot meal immediately, yet that was never the case. This is in contrast to home deliveries where culturally, hot porridge would be provided for the woman to gain the strength to start breastfeeding her baby.

> I spent the whole night in labour without food, then after delivery I had nothing to eat until lunch time, but we are paying for these services.

Women's expectations of support from midwives were not met in most instances, even when requested.

Discussion

This study aimed to evaluate women's perspectives on midwives' provision of culturally sensitive care during the intrapartum period. Two FGDs were conducted in Zimbabwe's largest maternity referral center with women who had delivered in the institution's labor ward.

Women's Overall Perception of Midwives' Intrapartum Care Cultural Sensitivity

Women in this study perceived midwives as lacking cultural competence in providing intrapartum care, which was demonstrated in various ways. These findings are consistent with studies conducted elsewhere in the world where midwives' lack of respect and disregard for cultural preferences (Maputle, 2018), common occurrences of hitting, shouting, and neglecting women in the labor and delivery rooms (Yakubu et al., 2014, Bohren et al., 2015), and disrespect and abuse of women in terms of lack of choices, lack of communication, lack of support, and harsh treatment (van der Pijl et al., 2022) were observed. A systematic review of midwives' perspectives on (dis)respectful intrapartum care during facility-based deliveries in sub-Saharan Africa also reports varied forms of culture insensitivity instituted by midwives in the region (Bradley et al., 2019). In the Netherlands, disrespectful and abusive experiences of women during labor and birth are reported regularly, with migrant and primiparous women at higher risk of experiencing such (van der Pijl et al., 2022). These unbecoming practices create a need to develop midwives' skills in cultural competence since interventions that provide culturally appropriate care improve women's use of skilled maternity services and help achieve better pregnancy outcomes (Jones et al., 2017).

On the contrary, intercultural sensitivity among midwives was found to be of medium level in Turkey (Can et al., 2022). The variance in the findings of the cited studies could be related to individual and organizational factors, and differences in the samples used. The evidence base to support these themes intentionally includes low, middle, and high-income settings to give a global appreciation of the problem.

Midwife–Woman Partnership in Developing Maternity Care Plans

In this study, most women were not consulted on decisions about their birthing processes. Specifically, midwives did not ask about their religious or cultural preferences, and women considered it misplaced to make culture-related requests in a hospital setting. Findings are similar to those of a study carried out in Jordan (a lower-middle income country) on women's experiences of labor and birth, which also revealed that opportunities to request what they wanted were not availed, privacy was not offered, no personal care and support was provided, and women were left alone during labor as no support person was allowed in the labor room when requested, this in direct contrast to home deliveries (Hussein et al., 2020). A survey of women in the Netherlands also noted that women were not included in decisions such as deciding on the position to give birth, interventions continued despite women requesting for their discontinuation, and being forced to stay in bed (van der Pijl et al., 2022).

Borelli et al. (2018) suggest that midwives should listen to the women and consider their individual preferences, wishes, and cultural beliefs to assist them in meeting their expectations. The enabling gestures would also motivate women to form trusting relationships with midwives that empower them to be involved in decision-making and to exercise choice in their care. Furthermore, the ICM's essential competencies for midwifery practice promote the midwife's role in upholding women's rights and responsibilities and decision-making as a more woman-centered approach to maternity care (International Confederation of Midwives, 2019). Accordingly, midwives need to balance their responsibility to provide the best care with the woman's autonomy to make her own decisions, advocate for, and support women to be the central decision-makers in their care (International Confederation of Midwives, 2019).

Midwife–Woman Relationships

A particular theme from the participants' comments was poor relationships between women and the attendant midwives in labor and delivery. Examples were; lack of, or poor communication on labor progress, failure to seek informed consent for procedures, and a display of authority over women that carried connotations of women having to do as they are instructed. All these actions are considered culturally inappropriate.

In related studies, communication between women and midwives also occurred as part of midwifery care, focusing on assistive actions rather than on the activities that would promote women's participation (Maputle, 2018). However, good communication was noted in a study conducted in Ireland (Cornally et al., 2014), where midwives showed interest in the women, provided clear explanations, and constantly updated the women and their partners on all issues about their intrapartum care.

Several works (Bradley et al., 2019; Yakubu et al., 2014; and Hussein et al., 2020) have cited midwives' concerns relating to their accountability and responsibility for delivery outcomes. Supposedly, this justifies them to do whatever it takes to get laboring women to push when appropriate or behave in a manner that facilitates positive outcomes. Midwives are apparently blamed for negative outcomes and will, therefore, do all it takes to prevent them from occurring. This however is an unacceptable excuse for failing to meet women's intrapartum expectations. In alignment with Leininger's culture theory on culture care accommodation (McFarland & Wehbe-Alamah, 2019), midwives ought to negotiate with women and obtain informed consent to undertake the actions or interventions they consider as necessary for a positive health outcome.

Moreover, women should be seen as the principal actors. They invite others to be with them as they give birth and subsequently, the primary guests, midwives need to create enabling relationships with the woman's experience (Pembroke & Pembroke, 2008). The quality of the relationship between the midwife and the woman is, therefore, of fundamental importance in childbirth as it is remembered over time.

Experiences of Care in Labor

Research has demonstrated that providing continuous support during labor and delivery is an important responsibility of the midwife, improving women's and newborns' health outcomes (Ojelade et al., 2017). This study's findings however reveal that the needed support during labor was not offered. Women reported not being provided pain relief even when they requested it. No informational and emotional support was provided to allay their anxiety and was falsely accused of using traditional labor enhancers which caused them emotional trauma. In addition, a hot meal soon after delivery was not offered as anticipated.

Studies from other settings such as South Africa (Maputle, 2018) and Nigeria (Ojelade et al., 2017) similarly report that women were never given analgesia during labor, there was a lack of spiritual support, emotional support activities lacked respect and disregard for cultural preferences, and labor companions who provide physical care including massaging were not allowed. However, women desire this kind of support.

Contrary to the findings of other studies herein, midwives in Ireland (Cornally et al., 2014) played a vital role in supporting and guiding women through labor. Demonstrating helpful and caring attitudes, providing high-quality and timeous care including pain relief, providing accurate information on what to expect in labor, and providing good guidance and support in labor made women feel they could trust the midwives to provide safe care.

Limitations

This study was performed among women who had delivered normally in the institution's labor ward. During the study period, no participants who had stillbirths were available, nor were women who had been monitored in labor but delivered through cesarean section included in the FGDs. The views of this very important segment whose experiences could have greatly contributed to assessing midwives' cultural competencies were unheard, thus compromising the transferability of findings.

This study, therefore, suggests extending the evaluation to include all women regardless of birth method and outcome. A sample of midwives should also be used to identify factors that affect their provision of culturally sensitive care to women during labor and delivery. Findings would guide the adjustments required in midwifery education and practice. Moreover, the study should be replicated in a district setting where the patients are more likely to be familiar with the midwives to obtain a clearer picture of their implementation of culture-sensitive care.

Implications for Practice

The findings of this study have implications for maternal and newborn health and reflect the need for sustained education of midwives and research in the application of cultural sensitivity in providing maternity care. This calls for the development of innovative strategies that promote the concept of individualized woman-centered care, supported by enabling policies and infrastructure.

Consequently, the study recommends that cultural competence be incorporated into the clinical assessment schedule of students as part of the midwifery curriculum. Such practice could ensure midwives develop the appropriate knowledge, skills, and behaviors that fulfill women's expectations and satisfaction with the labor and delivery processes.

Conclusions

Women found intrapartum cultural sensitivity lacking among midwives which resulted in their dissatisfaction with the maternity care provided. This was comparable to studies done in other low and middle, and in some high-income countries among immigrant women.

Overall, based on Funai and Norwitz (2017)'s four factors that are considered important in determining women's satisfaction with their labor and delivery experience, this study concludes that women did not get satisfaction with the intrapartum care they received. This is supported by the key findings which revealed that:

- women's personal expectations were not met,
- minimal informational, emotional, and physical needs support was received,
- women were often not involved in decisions pertaining to their care and,
- the midwives' relationship with women was at variance with the anticipated standard, all this negatively impacting their intrapartum care cultural values.

Lack of cultural sensitivity in the provision of maternity care is associated with the underutilization of institutional deliveries which contributes to increased maternal and neonatal mortality and morbidity. Women who choose skilled birth attendance at health facilities resign themselves to the hospital way of 'doing things' even if their cultural beliefs are violated.

Culturally sensitive and supportive care is, therefore, recommended for midwives in their provision of care to women in labor and childbirth. This could improve the utilization of health facilities for childbirth and contribute to achieving Sustainable Development Goal 3.1 and 3.2, which talk to reducing the global maternal mortality ratio to less than 70 per 100,000 live births and neonatal mortality to at least 12 per 1000 live births by 2030, respectively (United Nations, 2022).

This study was grounded on Leininger's culture theory which talks about; culture care preservation, culture care accommodation, and culture care repatterning. There was no evidence of applying this theory in the provision of intrapartum care in the study setting. It is encouraged that from the study findings, midwives endeavor to apply Leininger's culture theory in the quest of providing culturally congruent care to women.

Midwives' cultural awareness and sensitivity are essential for improving the quality of maternity care, improving the rate of facility-based deliveries, and reducing intrapartum-related complications. It is envisioned that the findings of this study will guide midwives in reducing culturally insensitive care, enhance the quality of intrapartum care, and identify areas that require further research to increase the knowledge base on culture-sensitive care progressively.

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