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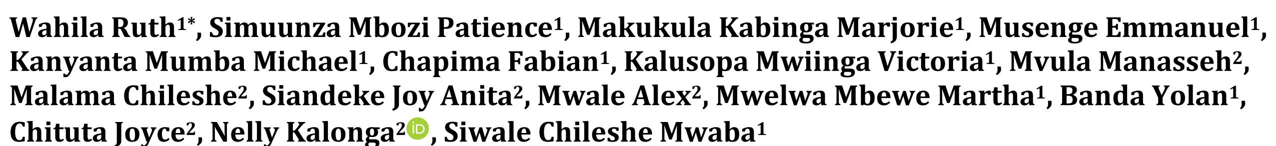
Midwives' Perspectives on Pain Management Practices among Post-Caesarean Section Mothers at the Women and Newborn Hospital, Lusaka, Zambia



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Abstract

Introduction: Postoperative pain following Caesarean Section is among the most common maternal complaints, with global reports indicating up to 89.8% of women experiencing it; 84.2% of which is moderate to severe within the first 24 hours. Uncontrolled pain can lead to multiple complications, including delayed recovery, prolonged hospitalization, poor wound healing, and long-term psychological distress. Therefore, midwives who play a key role in post-caesarean section pain management practices can provide critical insights that are important for improving the quality and effectiveness of care. Consequently, this study aimed to explore midwives' perspectives on the management practices of pain among post-caesarean section mothers at the Women and Newborn Hospital in Lusaka, Zambia. **Methodology**: The study, conducted at the Women and Newborn Hospital postnatal wards in Lusaka, Zambia adopted a qualitative descriptive design. Data were collected by conducting 15 individual face-to-face interviews with midwives using open ended questions on their perspectives on pain management. The interviews were audio recorded and transcribed verbatim. Thematic data analysis was employed through a structured process involving initial coding of the data, development of themes, refinement and review of identified themes and interpretation of findings. **Findings**: We identified four key themes. The first theme, protocol-driven and structured pain management practices, reflects the midwives' reliance on the institutional clinical protocols and standard procedures of post-caesarean section pain management. Midwives reported that they follow the

hospital's clinical guidelines and employ both pharmacological and non-pharmacological interventions for pain management. They viewed non-pharmacological pain management as supportive care but also perceived these interventions to have limitations, particularly their short-term effectiveness. In the second theme, midwives' clinical role in pain assessment and education, the recurrent pattern identified reflects the midwives' central role as assessors, educators and advocates in post-caesarean section management. Theme three, midwives' perceived competence in post-caesarean section pain management reflects their self-perceived ability and limitations to manage the pain. The fourth theme, systemic and contextual challenges in managing pain including medication overuse risks, balancing safety and effective pain relief, patient alcohol use, cultural and language barriers, drug shortages, and inadequate staffing were viewed as a constraint in optimal pain management. **Conclusion:** Pain management for post caesarean section mothers at the University Teaching Hospitals is characterized by a structured multifaceted approach that integrates pharmacological and non-pharmacological strategies supported by midwives' competence and adherence to protocols. While midwives perceived current practices as effective and well received, they highlighted significant challenges ranging from patient-related factors to systemic resource constraints that limit optimal pain control. Addressing these barriers through enhanced training, improved resource allocation, and culturally sensitive care is essential to strengthening pain management outcomes and promoting maternal recovery in this setting.

Keywords

Midwives, Perspectives, Pain Management Practices, Post-Caesarean Section, Postoperative Pain, Hospital

1. Introduction

Pain following a Caesarean Section (CS) is the leading complaint during the postoperative period [1]. [1] estimate that the magnitude of post-operative pain following CS is 89.8%, with about 84.2% reporting moderate to severe pain at 24 hours postoperatively. A distinguishing feature of a CS in comparison to other major laparotomies is not only the eagerness but also the requirement for a rapid and safe interaction between patients and their infants shortly after delivery [1] [2]. This underscores the urgency for effective and safe pain control, thereby the paramount importance of implementing effective pain management strategies by all midwives who are the immediate direct care providers for the mothers.

Demelash [3] adds that if postoperative pain is poorly treated, particularly in mothers who underwent CS, it will interfere with ambulation, breastfeeding, and other maternal care of the newborn. Moderate to severe pain after CS can cause morbidities, patient discomfort, dissatisfaction, poor wound healing, delayed recovery, prolonged hospital stays, poor quality of life, and chronic pain [3]-[5]. This highlights the need for continuous evaluation and improvement of pain

management practices. Effective postoperative pain management practices are thus a critical aspect of quality maternal care, significantly impacting the recovery and overall well-being of post-CS mothers.

Adequate control of postoperative pain has been shown to promote early recovery, enhance functional outcomes, improve psychological well-being, promote patient satisfaction and reduce the risk of postoperative complications. For instance, early ambulation is associated with reduced pain intensity, early resumption of functional activities and shorter hospital stays, which enhance overall recovery outcomes for post-CS mothers [6] [7]. Early movement also supports physiological processes such as improved uterine involution and gastrointestinal function [8] [9]. This is critical in the immediate postpartum period as it restores physiological homeostasis, enhances recovery, and prevents postoperative complications. Moreover, optimal pain relief has been linked to earlier initiation of breastfeeding and more successful mother-infant bonding, since unmanaged pain can delay breastfeeding and impede early maternal interaction with the newborn [10] [11]. Additionally, multimodal pain management protocols that combine pharmacological and non-pharmacological interventions have been demonstrated to lower pain scores while reducing reliance on opioids, which may otherwise carry risks of adverse effects for both mother and infant [12].

Midwives play a crucial role in the management of CS pain as they represent the primary professional group to provide midwifery care for childbearing women. They are uniquely positioned to identify workflow limitations, supply chain issues, and training limitations that affect pain management quality, thus allowing them to assess, intervene and monitor post-CS effectively. Midwives and nurses play a central role in routine postoperative care and pain assessment following cesarean birth, and their clinical practices directly influence analgesic effectiveness and patient-reported outcomes [4]. Their perspectives and experiences are therefore invaluable in understanding both the clinical and contextual challenges associated with providing optimal pain relief, and the opportunities to enhance practice and service delivery for post-CS mothers. Qualitative evidence from diverse settings indicates that mothers' satisfaction with pain management and overall CS experiences is strongly shaped by midwives' competence, responsiveness, and attitudes toward pain relief [13]. These findings underscore the value of midwives' experiential insights in interpreting pain management practices within routine clinical care environments.

Integrating midwives' experiences and professional judgments into evidence-based protocols supports the development of context-specific pain management guidelines that are both feasible and sensitive to patient needs, thereby improving clinical outcomes and patient satisfaction. Policy syntheses affirm that midwifery care delivered by appropriately trained, regulated, and integrated professionals is associated with improved maternal health outcomes [14]. This highlights the broader significance of incorporating midwives' views into health system planning and guideline development. This study, therefore, explored the midwives'

perspectives on pain management among post-CS section mothers at the Women and Newborn Hospital, Lusaka, Zambia, with the aim of generating evidence-based informed insights to enhance pain management strategies.

1.1. Justification/Significance

Pain management is a crucial aspect of postoperative care for CS mothers, directly influencing recovery times, patient satisfaction, and overall health outcomes [15]. Understanding midwives' perspectives on pain management practices provides a holistic view of the care process [16]. Findings provide insights into the challenges and opportunities for improving care practices, thereby directly contributing to better post-CS pain management outcomes for mothers. Furthermore, the study identified pain management practices and training needs of midwives so as to guide the development of timely training programmes and professional development initiatives. Findings will inform the development of evidence-based guidelines and policies on pain management following CS in obstetric care settings.

1.2. Research Question

What are the perspectives of midwives on pain management practices among post-operative caesarean section mothers at the Women and Newborn hospital in Lusaka, Zambia?

Study Aim

To explore the perspectives of midwives on pain management practices among post-operative caesarean section mothers at the Women and New-Born Hospital in Lusaka, Zambia.

Specific Objectives

1) To examine the pain management techniques commonly used by midwives for post-CS mothers.

2) To understand midwives' perceptions of the effectiveness of pain management practices for post-CS mothers.

3) To identify challenges faced by midwives in implementing effective pain management practices for post-CS mothers.

2. Methodology

2.1. Study Design

This study adopted a qualitative descriptive design.

2.2. Study Site

The study was conducted at the University Teaching Hospitals-Women and Newborn Hospital (UTH WNBH) in Lusaka, Zambia, within the postnatal wards where post-CS care is routinely provided. UTH WNBH comprises four postnatal wards that are managed by midwives responsible for the ongoing assessment, management and follow up of mothers who have delivered via CS. The hospital serves as Zambia's national referral centre for obstetric and neonatal care, receiv-

ing complex and high-risk cases from across the country. The site was purposefully selected because it allows access to midwives with extensive clinical experience in post-CS care and an exposure to various pain management practices. Additionally, the hospital is equipped with specialised infrastructure, medications, and clinical resources that support comprehensive postoperative pain management, thereby providing an environment suitable for exploring midwives' experiences and perceptions in depth.

2.3. Study Population

The study population was all midwives working in the postnatal wards at the University Teaching Hospital-Women and Newborn Hospital, Lusaka, Zambia.

2.4. Selection of Participants

This study employed purposive sampling to recruit participants who could provide rich and relevant information on post-CS pain management practices. Midwives were purposively selected based on their direct involvement in providing postoperative care to mothers who had undergone CS. Eligibility criteria included being a practicing midwife, currently working in the postnatal wards, and having a minimum of three months practical experience in assessing and managing post-CS pain. Midwives who had undergone CS deliveries were excluded from the study to reduce the likelihood of bias, as they may be influenced by their personal experiences of post CS pain and its management. Midwives who were not available at the time of the study due to illnesses or leave were also excluded.

Interviews were conducted by trained independent research assistants who were not employed at the hospital and had no prior relationship with the participants. This approach was intended to minimise social desirability bias associated with work-based research. Participants were assured of confidentiality and anonymity, and interviews were conducted in private settings to encourage open and honest responses. The research assistants approached the participants were approached in person and provided them with detailed information about the study prior to consent. Midwives with varying years of professional experience were included in the study in order to capture a broad range of insights and practices. Recruitment continued until data saturation was reached at 15 participants.

2.5. Sample Size Determination

A total of 15 in-depth interviews were conducted. The researchers concurrently collected the data and conducted preliminary analysis to assess its richness and redundancy. Interviews were continued until data saturation was achieved.

2.6. Data Collection

Data were collected using a semi-structured in-depth interview (IDI). The guide was developed with one core question and three sub-questions. The core question,

"What are your perspectives on pain management practices among post-CS mothers in your ward?" was designed to elicit responses that reflected the three key constructs of interest namely, perceived effectiveness, competence and pain assessment. These were incorporated into the interview guide and analytic process. During data collection, these constructs were explored through asking direct questions that were complemented by relevant by probes. *Perceived effectiveness* was explored by asking midwives to describe their experiences with pain management strategies and their views on their outcomes among post-CS section mothers. *Competence* was examined through questions on training, confidence, and skills in pain management practices. *Pain assessment* was explored by asking participants to describe how they assess pain, including tools used, frequency of assessment, and decision-making processes.

During analysis, these constructs informed the initial coding framework in an inductive approach. Relevant segments of data were coded based on participants' descriptions of effectiveness, competence, and assessment practices. These codes were then iteratively refined and grouped into broader categories and themes using reflexive thematic analysis, ensuring clear alignment between the study objectives, interview questions, and the final themes.

Prior to data collection, the researcher oriented the research team on conducting In-Depth interviews (IDIs) in English Language. Data collection was audio-recorded after obtaining consent from participants. Each interview was audio-recorded with the participants' informed consent, and sessions were conducted in private settings within the hospital to promote confidentiality and comfort.

2.7. Data Management

All interviews were audio recorded and later transcribed verbatim and all identifiable information was removed to ensure confidentiality. Data was stored on a password protected computer, while paper-based materials, including field notes and transcripts were secured in a lockable cabinet. The data was cleaned and verified by cross-checking transcripts with audio recordings and field notes to ensure accuracy and completeness.

2.8. Data Analysis

The research team repeatedly read the transcripts to identify emerging themes using NVivo software version 15 to facilitate coding and data organization. Data analysis were conducted using reflexive thematic analysis following Braun and Clarke's (2006) six-phase framework. The six steps involved familiasation with the data, generation of initial codes, development of themes, reviewing and refining themes, and defining and naming themes. Analysis was iterative and commenced concurrently with data collection, allowing preliminary findings to inform subsequent interviews. All interviews were audio recorded and transcribed verbatim immediately after data collection to enhance accuracy and familiarity with the

data. The researcher immersed themselves in the data by repeatedly reading the transcripts and listening to the recordings to gain a comprehensive understanding of participants' perspectives. Initial codes were generated and progressively refined through an inductive and interpretative process. Codes were then organised into potential themes, which were reviewed, defined and named in accordance with the six-phase framework. An experienced qualitative researcher reviewed the coding and theme development to provide reflexive input and enhance depth and credibility of the analysis.

2.9. Ethical Considerations

Ethical clearance was obtained from the University of Zambia Bioethics Research Ethics Committee (UNZABREC) with Ref Number 5827-2024 and permission to conduct the study was granted by the National Health Research Authority (NHRA) with Ref Number NHRA-1594/29/09/2024. Furthermore, permission was obtained from the UTH WNBH. Informed consent was obtained from participants and confidentiality was maintained through the use of participant identifiers. Participants were informed of their right to withdraw from the study at any point without consequence.

2.10. Dissemination of Findings

Research findings were disseminated to the University of Zambia, School of Nursing and Midwifery women and Newborn Hospital and the Ministry of Health. The findings will also be disseminated to conferences and symposia.

2.11. Limitations

The study did not include other healthcare providers, limiting triangulation of perspectives. To enhance diversity, midwives with varying experience and shifts were included. Response bias was possible due to the sensitive nature of pain management, confidentiality and indirect questioning encouraged honest responses. Cultural attitudes toward pain may have influenced views, so culturally sensitive questions were incorporated.

3. Results

A total of 20 midwives were approached for participation. Of these, three (3) did not meet the inclusion criteria, and 16 were enrolled. However, one participant withdrew, resulting in 15 participants included in the study. Participants' ages ranged from 26 to 51 years, with years of professional experience spanning from 2 to 23 years. The midwives were drawn from the postnatal ward and were interviewed during morning and afternoon shifts. All participants were part of a rotational system covering morning, afternoon, and night shifts in line with postnatal ward protocols.

From these 15 interviews, a codebook was developed, from which four themes and 14 subthemes were generated, as illustrated below.

Main Theme	Sub theme	Code
To examine the pain management techniques commonly used by midwives for post-CS mothers at the Women and Newborn Hospital, UTH in Lusaka, Zambia		
Structured and protocol-driven pain management practices	Adherence to Standard Operating Procedures (SOPs)	Following doctor's written instructions Administration protocols Patient history Pain assessment and monitoring
	Use of pharmacological and non-pharmacological techniques	Pethidine as the primary strong analgesic post-surgery (Use of Opioids) Transition to Diclofenac, Paracetamol, and Brufen after 24 hours (Use of non-steroidal anti-inflammatory drugs (NSAIDs) and Adjuvants) Post discharge pain management and follow up Counselling Pain education Posture, exercise Breathing Physical adjustment Breastfeeding as pain relief
To assess midwives perceived effectiveness of pain management practices for post-CS mothers at the Women and Newborn Hospital, UTH in Lusaka, Zambia		
Midwives' clinical role in post-CS pain management practices	Provision of post-CS care	Early intervention after surgery Careful handling of the mother Comfort seasures such as positioning, adjusting the bed, assisting with mobility Medication administration Monitoring side effects
	Patient advocacy within care practices	Anticipation of the mothers' pain experiences Administering medications before complaints from mothers Watching for adverse reactions Guiding mothers on what to expect
	Ongoing pain assessment and clinical surveillance	Pain level assessment Use of non-verbal cues Monitoring of pain relief Adjusting pain management approaches
	Patient education and counselling practices	Provide information on wound care, nutrition and others Offer individual and group counselling depending on staffing and workload
	Post-discharge pain management and follow-up	Monitoring mothers' pain at home Scheduled review visits Communication and support
Perceived competence in post-CS pain management	Perceived confidence in Pharmacological Methods	Observed Patient relief Effective if dose timing is followed
		Trained in pain management Self-rated competence Satisfied with current pain management strategies

Continued

	Limitations of non-pharmacological methods	Patients prefer for medication not counselling/positioning Non-pharmacological methods short duration of relief Patient scepticism Perceived value Helpful only when combined with drugs
To identify challenges faced by midwives in implementing effective pain management practices for post-CS mothers.		
Health system and patient-related challenges	Medication shortages	Shortage of stronger Opioids
	Inadequate staffing and workload	Inadequate staffing limiting individualized care
	Risk of medication overuse and dependency	Clinical safety Alcohol use as a barrier to pain management
	Mothers' expectations versus clinical protocols	Lack of response to pain medication Clinical safety Delayed Drug Absorption Mothers do not understand drugs are given in time
	Socio-cultural and language barriers	Cultural beliefs Language barriers

3.1. Themes and Sub-Themes

We identified four key themes. The first theme, protocol-driven and structured pain management practices reflect the midwives' reliance on the institutional clinical protocols and standard procedures of post-caesarean section pain management. Participants reported that they follow the hospital's clinical guidelines and employ both pharmacological and non-pharmacological interventions of pain management. They viewed non-pharmacological pain management as supportive care but also perceived these interventions to have limitations, particularly their short-term effectiveness. In the second theme, midwives' clinical role in post-CS pain management practices, the recurrent pattern identified reflects the midwives' central role as caregivers, assessors, educators and advocates. Theme three, midwives' perceived competence in post-CS pain management reflects their self-perceived ability and perceived limitations to manage the mothers. The fourth theme, health system and patient-related challenges in managing post-CS pain especially balancing safety and effective pain relief were viewed as constraints in optimal pain management.

3.2. Theme 1: Protocol-Driven and Structured Pain Management Practices

Participants described post-CS pain management as a structured process guided by established institutional protocols. They consistently narrated that they follow institutional protocols that directed pain assessment, medication administration, and documentation, which they perceived as promoting consistency, safety, and accountability in care delivery. In addition, pain management practices routinely

combined pharmacological interventions with selected non-pharmacological approaches. Pharmacological interventions were identified as the primary component of post-CS pain management. Strict adherence to prescribed medication schedules was viewed as central to achieving effective pain control and preventing complications. Non-pharmacological approaches were used as supportive measures alongside medication. Participants described interventions such as breastfeeding, positioning, and reassurance as beneficial for comfort and emotional support, although they were generally perceived as providing short-term relief and functioning as adjuncts rather than standalone pain management strategies.

3.2.1. Adherence to Standard Operating Procedures for Pain Management

Participants described adherence to SOPs as a fundamental aspect of post-CS pain management, with care delivery closely guided by documented clinical instructions and established protocols. While midwives often serve as the first line of care in post-operative pain relief, they shared that they operate within clearly defined professional boundaries, prioritizing the patient's safety and institutional protocol. Pain mmedication is only administered upon a Doctor's written instructions. In situations where no drug is prescribed, midwives are required to consult a Physician for proper documentation before any medication is given.

"*We only give drugs by per doctor's order if the patient is in pain and there's no uhh drug that has been written on the drug chart you go to the doctor with the file, let the doctor document that cause at the end of the day I wouldn't want to give a drug that is not documented yes what if it backfires on the patient? I'll be questioned. In as much as the patient is in pain always cause we're one so we work hand in hand with the doctors and the doctors are always on the ward*". *KII* 13

Participants also indicated that there is a SOP for administering controlled drugs for pain management in order to avoid side effects and dependency. For instance if a patient is still in pain after receiving pethidine, the midwife may switch to another analgesic such as tramadol to prevent addiction. This SOP guides their practice strictly. These instructions were viewed as essential for guiding safe and consistent pain management and for maintaining professional accountability within the multidisciplinary care team.

"*There is a standard protocol. So with controlled drugs, you cannot give up to a certain amount because you are also looking out for the side effects of the drug. It is addictive. So if I give pethidine and the patient is still in pain, I can switch to another pain killer, let's say I give tramadol. Because I do not want the patient to be dependent on pethidine. So there is a protocol we follow*". *KII* 5

The use of SOPs further structured pain management practices, with participants indicating that medications were administered according to standardised schedules and institutional guidelines. Participants emphasised that adherence to these protocols helped prevent missed doses. One participant explained:

"*We follow the drug schedule written on the drug chart. If you delay, the*

mother will start complaining of pain". *KII* 9

Another participant highlighted the role of protocols in maintaining patient safety and consistency:

"*The guidelines help us to give the right medication at the right time, and it reduces mistakes.*" *KII* 4

Routine history taking practice also formed a foundation in guiding post-CS pain management. Participants reported reviewing factors such as pain severity and duration, previous surgical experience and comorbidities to inform pain management decisions. This practice supported both the Doctors and midwives in safe medication administration and respectful maternity care. As two participants explained:

"*Before giving medication, I check the patient's history, hmmm… to know if she had problems with drugs or other medical conditions .*" *KII* 6

"*uh we get history from the patient, they tell us if they react to this medication or not so that is when the doctor will know which medication to prescribe*". *KII* 5

Another participant emphasised the importance of respectful maternity care within protocol limits:

"*Even though we follow the guidelines, the patient's condition and history guide how we manage the pain.*" *KII* 11

In addition, pain assessment and ongoing monitoring were consistently highlighted as routine practices embedded within SOPs. Participants described regularly assessing pain levels, mainly through history taking and monitoring mothers' responses to interventions. However, participants reported that findings were not consistently documented.

"*Pain is assessed almost always by asking the mothers on how severe the pain is and we continue to monitor after giving medication to see if it is effective.*" *KII* 2

Another participant indicated:

"*Pain assessment is continuous. I sometimes document my assessment findings in the nursing care book. Many times, I report to the incoming shift nurses during handover*" *KII* 14

3.2.2. Use of Both Pharmacological and Non-Pharmacological Pain Management Techniques

Participants described using a combination of both pharmacological and non-pharmacological methods to manage Post-CS pain among mothers. Pharmacological methods involved administering analgesics such as Pethidine, Metronidazole, Brufen, Diclofenac, Paracetamol, Fentanyl, Tramadol, and were effective in relieving pain and helping mothers in their recovery.

"*Okay, so all post-caesarean section mothers are under analgesia. So we put them under pethidine, diclofenac, and paracetamol*". *KII* 7

Use of pharmacological pain management techniques was observed to be closely related to adherence to SOPs. Participants emphasized that there is a structured protocol for pain relief following the CS at particular time intervals. It begins

with administering strong opioids such as Pethidine, which is given within the first 24 hours after the surgery. This is for the mother to have immediate and effective pain relief within this critical recovery window. After this window, the midwives transition to non-opioids analgesics, including Diclofenac and Paracetamol, to balance pain control and patient safety.

"*When they come from theatre the first 24 hours we give them uhh strongest pain killer which is Pethidine which is under control yes we give them that for 24 hours, 6 hours then after 24 hours we wean off then remain with Diclofenac from start we give them Diclofenac and Paracetamol then the first 24 hours we wean off Pethidine then remain with Diclofenac and Paracetamol then after 48 hours we wean off that Diclofenac injection that's the day they're even discharged we put them on orals we put them on Paracetamol and maybe Brufen depending on the pain we can even continue with Diclofenac or mmh hmm*". *KII* 13

"*Okay so all post caesarean section mothers are under analgesia. So we put them under pethidine, diclofenac and paracetamol. Yes so pethidine is given six hours times four times. Yes. Then we have paracetamol that is given one gram three times a day also diclofenac which is also given three times a day. Two times a day rather*". *KII* 7

Participants also employed non-pharmacological methods to complement the use of medications. These include techniques such as counselling, guiding on proper positioning, exercising, breathing, distractions, and compassionate communication in order to help mothers cope with the discomfort.

"*Yes, even breathing exercises. Give IEC so that the patient also understands what is happening, that also helps. Positioning and also just making the patient comfortable*". *KII* 3

Participants equally observed that increased breastfeeding among post CS mothers contributes to faster recovery and pain relief. They noted that breastfeeding is used to also support the bonding and milk flow but also aids in pain reduction and overall healing.

"*Yes, for post caesarean mothers, the more they breastfeed the more they heal faster and also the pain*". *KII* 2

Further, participants reported use of integrated methods for pain management approaches, with pharmacological interventions such as pethidine, intravenous paracetamol, and diclofenac routinely administered on the first postoperative day. However, some mothers continued to report pain shortly after receiving the analgesia. Midwives are cautious about repeating doses too soon, so in such cases, they incorporate non pharmacological methods such as diversion Therapy. At times, the baby is given to the mother to help her relax or sometimes taken away so she can sleep. This approach intends to enhance pain relief while reducing reliance on medication alone.

"*Then, Paracetamol we give it 8 hourly then we have Diclofenac which we give 12 hourly. So when it's time for their medication we give them their pain- the pain medication but when you see that those pain medications have been given but the*

patient is still in pain that's when we give psychological care that's when we counsel the patient or divert the pain by diverting the patient's mind by offering maybe you give the baby to the mother, you as-you ask ask them to breastfeed if the baby is in deep [inaudible segment] like in most cases you ask them to ambulate or to watch TV we have a big flat screen in the ward, yes just to help divert". *KII* 7

"*Sometimes you even divert, you give them the baby, to care for the baby that also diverts the pain sometimes we offer psychological care and we also divert the pain*". *KII* 13

3.3. Theme 2: Midwives' Clinical Role in Post-Caesarean Section Pain Management

Participants consistently described midwives as central to the effectiveness of post-caesarean section pain management, highlighting their multifaceted clinical role in ensuring timely, safe, and responsive care. Midwives' involvement extended beyond medication administration to include caregiving, continuous assessment, patient education, and advocacy within the clinical care pathway. These interconnected roles were perceived as critical in fostering pain relief outcomes, enhancing mothers' comfort, and supporting early recovery following CS. The effectiveness of pain management practices was therefore closely linked to how midwives enacted these roles within institutional protocols and in response to respectful maternity care.

3.3.1. Provision of Direct Post-Caesarean Section Care

Participants reported providing direct postoperative care by implementing comfort measures aimed at relieving post-CS pain. They also attended to minor yet impactful interventions. Participants shared that pain management begins the moment a woman is handed over from theatre, with the way she is handled physically and cared for. This includes the comfort of the trolley used during transport, gently transferring her from the trolley to the bed and positioning her once she is settled in the ward. This is essential in minimizing additional pain and discomfort.

"*So I feel it's the same thing I'm talking about like I mentioned uhh when I get a woman from theatre, yes, so the pain management begins from there when I get a hand over, what kind of a trolley am I using to transport this woman? Is it comfortable enough? Yeah does it have wheels that are able to carry her or it'll cause more pain and everything? When she reaches here in the ward I still continue with the type of bed that she's sleeps on and how do I even transfer her from the trolley to the bed all that is eh I should be mindful of the pain management as I'm even doing all that. Yeah so when I put her in the bed, how comfortable is she? How is she lying down? And then there comes in the drugs again*". *KII* 9.

Participants also monitored and managed medication-related side effects, ensuring that pharmacological interventions were both safe and tolerable for each mother. Participants reported that if patients react to particular drugs through symptoms such as vomiting, skin itches or scratching, then the midwives would discontinue and administer an alternative drug.

"*Sometimes the patient will vomit, sometimes there will be itchiness on the skin and they start scratching. Then most of the time we will know that this patient has reacted to this drug the we will stop. We will give the other drug*". *KII* 2

3.3.2. Patient Advocacy within Care Practices

Participants described an advocacy role in post-CS pain management, noting that they did not wait for mothers to verbally report pain before administering analgesia. Participants explained that pain following CS was anticipated, and that some women were unable or reluctant to express their discomfort. Participants aimed to stay ahead of the pain and reduce unnecessary agony among the mothers.

"*Even if a patient hasn't spoken about pain, we give them pain killers. As soon as they are back, we give them pain killers. Even when they have not complained we give them. Because we know that they are in pain*". *KII* 1

3.3.3. Ongoing Pain Assessment and Clinical Surveillance

Midwives emphasised continuous monitoring of post-CS pain as a central aspect of their clinical role, using different approaches to evaluate intensity and progression. Midwives described their approach to assessing pain level is by determining the time they came out of theatre and observation of nonverbal cues. For patients unable to communicate verbally at the moment they relied on body language, facial expressions to gauge pain intensity. For instance one midwife explained that the way the patient walks or bends often indicates the level of discomfort they are experiencing.

"*How I determine for those who are unable to verbalize, their body language, and facial expression I think. like the nonverbal patients, the way they walk you know like they would really bend you can see that this person is really in pain*". *KII* 3

They conducted regular checks to observe mothers' responses to analgesics and non-pharmacological interventions. This ongoing surveillance enabled timely adjustments to pain management strategies, ensuring that interventions were responsive to individual patient needs and effectively relieved discomfort.

"*Monitoring is continuous; we observe how they respond to the medicine and also check for any side effects. This helps us know if we need to adjust the care.*" *KII* 7

3.3.4. Pain Education and Counselling Practices

Participants described patient education as a key component of post-CS pain management, providing guidance on pain expectations, medication schedules, and comfort measures. They reported that group and individual counselling sessions were provided to mothers, whether they delivered via CS or through normal delivery. The mode of counselling was influenced by staffing levels during each shift: when staff numbers were limited, group counselling sessions were conducted to efficiently address common concerns, while adequate staffing allowed for individualized counselling, enabling more personalised guidance and tailored support for each mother. Through these interactions, participants reinforced the

importance of adhering to pain management protocols, encouraged early mobilisation, and provided strategies for coping with discomfort. Participants emphasised that ongoing communication not only informed mothers about their care but also fostered trust, promoted active participation in their recovery, and enhanced the perceived effectiveness of pain management interventions.

"*Yes we do counsel them. In fact we do group and individual counselling. For all the mother's both posts caesarean and just a normal birth. And also the counselling depends on the shift. If you are just the two of you in that shift, you do a group counselling and tackle the important points but if you are a lot of you, you can do the individual Counselling*". *KII* 15

Other participants corroborated with this statement:

"*If there are enough of us, we talk to each mother individually. This helps address her specific worries and teaches her how to manage the pain safely.*" KII 10

"*Education is part of pain management. When mothers know what to expect and how to cope, they recover faster and are more confident.*" KII 1

3.3.5. Post-Discharge Pain Management and Follow-Up

Participants reported that their clinical role in post-CS pain management extended beyond the immediate ward setting, with midwives continuing to provide care through follow-up interactions, patient guidance, and coordination of services after discharge. They described integrating their roles as caregivers, assessors, educators, and advocates to support ongoing pain control, recovery, and maternal well-being. Participants stated that after discharge the women are given mild analgesics such as paracetamol and Diclofenac. The women are advised to take the medication up to three (3) times a day but only if they are experiencing pain in order to reduce reliance on pain medication. The participants also shared there are scheduled review visits with the patients to assess the wound healing and inquire about the pain status. This continuity of care was perceived as important in sustaining the effectiveness of pain management practices beyond hospitalisation.

"*So when we discharge them we give them pain killers, the mild ones more especially Paracetamol and Diclofenac. So we usually tell them to be taking 3 times a day but if they are not in pain we don't, we ask them not to take. So that they start getting used to not take uh every day and also we ask them to come for review. So when they come for that review day we'll come and ask them how is the wound? How is the pain*". *KII* 10

Similarly, efforts to reduce unnecessary reliance on analgesics were emphasised through clear dosage instructions:

"*We advise them to take the medication up to three times a day if the pain is there, but also encourage them not to overuse the drugs.*" KII 2

Participants also described structured follow-up and clinical reassessment as part of continuity of pain management care. One participant explained:

"*During follow-up visits, we check the wound, ask about the pain, and see if the medications are helping or if there are any problems.*" KII 11

3.4. Theme 3: Perceived Competence in Post-Caesarean Section Pain Management

Participants described a strong sense of perceived competence in managing post-CS, reporting both their confidence in pharmacological interventions and their appraisal of the role and limitations of non-pharmacological approaches. Participants stated that adherence to institutional protocols and clear medication schedules reinforced their confidence in administering analgesics safely and effectively, allowing them to anticipate and respond promptly to patients' pain needs. At the same time, they recognised that non-pharmacological approaches, while supportive and valuable for comfort, provided only temporary relief and could not replace medications for sustained pain control. This combination of self-assured pharmacological practice and realistic appraisal of complementary methods underscored the participants' perception of their own competence.

3.4.1. Confidence in Pharmacological Post-Caesarean Section Pain Management

Participants reported confidence in administering pharmacological interventions as a core component of post-CS pain management. Some of the participants felt confident on their pain management practices due to the training and institutional support they received. Several participants mentioned attending workshops and trainings focused on pain relief techniques. Others cited receiving guidance on pharmacological techniques including both Opioid and non-opioid analgestics as well as non-pharmacological techniques such as guided breathing. Some participants explained:

"*We are supported yes. There are some work shops that they conduct at times to teach about pain relief and management. I was trained in pain management that was under a program for UTH children something*". *KII* 3

"*Uh the one we received is the pharmacological one. Yes and also the pharmacological one for an algesia, opioid and non opioid and also showing them how to use the breathing technique*" *KII* 7

Participants also emphasized that the effectiveness of pain management for patients was strongly tied to their own commitment and adherence to scheduled drug administration. Maintaining strict timing was crucial to ensuring the pain does not reoccur and deviating from these intervals such as giving medication after nine hours instead of six was perceived to reduce the effectiveness of the pain relief regimen. This highlight how the staff diligence and time management directly influence the effectiveness of the pain management.

"*So for the pain management to be effective one we need to be committed like the us the nurses when you're working on the ward you need to be checking the charts like I was saying pethidine you need to give every after 6 hours. So you need to make sure that as you are when you give maybe at 06:00 hours so* 7, 8, 9, 10, 11, 12:00 *hours that's when the next dose so you need to make sure at 12:00 hours exactly you repeat the second dose again after 6hours you repeat so that pain management is effective other than giving after 8hours or 9 hours that won't be effec-*

tive [pause] mhm". *KII* 13.

Some participants adds that they perceived their pain management practices to be effective based on patients immediate responses following the treatment. They reported that after receiving pain medication most Post-CS mothers expressed feeling significantly better. There are also visible improvement in demeanour such as smiling and engaging in conversation. These were indicators that the pain interventions had been successful. This reinforced the participants' confidence in their pain management practices

"*All the patients always have positive answers to say I am feeling better now after giving them the pain management. Can you find that when you treat the patient where you give them the painkillers and they feel good they even start smiling at you in laugh with you*". *KII* 8

Further, participants expressed satisfaction that the current pain management methods used in the post-CS wards are adequate and effective in relieving patient pain. According to their experience, these existing approaches significantly contribute to patient comfort and recovery. Some expressed confidence in their current training and may only require training if new pain management strategies are introduced by the healthcare system. This reflects the participants' trust in the current protocols and suggests that these methods meet the patients need within the existing healthcare framework.

"*It is adequate in fact, the one that we have already unless if at all the healthcare system introduces new methods. I think the same management that we are doing. It helps the patient. I don't think there would be any additional training that can surpass the one that we have already. Unless they introduce another one, but otherwise the ones that we have already they helped the patient*". *KII* 4

3.4.2. Perceived Limitations in Effectiveness of Non-Pharmacological Methods

While participants acknowledged the value of non-pharmacological strategies, they reported perceiving these methods as limited in their effectiveness for managing post-CS pain. Some participants shared that some of the non-pharmacological pain management techniques are short lived in their effect compared to pharmacological methods. These approaches require frequent repetition over a short period to maintain relief. They also shared that it is impractical and challenging due to staffing shortages and high patient loads. As a result, interventions such as massages, therapeutic communication are not always feasible despite their potential benefits. They suggested that if there were more staff available, they could offer non-pharmacological methods effectively. One participant exemplified:

"*Non pharmacological like breathing exercises, massages post operatively if it is there it is not so significant. They do help but just for a short time then the patient is back to pain. Cause you know we have a lot of patients so you cannot be offering non pharmacological like massage or talking to the patient and telling her stories cause work will be waiting. Otherwise maybe if we were staffed, maybe i would have a better experience*". *KII* 7

The repetitive nature of these interventions was also highlighted as a limitation, with midwives noting the difficulty of maintaining consistency across multiple patients. One participant stated:

"*They are effective, but they are very short-lived compared to pharmacological methods. So these are things that you have to do repeatedly over a short period of time*". *KII* 6

Participants further reflected that while these methods were valued for their supportive and comfort role, their impact on significant pain relief was inconsistent. A participant shared:

"*I always try to do positioning and simple comfort measures, but the effect is temporary. You need the medicine for real pain relief.*" *KII* 2

Another participant highlighted the potential for these strategies if staffing were sufficient:

"*Non-drug methods work, and I believe they help, but in this setting, we do not have the time to apply them properly. Maybe with more staff, we could use them more effectively.*" *KII* 5

3.5. Theme 4: Health System and Patient-Related Challenges

Participants described several challenges within the health system and patient context that affected the effectiveness of post-CS pain management. These challenges were both structural, related to availability of medications for pain and staffing, and patient-centered, including socio-cultural influences and individual responses to treatment. Participants observed that such challenges could influence the timeliness, consistency, and overall success of pain management strategies, often requiring them to adapt their practice within existing constraints.

3.5.1. Risk of Medication Overuse and Dependency

Most participants described a significant challenges in managing the risk of opioid misuse and potential addiction among mothers. Some mother begin requesting the drugs even before completing their prescribed course, often demanding for additional doses of opioids even when they are no longer in severe pain. As a safeguard, participants counsel the mothers on the importance of using opioids only for a short period of time and explaining that extended use is not permitted.

"*Yes, the challenges are there like for the opioid use some they go into addiction. So they would want you to be giving them every day even if they're not in pain so those are the challenges we face. And then we try to explain to them why we cannot give them for a prolonged period of time*". *KII* 4

In addition, participants described that some mothers had prior knowledge of certain medications before hospitalization and would specifically request drugs such as hypnotics and sedatives. They were of the view that this prior exposure influenced mothers to repeatedly ask for additional doses, with participants expressing that these requests were often justified by claims of experiencing severe and persistent pain. This behaviour reflects an awareness of the sedative or euphotic effect of medications, raising concerns about possible psychological de-

pendence or misuse.

"*Sometimes mothers are addicted to these drugs that we give them, they've heard about them on the streets. So you'll find that even before time to be given that drug they'll ask you sister I'm asking for that sleeping pill, they know the effects the drug has on them. So they'll want it even when it's not time for them to be given and when cause the doctor's order is 4 doses 6 hourly, so you'll find that they've finished the 4 doses but they'll continue following you telling you they are in severe pain so that you give them that drug, yes*". *KII* 13

Most participants also identified alcohol use as a specific challenge impacting pain management outcomes among post-CS mothers including risk of medication overuse. They explained that in cases where the mother has a history of alcohol use of is currently under its influence, even if you administer pain medications they will be less effective. This reduces the expected relief from analgesics and complicated the task of ensuring patient comfort.

"*I think the only challenge that we have is if the mother is a drunkard. You find that you give these pain killers but they are not working. Because alcohol and certain drugs don't go together*". *KII* 15

Additionally, the participants indicated that some mothers do not respond to the prescribed medication regardless of the type of drug or amount administered. Despite adherence to guidelines and administration of correct doses, patients may still experience persistent pain, constraining the participants' capacity to promote effective comfort and relief.

"*Challenges that when we give that woman the medicine and she doesn't respond to it. No matter how much you give she does not respond to it*". *KII* 1

Participants further explained that pharmacological pain management while effective is sometimes limited by clinical safety concerns. For instance, before administering pethidine, midwives are required to check the patient's blood pressure and if it is low, the drug cannot be given due to risk of further hypotension which can be dangerous. This becomes difficult because despite visible distress and requesting relief, the medication cannot be administered. This results in ongoing patient suffering, as participants are limited by safety protocols in their ability to intervene. As one participant stated:

"*Okay the specific challenge is that sometime is like when you giving like the same pethidine I'm talking about you need to check the BP. So if you see that the BP is uhh very low you can't uhh give that pain killer and it's a strong pain killer but the patient uhh needs it so those are the challenges, you'll find that when the BP is low you won't give that pain killer and the patient will suffer*". *KII* 13.

3.5.2. Shortage of Pain Medications

One of the most pressing challenges in pain management for Post-CS mother is the frequent shortage of essential drugs. Participants noted that the stronger medications are often unavailable in the pharmacy despite being central to the pain management protocol. This disrupts the recommended combination of administering pethidine, paracetamol, and diclofenac for optimal effect. In such situation

midwives are forced to either use less effective alternatives like Brufen or Panadol or sometimes as patients to purchase the missing drugs themselves which is not feasible for low-income mothers. As one participant mentioned:

"*The main challenge we encounter sometimes we find that the pharmacy does not have the medication that we need the stronger ones. So you have to tell the patient to buy either diclofenac and if that isn't there then you have to give them brufen or Panadol*". *KII* 4

Another participant echoed this concern, noting the impact on multimodal analgesia:

"*Most of the challenge is for us to manage this pain we combine three Analgesia which is Pethidine, Paracetamol and Diclofenac. But most of the time you find that ehh one or two of these drugs are out of stock. Yes, we are not supplied by pharmacy and so that's not on me as a midwife*". *KII* 9

3.5.3. Inadequate Staffing and Workload Pressures

One of the most pressing challenges shared was the shortage of staff in the hospital during shifts, consequently translating into workload. Participants reported being alone or having one or two colleagues on duty especially during night shifts or weekends making it almost impossible to administer pain medication on time. There are competing demands of attending to mothers in the theatre, labouring women in the main ward, managing emergencies resulting in pain management being deprioritized due to the triaging of critical cases first. Participants lamented:

"*The shortages are there especially in these big hospitals. Cause you find that maybe you are alone on duty and then you are trying to manage those who are from the theatre then there are those in the main ward who have not yet delivered. So you find that maybe you forget to administer the pain killer or you administer at another time and the patient is in severe pain. So mostly shortage of staff has really affected us*". *KII* 6

"*Sometimes these women they don't receive these pain killers because maybe you're alone in the shift, or maybe you're just the two of you and if you have an emergency if you have an emergency for you to get back to those pain killers first you save lives that's when you go back*". *KII* 12

3.5.4. Patients' Expectations vs Clinical Protocols

Participants expressed that the patients expectations often clash with clinical pain management protocols. A common challenge is when mothers report that the medication given does not seem to work, prompting them to request for more doses before the prescribed interval has elapsed. They believe that medication should be taken immediately at the onset of any pain, regardless of dosage instructions. This leads to patients expecting constant access to painkillers in the hospital setting. Providers must navigate these expectations carefully maintaining professional guidelines while managing patient trust and comfort.

"*The challenges that we have is that when we give them the pain killers, sometimes they will want us to give them every after one hour but they are supposed to*

receive sometimes after six hours. There are those patients who are just like that". *KII* 8

"*Another challenge we face is when you give that mother the medication but she doesn't feel it working so she will want some more so such challenges you find that you give her at 06:00 and then again at 09:00 she will say no I'm feeling a headache. So those are the challenges that we face because in the compounds what they know is that whenever you feel any slight pain, you just take any medication*". *KII* 2

Participants also noted a common challenge of the variation in individual physiological responses to analgesics, which can create a disconnect between clinical protocols and patient expectations. These individual differences in physiology present a challenge to effective post-CS pain management. Participants observed that despite the mothers being given full recommended doses of analgesics such as pethidine, it takes longer to experience relief for some because their bodies absorb and respond to the medication slowly. Participants noticed that this resulted in the continued suffering and frustration for the patient and care provider. One participant explained:

"*So there are others that have got uhh maybe they are- their immune system, their body really takes time to absorb the drug so you might give them the Pethidine, you might give them the all drugs that they need but for their system to just absorb that Analgesia into their body and begin to work. It takes a lot of time, yeah so that also is a challenge, we differ, yes*". *KII* 9

3.5.5. Socio-Cultural Beliefs and Language Challenges

Participants shared the influence of cultural norms that discourage women from showing signs of pain. Some mothers choose to remain silent or appear strong despite being in significant pain. Some mothers prefer to use herbal medication and will hide some of the medications that the midwives gives them. As some participants noted:

"*Yes they're there. Some women would rather be strong through the pain cause they feel like bringing it out is a sign of weakness. Maybe there is a relative close by and they are told to say no a woman should be strong even if you are in pain you shouldn't show it. So for me as a nurse i wouldn't know how much pain she is in cause she is trying to shield the pain to put up a strong face. So there are cultural barriers*". *KII* 2

"*Uhh there are some women who cooperate and there are others who will want non-pharmacological methods, they'll say their relatives are bringing medicine. So it's a bit difficult to cooperate with them*". *KII* 15

Another significant barrier to managing post-CS is language. Some patients especially those from different linguistic backgrounds or neighbouring countries may not understand or speak English. This results in patients silently enduring pain without being able to express themselves and communication barriers become strained. Sometimes, participants attempted to bridge the gap by asking other patients to interpret but this is unreliable and compromise accuracy and

privacy. The language barrier not only delays pain assessment and quality of care.

"Uhh language barrier, so there are some that come from countries where they don't use English. They won't be able to tell you they are in pain they'll just keep quiet. So one of them is language barrier". KII 12

"Sometimes it the language barrier. You find the patient only understands and speaks Lozi. Even if you try to explain it becomes a bit difficult to communicate to the patient. Even if you ask another patient to interpret it would not be as- I don't know". KII 3

4. Discussion

The findings from this study demonstrate that post-CS pain management at the Women and Newborn Hospital is highly structured and guided by institutional protocols and SOPs. The study has also revealed that pharmacological interventions, largely based on institutional protocols, were viewed as the primary and most reliable component of post-CS pain management while non-pharmacological methods offered short-term pain relief. This reflects a strong institutional commitment to balancing effective analgesia with patient safety. The findings support emerging evidence that structured pain management protocols contribute to better organisation of postoperative analgesia and reduced variability in clinician practice [17]. For example, implementation of multimodal pain control pathways within Enhanced recovery after Caesarean (ERAC) protocols has led to reductions in opioid consumption while maintaining acceptable pain outcomes, highlighting the value of standardised, evidence-based frameworks for post-CS pain relief [18].

However, the study's findings also illustrate some contrasts with current perspectives that promote flexibility and patient-centred care. While strict adherence to SOPs can enhance safety and consistency, studies in surgical pain management have noted that overly rigid protocols may limit clinicians' ability to tailor care to individual patient responses, particularly when physiological variability affects drug absorption or subjective pain experience [19] [20]. This tension between standardised practice and clinical discretion suggests that SOPs should include mechanisms for personalised assessment and modification of pain regimens based on real-time patient feedback, a perspective gaining attention in recent enhanced recovery literature.

The findings also indicate that midwives occupy a central and multifaceted role in post-CS pain management, encompassing direct caregiving, continuous assessment, patient education, advocacy, and post-discharge follow-up, all of which enhance the perceived effectiveness of pain control. This aligns with literature showing that nurse- and midwife-led pain management improves postoperative comfort, early mobilisation, and maternal satisfaction by ensuring timely interventions and sustained clinical surveillance [21]-[23]. The proactive advocacy role described, where midwives anticipate pain rather than waiting for verbal reports, is supported by literature emphasising anticipatory analgesia and continuous nursing presence as key to reducing postoperative suffering and anxiety after cae-

sarean delivery [19] [24].

On the contrary, some studies suggest that although such midwifery roles enhance responsiveness, heavy workloads and staffing constraints may limit the consistency of assessment, education, and follow-up, which can reduce the overall impact of these roles on pain outcomes [18] [25]. The study, though, supports a growing body of evidence that effective post-CS pain management is strongly linked to how well midwives enact integrated clinical roles within institutional protocols, while also highlighting the need for adequate staffing and system support to fully realise patient-centred pain care.

A strong sense of competence in managing post-CS pain was reported, grounded in confidence with pharmacological interventions and a realistic understanding of non-pharmacological methods. Midwives gauged effectiveness through observable patient responses, noting that some mothers often reported immediate pain relief, improved mood, and better engagement following analgesic administration. This indicated their confidence in their current pain management approach and is consistent with studies showing that patient reported outcomes and non-verbal cues are reliable measures of analgesic efficacy in clinical settings [26] [27]. While non-pharmacological interventions provide valuable support, their effectiveness is limited without adequate staffing and repeated application [27].

Health system and patient-related challenges identified in this study, such as a shortage of drugs and staffing, are well-documented barriers in resource-limited settings and hinder optimal pain management [28] [29]. Inadequate supply often forces midwives to resort to less effective alternatives, thereby prolonging patient discomfort. Similarly, staff shortages impede the timely administration of medication and reduce opportunities for individualised care. To address this, there is a pressing need for health system strengthening through improved drug procurement processes and strategic investment in human resources. Furthermore, the strict requirement for physician authorisation before administering pain relief, while important for patient safety, can introduce delays in pain relief especially in busy wards with limited medical personnel. Exploring task-shifting strategies or standing orders for certain analgesics may help streamline pain management in such settings.

The study also revealed patient centered barriers to effective post-CS pain management. Alcohol use among some mothers was noted to reduce the efficacy of the analgesics, complicating treatment [30] [31]. Language barriers limited communication making it difficult to assess pain and provide instructions which is known to impact care quality in multilingual settings [32] [33]. Cultural preferences for herbal medicine led some mothers to reject or supplement hospital medications, reflecting a need for culturally sensitive care and health education [34] [35].

This study acknowledges that midwives' structured, protocol-driven approach and adherence to scheduled analgesic administration underpin their perceived competence in post-CS pain management. While pharmacological methods re-

main central to effective pain control, non-pharmacological strategies provide important supportive benefits, particularly when staffing and workload allow their proper implementation. Strengthening training, ensuring adequate resources, and maintaining flexibility within protocols can further enhance midwives' effectiveness and patient outcomes in post-CS care.

5. Conclusion

The study provides a comprehensive insight into a combined approach employed by midwives for pain management post CS at the University Teaching Hospitals-Women and Newborn Hospital in Lusaka, Zambia. It highlights their commitment to balancing effective pharmacological and non-pharmacological strategies for patient safety, adherence to clinical guidelines and responsiveness to individual needs. The practices align with global best standards in maternal pain management but do not fall short of systemic challenges such as drug shortages, inadequate staffing and delays due to prescribing protocols. Additionally, patient centred barriers including, socio-cultural beliefs, language barriers and expectations versus clinical protocols further complicate care. The findings underscore the need for a strengthened health system support, culturally sensitive education and continued capacity building to enhance maternal pain management in resource limited settings. Addressing these gaps is essential not only for improving clinical outcomes but also for promoting respectful, dignified and patient centred maternity care.

Conflicts of Interest

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

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