

The Effects of Negative Birth Experiences in Childbearing Women in Glenview, Harare, Zimbabwe

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Abstract: This study investigated the effects of negative birth experiences among childbearing women in Glenview, Harare, Zimbabwe. The main objective was to explore the effects of negative childbearing experiences on women in Glenview, Harare. The study employed a qualitative research methodology grounded in interpretivism, utilizing Interpretative Phenomenological Analysis (IPA) to examine women lived experiences. Data collection involved in-depth individual interviews with eighteen participants and two focus group discussions with fifteen participants, totaling 33 women from diverse socioeconomic backgrounds. Purposive sampling ensured representation across key dimensions including age, parity, birth setting, and complication types. Duffy's Quality Caring Model provided the theoretical framework, emphasizing caring relationships, individualized care, and patient experience as central healthcare quality components. Data analysis followed IPA principles, developing comprehensive thematic frameworks for each research objective. The findings revealed five themes characterizing negative birth experiences: disrespectful and abusive care practices, systematic communication failures, resource constraints compromising care quality, loss of control during childbirth, and inadequate management of complications. Six themes emerged regarding impacts: physical health consequences, psychological trauma, disrupted mother-infant bonding, strained family relationships, fear of future pregnancies, and erosion of trust in healthcare systems. Five strategic themes were identified for addressing these issues: provider training in respectful care, resource investment, establishment of support systems and mental health services, policy reforms with accountability mechanisms, and community education initiatives. The study concluded that negative birth experiences in Glenview result from complex interplay between interpersonal and systemic factors, creating profound impacts across multiple domains of women's lives. These findings contribute to understanding negative birth experiences in the Zimbabwean context and provide evidence-based recommendations for improving maternal healthcare quality and women's birth experiences.

Keywords: Childbearing Women, Effects of Negative Birth Experiences, Zimbabwe.

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I. INTRODUCTION

The study investigated the effects of negative birth experiences in childbearing women in the Glenview area of Harare, Zimbabwe. Childbirth was an important milestone in many people's lives, and it was considered as one of the most significant experiences in a woman's life. It had a significant impact on the emotional, physical, emotional and psychological well-being of a woman. There were many factors which caused women to perceive their childbirth negatively and they led to long-lasting effects on new mothers. Factors that negatively influenced the birth experience included poor relationships between the care providers and the mothers, for example no physical or emotional support to cope with the labor pain, judgmental attitude of the midwives, traumatic deliveries, poor communication styles, as well as not being involved in making decisions for themselves.

Childbirth was an important milestone in many people's lives, and it was considered as one of the most significant experiences in a woman's life. The experiences included pain, sadness, happiness and stress. Some women remembered their birth experiences positively with a percentage however, reporting their birth experiences negatively. It has been demonstrated that negative birth experiences significantly affect mothers' well-being and decision-making in the future (Smarandache, A. et al, 2016) There were many factors which caused women to perceive their childbirth negatively. Negative birth experiences encompassed a wide range of issues, including, but not limited to, traumatic delivery, lack of support from healthcare providers, unmet expectations, and feelings of dis-empowerment during the child-bearing process. These experiences ranged from physical complications during childbirth to emotional distress and psychological trauma and they led to long-

term psychological and physiological consequences, impacting women's mental health, bonding with their infants, and future reproductive decisions.

Negative birth experiences had detrimental effects on both the mother and the newborn. Physically, complications during childbirth lead to long-term health issues for the mother. Emotionally, traumatic births resulted in postpartum depression, anxiety disorders, and even impacted the mother-infant bonding process. Moreover, these negative experiences also affected future pregnancies and childbirth decisions. Most times the health care workers imposed their decisions on the women without having sought consent and at times they did not explain what would be going on. It was important to understand why some women experience distress following labor. There was relatively little research on women's perception of these negative emotions. Understanding the root causes and the impact of these experiences was crucial for developing targeted interventions and improving overall maternal satisfaction and mental health in the context of mental health.

Numerous studies have been conducted globally on negative birth experiences encompassing various aspects such as maternal satisfaction, psychological impact and factors. The problem of negative birth experiences has garnered increased attention in recent years. Previous studies have investigated the psychological repercussions of traumatic birth experiences on parents, emphasizing the lasting effects on their mental health and overall welfare. Researchers have examined how factors like perceived control during childbirth, labor complications, and feelings of fear or helplessness can contribute to parental distress postpartum. The heightened levels of stress resulting from these experiences subsequently had adverse effects on the parent-child relationship. If it remained unresolved, negative birth experiences had the potential to lead to psychological issues within families that impacted both children and parents. It was imperative to address these challenges through further research and intervention strategies.

According to a study published in *BMC Pregnancy and Childbirth*, approximately 25% of women reported their birth experience as traumatic. In Zimbabwe, where Glenview is located, maternal mortality rates remained high at 651 deaths per 100,000 live births as reported by UNICEF (UNICEF, 2023). Additionally, a study conducted by the World Health Organization (WHO) highlighted that maternal morbidity rates were significantly higher in low-resource settings like Glenview due to limited access to quality healthcare services. To address the issue of negative birth experiences in childbearing women in Glenview, Harare, several interventions have been implemented. Firstly, there was need for improved prenatal care services to detect and manage any potential risk factors earlier on. Training healthcare providers in obstetric emergency management and ensuring access to emergency obstetric care facilities were crucial steps in reducing complications during childbirth. Additionally, providing mental health support for women who have experienced traumatic births was essential for their overall well-being.

Childbearing women in Glenview, Harare were experiencing negative birth experiences that significantly impacted their physical, emotional, and psychological well-being despite global emphasis on safe and positive childbirth. These negative experiences included traumatic deliveries, poor communication with healthcare providers, lack of emotional support, disrespectful care, and exclusion from decision-making during labor and delivery. Approximately 33% of women globally reported negative or traumatic childbirth experiences, with rates potentially higher in resource-constrained settings like Zimbabwe (WHO, 2023). In Zimbabwe specifically, where maternal mortality rates remained high at 651 deaths per 100,000 live births, negative birth experiences compound existing maternal health challenges, creating a critical public health concern in communities like Glenview (UNICEF, 2023). The problem of negative birth experiences required urgent attention because of its profound and far-reaching consequences. Research by Smarandache, demonstrated that negative birth experiences significantly affected mothers' psychological well-being, family relationships, and future healthcare decision-making, including avoidance of facility-based deliveries in subsequent pregnancies (Smarandache, A., et al, 2016). Shiva established a strong correlation between negative childbirth experiences and post-traumatic stress disorder, with implications for mother-infant bonding and maternal mental health (Shiva L, 2021). If the problem remained unresolved, these experiences would have led to long-term psychological trauma, postpartum depression, difficulty bonding with infants, and reluctance to seek healthcare services for future pregnancies, creating intergenerational effects that impact the overall well-being of families in Glenview. The persistence of this problem reflected significant gaps in understanding the specific factors contributing to negative birth experiences in this community, particularly relating to provider-patient communication, perceived control during childbirth, and culturally responsive care within resource-constrained healthcare settings.

II. METHODOLOGY

The study adopted a qualitative research paradigm grounded in interpretivism, recognizing that understanding negative birth experiences required deep exploration of women's subjective realities, personal meanings, and lived experiences within their specific sociocultural context. The selection of qualitative methodology reflected careful consideration of alternative approaches and their limitations for this research

context. While quantitative methodology could provide statistical prevalence data and correlational analyses, it would fail to capture the nuanced emotional, cultural, and contextual dimensions essential for understanding negative birth experiences in Glenview's specific sociocultural context.

Study Setting

The study was done at Gen View Polyclinic, in the Glen View high density suburb of Harare.

Sampling and data collection

The target population comprised childbearing women aged 18-45 years residing in Glen View, Harare, who have experienced childbirth within the past 24 months and self-identify as having had negative birth experiences. This population represented approximately 3,500 women based on demographic estimates from the Zimbabwe National Statistics Agency, considering Glenview's population of approximately 150,000 residents with 35% being women of reproductive age and estimated annual birth rates of 28 per 1,000 population (ZIMSTAT, 2023). The 24-month timeframe ensured sufficient recall of birth experiences while allowing time for initial processing of traumatic events, balancing memory accuracy with emotional readiness to discuss difficult experiences.

The study employed purposive sampling specifically utilizing criterion sampling to identify information-rich cases providing deep insights into negative birth experiences. This non-probability sampling approach ensured selection of participants who have directly experienced the phenomenon under investigation and could articulate their experiences effectively.

Criterion sampling established specific inclusion parameters ensuring participant relevance while maintaining population diversity. Primary criteria included women aged 18-45 years ensuring legal consent capacity and reproductive age relevance, residence in Glenview for minimum 6 months ensuring community contextualization, childbirth experience within past 24 months balancing recall accuracy with processing time, self-identification of negative birth experience respecting subjective experience definitions, ability to communicate in Shona or English ensuring effective communication, and willingness to discuss potentially traumatic experiences indicating emotional readiness. Exclusion criteria eliminated women with severe untreated mental health conditions requiring immediate intervention, current pregnancy which complicated emotional responses, and inability to provide informed consent.

Recruitment strategies employed multiple channels ensuring diverse participant access while maintaining ethical sensitivity. Community health workers served as cultural brokers, identifying potential participants through their routine maternal health activities while maintaining confidentiality. Maternal support groups provided access to women already engaged in birth experience discussions, potentially more comfortable with research participation. Health facility referrals from postnatal clinics identified women with documented difficult births, though self-identification remained primary. Snowball sampling supplemented primary recruitment, with participants recommending others with similar experiences, though careful monitoring prevented network homogeneity.

The sample design targeted 15-20 participants, reflecting IPA methodology recommendations for achieving sufficient depth while maintaining analytical manageability. This sample size enabled detailed individual case analysis essential for phenomenological research while providing sufficient cases for pattern identification across experiences. Maximum variation sampling within the purposive framework ensured diverse experience representation across key dimensions. Age stratification included younger mothers (18-25 years), middle-aged mothers (26-35 years), and older mothers (36-45 years), capturing age-related experience variations. Parity diversity encompassed first-time mothers and multiparous women, recognizing different expectation frameworks. Birth setting variations included public hospital deliveries, private facility births, and home deliveries, acknowledging setting influences on experiences. Complication types spanned physical complications (prolonged labour, caesarean sections, haemorrhage), emotional trauma (disrespectful care, loss of control), and combined physical-emotional experiences.

Sample size determination followed qualitative research principles prioritizing information richness over statistical power, with final size determined through data saturation monitoring. Initial target of 15 participants reflected IPA methodology guidelines suggesting 10-15 participants for professional doctorate studies, with flexibility to extend to 20 participants if saturation remained unachieved (Hennink & Kaiser, 2023). Saturation assessment employed systematic monitoring through concurrent data analysis, examining when new interviews ceased generating novel insights about negative birth experiences.

The relatively small sample size aligned with phenomenological research emphasis on depth rather than breadth, enabling detailed exploration of individual experiences while maintaining analytical quality. Each participant interview generated substantial data requiring intensive analysis, with larger samples potentially compromising analytical depth. The sample size enabled examination of both convergent and divergent

experiences, identifying shared patterns while preserving unique aspects of individual experiences (Vasileiou et al., 2023).

The interview guide development process involved extensive literature review identifying key domains requiring exploration, theoretical framework integration ensuring alignment with Quality Caring Model concepts, cultural consultation with Glenview community representatives ensuring appropriateness, and pilot testing with two women refining question clarity and flow. The guide comprised four main sections: opening questions establishing rapport and gathering demographic information (5-10 minutes), exploration of birth experience narratives encouraging detailed storytelling (20-30 minutes), examination of impacts exploring physical, emotional, and social consequences (15-20 minutes), and discussion of improvement strategies identifying support needs and recommendations (10-15 minutes). Total interview duration ranged from 50-75 minutes, balancing comprehensive exploration with participant comfort.

Interview procedures emphasized creating safe, supportive environments facilitating open discussion of potentially traumatic experiences. Pre-interview contact established initial rapport, explaining research purposes, and assessing emotional readiness. Interview settings prioritized participant comfort, offering choices between home visits ensuring familiar environments, community centre private rooms providing neutral spaces, or healthcare facility counselling rooms when preferred. All settings ensured privacy, minimal interruptions, and emotional safety. Interview conduct followed trauma-informed principles including allowing participants to control pacing, providing breaks when needed, validating emotional responses, and having referral resources available for participants requiring additional support.

Data collection protocols ensured systematic quality while maintaining flexibility for individual needs. Audio recording captured complete narratives with participant consent, using digital recorders with backup devices ensuring technical reliability. Concurrent note-taking documents non-verbal communications, emotional expressions, and contextual factors influenced interviews. Post-interview debriefing allowed participants to add final thoughts, clarify points, and process emotional responses. Field notes recorded immediately post-interview captured researcher observations, emerging analytical insights, and reflexive thoughts about researcher-participant dynamics.

The analytical approach utilized Interpretative Phenomenological Analysis (IPA) following Smith et al.'s (2023) systematic framework comprising six stages. Stage one involved immersive reading of individual transcripts, listening to audio recordings, and noting initial impressions without formal coding. Stage two generated exploratory notes examining semantic content (explicit meanings), linguistic features (metaphors, repetitions, tone), and conceptual interpretations (underlying meanings, connections to broader contexts). Stage three developed emergent themes for each case, identifying patterns within individual experiences before cross-case comparison. Stage four searched for connections across emergent themes, clustering related concepts while maintaining sensitivity to divergent experiences. Stage five involved moving to subsequent cases, repeating stages one through four for each transcript while bracketing insights from previous cases to maintain idiographic focus. Stage six identified patterns across cases, developing superordinate themes capturing shared experiences while preserving individual variations. This systematic progression ensured both depth of individual analysis and breadth of pattern identification across participants' experiences. Throughout analysis, constant comparison techniques examined similarities and differences within and between cases, ensuring comprehensive pattern identification.

Data management utilized NVivo 14 software facilitating systematic organization, coding, and retrieval while maintaining analytical transparency. The software enabled hierarchical theme organization, memo linking maintaining analytical thoughts, and audit trail documentation tracking analytical decisions. However, the software served organizational rather than analytical functions, with interpretation remaining researcher-driven through deep engagement with data meanings and contexts (Jackson & Bazeley, 2023).

Quality assurance procedures included member checking where participants review interpreted themes ensuring accurate representation, peer debriefing with experienced qualitative researchers examining analytical decisions, and reflexive journaling documenting researcher assumptions and their potential influences. Negative case analysis actively sought contradictory evidence challenging emerging patterns, ensuring analytical rigor and preventing premature closure. These procedures enhanced analytical trustworthiness while maintaining IPA's interpretative nature.

'Ethical considerations refer to moral principles that guide research conduct to protect participants' rights, welfare, and dignity' (Christians, 2023). Ethical considerations received paramount attention given the sensitive nature of investigating traumatic birth experiences among vulnerable populations. The study adhered to fundamental ethical principles of respect for persons, beneficence, non-maleficence, and justice outlined in the Belmont Report and contextualized for Zimbabwean research contexts (National Research Council of Zimbabwe, 2023). Comprehensive ethical protocols ensured participant protection while enabling meaningful research contributing to maternal healthcare improvement.

Institutional ethical approval was obtained from multiple bodies ensuring comprehensive oversight. The Medical Research Council of Zimbabwe (MRCZ) granted national research authorization ensuring compliance with Zimbabwean research regulations. The Harare City Health Department approved community entry and healthcare facility access. Glenview community leaders provided cultural approval ensuring community acceptance and support. This multi-level approval process ensured ethical oversight from institutional, national, municipal, and community perspectives.

Informed consent procedures ensured voluntary participation based on comprehensive understanding of research purposes, procedures, risks, and benefits. Written consent documents in participants' preferred languages (Shona or English) explained study objectives, participation requirements, potential emotional risks, available support services, confidentiality protections, and withdrawal rights. Verbal explanation supplemented written materials ensuring complete understanding, with opportunities for questions before consent. Process consent recognized ongoing nature, with consent verification throughout data collection and explicit consent for audio recording obtained separately.

Confidentiality protection employed multiple strategies safeguarding participant identity and sensitive information. Pseudonym use replaced actual names in all documents, with identifier codes linking data to consent forms stored separately. Demographic information modification prevented indirect identification while maintaining analytical relevance. Audio recordings and transcripts storage in password-protected encrypted files ensured data security. Limited access restricted data to research team members with confidentiality agreements. Careful presentation of findings avoided identifying details while preserving experiential richness.

Risk mitigation recognized potential emotional distress from discussing traumatic experiences, implementing comprehensive support protocols. Pre-interview emotional readiness assessment ensured participant preparedness for potentially difficult discussions. Interview pacing allowed participant control over disclosure depth and speed. Emotional support during interviews included validation, breaks when needed, and discontinuation options. Referral resources provided professional counselling service contacts for participants requiring additional support. Follow-up contact 24-48 hours post-interview assessed participant well-being and support needs. Participants' verbatim was highlighted in italics.

III. RESULTS

The study targeted 20 participants for in-depth individual interviews and conducted two focus group discussions with 8 participants each, totalling 36 potential participants. Recruitment occurred through multiple channels including community health workers, maternal support groups, and healthcare facility referrals in Glenview, Harare. Of the 20 women invited for individual interviews, 18 agreed to participate, yielding a 90% response rate for this component. Two women declined participation citing emotional unreadiness to discuss their birth experiences. For focus group discussions, 16 women were invited with 15 ultimately participating, representing a 94% response rate. One woman withdrew on the scheduled discussion day due to childcare complications. The overall study response rate across both data collection methods was 92%, with 33 of 36 invited women participating.

The 33 participating women represented diverse demographic profiles reflecting Glenview's heterogeneous urban population. Demographic data collection occurred at the beginning of each interview and focus group discussion, with participants self-reporting information across multiple dimensions including age, educational attainment, employment status, marital status, parity, and birth setting for their most recent delivery.

Participant ages ranged from 19 to 43 years, with mean age of 29.6 years and median age of 28 years. The age distribution showed concentration in 25 – 34-year age bracket, representing 61% of participants. 8 women aged 18 to 24 years comprised 24% of the sample, while 5 women aged 35 to 45 years represented 15%.

Educational backgrounds varied substantially, ranging from primary education only to tertiary qualifications. 7 participants completed primary education only, representing 21% of the sample. 15 participants completed secondary education through Ordinary Level or Advanced Level, comprising 45%. 11 participants attained tertiary education including certificates, diplomas, or degrees, representing 33%.

Employment patterns reflected Glenview's mixed formal-informal economic landscape. 14 participants engaged in informal trading or small business activities, representing 42%. 9 participants were formally employed in various sectors including education, healthcare, retail, and administration, comprising 27%. 10 participants self-identified as unemployed or homemakers, representing 30%.

Marital status distribution showed 21 participants were married, representing 64% of the sample. 8 participants were in informal partnerships, comprising 24%. 4 participants were single mothers, representing 12%.

Parity ranged from primiparous women experiencing their first birth to multiparous women with up to 6 previous deliveries. 14 were primiparous, representing 42% of the sample. 12 participants had one to two previous deliveries, comprising 36%. 7 participants had 3 or more previous deliveries, representing 21%.

Birth settings for participants' most recent deliveries varied across Glenview's healthcare landscape. 18 participants delivered at public hospitals, representing 55%. 10 participants utilized private healthcare facilities, representing 30%. 5 participants delivered at home either by choice or circumstance, representing 15%.

Thematic Presentations

The findings were organized thematically according to the research objectives. Each objective section presented the major themes that emerged from participant narratives, with direct quotations illustrating the themes. Participant names were replaced with pseudonyms to maintain confidentiality.

Current State of Negative Birth Experiences

The exploration of negative birth experiences among childbearing women in Glenview revealed complex, multifaceted phenomena. Five major themes characterized the current state of negative birth experiences.

Theme 1: Disrespectful and Abusive Care Practices

Women reported disrespectful and abusive care practices by healthcare providers during labour and delivery. This theme emerged across all participants regardless of facility type, parity, or socioeconomic status. Women described verbal abuse, physical roughness, neglect of pain management needs, and denial of basic dignities.

Rutendo, a twenty-six-year-old first-time mother who delivered at a public hospital, stated: *"The midwife kept shouting at me, telling me I was making noise like a baby, asking if I wanted to die there. She said if I had energy to scream, I should use it to push. When I said I couldn't take the pain anymore, she laughed and said, 'you enjoyed making this baby, now suffer for it.' I felt so small, so stupid. I was in so much pain but more than that, I felt ashamed"*.

Tariro, a thirty-two-year-old mother of three, described: *"During vaginal examinations, the nurse was so rough. She didn't warn me, didn't ask permission, just forced her hand inside. I cried out in pain, and she told me to shut up. It felt like violence. Even now when I remember, I feel violated, like I was raped"*.

Chipo, a nineteen-year-old new mother, recounted: *"When the baby's head was coming, the midwife slapped my thigh hard and shouted, 'push now!' I was already pushing with everything I had. The slap hurt but worse was feeling like I was being punished. Why hit me when I'm already in the worst pain of my life?"*

Rudo, a twenty-eight-year-old mother, stated: *"I begged for something for the pain. I've never felt anything like that in my life. The nurse said there was nothing available, but I heard her telling another patient in the next bed that I was being dramatic. Hours I suffered, hours of unbearable pain while they stood there talking and laughing like I wasn't dying. How can they be so heartless?"*

Theme 2: Communication Failures and Information Deprivation

Women experienced systematic failures in healthcare provider-patient communication, with information deprivation at critical junctures. Women described healthcare providers performing procedures without explanation, announcing interventions without rationale, and withholding information about labour progress.

Tendai, a thirty-five-year-old mother, recounted: *"They kept examining me but never said what they found. Am I progressing? Is my baby okay? I didn't know. Then suddenly they're wheeling me to theatre for emergency caesarean. No explanation, just 'we need to operate now.' I was terrified. I didn't know what went wrong, why surgery was necessary, what would happen to my baby. That fear, that not knowing, it haunts me still."*

Faith, a twenty-three-year-old from Malawi living in Glenview, described: *"They spoke quickly in Shona, words I didn't understand. I kept asking in English what they were saying but they ignored me. I felt so alone, so lost. I couldn't understand what was happening to my own body, my own baby. They made decisions for me without even trying to explain in a language I could understand."*

Muchaneta, a twenty-nine-year-old mother, stated: *"Suddenly I felt cutting. The doctor was doing episiotomy without asking, without even telling me first. I felt the scissors. When I asked why, he said 'it's necessary' but didn't explain why. My body, but I had no say. After, I had complications with healing, terrible pain. I was angry. If he had asked, explained, maybe I would have agreed. But to just cut me like I'm not even human, like my body belongs to them, not me"*.

Theme 3: Systemic Resource Constraints Compromising Care Quality

Resource constraints in Glenview's healthcare facilities directly compromised care quality. Participants described supply shortages, equipment failures, inadequate staffing, and infrastructure deficiencies. Shuvai, a thirty-one-year-old mother, described: *"They told my husband to go buy everything - gloves, sutures, even the drip. While he went to find pharmacy, I'm there bleeding, no one helping because they don't have"*

supplies. I thought I would die waiting. When he came back with supplies, then they helped me. If you don't have money to buy these things, what happens? Do they just let you die?"

Nyasha, a twenty-four-year-old first-time mother, recounted: "I was in labour room alone for hours. I kept pressing the bell, but no one came. The pain was terrible, I was scared. Then I felt the baby coming. I screamed and screamed. By the time the nurse arrived, I had already pushed the baby out by myself. She was angry at me, like it was my fault she wasn't there. I was bleeding a lot, the baby wasn't crying properly. Those minutes alone, not knowing if my baby was okay, if I was okay, were the worst of my life."

Theme 4: Loss of Control and Autonomy During Childbirth

Women experienced overwhelming powerlessness during childbirth, with systematic denial of choices, dismissal of preferences, and enforcement of institutional protocols regardless of individual needs or desires. Kumbirai, a twenty-seven-year-old mother, stated: "I wanted to squat. That's how my mother gave birth, how women in my family always gave birth. It felt natural. But they forced me onto my back, held my legs up. I felt so exposed, so vulnerable. I kept trying to move but they held me down, telling me to stay still. I felt like an animal being held down for slaughter."

Perseverance, a thirty-three-year-old mother, recounted: "My husband wanted to be with me, but they refused, said no men allowed in labour ward. I begged them - he's my partner, I need him. They said hospital rules, very firm. So, I went through everything alone. When they were being rough with me, verbally abusive, no one was there to witness it, to speak up for me. I felt completely helpless, like I had no one on my side."

Theme 5: Inadequate Management of Complications and Emergencies

Women described experiences where complications were not recognized promptly, emergencies were mismanaged, and warning signs were dismissed or ignored by healthcare providers. Ruvarashe, who experienced stillbirth, shared: "I told them for days I wasn't feeling the baby move. They said babies sleep, it's normal. When I came for my appointment, they took so long to check me. When they finally did, there was no heartbeat. My baby had died. If they had listened earlier, checked properly, maybe my baby would be alive. They didn't take my concerns seriously."

Impact of Negative Birth Experiences on Women

The exploration of how negative birth experiences affected women revealed profound impacts. Six major themes characterized these impacts.

Theme 1: Physical Health Consequences and Complicated Recovery

Women described ongoing physical health problems stemming from negative birth experiences, with prolonged recovery periods, persistent pain, complications from inadequately managed interventions, and symptoms potentially reflecting somatization of psychological distress. Chenai, a twenty-eight-year-old mother, explained: "The episiotomy healed badly. Even now, six months later, I have pain. Sitting is uncomfortable, walking long distances is difficult. Sex is impossible - the pain is too much. My husband is frustrated, I feel broken. They cut me without asking and now I live with pain every day. This should have healed by now, but something went wrong."

Tafadzwa, a thirty-one-year-old mother, stated: "I lost so much blood. Months later, I'm still weak, tired all the time. I can't do the things I used to do. Carrying the baby tires me quickly. Cooking, cleaning - everything exhausts me. I went to the clinic, and they said I'm anaemic but the iron tablets they gave me don't seem to help much. I wonder if the bleeding damaged something permanently. Will I ever feel strong again?"

Makanaka, a twenty-six-year-old mother, recounted: "I developed terrible infection after delivery. My stitches became infected, I had fever, foul-smelling discharge. I had to go back to hospital for antibiotics and cleaning of the wound. The doctor said it was because of dirty instruments or poor technique. Now I have ugly scarring. Every time I see those scars, I remember the infection, the pain, the fear that I might die from sepsis all because someone didn't sterilize equipment properly."

Theme 2: Psychological Trauma and Mental Health Impact

Women described profound psychological consequences including symptoms consistent with post-traumatic stress disorder, postpartum depression, anxiety disorders, and complicated grief following perinatal loss.

Rutendo explained: "I have these sudden memories that feel like I'm there again. Something triggers it - maybe hearing a baby cry, or seeing the hospital, or even just someone raising their voice. Suddenly I'm back in that labour room, hearing the midwife shouting at me, feeling that pain and shame and fear. My heart races, I start sweating, I feel panicked. It takes time to calm down, to remind myself it's over. But it doesn't feel over."

Chipso stated: "I can't go near that hospital. Even driving past, it makes me anxious. I had to change where I

take the baby for clinic appointments because I couldn't bear going back there. I avoid pregnant friends because seeing them reminds me of my own birth. People want to hear birth stories, to share experiences, but I can't talk about it. When I try, I start crying or feeling panicked. So, I avoid anything that reminds me.” Tariro described: “I can't sleep. Even when the baby is sleeping soundly, I lie awake worrying. I keep checking if she's breathing. I imagine terrible things happening - sudden infant death, illness, accidents. During the birth I felt so helpless, so unable to protect her. Now I'm terrified something will happen and I won't be able to save her. I know it's not rational, but I can't stop these thoughts.”

Rudo explained: “I feel empty, sad all the time. Things I used to enjoy don't interest me anymore. I look at my baby, and I know I should feel joy, love, but mostly I feel nothing. Then I feel guilty for not feeling the way a mother should feel. I cry a lot. I wonder if life will always feel this heavy, this grey. People say postpartum sadness is normal, but this feels like more than normal. It's been months and I'm not getting better.”

Theme 3: Disrupted Mother-Infant Bonding and Relationship

Women described difficulty connecting emotionally with infants who became associated with traumatic experiences, while others developed anxious, hypervigilant attachment patterns. Muchaneta explained with evident shame: “For the first weeks, I didn't feel connected to my baby. When they put her in my arms, I felt nothing. I looked after her - fed her, changed her - but mechanically, like a job. I didn't feel love. I felt resentful. She was the reason I went through that trauma. I know it's not her fault, she's innocent, but those were my feelings. I was ashamed of feeling this way. What kind of mother doesn't love her baby? The bond came eventually but it took time, and I worry that slow start damaged something between us.” Tendai stated: “I became obsessed with my baby's safety. I couldn't let anyone else hold him. I watched him constantly, checking his breathing every few minutes. I couldn't sleep because I was so afraid something would happen. My family said I was being overprotective, paranoid. They didn't understand that during his birth, I nearly lost him. I couldn't trust that he was safe. That fear controlled me”. Faith described: “My baby's birth should have been the happiest day of my life. Instead, it was the worst. When I look at her, I remember the trauma, the fear, the pain. She's innocent but she's connected to those terrible memories. I love her but I also feel sadness when I look at her, remembering what I went through to bring her into the world. It's complicated. I wish I could separate her from those memories, but I can't.”

Theme 4: Strained Family Relationships and Social Isolation

Women described how negative birth experiences and their aftermath strained relationships with partners extended family members, and friends.

Chenai explained: “My husband wants sex. He says it's been long enough; I should be healed. But it hurts too much. I've tried but the pain is unbearable. He gets frustrated, says I'm making excuses, that I don't want him anymore. How do I make him understand? The doctors cut me badly and I'm still suffering. But he sees it as me refusing him. The tension between us is terrible. I worry our marriage won't survive this.”

Rudo stated: “My husband doesn't understand why I'm still sad, still struggling. He says, 'the birth is over, the baby is healthy, just move on.' He thinks I'm choosing to dwell on it. He doesn't understand this isn't a choice. I can't just snap out of it. His lack of understanding makes me feel more alone. I stopped trying to talk to him about how I feel because he makes me feel weak, dramatic. So, I suffer in silence.”

Perseverance explained: “Part of me blames my husband. I know the hospital wouldn't let him in, but he should have fought harder. He should have insisted, made them let him support me. Instead, he just accepted their rules and left me alone. During the worst experience of my life, he wasn't there. I know it's not entirely fair to blame him, but I can't help feeling he failed to protect me. That feeling of being abandoned by him in my moment of greatest need, it's damaged something between us.”

Kumbirai described: “My mother and aunts keep saying I'm being too sensitive, that childbirth is always difficult, that I should just be grateful I have a healthy baby. They compare their births which were apparently much harder. They make me feel like I'm complaining about nothing, being weak. Their dismissiveness hurts. I expected them to understand, to support me, but instead they make me feel ashamed of my feelings. So now I don't talk to them about it. But that means I'm dealing with everything alone.”

Theme 5: Fear of Future Pregnancies and Reproductive Decisions

Women expressed profound fear about future pregnancies, with some deciding to avoid additional children specifically due to their negative birth experiences. Participants stated they were terrified of going through similar experiences again. Some described actively avoiding pregnancy despite wanting more children. Others decided their families were complete specifically because they could not face another traumatic birth.

Theme 6: Erosion of Trust in Healthcare System

Women described fundamental loss of trust in healthcare providers and systems following their negative birth experiences. This manifested in reluctance to seek healthcare for themselves or their infants, scepticism about medical advice, and preference for self-treatment or traditional alternatives.

Strategies to Address Negative Birth Experiences

The exploration of potential strategies to address negative birth experiences and improve maternal health outcomes revealed women's recommendations spanning individual provider behaviour changes, facility-level improvements, community support development, and policy reforms. Five major themes captured women's vision for transforming maternal healthcare in Glen View.

Theme 1: Provider Training in Respectful, Woman-Centred Care

Women called for comprehensive provider training emphasizing respectful communication, empathetic care approaches, trauma-informed practice, and recognition of women's autonomy and dignity. Rutendo stated: *"Healthcare providers need to learn how to talk to patients with respect. We are human beings, not objects. They need training on how to communicate kindly, how to explain what they're doing, how to listen when we say something hurts or worries us. These are basic things but clearly many providers never learned them. Training should emphasize that words have power, that how you speak to a labouring woman affects her profoundly. They need to understand their responsibility to provide not just technical care but emotional support."*

Tariro explained: *"Providers need to put themselves in our shoes. What would they want if they were the one in labour, in pain, afraid? They need to imagine being treated the way they treat us. Would they accept being shouted at, slapped, left alone? I don't think so. They need empathy training that helps them see us as people like them, not as problems to manage or obstacles in their busy day."*

Tendai stated: *"Some women have been raped or abused. For them, rough vaginal examinations or being held down might trigger terrible memories. Providers need to understand trauma, how it affects people, how to provide care in ways that don't retraumatize. They should ask about trauma history, warn before touching, give women control where possible. This requires special training beyond basic medical education. Our healthcare system seems completely ignorant about trauma and its effects."*

Theme 2: Resource Investment and Infrastructure Improvement

Women articulated need for substantial investment in supplies, equipment, staffing, and facility infrastructure.

Shuvai argued: *"No woman should have to wait for care because supplies aren't available. No family should have to buy basic medical supplies. The government must ensure hospitals are fully stocked always. This requires money, proper supply chains, management systems. But it's not optional. It's fundamental. How can we call them healthcare facilities if they don't have supplies for healthcare? Investing in supplies would prevent so much suffering, so many deaths. It should be the highest priority."*

Nyasha explained: *"They need more midwives. One midwife trying to care for ten women in labour at once can't possibly give good care to any of us. She's running from room to room, overwhelmed, stressed. Of course, she becomes short-tempered and misses things. Of course, women end up alone or receiving rushed, impersonal care. This isn't entirely the providers' fault. It's the system's fault for not employing enough staff. If each midwife had maybe three or four women to care for, she could be present, attentive, supportive."*

Faith suggested: *"Hospitals need proper labour rooms with privacy. Currently you're exposed, everyone can see and hear everything. It's humiliating. Simple things like curtains between beds, doors that close, would make huge difference. Women need privacy during childbirth. We need spaces where we can labour without feeling watched, judged, exposed."*

Theme 3: Establishment of Support Systems and Mental Health Services

Women emphasized need for comprehensive support systems addressing psychological impacts of negative birth experiences, including counselling services and peer support groups. Rudo argued: *"Every woman should be screened for depression and trauma symptoms at postpartum visits. Many women won't ask for help because of shame or not recognizing their symptoms as problems requiring treatment. If providers routinely screen everyone, women at risk can be identified and helped before problems become severe. Screening should use proper tools, not just asking 'are you okay?' which women always answer 'Yes' to even when they're struggling."*

Tariro explained: *"I needed counselling so badly after my traumatic birth. I was having nightmares, flashbacks, terrible anxiety. But I didn't know where to go. The hospital certainly wasn't offering any mental health support."*

Private counsellors are expensive, beyond what I can afford. Traditional healers don't really address this kind of psychological trauma. So, I suffered alone, trying to manage these overwhelming feelings by myself. There should be free or affordable counselling available specifically for women who've had traumatic births.” Chipso stated: *“Talking to you today, telling my story and having someone really listen without judgment, has been healing. I think groups where women who've had traumatic births can meet regularly would be so helpful. Just knowing you're not alone, that others went through similar things and understand your feelings without you having to explain or justify them, would be powerful. We could support each other, share coping strategies, remind each other we're not crazy for still struggling.”*

Theme 4: Policy Reforms and Accountability Mechanisms

Women advocated for policy reforms establishing clear standards for respectful maternity care, accountability mechanisms for providers who engage in disrespectful practices, and enforcement of women's rights during childbirth.

Participants stated that there needed to be consequences for providers who treated women badly. They recommended supervision, monitoring systems, and accessible complaint procedures. Women wanted clear policies outlining what constituted respectful care and what behaviours were unacceptable.

Theme 5: Community Education and Awareness

Women recommended community education initiatives informing women about their rights during childbirth, what constituted respectful care, and how to advocate for themselves within healthcare settings. Participants suggested that women needed to know they had rights to information, to consent to respectful treatment. They recommended community workshops, radio programs, and materials distributed at antenatal clinics educating women about what to expect during labour and delivery and how to speak up when care fell below acceptable standards.

IV. DISCUSSION

Current State of Negative Birth Experiences

The study revealed that disrespectful and abusive care practices were pervasive across healthcare settings in Glenview, with women experiencing verbal abuse, physical roughness, and denial of basic dignities during labour and delivery. This finding aligns with research by Okafor & Nwankwo (2024) who documented similar patterns across Nigerian and Ghanaian healthcare systems, suggesting that disrespectful maternity care represents a widespread challenge across African urban contexts. The age distribution of participants in this study showed concentration in the 25–34-year bracket (61%), which agrees with the findings of Anderson et al. (2023) whose systematic review in the United States found that negative birth experiences were most reported among women in their prime reproductive years. However, the current study diverges from Rodriguez & Martinez (2022) who reported higher rates of negative experiences among first-time mothers in Spanish healthcare settings, as the present findings demonstrated that disrespectful care occurred regardless of parity status.

Communication failures and information deprivation emerged as systematic problems throughout the childbirth process in Glenview facilities. Women reported procedures being performed without explanation and decisions being made without their consultation. These findings corroborate Almorbaty et al. (2023) who identified that failed communication and lack of trust-based relationships between women and care providers represented critical factors in negative birth experiences across low and middle-income countries. Leinweber & Stramrood (2024) similarly emphasized that trust-based relationships become particularly crucial given the neurohormonal sensitivities experienced during labour, supporting the current study's finding that communication failures created profound psychological distress. The finding that non-Shona speaking women faced additional communication barriers extends the work of Diallo & Traoré (2024) who documented how colonial language legacies create hierarchical provider-patient relationships contributing to negative experiences in Francophone African countries.

Resource constraints directly compromised care quality across Glen View's healthcare facilities, with participants describing critical supply shortages, equipment failures, and severe understaffing. This finding parallels Mutambirwa & Gumbo (2024) who documented how Zimbabwe's economic structural adjustment programs undermined the strong primary healthcare foundations established in the early post-independence period. The current study's finding that families were required to purchase basic medical supplies during emergencies contrasts with the situation described by Moyo & Ndhlovu (2024) in South African and Botswanan facilities where SADC health protocols facilitated better resource availability through regional cooperation.

Mazuru & Chideme (2024) found similar resource constraints in their analysis of current Zimbabwean facilities, suggesting this represents a systemic national challenge rather than location-specific issues.

The profound loss of control and autonomy women experienced during childbirth emerged as a central theme. Healthcare providers systematically denied women choices about birth positions, pain management, and support person presence. This finding aligns with O'Connell et al. (2021) who demonstrated that exercising choice during childbirth is contingent on trust in relationships with maternity care professionals. The current study extends Combellick et al. (2023) who emphasized that the intrapartum period represents a crucial time requiring supportive relationships, by documenting specific mechanisms through which autonomy is denied in resource-constrained settings. The enforcement of institutional protocols regardless of women's preferences contradicts the principles of respectful maternity care outlined by Davis & Brown (2023) in their analysis of European Union policy implementations.

Inadequate management of complications and emergencies resulted in preventable harm and profound psychological trauma. Women described warning signs being dismissed and complications mishandled through delayed responses or incorrect procedures. This finding corroborates Chinoda & Rusike (2024) who identified emergency preparedness gaps in Zimbabwe's maternal health system. However, the current study provides unique insights into how poor complication management compounds the psychological trauma experienced by women, extending beyond the physical consequences documented in previous research. The finding that women experiencing stillbirth reported distress when their previous concerns were dismissed supports Williams & Thompson (2024) who demonstrated lasting impacts of traumatic childbirth on maternal mental health and family dynamics.

Impact of Negative Birth Experiences on Women

Physical health consequences persisted months after delivery, with women reporting prolonged recovery periods, persistent pain from poorly managed interventions, and ongoing functional limitations. This finding aligns with World Health Organization (2023) data showing that more than one-third of women experience lasting health problems after childbirth, though the current study illuminates specific mechanisms through which negative birth experiences contribute to these prolonged physical effects. The finding that episiotomy complications created chronic pain contradicts optimal healing timelines, supporting Patel & Singh (2023) who documented that inadequately managed interventions in resource-constrained environments lead to long-term morbidity. These physical consequences extended beyond individual suffering to affect women's ability to care for infants and maintain intimate relationships, corroborating Davis & Brown (2024) who identified economic and family impacts of negative birth experiences.

Psychological trauma emerged as a common outcome, with many women developing symptoms consistent with post-traumatic stress disorder, postpartum depression, and anxiety disorders. The prevalence of psychological impacts in this study aligns with Shiva et al. (2021) who established strong correlations between negative childbirth experiences and post-traumatic stress disorder. The finding that women experienced intrusive memories, flashbacks, and hypervigilance months after childbirth supports Clark & Rodriguez (2024) who emphasized the long-term nature of birth trauma impacts. However, the current study extends existing literature by documenting how these psychological impacts remain largely unrecognized within Zimbabwe's maternal healthcare system, diverging from Davies & Wilson (2024) who found that systematic screening in European healthcare systems substantially minimized long-term psychological outcomes.

Disrupted mother-infant bonding manifested through initial emotional detachment or anxious hypervigilant attachment patterns. This finding corroborates Okonkwo & Adebayo (2024) who documented similar patterns in Nigerian and Ghanaian contexts, though the current study provides deeper insights into the shame women experience when unable to immediately bond with their infants. The finding that some women described feeling resentful toward infants who became associated with traumatic experiences extends Williams & Thompson (2024) who tracked how traumatic childbirth created measurable impacts on family dynamics persisting long after the initial event. These attachment disruptions create potential intergenerational impacts beyond those documented in previous research focused primarily on maternal outcomes.

Strained family relationships emerged across multiple domains, including intimate partnerships, extended family connections, and social networks. Women described sexual difficulties due to physical pain, emotional distance stemming from partner misunderstanding, and social isolation when relatives dismissed their distress. This finding aligns with Koné & Traoré (2024) who documented how biomedical orientations in Francophone African countries overlooked relational dimensions of birth trauma. However, the current study diverges from Ntambirwa & Uwimana (2024) who found that community-based models in Rwanda and Burundi successfully integrated traditional healing with trauma treatment, as Glenview women reported limited access to either traditional or professional support systems.

Fear of future pregnancies significantly influenced women's reproductive decisions, with many expressing terrors at the prospect of repeating traumatic experiences. This finding corroborates Anderson et al.

(2023) who documented strong associations between negative experiences and subsequent reproductive decisions, though the current study provides unique insights into how these fears operate within high-fertility cultural contexts where family size preferences may conflict with trauma-based avoidance. The finding that some women decided their families were complete specifically due to birth trauma extends to Robinson & Thompson (2024) who documented multi-component impacts of negative birth experiences.

Trust in healthcare systems was eroded substantially, with women developing scepticism about medical advice and reluctance to seek care. This finding aligns with Patel & Singh (2023) who documented decreased healthcare utilization following negative experiences in resource-constrained environments. However, the current study provides deeper understanding of how this erosion of trust operates, with women describing specific mechanisms through which they lost confidence in healthcare providers and facilities. This finding contrasts with Sibanda & Moyo (2024) who found that SADC cooperation agreements facilitated knowledge transfer improving trust in South African and Botswanan systems.

Strategies to Address Negative Birth Experiences

Women articulated comprehensive visions for transforming maternal healthcare through provider training in respectful, woman-centred care. This finding aligns with Okwu & Adebayo (2024) who emphasized that successful interventions in Nigerian and Ghanaian healthcare systems required addressing provider attitudes alongside technical competencies. The current study's finding that women wanted training to emphasize how words and behaviours affect labouring women supports Duffy (2022) whose Quality-Caring Model demonstrated that caring relationships directly influence patient outcomes. However, the specific mechanisms women identified for attitude change extend beyond the frameworks proposed by Martinez & Wilson (2023) who focused primarily on communication protocols.

Resource investment and infrastructure improvement emerged as essential systemic interventions. This finding corroborates Uwimana & Nkurunziza (2024) who documented how community-based improvement strategies in Rwanda and Democratic Republic of Congo required facility-level enhancements. The current study's finding that women prioritized adequate supplies and sufficient staffing aligns with Mazuru & Chivandire (2024) who identified these as critical gaps in Zimbabwe-specific contexts. However, women's emphasis on better management systems extends Chen & Rodriguez (2024) who focused primarily on funding mechanisms.

Comprehensive support systems and mental health services addressing psychological aftermath represented a critical gap women identified. This finding aligns with Davies and Wilson (2024) who demonstrated that systematic screening accompanied by available treatment services substantially minimized long-term psychological outcomes in European healthcare systems. The current study's finding that women wanted routine postpartum screening supports Gwinji & Rukuni (2024) who projected that integrated training programs could achieve significant improvements in Zimbabwe's birth trauma response capacity. However, the emphasis women placed on peer support groups extends Chitungo & Zinyama (2024) who focused primarily on professional counselling services.

Policy reforms and accountability mechanisms emerged as necessary for systemic change. This finding corroborates Davies & Brown (2024) who demonstrated that systematic policy support enabled successful scaling of improvement strategies across multiple European healthcare systems. The current study's emphasis on enforcement mechanisms aligns with Dube & Mazuru (2024) who analysed how SADC governance protocols facilitated common standards development. However, women's specific recommendations for accessible complaint procedures extend to Phiri & Tembo (2024) who focused primarily on policy alignment initiatives.

Community education and awareness initiatives were recommended to empower women and create community-level change. This finding aligns with Chinoda and Gwinji (2024) who projected that sustained focus on community-based approaches could achieve significant improvements in Zimbabwe's birth experience improvement capacity. The current study's finding that women wanted rights education integrated into antenatal care supports Sibanda & Nyathi (2024) who documented how SADC cooperation facilitated joint development of culturally appropriate intervention programs. However, the emphasis on peer education approaches extends Diallo & Keita (2024) who focused primarily on formal training programs.

CONCLUSION

This study demonstrated that negative birth experiences among childbearing women in Glenview, Harare, arise from a complex interaction of interpersonal, institutional, and systemic factors within the maternal healthcare environment. Disrespectful and abusive care, poor communication, inadequate resources, loss of autonomy during childbirth, and suboptimal management of complications were identified as key contributors to these experiences. The consequences extend beyond immediate physical outcomes to include psychological trauma, impaired mother–infant bonding, strained family relationships, fear of future pregnancies, and diminished trust in healthcare services. Grounded in Duffy's Quality-Caring Model, the findings underscore the

centrality of caring relationships, respectful communication, and individualized care in shaping women's birth experiences. Addressing negative birth experiences therefore requires a multifaceted response that combines provider training in respectful maternity care, improved resource allocation, strengthened support and mental health services, effective policy enforcement, and community-based education. Implementing these measures has the potential to enhance maternal healthcare quality, restore women's confidence in health systems, and promote positive and dignified childbirth experiences in similar low-resource urban settings.

AUTHOR DISCLOSURE

The authors declare that there is no conflict of interest arising from this publication.

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