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Antenatal Lived Experiences of Women who Delivered Preterm Babies at a Referral Hospital in Harare, Zimbabwe

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Introduction: A lived experience is normally an undervalued and complex phenomena in nursing and midwifery despite its crucial influence on maternal and birth outcomes. During antenatal care, health care providers tend to concentrate on the pregnancy at the expense of experiences that women go through. Research studies have also bias towards the medical perspective leaving out the experiences that occur during the antenatal period.
Aim: The aim of this study was to explore the antenatal lived experiences of women who delivered preterm babies.
Study Design: A descriptive phenomenological research design was employed to understand the diverse antenatal lived experiences.
Setting and Duration: Parirenyatwa Mbuya Nehanda Maternity Hospital was the study site.
Methodology: All accessible women who delivered preterm babies between October, 2016 and March, 2017 with babies admitted in neonatal intensive care unit, Kangaroo care unit and those

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coming to preterm outpatient clinic were included in this study. Purposive sampling method was used to select the eligible participants. Audio recorded in-depth interviews using semi-structured interview guide were used to collect data. Thematic analysis was used to analyze data manually.
Results: Eleven women participated in this study. Their ages ranged from 17 to 42 years. The lowest level of education was primary (9%, n = 1) and highest being secondary (91%, n = 10). Three major themes came out, which included stressful life events, perceived mismanagement of physical problems and care and support. Support during antenatal period is crucial as it helps pregnant women to adjust and cope with life stressors and it helps them to have a smooth journey of pregnancy which leads to a healthy pregnancy outcome.
Conclusion: Pregnant women are experiencing a variety of stressful life events. A holistic individualized approach comprising comprehensive history on experiences during pregnancy should be adopted to capture and detect adverse health symptoms early.

Keywords: Antenatal; lived experiences; pre-term birth; phenomenology.

1. INTRODUCTION

Preterm birth is defined as birth of babies born alive before 37 completed weeks of gestation or before 259 days of gestation [1]. Globally, out of 135 million live births an estimated 14, 9 million babies are born too early every year representing a preterm birth rate of 9, 1% [2]. According to Centre for Disease Control (CDC), (2020), out of every 10 live births born in the United States in the year 2014, one was a preterm. More than 60% of preterm births are born in sub-Saharan Africa and South Asia where 9.1 million deaths (12.8%) are preterm. In the African region Malawi tops the list with 18.1%, followed by Comoros (16.7), Congo (16.7%), Zimbabwe (16.6%) and Mozambique with 16.4% [2].

Globally, preterm birth complications are a major cause of mortality and morbidity in children under five [1]. Almost 1 million children die each year due to complications of preterm birth World Health Organization [1]. Preterm birth is responsible for 35% of the world's 3.1 million deaths a year and the second most common cause of under -5 deaths after pneumonia, and has long-term adverse consequences for health [3]. Many studies have documented the prevalence of a broad range of neurodevelopmental impairments in preterm survivors [4]. Neurodevelopmental disabilities include cerebral palsy, mental retardation, visual and hearing impairments, language disorders, learning disabilities, attention deficit hyperactivity disorder, developmental co-ordination disorders and behavioral problems [5]. Preterm infants are more likely to have lower intelligence quotients and experience greater difficulties at school and require significantly more educational assistance than children who were born term [2]. Preterm infants have an increased risk of pre-hospitalization during the first few years of life.

There are several risks of preterm birth, which include previous preterm birth, black race, periodontal disease, and low maternal body mass index [6]. A short cervical length and a raised cervical vaginal fibronectin concentration are the strongest predictors of spontaneous preterm birth. A meta-analysis done on intimate partner violence (IPV) during pregnancy revealed that IPV during pregnancy was significantly associated with preterm, low birth weight and small for gestational age [7]. However, not all causes of preterm births are known because very few studies have been designed to include the pregnant woman's perspective of their experience during pregnancy. Novick, (2009) said that, "you can only know the world of suffering patients based on their narrative or story" [8].

A lived experience is normally an undervalued and complex phenomenon in nursing and midwifery despite its crucial influence on maternal and birth outcomes. Collins dictionary defines lived experience as direct personal participation or observation, actual knowledge or contact with a particular incident or feeling a person has gone through [9]. A lived experience involves our immediate, pre-reflective consciousness of life, a reflexive or self-given awareness which is, awareness is unaware of itself, [10]. A growing collection of data indicated the adverse effects of psychosocial factors like stress on the consequences of pregnancy [11].

In Zimbabwe, no studies have been done to explore the lived experiences of women during pregnancy. Nurses often fall into the trap of

stereotypes, which can be a problem in identifying other problems being faced by pregnant women at home. Therefore little is known concerning the antenatal lived experiences of women in Zimbabwe. There appears to be a gap on some of the factors that may result in preterm birth as most researchers have turned a blind eye on the lived experiences of women during pregnancy. There is need for all health care professionals to discover the significance of the pregnant women's experiences and its impact on the women's health and birth outcomes. The present study aimed to bridge the gap in literature and focused on experiences or events either physical, spiritual, cultural, emotional or psychosocial that women went through during pregnancy which could be the cause of preterm birth. In this study, the researcher sought to explore the antenatal lived experiences of women who delivered preterm babies at Parirenyatwa Mbuya Nehanda Maternity Hospital. Results from this study could help to add nursing knowledge on some of the factors that predispose to preterm birth.

2. MATERIALS AND METHODS

A descriptive phenomenological research design was employed to describe life experiences and give them significance. The Systems Model by Neuman, (2011) was the organizing framework used [12]. Parirenyatwa Mbuya Nehanda Maternity Hospital, a tertiary health center has a big catchment area as it admits patients referred from local urban council clinics, provincial and district hospitals. The hospital is situated in Harare, the capital city of Zimbabwe. All women who delivered live preterm babies preterm babies admitted in the NICU, Kangaroo care unit and those coming to the preterm outpatient clinic for follow up care at Parirenyatwa Mbuya Nehanda Maternity hospital between October 2016 and March, 2017 were eligible to participate in this study. All women whose preterm babies died were excluded from the study. Purposive sampling method was used. Data saturation determined the final number of participants. Non probability sampling was used.

This study involved three phases, namely the conceptual, narrative and interpretative phases. The conceptual phase consisted of the question: what were the diverse antenatal experiences of women who delivered preterm babies at a central hospital? The narrative phase involved planning the research design. The empirical research phase involved data collection, analysis and interpretation. The researcher developed an in-depth interview guide to get rich detailed information about the antenatal lived experiences. Experts in the Nursing Science Unit reviewed the research instruments, and made necessary adjustments before the pre-test. The first two interviews were used as a pretest and the findings were not used in the final report. The researcher was the main data collecting instrument. Bracketing was used to lay aside any preconceived ideas about the phenomena under study. Data collection included qualitative information that was collected during in-depth interviews.

To achieve credibility of the study, the researcher adopted a self-critical stance to the study, the participants, their role, relationships and assumptions. Reflexivity was used in this study as the researcher wrote down any feelings, preconceptions, conflicts and assumptions she had about the study. This enabled self-monitoring to prevent bias and increase objectivity. Bracketing was achieved by writing down everything that she thought about the topic and her opinions at the beginning of the study. Bracketing made it possible for the researcher to focus on the participants' experience and shape the data collection process according to it and helped the researcher to see participants as unique individuals regarding their own experience. Data was transcribed and reviewed from what the participants described as their antenatal lived experiences. The researcher suspended her preconceived ideas and was open minded as she listened to the participants antenatal lived experiences. Trustworthiness was ensured through use of credibility, dependability, confirmability and transferability. To ensure credibility, triangulation which involved women from diverse ethnic groups in the country was done. Confirmability was achieved by giving a detailed methodological description which enables the reader to determine how far data and constructs emerging from it may be accepted. Dependability was achieved by in-depth methodological description to allow the study to be repeated. In quantitative research transferability is generalizability [13]. This was achieved through provision of background data to establish the context of the study and detailed

description of phenomenon in question to allow comparisons to be made. Triangulation through sampling from a population of women from diverse ethnic groups enabled the researcher to get a better and more stable view of reality based on a wide spectrum.

The plan for data collection encompassed human rights considerations. The researcher ensured anonymity, which was achieved by tape-recording the interview conducted. The participants were assured of confidentiality. To ensure confidentiality precautions were observed: Transcriptions and notes were kept in a locked safe. The list of names were kept separate from recordings, transcription and notes so that the recording could not be matched with participant names for confidentiality purposes and no names were attached to the tapes, transcription or notes. Participants were identified by numbers. A private room was identified and permission to use the room for interviews was sought. All participants were given the interview guide prior to the interview to promote deeper reflection. Participants were interviewed privately without family or friends in attendance during the interviews.

Data was collected through in depth interviews to allow the participants to express sensitive issues freely in the absence of many participants. Data collection included one audio-recorded interview ranging from 30 to 60 minutes and was transcribed verbatim immediately afterwards. The interviews were conducted from 0800 to 1600 hours only every Monday to Friday and the participants were asked to choose best times to be interviewed where they felt most comfortable to protect their privacy. An open ended in-depth interview guide was used to promote rich descriptions of the participants' experiences. Semi-structured interviews consisted of lead questions that helped to explain the areas to be explored. They also allowed the interviewer or interviewee to diverge and follow an idea or response in order to get more detail.

Code validation was done to ensure integrity of the codes, prevent misinterpretation and bias. More than one researcher read and double checked the codes. The codes were integrated from the data to become codebook from which the themes emerged. The researcher finalized the name of each theme, wrote its description and illustrated it with a few quotations from the original text to help communicate its meaning to the reader. The researcher consulted with the dissertation advisor and peer reviewers for validation of thematic content. Phenomenological thematic analysis was done using Braun & Clarke, (2006) (Table 1) [14].

Anticipated problems included situational contaminants, response set bias, transient personal factors and administrative factor**s.** To exclude situational contaminants a well-lit and well ventilated room. The researcher also sat at the same level with the participant and used same chairs which were close to the tape recorder. A 'do not disturb" sign was put outside the interview room, to limit access during the data collection session. Personal characteristics of participants may influence their responses to questions, resulting in the phenomenon of social desirability of response, extreme of response and acquiescence. To reduce response set bias, the researcher explained the purpose of the study, assured participants of confidentiality, obtained a signed informed consent and explained the interview technique to minimize response bias. Administration variations can be a problem during data collection. In this study the researcher practiced how to use the tape recorder. The researcher also put batteries in the tape recorder as a back-up in the event of a power failure and had extra audiocassettes in case the one in use got full. The researcher operated the tape recorder, and appointed a colleague to take field notes. Since the researcher was the main data collecting instrument this could lead to distortion of the findings of the study. To cater for this the researcher practiced bracketing as well as reflexivity to overcome this problem. The researcher also went back to participants to verify and clarify their responses.

Participants were informed of the purpose of the study. A colleague was asked to take notes and operate the tape recorder. The researcher maintained open-mindedness and skills in eliciting information. Questions were asked inductively, proceeding from general to specific using a semi-structured interview guide prepared before the session. In order to collect data effectively while at the same time limiting problems, the researcher practiced the use of the tape recorder in preparation for the interview to boost her confidence.

Thematic analysis, a method of identifying, analyzing, and reporting themes was used in data analysis. Code validation was done to ensure integrity of the codes, prevent misinterpretation and bias. More than one researcher read and double checked the codes. The codes were integrated from the data to become codebook from which the themes emerged. The researcher finalized the name of each theme, wrote its description and illustrated it with a few quotations from the original text to help communicate its meaning to the reader. The researcher consulted with the dissertation advisor and peer reviewers for validation of thematic content. Phenomenological thematic analysis method was used to gain an in-depth understanding of the participants' experiences and interpretations related to their antenatal lived experiences. The phases of thematic analysis were observed as illustrated on Table 1 below. Following the initial steps in interpretive analysis method, all transcripts were read and re-read several times. This was done to reduce raw data to something more manageable and to extract narrative descriptions of the antenatal lived experiences. Notes were made and key issues were identified. The researcher did a comparison analysis between the participant's main claims and the researcher's interpretation of the meaning of the claims. Data was manually analyzed. Nine major themes were identified in the initial inductive analysis but were condensed to three major themes. Researcher did an in-depth consultation with the dissertation supervisor prior to finalization of theme analysis.

3. RESULTS

The youngest participant was 17 years old and the oldest was 42 years. Participants who delivered very preterm babies (28 weeks) were 2 and late preterm (32 weeks –less than 37 weeks) were 9. One participant was single, 1 was widowed and 9 were married. Table 2 shows the results on the demographic characteristics of the participants.

Table 1. Thematic analysis

Phase of Thematic Analysis	
Phases	**Desricption of Analysis Process**
1 Familiarizing myself with data	i) Narrative preparation, i.e. transcribing data ii) (Re)reading the data and noting down initial ideas
2 Generation initial codes	i) Coding interesting features of the data in a systematic fashion across entire data set. ii) Collating data relevant to each code
3 Searching for themes	i) Collating codes into potential themes ii) Gathering all data relevant to each potential theme.
4 Reviewing themes	i) Checking if themes work in relation to the coded extracts. ii) Checking if themes work in relation to the entire data set. iii) Reviewing data to search for additional themes. iv) Generating a thematic "map" of the analysis.
5 Defining and naming themes	i) On-going analysis to refine the specifics of each theme and the overall story the analysis tells. ii) Generating clear definition and names for each theme
6 Producing the report	i) Selection of vivid, compelling extract examples ii) Final analysis of selecting extracts iii) Relating the analysis back to the research question, objectives and previous literature reviewed.

Adapted from Braun and Clarke, 2006

Table 2. Demographic characteristics for participants

Age range in years	Frequency
17 – 24	5
25 – 32	4
33 – 40	1
Above 40	1
Total	**11**
Gestational Age at Birth In Weeks	
28	2
32	2
35	4
36	3
Total	**11**
Parity	
Para 1	4
Para 2	3
Para 3	3
Para 6	1
Total	**11**
Marital Status	
Single	1
Married	9
Widowed	1
Total	**11**
Level of Education	
Primary	1
Secondary	10
Total	**11**

Three major themes were identified, including; stressful life events, care and support, and perceived mismanagement of physical problems. Table 3 presents all three major themes with their respective sub-themes. Stressful life events had 4 sub-themes, perceived mismanagement of physical problems by patients was made up of 2 sub – themes, whilst care and support had 3 sub-themes.

3.1 Stressful Life Events

All the 11 (100%) participants described with passion their lived experiences during pregnancy. Four sub-themes that were related to stressful life events emerged as illustrated on Fig. 1.

Table 3. Major themes and sub-themes

Major theme	Sub-theme (category)	Frequency
1. Stressful life events	Working too hard to sustain self Continuous	6
	backache due to overwork HIV positivity and	6
	stress	4
	Physical violence in pregnancy	3
2. Perceived mismanagement (	Problems with passing urine.	4
	No examination by nurses it was considered	4
	to be normal	
3. Care and support	Adequate psychosocial support	3
	Limited psychosocial support	6
	Inadequate professional support	8

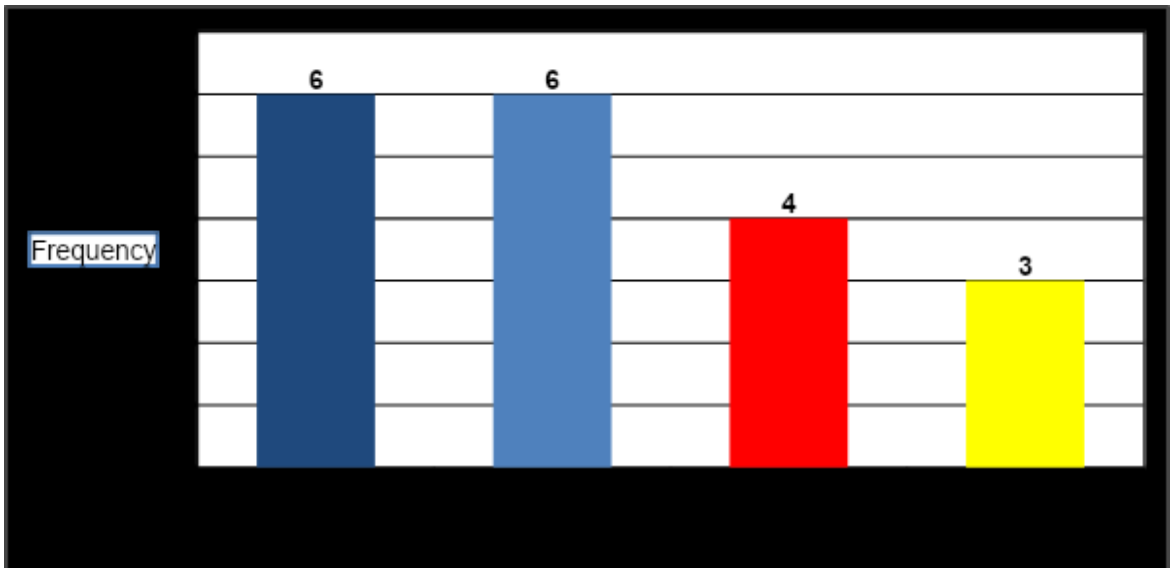

Fig. 1. Stressful life events

3.2 Working Too Hard to Sustain Self and Continuous Backache

Descriptions of working too hard to sustain self were experienced by 6 women (Fig. 1). The nature of the work they did later caused them to have continuous backache due to overwork. Participant 1 narrated of how her mother in-law made her to do all the household chores from morning till evening: *"…I would wake up early in the morning at 04:00am clean the house, fetch water, cook for everyone and clean the dishes…no-one helped me I worked alone…I was the first person to wake up and the last person to sleep…by the time I went to sleep I would be very tired …I started to have my back aching everyday".* Participant 3 conceived during the planting season and she narrated how she worked in her fields: *"I would go to the fields early morning weeding till evening".* Participant 8 narrated how she had to fend for her children and self because her husband was a drunkard and did not help much. She was working at a farm: *"…picking potatoes…lifting 25kgs bags of potatoes, but they are similar to 50kgs we use for maize". I continued to work at home as I had 5 young children to look after. "…I had to work again at home, to cook, wash clothes for my children, and backache and swollen legs became part of me because of continuous working. I worked every day Monday to Sunday, on Sunday we finished at 1pm".* Participant 7 gave an account of poverty and suffering which made her to work for other people as they had no cattle to use for ploughing. She survived by working in the fields of different people as well as doing household chores for a teacher at a nearby school. *"I worked in the fields of other people together with my husband… I survived by doing piece jobs. I removed weeds from their fields…and sometimes I would do laundry for a nearby school teacher fetch water from a well which was a bit far and fetch firewood".* Participant 10 was the only participant who was formerly employed at a clothing factory. However her job involved standing for a long time. She was employed as a material cutter which was the first step of making clothes; her job involved cutting patterns of garments only. That meant she had to be standing all day. Her duties could not be changed *"...it was impossible to change positions because cutting is the job I was hired for…besides nowadays industry is tough there are no jobs. I was standing the whole day, only rested during tea and lunch break and started work at 6am and finished at 6pm".* As a known hypertensive patient who was pregnant, this became heavy for her and she started having backache and swollen feet because of standing for long periods of time. Participant 11 worked as a house maid 3 times a week in different houses. She started working after losing her husband: *"… I clean houses, do laundry and ironing at 3 times a week at different households…the work is too much because I work the whole week in one day…that is why I ended up having backache. I have no choice I must work for my other 2 children".*

3.3 HIV Positive Status and Stress

Participants' accounts of a wide variety of stressful life events had far-reaching effects on their lives. Four of the participants narrated how testing HIV positive completely changed their once happy lives to a stressful life. Participant 11 had the worst scenario of them all. After being tested on her ANC booking she was shocked with a positive HIV result as trusted her husband and never dreamt of him cheating on her: *"…I tested positive sister, I was deeply hurt. It affected me so much…I never thought I would get such a result. I never thought my husband was unfaithful because we were so much in love. I cried I was worried about the outcome of my baby".* For participant 11 her situation became worse when she told her husband who of course agreed to be tested and failed to accept the HIV positive result and started drinking and smoking and eventually committed suicide: *"…sister I cried, I was worried so much because I thought we were going to support each other but there I was alone with two little children and pregnant and not working…life was tough".* However, after a long time worrying and crying with no one helping her, she asked her friends to help her find a job so that she could fend for her children. She started working as a maid 3 times a week which later triggered backache problems as described in sub-theme working too hard to sustain self. Participant 9's journey of stressful life after testing positive during routine screening at ANC led to neglect by husband, name calling and emotional stress. Her husband refused to be tested and told her he was not positive: *"He was saying your AIDS and chased me from the bedroom…he said I'm going to look for women who do not have aids…I cried every day because I knew he was the one who had infected me …I had noticed some sores on his male organ".* After participant 2 tested positive during routine screening at ANC she completely failed to accept it. She was worried and was always crying this was worsened by her husband who refused to get tested but never wanted to use condoms during sex: *"…I worried I could not deny him sex…I was worried of my baby".*

As if that was not enough her grandmother died: *"…sister I started thinking a lot…it really troubled me because we no longer have an elderly person to look after us my mother died last year…and I am positive…I cried a lot people thought I was crying for grandmother but I was crying for my positive status".* Participant 5 is a street girl who has been staying in the streets her entire life. She started losing weight and her friend told her she might be positive and she started worrying even before getting tested: *"…I was afraid to go to hospital…mmm my friend said maybe I have HIV so I just wanted to deliver in the streets". After asking her why she was afraid she said"… I knew the road I had travelled besides one of our friends died, she was positive.*

3.4 Physical Violence in Pregnancy

To some participants testing HIV positive led to physical violence as their partners failed to accept reality and resorted to wife bartering as a way of trying to come to terms with reality. Participant 9 narrated her ordeals that followed after testing HIV positive during ANC booking: *"…my husband did not accept it…that is when all the trouble started…we were always fighting. He started drinking and he was beating me almost every day, all these scars it's him".* She narrated that it got so bad that at one point her eldest son shouted at his father: *"…my son got so cross and shouted at him say what's wrong with you…you are always beating our mother here".* When the researcher asked why she did not report him to the police she had this to say: *"…mmm sister it was not easy…he became an animal there was no peace at home…he said if you tell anyone I will kill you…for me to get into labour I was beaten the whole night. My body was always in pain because I was always beaten".* Participant 5 had to suffer physical violence in the streets where she lived from the men she slept with because she refused to terminate the pregnancy: *"…two of the men always beat me up because I didn't abort the pregnancy".* The scenario was different with participant 3 who came from a big family. The family included the grandmother (mother to her mother in-law), the mother in law and siblings of her husband. She narrated how the grandmother and mother in-law used to beat her when her husband was not at home: *"…they would team up and beat me whenever my husband was not at home saying prostitute…I could not report to my husband because I did to want to cause discord in the family…they beat me because they wanted me to join them in witchcraft and I refused".*

3.5 Perceived Mismanagement of Physical Problems

The second most frequent theme of the four major themes was significant for 8 participants

with participants appearing in the two sub-themes/categories of this major theme. Participants were posed questions that asked them to give a detailed account of the professional help they received during their antenatal care visits from nurses and midwives (see Appendix C). Four participants shared the same experience of pain during passing urine which was never attended to as it was considered to be a normal symptom during pregnancy (Fig. 2).

3.6 Problems with Passing Urine

Four participants experienced problem with passing urine. Participant 4 narrated that: *"…approximately 3 months I started to have a burning sensation when I was urinating…I became afraid to pass urine…sometimes I would feel cold sometimes hot and sweat…my vagina discharge increased".* The same experience was narrated by participant 6 who said: *"…I thought I had malaria because I felt hot and cold but what worried me was my urine which was burning and itching".* The symptoms persisted until she delivered. Participant also experienced the problems with passing urine such that she ended up being afraid of passing urine because of the burning sensation and itchiness that she felt. However participant 5 developed sores apart from the burning sensation that she felt during passing urine: *"…my urine had a burning sensation and sometimes I had sores on my private parts…sores would disappear and reappear but urine never changed I continued to have a burning sensation until I delivered".*

3.7 No Examination as it was Considered Normal during Pregnancy

All the four participants explained how they endured the pain throughout pregnancy and delayed management and diagnosis which they perceived contributed to them delivering before their time. When they were asked if they told the nurses of their problem of urine having a burning sensation during their antenatal visits they all said they did but received no treatment. Participant 4 had this to say: *"…I was told that it will disappear when I give birth…I was not examined to see if I had sores or to check the type of discharge I was having…I ended up not putting on an underwear because I thought it was the one causing the itchiness and burning sensation…The nurses said it was normal with first pregnancy".* Participant 6 narrated how she ended up accusing her husband of giving her an sexually transmitted infection (STI) when nurses told her it was normal in pregnancy to have a burning sensation when passing urine: *"…I confronted my husband and told him you have given me STI because at the clinic they are saying its normal but I don't believe it…this resulted in me getting a thorough beating from my husband".* She had to seek for help from an aunt, which did not help: *"…I told my aunt and she gave me traditional medicine, some I drank and some I put in my private parts but it did not help".* The same scenario was experienced by participant 1 who reported to the clinic several times explaining to nurses her symptoms of the burning sensation when passing urine and signs of hot and cold she felt. According to her, the nurses only tested for malaria, which was negative but never tested her urine. All the participants shared a common description of enduring burning sensation of urine throughout pregnancy, delayed misdiagnosis and lack of treatment that resulted in prolonged pain and perceived complications of delivering pre-term babies.

3.8 Care and Support

Care and support are mainly linked and focused on family issues because in pregnancy family members play a vital role for emotional support, financial support and encouragement. Three sub-themes emerged from this major theme: adequate family psychosocial support, limited psychosocial support and inadequate professional support and care.

3.9 Adequate Family Psychosocial Support

Only three participants reported having effective family support. Participant 10 alluded to receiving effective support from her husband and children: *"I was well supported by my husband and children, family and children, I didn't have problems at home".* Participant 2 said despite testing positive her husband continued to love her and to provide for her even though he refused to get tested: *"…he is supporting me, he reminds me to take my medication and provides with everything".* Participant 7 narrated of the care and support that she received from a teacher whom she worked for and also praised the love from her husband despite him being poor. *"… the teacher saw that my pregnancy had progressed and she gave me money to book for ANC…I*

was really helped by the teacher…she took me to Parirenyatwa from Guruve with her own car and processed all my papers since it was my first time to come to a big hospital in Harare". "My husband also did his best to work in the fields so that we could get something to eat'.

3.10 Limited Psychosocial Support

Testing HIV positive for participant 9 resulted in neglect by husband*"…he was saying your AIDS, and he chased me from my bedroom and was always beating me"*. However, her children were her pillar of strength and supported her: *"My son from university comforted me and always counselled me".* Participant 11 had the worst case scenario after testing positive. She narrated how her husband failed to accept it and started drinking and smoking cigarettes and later killed himself leaving her with no one to support her financially such that she had to work as a maid. Her mother in-law despite being there for her could only give her emotional support as she also relied on her for support: *"I could not ask for help from my relatives because with our economy everyone is struggling so I had to be strong and work for my children'. P*articipant 5 had her street friends as a pillar of support. Her fellow street friends are the ones who took her to the hospital when she got into labour: She went on to give detail on how she struggled to get food because of lack of money. She was living in the streets begging doing sex work in order to get food: *"…I would sleep with men even with those sores in-order to get money for food. We beg from people but sometimes you spend the whole day without being given a bun or sweet…sometimes I would go to the hotel to get food from the bins".* Participant 8 had no one to offer her support as her husband was a drunkard and cared less. Her fellow sisters in marriage scolded her for bearing many children and could not help her: *"…they scolded me saying why you continue to bear children, and how can you have six children in this era?"* Participant 1 narrated her experiences of lack of food while pregnant: *"I would roast groundnuts and eat or eat wild fruits in Guruve, where I come from as there are lots of them including ziziphu. Sometimes I would eat sadza and pumpkin seeds".*

3.11 Inadequate Professional Support and Care

Participants were asked to give an account of care and support that professional care givers rendered that was helpful or not helpful and the care they desired to be given during antenatal care visits. The aim of the researcher was to foster an awareness of stressful life events experienced by participants and their families to enhance effective professional interventions during antenatal period for those with problems. Only 3 participants appreciated the care and support they received from nurse counsellors when they tested positive but however indicated that midwives who attended to them during ANC had nothing to do with them as individuals as they only concentrated on the pregnancy they were carrying. Participant 11 had this to say: *"I only received support during counseling when I got tested…after that nurses did not have time for us".* The same sentiments were echoed by participant 2 and 9. When asked what they thought should be done, participants wished for continued provider support and peer support options for the mothers who test positive during ANC. Participant 9 said: *"I want nurses to take us aside women who are positive after our routine checkup and talk to us to find out if we have any problems and also give us lessons on how we can live". Participant 11 had this to say "…nurses don't have time for us, may be they are busy. So I think there should be nurses set aside for HIV positive mothers during check up to talk to us and continuously give us lessons on how we should live and what we should eat".* Eight participants reported not receiving supportive care from professional care givers. However, they expressed a desire for nurses to improve the care for future clients. Participant 6 interpreted the burning sensation of urine as a sexually transmitted infection and went on to accuse her husband which resulted in her being thoroughly beaten: *"… when this persisted and nurses told me that its normal in pregnancy, I didn't understand it and I thought I had sexually transmitted infection…I confronted my husband and told him you have given me sick…and he gave me a thorough beating for accusing him".* The Fig. 3 illustrates the results on care and support received by participants.

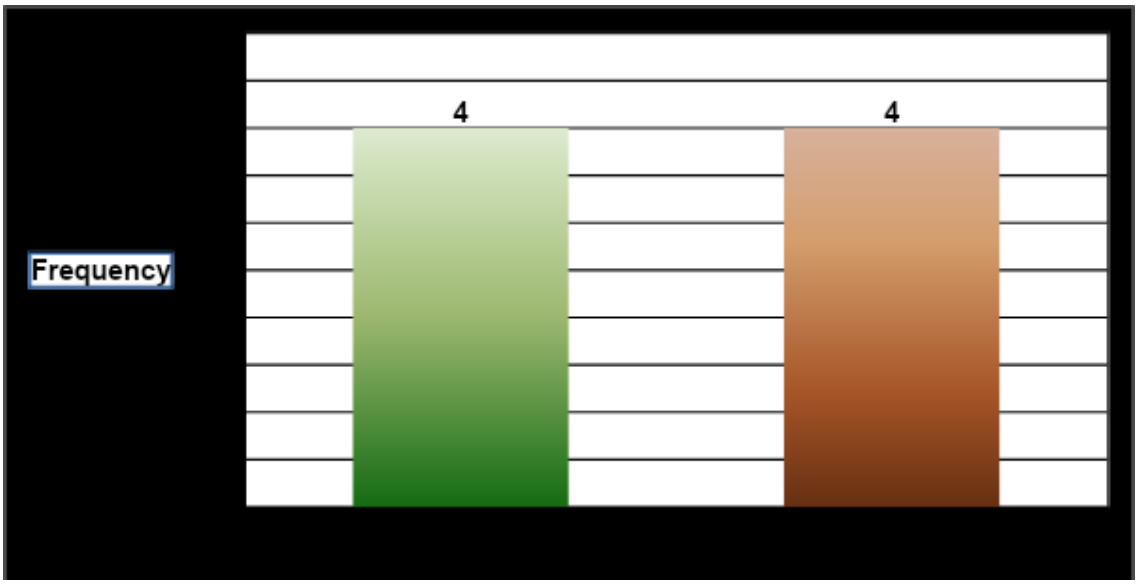

Fig. 2. Perceived mismanagement of physical problems by participants

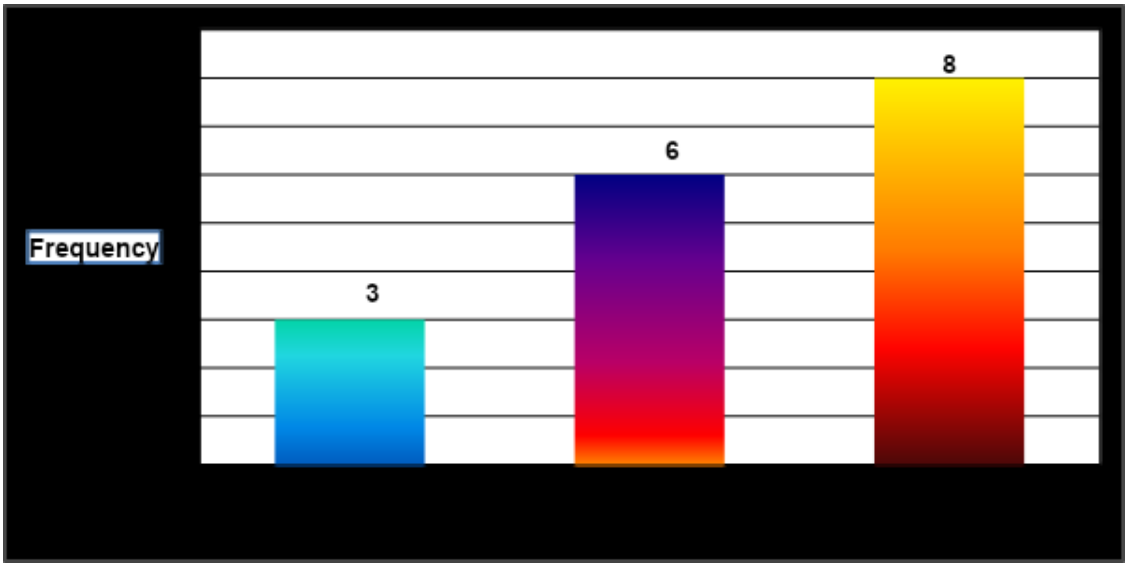

Fig. 3. Care and support received during pregnancy

4. DISCUSSION

4.1 Theoretical Contexts for Lived Experience

A lived experience leaves a mark or a print on many facets of peoples' lives. A mark or a print leaves a permanent effect that stays and is noticeable for a long time. Lived experience is to the soul what breath is to the body, lived experience is the breathing of meaning [15]. Thus a lived experience has a certain essence, a unique "quality" that we recognize in retrospect [15].

Life impacting events posed various emotional, physical and psychological changes in the lives of the participants. The impact of psychological and emotional hazards was great as it caused discord in the families. Besides being psychologically and emotionally unstable because of the new health status of being HIV positive, women suffered more pain because of physical and verbal insults from their spouses. Testing HIV positive became a factor that precipitated some to untimely widowhood as their husband could not cope with the new status hence leaving women emotionally, psychologically and economically

disempowered and vulnerable. Working too hard to sustain self and family became the order of the day. For some it meant spending long hours standing, and for others, the type of work involved bending for long periods and lifting heavy loads. The imprint of stressful life events rippled through spouses destabilizing and causing discord in the once happy union. The stories of stressful life events shared by the participants offered common threads about the theme of stressful life events and its effect on all facets of their lives.

The findings uncovered by this phenomenological study affirm the impact of stress on pregnancy. Evidence from published findings suggests that stress can interfere with the ability of a pregnant woman to obtain adequate nutrition, rest, exercise, and medical care, which may also lead to adverse pregnancy outcomes [16]. From a study done at a hospital in Ethiopia, it was found that 40.8% (N = 984) of pregnant women experienced intimate partner violence, and were three times more likely to have preterm birth [17]. The same sentiments were echoed in a separate research, which revealed that domestic violence has effects on neonatal outcomes including preterm birth [18]. Pregnant women often find themselves working too hard to sustain themselves and their families. No-matter how noble the idea is, studies have shown that too much strenuous activities can be toxic to the pregnancy. According to Muglia and Katz (2010) stress, excessive physical work and long periods of standing during pregnancy contribute to spontaneous preterm birth [19]. It was therefore recommend that women who work more than four hours a day on their feet, should switch to a desk job or quit by the 24th week of gestation, those who stand for 30 minutes out of each hour should change jobs or quit by the 32nd week of gestation. Job reassignment is recommended by the 20th week of gestation because heavy lifting is a concern during pregnancy and should be avoided at all costs in order to lower risks of complications of birth outcomes like pre-term birth [20]. The theme stressful life events unveiled diversity of stressors experienced by women during antenatal period, which later impacted negatively to their health and birth outcomes.

4.2 Perceived Mismanagement of Physical Problems by Participants

Participants expressed the undesirable treatment they received and perceived to be mismanagement. They verbalized how failure to get help and treatment worsened their physical problems as summarized in the following essence of perceived mismanagement of physical problems.

The experience of having burning sensation when passing urine prompted women to seek professional help even before booking for antenatal care. They narrated how they noticed change only after becoming pregnant. To some the burning sensation was accompanied by itchiness and increased vaginal discharge and it worsened each day. The striking feature which baffled them was to be told that it was normal during pregnancy and would wear off after delivery. As non-medical personnel they expected to be examined and have some urine which was causing discomfort to be tested which was not done. They explained the horror of having to live with the pain when passing urine and the fear they later had of passing urine because of pain. No-matter the number of times they visited the clinic for antenatal care the treatment and explanation was the same that it was normal with pregnancy. Others ended up diagnosing themselves as having a sexually transmitted infection and had to accuse their spouses. The continuous discomfort led to use of traditional medicine which was being inserted into the vagina exposing them to harmful practices. Individualized holistic nursing care will enable professional health care providers to identify various stressors that affect women during pregnancy and improve maternal and birth outcomes.

The descriptions given by participants brought to light the importance of looking at a patient as an open system as explained in Neumann's system theory (2011). Neuman regards a person as an open system who can have different stressors that will affect line of defense if not addressed. Nursing deals with variables affecting the person and assists the person to attain a level of wellness. In the study a holistic nature lacked leaving participants to endure a nasty pregnancy experience. Failure to conduct a physical health assessment perpetuated the intensity of symptoms and delayed diagnosis and treatment which resulted in pre-term delivery. UTI has been reported among 20% of the pregnant women and it is the most common cause of admission in obstetric wards [21]. As cited in Fasalu, 2015, Rahimkhani et al. (2006) the risk of UTI may

begin in the 6th week of gestation and will be at pick during 22-24th week of gestation [22]. Signs and symptoms of UTI during pregnancy include dysuria, urethral discharge, burning or painful voiding of small volumes of urine and low grade fever may develop [22]. The women reported an experience of burning sensation and pain when passing urine as well as increase in vaginal discharge even before registering for antenatal care. These signs are consistent with the signs of UTI. Untreated UTI may lead to several serious complications like pre-term deliveries, intrauterine growth retardation and pre-eclampsia [23]. Untreated UTI during pregnancy can cause severe maternal and paternal complications. Thirty percent of patients with untreated asymptomatic bacteriuria may develop symptomatic cystitis [24]. The presence of UTI is associated with premature labour, hypertensive disorders of pregnancy as pregnancy induced hypertension and pre-eclampsia, anaemia and amnionitis [22].

4.3 Care and Support

Participants expressed their perceptions of adequate and limited psychosocial support from family and professional caregivers. A journey of stressful life events required care and support from family, friends and professional care providers. Those who received support found the stress a bit bearable. However, lack of support was a striking feature as spouses who needed to offer support turned out to be violent in some cases and in other cases they could not cope and committed suicide leaving their partners with no supporting structures. Limited support forced some to indulge in unsafe sex practices in order to get food. In other cases children became a pillar of support for their mother during the stressful life events. Participants highlighted the level of ineffective and non-supportive care from health care providers. They yearned for professional caring and therapeutic support during antenatal care which was sadly found to be lacking leaving women vulnerable. Family support in pregnancy is essential as the family offers immediate emotional and morale support.

The findings provide crucial information on the quality of care desired by women during the antenatal period and echo findings from other researchers that suggest that convenience of care and support is a key consideration in prenatal care [25]. Participants bemoaned lack of continuity of care and support. For those who tested HIV positive, they really appreciated the care .and support they received from nurse counselors but sadly no follow up sessions continued during their antenatal care visits. This was also reiterated in a qualitative study, where women highlighted the importance of continuity of care and desired clinicians to know them from one visit to the next and remember their stories [26]. Lori, Yi & Martin (2011) state that being sensitive to women's life contexts or circumstances is an essential element of enhancing women centered approach during prenatal care as women come with different pregnancy experiences and emphasize that every pregnancy is unique and should be managed differently. Hence it is important to consider each woman's unique state and needs for early detection and intervention of risk factors associated with adverse life circumstances and socioeconomic conditions [26].

In this study participants reported a persistent neglect of their emotional needs by caregivers. Participants needed time to express their experiences to their care givers and have guidance on how to sail through. They required open access to their health care providers and the ability to connect with them. They desired person-centered care. In her theory of caring, Watson, (2016) explains how the care given by nurses progresses into better plans to promote health and wellness, prevent illness and restore health. Watson argues that caring promotes health better than a simple cure [27]. Failure to get necessary care and support resulted in perpetual suffering of women as they could not get anyone to tell their problems. Support during antenatal period is crucial as it helps them to adjust and cope with life stressors and it helps them to have a smooth journey of pregnancy which leads to a healthy pregnancy outcome. In this study, women had to endure an antenatal period without effective care and support which is important in helping women to adopt healthy behaviors in order to have a healthy birth outcome.

A qualitative study done to explore women's perspectives of their experience of pregnancy revealed that inadequate family support during pregnancy and lack of experience of pregnancy itself resulted in self-care deficit during pregnancy which had an impact on the birth outcome [28]. The same study also suggested that lack of guidance and access to multiple sources of support during pregnancy contributed significantly to the birth outcome. Healthcare systems can provide a safe

environment where pregnant women can feel safe to disclose their experiences during pregnancy. However, in order to do this there is need for midwives to receive specialist education to be able to ask questions in a sensitive manner and respond appropriately to a disclosure from a woman. Physical blows and kicks to the gravid abdomen can result in antepartum hemorrhage and placenta abruption which can lead to pre-term birth. The Zimbabwe Demographic Health Survey, (2010/11), reported, 30% of pregnant women aged 15 – 49 have experienced domestic violence but sadly has not been reported because women are not economically empowered and fear divorce and hence choose to suffer silently [29]. In a qualitative study done, to understand the experiences of rural pregnant women and their birth outcomes, the stories told by women revealed that all women were subjected to intimate partner violence which resulted in them having antepartum hemorrhage and preterm birth [30]. Ten women who participated in the study were rural women with low income. In depth semi-structured interviews were used to collect data. A critical analysis of the study highlighted that all women could not share events they experienced with health professionals. Women narrated that institutions that are designed to help them did not prove to be efficacious in facilitating complete help as health workers focused on the pregnancy only.

5. CONCLUSION

Life impacting events posed various emotional, physical and psychological changes in the lives of the participants. The impact of these changes was significant, as it caused discord in the families. Besides being psychologically and emotionally unstable because of the new health status of being HIV positive, women suffered more pain because of physical and verbal insults from their spouses. Support during antenatal period is crucial as it helps the pregnant women to adjust and cope with life stressors and it helps them to have a smooth journey of pregnancy which leads to a healthy pregnancy outcome. A holistic individualized approach comprising of comprehensive history taking and physical health assessment should be adopted to capture and detect adverse health symptoms early. Health care providers should desist from focusing on the pregnancy only and consider a patient as an open system who can also have psychosocial problems.

CONSENT

All authors declare that 'written informed consent was obtained from the participants for their participation and publication of this research.

ETHICAL APPROVAL

The conduction of this study was approved by Parirenyatwa Group of Hospitals, Joint Research Ethics Committee for University of Zimbabwe College of Health Sciences and the Parirenyatwa Group of Hospitals (JREC) and the Medical Research Council of Zimbabwe (MRCZ).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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