The role of professional nurses in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town

A thesis for a Masters of Nursing Science

by

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DECLARATION

I, Zama Mfundisi, declare that “The role of professional nurses in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town” is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Signed by: _________________________

Zama Mfundisi

This _____________ day of _________________ 2019

01                                    October
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ABSTRACT

In the fight against the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), one of the aspects to be taken into consideration is the self-esteem of pregnant women. Professional nurses in maternity settings need to support pregnant women, with a focus on providing balanced care to meet all of the women’s needs and build their self-esteem. Self-esteem reflects one’s subjective emotional evaluation of one’s worth. A decrease in the self-esteem of the individual with HIV/AIDS infections is common and professional nurses should advise patients on the appropriate ways to deal with HIV/AIDS. A supportive environment for HIV/AIDS women could enhance their self-esteem. The researcher overheard HIV/AIDS positive patients in a maternity unit express their feelings of worthlessness and wondered how he could support them to have self-worth. The purpose of the study was to explore and describe the role of professional nurses in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town. The study was qualitative in nature, departing from assumptions of the theoretical framework of Eric Erikson.

An exploratory, descriptive, contextual, qualitative design was followed when the semi-structured interviews were conducted. The accessible population comprised of 15 professional nurses working at the maternity unit. Purposive sampling was used to obtain a sample of 11 professional nurses (participants) working in a maternity unit who met the eligibility criteria. Individual interviews were conducted with eight participants as a starting point until data saturation was reached. After obtaining permission from the necessary authorities, the researcher visited the manager of the unit. Two pilot individual interviews were conducted to determine whether the research questions were understood. The researcher explained the purpose and information on the information sheet and obtained informed consent. Interviews lasted 45 minutes were conducted in a private room and recorded. The researcher used an interview schedule and made field notes while conducting the interviews. Data triangulation of the interviews and field notes were done. Thematic analysis coding was applied to analyse data. Trustworthiness was ensured through credibility, transferability, dependability and conformability. The following ethical principles of privacy, the right to withdraw and anonymity were followed. The findings indicated HIV/AIDS-related stigma as the main cause of a poor self-esteem among pregnant women with HIV/AIDS. Participants furthermore felt that there is a
need for training and skills development of professional nurses to enable them to understand how to support HIV/AIDS pregnant women and enhance their self-esteem. It was concluded that professional nurses should support pregnant women with HIV/AIDS places a socio-economic burden on societies and has set the world into spending millions on healthcare settings in an attempt to curb the disease.

KEY TERMS: HIV/AIDS, maternity, professional nurse, midwife, self-esteem, health, promotion, professional nurses’ views, semi-structured interviews, maternity unit, role
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**LIST OF ABBREVIATIONS**

AIDS: acquired immune deficiency syndrome
ART: antiretroviral therapy
ARVs: antiretroviral
CPUT: Cape Peninsula University of Technology
UCT: University of Cape Town
HIV: human immunodeficiency virus
HWs: healthcare workers
MTCT: mother-to-child-transmission of HIV
NGO: non-governmental organizations
OHNP: occupational health nurse practitioner
PMTCT: prevention of mother-to-child-transmission of HIV/AIDS
SA: South Africa
STI: sexually transmitted infection
UNAIDS: United Nations Programme on HIV/AIDS
WHO: World Health Organization
BFHI: baby friendly hospital initiative
BBI: building bridges initiatives
ESMOE: essential steps in the management of obstetric emergences
LABU: Liesbeek Active Birth Unit
MOU: maternity obstetric unit
CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION

HIV/AIDS remains a key challenge that requires the combined efforts of healthcare professionals (including midwives) for the worldwide fight against the epidemic. The approaches planned and implemented to curb the scourge of this disease across the globe, include reversing and halting the spread of HIV/AIDS, ensuring access to healthcare and equipping the healthcare system to cope with the burden of HIV/AIDS (Modeste & Adejumo, 2015:1). Professional nurses in maternity settings are recognised as responsible and accountable professionals who work in partnership with women, especially the high-risk patients such as those with HIV/AIDS, to give the necessary support, care and advice (SANC, 2005). To combat HIV/AIDS, one of the aspects also to be taken into consideration is the self-esteem of pregnant women (Williams, 2018:1). Self-esteem reflects a person’s overall subjective emotional evaluation of his or her own worth; it is a judgement of oneself as well as an attitude towards the self (Ponton, 2016:1). A decreased self-esteem in the individual with HIV/AIDS infections is common (Jan, Soomro & Ahmad, 2017:1).

The South African government has strategically devised plans to assist professional nurses in the management of HIV/AIDS. This is important in order for these professionals to demonstrate commitment and their preparedness to tackle the issues of HIV/AIDS and particularly, to change their attitudes when dealing with HIV-Positive pregnant women (Modeste & Adejumo, 2015:1). Professional nurses in maternity settings need to support pregnant women by focusing on providing balanced care to meet all of the women’s needs and build their self-esteem (Burton, 2017:1).

HIV is a virus that destroys the immune system, while AIDS is a condition that is caused by HIV (Timothy & Leqq, 2016). AIDS is considered the final stage of HIV, with symptoms presenting differently for each person because the symptoms of each condition come from opportunistic infections (Timothy & Leqq, 2016). According to Telfer (2018:1), HIV is present in blood, genital fluids (semen, vaginal fluids and moisture in the rectum) and breast milk. This can lead to a combination of possible serious infections and cancers, which can develop when someone’s immune system has been damaged by HIV/AIDS, often exists (Prerna, 2015).
HIV/AIDS is mostly a sexually transmitted infection (STI) which has become one of the greatest health problems facing the world today, especially among pregnant women (Pulerwitz, Mathur & Woznica, 2018:1). The virus has spread rapidly throughout the world over the last 30 years and it is particularly important to combat it because it is incurable and devastating and exacerbates other health conditions.

Furthermore, the growth rates of the HIV/AIDS infections and AIDS epidemic among pregnant women in South Africa could have a devastating impact on this country’s society (Kharsany, Frohlich, Yende-Zuma, Mahlase, Samsunder, Dellar, Zuma-Mkhonza, Karim & Karim, 2016:289). Pregnant women who are infected with the HIV virus are fearful of revealing their HIV/AIDS status to healthcare professionals. This is because they are scared that if their partners, family members, friends, community members, employers and healthcare providers, find out, that they will be discriminated against and will lose everyone’s trust (Arora & Wilkinson, 2015:142). Being rejected could be associated with a low self-esteem. It has been found that individuals with a high self-esteem believe that they are adequate, strong and worthy of a good life, while those with low self-esteem feel inadequate and worthless (Ponton, 2016:1).

The nursing profession expects professional nurses to practice their profession in an ethical manner at all times (SANC, 2005), inter alia respecting the privacy and confidentiality of patients’ information. One of the basics in the caring practice of nursing includes having an open-minded approach towards persons living with HIV/AIDS. The public should view professional nurses as supportive and respectful of their patient’s personhood and needs. This includes no discrimination against any patient (SANC, 2005). Enhancing a positive self-esteem of others is extremely important and can go a long way in helping others and re-enforcing positive attitudes towards successes and wellbeing (Lawrence, 2014:1). Lawrence further states that positive behaviour towards HIV/AIDS pregnant women could uplift and boost their self-esteem, as they are accepted for who they are. An exploratory, descriptive, contextual design was followed to investigate the role of nurses in promoting the self-esteem of pregnant women with HIV/AIDS.
1.2 BACKGROUND TO THE STUDY

1.2.1 HIV/AIDS

HIV/AIDS places a socio-economic burden on societies and has set the world into spending millions in healthcare settings in an attempt to curb this lifestyle disease (Poudel, Newlands & Simkhada, 2017:1). The statistics on the incidence of HIV/AIDS in pregnant women globally, are devastating. According to the United Nation Agency for AIDS (UNAIDS) over 40 million people were living with HIV/AIDS in 2001 and that nearly 25 million people have died of AIDS since the disease was first discovered in the early 1980’s. Together with these statistics, more than 15.6 million children under 15 have lost either their mother, father or both parents as a direct result of AIDS (UNAIDS, 2018). According to Platt, Easterbrook, Gower, Mcdonald, Sabin, Mcegowan, Yanny, Razavi and Vickerman (2016:797), Africa has been experiencing more deaths than any other nation. Twenty-eight million people in Africa are living with AIDS. Southern Africa has the highest HIV/AIDS prevalence in the world, while over two-thirds of the HIV/AIDS-related deaths are from Africa.

In South Africa, HIV/AIDS has become a disease that affects all ethnic groups, social classes and ages. It is perceived to be more prevalent in South Africa than anywhere else in the world – about 12% of the South African female population is affected by HIV/AIDS (Morgenstern, 2017:1). According to the National Strategic Plan for HIV/AIDS and AIDS (2012–2016), black female South Africans aged 25–29 have consistently higher HIV/AIDS prevalence rates for STIs and tuberculosis (TB) as compared to other ethnic groups. Young people are at high risk of unwanted and unplanned pregnancies. This also makes these youth vulnerable to STIs. Hence, the incidence of HIV/AIDS is high among adolescents and almost half of all new HIV/AIDS infections occur in young people, particularly women (Maputo Plan of Action, 2016–2030). The HIV/AIDS pandemic disproportionately affects women, who already carry a very heavy burden in many African countries (Sia, Onadja, Hajizadeh, Heymann, Brewer & Nandi, 2016:1136).

1.2.2 AIDS, healthcare and the process of self-esteem

According to the National Health Act, Article 7(1) of 2003, as amended, a healthcare facility must ensure that patients are informed of their health status and treatment plans in a respectful manner to promote the patients’ active participation and responsibility for their care. This means
the nurses should provide patients with advice on the appropriate way to deal with HIV/AIDS. A supportive environment for HIV/AIDS women could enhance a positive self-esteem, even in the absence of medication (Campbell, Andersen, Mutsikiwa, Madanhire, Nyamukapa & Gregson, 2016:1). HIV/AIDS in pregnancy presents a multitude of diverse stresses that can negatively affect pregnant women’s self-esteem (Parker, Jelsma & Stein, 2017:1). The importance of high self-esteem in patients with psychiatric disorders and the provision of interventions to 121 patients to improve it is outlined in a clinical trial by Vracotas, Iyer and Malla (2015:41). Self-esteem, assessed early in the course of treatment, was closely linked to supportive treatment at six months. Finlay-Jones, Rees and Kane (2015:1) assessed the correlation between self-esteem and the extent of coping strategies and self-care programs in patients with multiple sclerosis. Results revealed that self-care education by nurses could enhance self-esteem (Department of Health and Service, 2018:1).

UNICEF (2019) directs interventions in several key areas to combat HIV/AIDS, the first being prevention. UNICEF organises information campaigns on HIV/AIDS prevention and treatment and assists in increasing young people’s access to youth-friendly, gender-sensitive health services that provide voluntary testing and counselling, especially in countries affected by emergencies (UNICEF, 2019). The overall goal of these sessions is to educate HIV/AIDS pregnant women and to strengthen their self-esteem, enabling them to become peer-educators in their community so that they can spread the received knowledge about HIV/AIDS (UNICEF, 2019).

The underlying causes around self-esteem and HIV/AIDS risk remains unclear, although there are indications that that low self-esteem is generally associated with high-risk behaviour. Low self-esteem in pregnant women results in depression, which has been shown to directly compromise the immune system, which in turn could accelerate the progression of diseases and have negative repercussions for a pregnancy (Wang, Fu, Kaminga, Li, Guo, Chen & Li, 2018:1). On the contrary, high self-esteem has been associated with decreased disease progression (Saari, Kentala & Mattila, 2015:5).

1.3 LITERATURE

This study is qualitative and inductive in nature, departing from the theoretical framework of Erik Erikson (1950–1963). The literature focuses on an overview of the importance of the topic
of the self-esteem of patients, with reference to (i) having to deal with a crisis; (ii) going through different stages while having HIV/AIDS; (iii) self-identity; and (iv) building trust in others.

Pregnancy in itself is a stressful and demanding life event (for some a crisis) and the news of HIV/AIDS-infection during this period can be devastating for a pregnant woman, potentially affecting her ability to cope (Monteiro, Villela, Fraga, Soares & Pinho, 2016:1). This could have an influence on their self-esteem (Scott, 2018:1). Self-esteem can be described as how you feel about yourself (Woolfe, 2018:1). Those with high self-esteem believe that they are adequate, strong and worthy of a good life, while those with a low self-esteem feel inadequate and worthless. Many people base their self-esteem on external factors, such as personal status, how much money they earn, how much they weigh and whether people like and appreciate them. If any one of these external variables changes, self-esteem can be broadly affected as well (Ponton, 2016:1).

Women with HIV/AIDS can be of different ages and in different stages of their lives. Pregnant women account for an estimated 58% of all HIV/AIDS infections in South Africa (UNAIDS, 2018) and the risk of infection for pregnant women between the ages of 20 and 29 years is almost six times higher than for males in the same age group (Ramjee, Dassaye, Reddy & Wand, 2018:1759). South Africa has the biggest and most high-profile HIV epidemic in the world, with an estimated 7.2 million people living with HIV. In 2016, more than 95% of HIV positive pregnant women received antiretroviral medicine to reduce the risk of MTCT. As a result, MTCT rates have fallen from 3.6% to 1.5% between 2011 and 2016 – achieving the national target for 2015 of a transmission rate below 2% (Department of Health, 2009).

HIV/AIDS can also be linked to self-identity (Huang, Zhang & Yu, 2019:1). A strong link has been found between the level of knowledge of HIV/AIDS and sexual activity in a number of studies. It was discovered that pregnant women with more knowledge about HIV/AIDS appeared to be more likely to develop low self-esteem, abstain from high-risk sexual activities and consistently use condoms (Ali & Cleland, 2018:1). On the other hand, several studies on HIV/AIDS-infected pregnant women have demonstrated the importance of the correlation between self-esteem and HIV/AIDS risk behaviours (Qiao & Li, 2015:419).

According to Abdel-Khalek (2016:1), the relationship between self-esteem and trust in others is evident and that an increase in self-esteem will lead to an increase in trust. Abdel-Khalek
further states that trust and self-esteem are vital to social functioning and that social functioning has an impact on the mental health of all individuals. According to his study, the relationship between self-esteem and trust in others, as a whole, impact the individual’s psychological wellbeing. HIV/AIDS pregnant women with low self-esteem are more likely to be depressed than those with high self-esteem and stigmatisation related to the infection seemed to be an antecedent of low self-esteem (Galanakis, Palaiologou, Patsi, Velegraki & Darviri, 2016:10).

1.4 THEORETICAL DEPARTURE OF THE STUDY

1.4.1 Self-esteem theory

This study departs from some assumptions adapted from the self-esteem framework of Erik Erikson (1950–1963). He emphasised the role of conflicts that can take place within the ego itself, taking cognisance of certain stages of psychosocial development. Assumptions are statements that are considered true, even though they have not been scientifically tested. For the purposes of this study, it was assumed that the professional nurses have a role to play in supporting HIV/AIDS pregnant women to:

- develop their self-esteem (ego) when they successfully resolve their crises (distinctly social in nature) around having HIV/AIDS;
- incorporate a wider and integrated set of life skills that will help them to function as an autonomous individual;
- develop a sense of identity in society, as they can help other HIV/AIDS persons in improving their health; and
- establish a sense of trust in others (such as the midwife in an antenatal unit) while in hospital.

1.5 DEFINITION OF CONCEPTS

1.5.1 Professional nurse

SANC (2005) states that in South Africa, a professional nurse is a registered nurse and midwife who is recognised as a practitioner in her own right and is accountable for her own acts and
omissions in terms of the Nursing Act (Act no. 50 of 1978, as amended). The SANC requires annual registration by all registered nurses and midwives in order to practice nursing. For the purpose of this study, a professional nurse is expected to provide nursing care to all patients, including pregnant women with HIV/AIDS (SANC, 2005).

1.5.2 Midwife

The international confederation of midwives defined a midwife as a person who has been regularly admitted to a midwifery education programme (duly recognised in the country in which it is located), has successfully completed the prescribed course of studies and acquired the requisite qualifications to be registered and/or legally licensed to practice as a midwife (Li, Lu & Hou, 2018:165). SANC (2005) states that in South Africa, the midwife is a registered professional nurse who is recognised as a practitioner in her own right and is accountable for her own acts and omissions in terms of the Nursing Act (Act no. 50 of 1978, as amended). For the purpose of this report, a midwife is a professional nurse who is expected to provide nursing care to all patients, including HIV/AIDS pregnant women with respect and dignity (SANC, 2005).

1.5.3 Women

Women are defined as females or ladies, nouns referring to adult human beings who are biologically female and who are capable of bearing offspring (Goldberg, 2014:1). In this study, ‘women’ refer to pregnant women who have been hospitalised in a public hospital.

1.5.4 Pregnant

Being pregnant is defined as the state in which a woman carries a fertilised egg inside her body, the period from conception, after the egg is fertilised by the sperm and implanted in the lining of the uterus. This process usually lasts 40 weeks up until birth.

1.5.5 Self-esteem

Ponton (2016:1) defines self-esteem as how you feel about yourself as a person. Those with high self-esteem believe that they are adequate, strong and worthy of a good life, while those with low self-esteem feel inadequate and worthless. In this study, a healthy self-esteem (Galanakis et al., 2016) was defined as feeling of good about oneself and deserving the respect of others, whereas someone with low self-esteem puts little value on his/her opinions and ideas.
1.5.6 Role

Role is a prescribed or expected behaviour associated with a particular position or status in an institution (Business dictionary, 2019). For the purpose of this study, a role refers to the role of a professional nurse who is expected to assist pregnant woman with HIV/AIDS holistically (physically, socially and mentally) to develop life skills while preserving their dignity and self-esteem (SANC, 2005). Life skills are abilities for adaptive and positive behaviour that enable humans to deal effectively with the demands and challenges of life (Doyle, 2018).

1.5.7 Public hospital

A public hospital is open to the general public and is operated without the purpose of gaining private profit. According to Van Rensburg (2014:84), the majority of these public hospitals fall under the Ministry of Public Health, which has full geographical coverage of all districts and provinces. In this study, the setting was a maternal unit in a public hospital in Cape Town.

1.6 RESEARCH PROBLEM

A study among pregnant women with HIV/AIDS in rural Eastern Cape has found that the prevalence of HIV/AIDS among them has remained at a very high rate of about 29%, despite a substantial decline in several sub-Saharan countries (Businge, Longo-Mbenza & Mathews, 2016:1). The professional nurse is expected to provide nursing care to all patients, including HIV/AIDS pregnant women, while treating the individual with respect and dignity (SANC, 2005). While in an antenatal clinic, the researcher observed that some of the pregnant women with HIV/AIDS were young, lacked confidence and were shy to answer questions about e.g. their personal health and circumstances.

The diagnosis of HIV/AIDS is life-changing and requires people not only to deal with the disease but also to cope with the stigma attached to it (Salih, Tessema, Cherkos, Ferede & Anlay, 2017). Professional nurses working as midwives are thus destined to play a role in promoting the self-esteem of patients such as pregnant women who are diagnosed with HIV/AIDS. The fundamental purpose is to promote health and to motivate the individual to adopt healthy and autonomous habits in order to promote their self-esteem and mental health (Hardcastle, Hancox, Hattar, Maxwell-Smith, Thogersen-Ntoumani & Hagger, 2015:1). In a maternity clinic the researcher overheard patients who were HIV/AIDS positive expressing their feelings of
worthlessness and wondered how he could support them to have more self-worth. It was also unclear what the views of professional nurses were on their role in promoting the self-esteem of hospitalised, pregnant women with HIV/AIDS in a public maternity hospital.

From the problem, the following research questions were posed:

- What is the view of professional nurses on the self-esteem of hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town?
- How can professional nurses promote a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town?

Professional nurses are well positioned to create and maintain a trusting relationship with their patients and provide care that promotes wellbeing at all stages of illnesses, particularly to those who are vulnerable (SANC, 2005).

1.7 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the role of professional nurses in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town.

1.8 OBJECTIVES

The objectives of the study were to:

- explore and describe professional nurses’ views on the self-esteem of hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in a public hospital in Cape Town; and
- develop guidelines for professional nurses on their role in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town.

1.9 RESEARCH METHODOLOGY

According to Eldridge, Lancaster, Campbell, Thabane, Hopewell, Coleman and Bond (2016:1), methodology includes the design, setting, sample, methodological limitations and the data collection and analysis techniques in a study. According to Holloway and Galvin (2017:1),
methodology means a framework of principles on which methods and procedures are based. In this study, methodology refers to how the research was done and what its logical sequence was. The main aim of this study was to explore the views of professional nurses and the role they play in enhancing the self-esteem of hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital.

1.9.1 Paradigm and approach

A paradigm is essentially a worldview, a whole framework of beliefs, values and methods within which research takes place. The researcher conducted the research within a constructivism paradigm, as it is believed that there is no single reality or truth and therefore reality needs to be interpreted. In order to acquire these multiple realities, qualitative methods such as interviews were used (Patel, 2015:1). Qualitative research is the approach usually associated with the social constructivist paradigm and emphasises the socially constructed nature of reality. This study attempted to uncover the deeper meaning of human experiences. The researcher followed an inductive approach in gaining a rich understanding of participants’ views, as opposed to a deductive approach through which information is obtained which can be generalised to other, larger groups (Alzheimer Europe, 2017).

1.9.2 Research setting

The study was conducted in the Cape Town Central Health District Metropolitan Region, under the City of Cape Town, in the Western Cape Province in South Africa. The site is approximately ten (10) kilometres from the Cape Town Central Business District (approximately 15 minutes by car). The site was a maternity unit in a referral public hospital, which caters for obstetric patients living within its catchment areas (i.e. Woodstock to Claremont; Mowbray to Sawkins Road; all the avenues in Rondebosch East); however, the public hospital also accepts all obstetric patients referred to it from around the Western Cape Province who require a higher level of care. This public hospital has 106 beds in the obstetrics unit and 74 neonatal beds. The hospital offers a full range of high-level maternity services, spanning the three main stages of childbirth, antenatal care, labour and delivery and postnatal care. The majority of patients seen at the maternity hospital were blacks and coloureds. The maternity unit in this public hospital is equipped with 15 midwives over 24 hours (five per day shift, three and two per night shift).
1.9.3 Research design

The research design refers to the overall strategy that begins at the underlying philosophical assumptions and moves to specifying the selection of participants (Maree, 2017:72). An exploratory, descriptive, contextual approach within a qualitative design was followed to answer the research questions. The main reason for the use of a qualitative design was to uncover trends in thoughts and views and to provide insight into the problem (Maree, 2017:54). According to Dudovskiy (2016:1), exploratory research describes research that is conducted to explore the research questions and nature of the problem, provide conclusive evidence, acquire a better understanding of the problem and reveal new data and new insights, usually used to tackle new problems on which little or no previous research has been done. Gray (2017:37) argues that exploratory research refers to asking questions about what is happening and is particular useful when not enough is known about a phenomenon. Maree (2017:54) states that a descriptive design in qualitative research is primarily used to find answers and to clarify and describe more aspects of the phenomenon being studied. Descriptive designs may be used to cast light on current issues and problems. This is done through the process of data collection to enable the researcher to describe phenomena more completely than was possible without using this method (Maree, 2017:54). In this study, the researcher explored and described the views of the professional nurses on their role in promoting the self-esteem of hospitalised, pregnant women with HIV/AIDS in a maternity unit.

According to Holtzblatt and Beyer (2016:530), contextual designs focus on real-world phenomena and findings are described within the time, space and value context in which the study is being done. Holtzblatt and Beyer also mention that contextual studies are based on critical real-world views where reality is constructed.

1.9.4 Population

Population refers to all the individuals or units of interest; the individuals who have certain characteristics and are of interest to a researcher (Alvi, 2016:3). Asiamah, Mensah and Oteng-Abayie (2017:6) define population as a group of individuals of the same species living within a given area. According to Etikan, Musa and Alkassim (2015:1), population is the target population, all elements (individuals, events or circumstances) that meet the sample criteria for inclusion in a study. The accessible population for this study comprised professional nurses (N =
15) working at the maternity unit in a public hospital in Cape Town in the Western Cape Province.

1.9.5 Sampling and sample

1.9.5.1 Sampling technique

Sampling is the act, process or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population (Etikan et al., 2015:1). Sampling is explained as a specific principle used to select members of a population to be included in the study. Due to large numbers of populations of interest, researchers have to study a number of cases of elements within the population to represent the population and to reach conclusions about the population (Dudovskiy, 2016:1). A nonprobability sampling approach, using the purposive sampling method, was used to obtain a sample of participants. According to Daftary and Craig (2018:42), purposive sampling in qualitative research is a way to gain insight into new extents of study and to get in-depth understanding of a multifaceted experience. Etikan et al. (2015:1) state that purposive sampling (also known as judgement, selective or subjective sampling) is a sampling technique in which a researcher relies on his or her own judgement of a criteria when choosing members of a population to participate in the study, i.e. cases that will help to answer research questions and achieve research objectives. Purposive sampling is believed to be one of most cost- and time-effective sampling methods available (Dudovskiy, 2016:1).

The eligibility criteria for including participants in this study were as follows:

- at least one year of work experience in the maternity unit;
- participation in seeing pregnant women with HIV/AIDS on a daily basis; and
- registered with the South African Nursing Council as a professional nurse and midwife.

1.9.5.2 Sample

A sample is a subset of a population (Cherry, 2016). When dealing with people, it can be defined as a set of respondents (people) selected from a larger population (Martinez-Mesa, Gonzalez-Chica, Duquia, Bonamigo & Bastos, 2016:326). For the purpose of this study, the sample was selected from the accessible population of professional nurses working at a maternity unit in a
public hospital in the Western Cape. The sample size was not pre-decided, which means that the researcher conducted interviews up to the point where no new data emerged. Patricia, Fusch and Ness (2015:1408) state that the number of interviews needed for a qualitative study to reach data saturation is a number that could not be quantified and that the researcher should take what he or she can possibly get. Faulkner and Trotter (2017:1) said that two criteria relating to the size of the sample should be kept in mind. The first one is sufficiency, which can be determined by the interviewer him/herself. The second criterion is saturation, which happens when the interviewer begins to hear the same information he/she has already obtained from previous interviewees. Kayleuetki (2018:1) states that data saturation is usually thought of as the point where there are no new codes, or no new data for development of themes, or where the complete range of theoretical constructs is fully represented by the data. The researcher of this study conducted eight interviews, at which stage saturation was obtained.

Faulkner and Trotter (2017:1) also state that data saturation should be supported by details and evidence on how it was reached in order to bolster transparency of the data collection and analysis process, which is a standard quality criterion in qualitative research. Faulkner and Trotter (2017:1) argue that data saturation is reached when there is enough information to replicate the study, when the ability to obtain additional new information has been attained and when further coding is no longer feasible.

1.9.6 Data collection

1.9.6.1 Method

The proposed study used semi-structured, individual, in-depth interviews. Maree (2017:93) states that the benefit of this method is that it allows researchers to explore views, ideas, beliefs and attitudes of the participants about study phenomena. In-depth interviews offered the opportunity to capture rich, descriptive data about people’s behaviours, attitudes, perceptions and unfolding complex processes (McGrath, Palmgren & Liljedahl, 2017:1). It is a conversation with an individual that usually collects specific information about one person. Qualitative data collection methods, such as semi-structured interviews, are believed to be appropriate for providing a deeper understanding of social phenomena than would not be obtained from purely quantitative methods such as questionnaires (Dyab Elkalmi, Bux & Jamshed, 2018:1). Therefore, semi-
structured interviews were used as little was known about the study phenomenon of the self-esteem of pregnant women with HIV/AIDS and detailed information was required from individual participants (Dyab et al., 2018:1). Semi-structured interviews are not highly structured and, as such, the interviewee could talk freely about whatever came up. Semi-structured interviews elicited the interviewee’s experiences of the topic of interest, as opposed to structured interviews that could lead the interviewee towards preconceived choices (Dyab et al., 2018:1).

1.9.6.2 Preparation of the field

Ethical approval was obtained from the Ethics committee of the Faculty of Health and Wellness Sciences at Cape Peninsula University of Technology, the Western Cape Department of Health and the Head of the Hospital (Annexure A). Only after obtaining permission from the official authorities, the researcher visited the manager of the maternity unit. The researcher invited the participants to participate in the study. The information letter was given to all prospective participants to inform them about the purpose of the study (Annexure B). The purpose and benefits of the study were explained and a private room requested in which interviews were conducted at a time that was convenient to the participants.

1.9.6.3 Pilot interviews

A pilot individual interview was conducted to explore whether any adjustments to the interview guide were necessary. No adjustments were required. A pilot study is a trial run of the research; a small-scale version of the major study, used to access feasibility of the intended research (Cadete, 2017:1). According to Eldridge et al. (2016:1), a pilot study is a smaller version of a proposed study, conducted to develop and refine the methodology such as the instrument or data collection process to be used in the larger study. One pilot individual interview was conducted to identify problems and strengthen the research questions (Eldridge et al., 2016:1). Semi-structured interviews do not have a very rigid format (which may hinder the depth and richness of the responses) (Dyab et al., 2018:1). Therefore, two open-ended questions were piloted in advance (Robertson, Curtis & Dann, 2018:88).
1.9.6.4 Procedure

Respected scholars warn that in conducting an interview, the interviewer should endeavour to create a pleasant, non-threatening atmosphere (Dudovskiy, 2016:1). The researcher made appointments with the participants and agreed on a specific date and time to conduct the interview. However, the researcher has also learned that there is no standard or fixed time for the duration of semi-structured interview; it purely depends on the questions (Dyab et al., 2018:1). The researcher envisaged that an interview would not last longer than 45 minutes. Each interview was conducted in a private room and digitally recorded after obtaining written informed consent and explaining the purpose of the study and the information sheet. The researcher used an interview schedule and made field notes during interviews. Maree (2017:94) states that it is often helpful to take notes so that the researcher can reflect on the interview at the end thereof. Probing was used to gain an in-depth understanding of the views of participants and to cover every aspect in as much depth as possible (Annexure C).

1.10 DATA ANALYSIS

Loubere and Shen (2018:418) claim that recording and transcribing interviews enhances the analysis of the interviewee’s response and allow the researcher to listen to the interview more than once and share the data obtained with other researchers who can evaluate the analytical process, thereby refuting the claims of researcher bias and allowing the data to be reused for other research purposes. Data triangulation with the interviews and field notes was done. Data triangulation refers to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena and to capture the different dimension of the same phenomenon (Fusch, Fusch & Ness, 2018:19).

Qualitative data analysis is a process and procedure whereby a researcher moves from the data collected into some form of explanation, understanding and interpretation; the idea is to examine the meaningful content of qualitative data (Wibren, 2019:11). Thematic coding was followed, which entailed: familiarising oneself with the data on one’s own for a few times; generating the initial codes; identifying themes and subthemes; and reviewing and interpreting themes. Guidelines were developed from the data in the themes and categories.
Chapter 2 outlines the steps taken during the data analysis. An independent coder helped to limit bias in the data analysis and a meeting was held between the researcher and coder to establish consensus.

1.11 RIGOR

Trustworthiness is of the greatest importance in qualitative research (Maree, 2017:123). According to (Maree, 2017:122), validity in qualitative research depends on the presentation of solid descriptive data. The researcher should lead the reader to an understanding of the meaning of the experience under study. The researcher was constantly aware of biased assumptions and took active steps to prevent them to cloud the crystallised reality (Maree, 2017:121).

In establishing trustworthiness in qualitative research, Maree (2017:123) proposes four criteria that should be respected by qualitative researchers in pursuit of a trustworthy study. These criteria include credibility, transferability, dependability and conformability. Trustworthiness will be discussed in more detail in Chapter 2.

Credibility was enhanced when the researcher showed the ability to describe and document the research experience (Maree, 2017:123). The researcher undertook purposive sampling, detailed data collection methods and executed data triangulation. To strengthen the credibility of the research, the researcher focused on prolonged engagement in the field and persistent observation. He furthermore spent sufficient time in the research setting to develop relationships and co-construct meanings with the participants of the research. Credibility was further enhanced through the use of a thick description of the phenomenon under scrutiny (Maree, 2017:123). This was done by self-reflection and by keeping notes on the views of participants on the topic. The researcher also established credibility through member checking to address the co-constructed nature of knowledge by proving participants with the opportunity to engage with researcher (Birt, Scort, Cavers, Campbell & Walter, 2016:1).

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other participants (Maher, Hadfield, Hutchings & Eyto, 2018:1). To reinforce transferability, Lincoln and Guba (1989), cited in Poduthase (2015:25), propose the use of a thick description that requires the provision of a highly detailed account of one’s research to check the potential for application to other times, places, people and contexts. Thick descriptions
mean that the researcher of this study provided the reader with a full and purposeful account of the context, participants and research design so that readers can make their own decision about transferability (Maree, 2017:124). The findings of this study might be useful for another, similar maternity unit.

Dependability is a process whereby a researcher takes a stance to evaluate research findings, interpretations and recommendations to confirm that they were indeed supported by the data received from study participants (Maher et al., 2018:1). Maree (2017:124) claims that dependability in qualitative research is demonstrated through the research design and its implementation, data gathering and the reflective appraisal of the project. The researcher took field notes during the interviews. Maree also says that dependability cannot be established without credibility. The researcher of this study was consistent in data collection to establish trustworthiness of the study. The researcher provided a detailed description of how the data was collected, analysed, recorded and kept for audit purposes.

Confirmability is described by Lincoln and Guba (1985), cited in Maree (2017:125) as the degree of neutrality or the extent to which the findings of the study are shaped by the participants and not by the researcher’s bias, motivation and interests. Maher et al. (2018:1) argue that confirmability shows that data and interpretations of the findings are not figments of the inquirer’s imagination, but are clearly derived from the data. The findings of this study were supported by presented data. Researcher and independent coder reached consensus on the themes and categories. Written field notes and the audio recordings of the semi-structured individual interviews served as reference and support of the data.

1.12 ETHICAL CONSIDERATION

Gray (2017:72) defines ethics as the appropriate behaviour of the researcher in relation to the rights of those who become the participants in the research or are affected by it. Gray also states that ethics refers to conducting research in a way that goes beyond merely adopting the most appropriate research methodology – it refers to conducting research in a responsible and morally defensible way.

The main ethical principles of informed consent, confidentiality and anonymity, justice, maleficence and beneficence were followed throughout the study.
Informed written consent: All participants in this research study were informed of the nature of the study. Adequate and relevant information on the purpose of study, the type of information that would be requested from them as well as the use of the information were discussed. Participants were afforded an opportunity to choose whether or not to participate. Participants were also reassured that they could withdraw from the study at any time without any recrimination or risks. Written informed consent was obtained from the participants.

Confidentiality and anonymity: Participants were reassured that information obtained in this study would not be given to anyone else. No identifying information about participants was revealed in written or any form of communication. The principle of doing well and preventing harm was ensured (Evans, 2017:10). The nature and quality of participation were kept strictly confidential by using study numbers instead of real names.

Justice: The selection and treatment of participants were fair and equal (King, 2017:1). There was no bias and their right to privacy was maintained. Sensitive issues arising from the study was kept private and confidential.

Maleficence: The researcher took all necessary precautions to protect the wellbeing of participants. This included physical, psychological or emotional wellbeing of the participants. Participants in this research study were not subjected to any situation in which they could be harmed.

Beneficence concerns the moral obligation of doing good to others and to maintain a balance between benefit and harm. The researcher made it clear to participants that there would be no direct benefits resulting from their participation in this study, but that the outcome of the study could contribute to routine management of HIV/AIDS pregnant women (King, 2017:1).

1.13 SIGNIFICANCE OF THE STUDY

It is important for professional nurses to support pregnant women with HIV/AIDS as in some cases they are at greater risk of getting infected with other diseases, are solely responsible for the household and the children and mostly have less financial and material reserves to fall back on.
(Spindola, Dantas, Cadavez, Fonte & Oliveira, 2015:120). The outcome of this study led to guidelines for professional nurses on how to enhance the self-esteem of pregnant women in a maternal unit. This study is unique in nature and can inform the nursing curricula’s course on mental health in the graduate degree undertaken by student learners. The results of this study can guide other professional nurses in focusing on the self-esteem and self-leadership of pregnant women with HIV/AIDS and focusing on holistic health.

1.14 OUTLINE OF THE REPORT

The layout of the study is as follows:

Chapter 1

In this chapter, the introduction and motivation, background to the research problem, research question, aim and objectives of the study were discussed. Furthermore, the research design and method, validity and reliability, ethical considerations and justification were outlined.

Chapter 2

This chapter describes the methodology, including the design, the population, sampling techniques and the method of data collection. Measures that the researcher used related to trustworthiness (credibility, applicability, dependability and reflexivity) to ensure rigor of the research process are outlined.

Chapter 3

In this chapter, findings from thematic coding are discussed.

Chapter 4

This chapter describes the conclusions, guidelines and recommendations drawn from the study. The limitations are also highlighted.

1.15 CONCLUSION

HIV/AIDS among pregnant women places a socio-economic burden on societies and has set the world into spending millions on healthcare settings in an attempt to curb this lifestyle disease. A clear, specific problem statement was formulated from which two questions came to the fore. This was in line with the purpose and objectives of the study. A qualitative design was chosen as
the researcher wanted to investigate the experiences of professional nurses. Therefore, individual, semi-structured interviews were conducted, followed by thematic coding. During the research process, trustworthiness was ensured and ethical principles followed.
CHAPTER 2: METHODOLOGY

2.1 INTRODUCTION

This chapter deals with the research design, population, sampling instrument and procedures for data collection and analysis. It therefore outlines how the research was conducted. The methodology focuses on procedures the researcher used in this study to explore and describe the research phenomenon of self-esteem. Walt, Brink and Van Rensburg (2017:99) mention that the methodology used in any study has to answer the research question. Polit and Beck (2017:169) argue that the methodology influences the research from the first to the last step of a study. Criteria for establishing trustworthiness and ethical consideration were also discussed.

2.2 RESEARCH DESIGN

According to Maree (2017:1), a research design serves as a guide, plan, structure and strategy of investigation for collecting data and obtaining answers to the research question or problem. Maree also states that a research design has questions that determine the path proposed for the research journey. Creswell (2016:300) states that research design refers to the entire process of research – from conceptualising a problem to writing the narrative – and not simply the methods such as data collection, analysis and report writing. Kumar (2018:94) defines design as the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with procedures. In this study, the researcher concurred with Denzin and Lincon (2011), cited in Creswell (2016:12), who claimed that a research design is a strategy of inquiry, a plan for conducting research, implemented in an attempt to find answers to the research question.

An exploratory, descriptive, contextual, qualitative design was followed in this study.

2.2.1 Qualitative design

According to Nxumalo and Mchunu (2018:202) qualitative research refers to a broad range of research designs and methods used to study phenomena of social action. Daher, Carre, Jaramillo, Olivaries and Tomicic (2017:1) state that qualitative research is often used when a problem has not been investigated before. Generally, this method uses smaller samples than in a quantitative
Kumar (2018:12) argues that qualitative research is primarily used to describe a situation, phenomenon, problem or event and to gather in-depth information and analyse it qualitatively, while in a quantitative design, variables are measured on e.g. nominal or ordinal scales and the analysis is done to establish the variations in the situation, phenomenon or problem while quantifying it. The focus of qualitative research is on the exploration of what participants think and feel about a particular phenomenon, on interpreting reality from the participant’s frame of reference and on attempting to understand the phenomenon in its natural context (as opposed to a more controlled environment as preferred in quantitative research) (Daher et al., 2017:1). In this study, the researcher aimed to engage in a qualitative approach of enquiry. One of the most prominent goals of the researcher in this study was to collect data in a natural setting, while remaining sensitive to the people and places being studied. The researcher described the role of professional nurses in the promotion of a healthy self-esteem of hospitalised pregnant women with HIV/AIDS in a public maternity antenatal unit.

The researcher followed inductive reasoning throughout the qualitative study. According to Bradford (2017:1), inductive reasoning, makes broad generalisations from specific observations. Conclusions are drawn from the data. Deductive reasoning or deduction, the opposite of inductive reasoning, starts out with a general statement or hypothesis and examines the possibilities of reaching a specific, logical conclusion (Bradford, 2017:1).

### 2.2.2 Exploratory design

Kumar (2018:11) states that exploratory research is undertaken with the objective to explore an area where little or no knowledge exists about a phenomenon. According to Nosratabadi, Rarani, Shahidi and Rahimi (2019:1), exploratory research focuses on becoming familiar with the basic facts, settings and concerns. Exploratory research is used to formulate and focus questions for future research (Nosratabadi et al., 2019). The researcher of an exploratory study wants to determine the breadth and scope of a particular topic and wants to generate initial questions which could guide the research. Lune and Berg (2017:32) also stated that an exploratory design is used to gain a broad understanding of a situation, phenomenon or community where limited knowledge or information exists. The researcher explored the role of professional nurses in promoting the self-esteem of hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in Cape Town.
2.2.3 Descriptive design

Descriptive research is important and appropriate for research questions focused on discovering the events and exploring the views and experiences of the participants regarding a poorly understood phenomenon (Xie, Shan, Niu, Chen & Wang, 2017:1). According to Daher et al. (2017:57), descriptive research is used when a researcher is interested in describing a phenomenon. The researcher uses a descriptive design to draw a naturalistic perspective and examine a phenomenon in its natural state (Xie et al., 2017). In this study, the researcher concurred with Murphy (2018:1) who defines a descriptive design as a researcher’s attempt to provide a detailed, highly accurate picture of a phenomenon such as the role of professional nurses in promoting self-esteem of hospitalised pregnant women with HIV/AIDS in a public maternity antenatal unit in Cape Town.

2.2.4 Contextual design

A contextual design refers to research that focuses on specific events in naturalistic settings (Murphy, 2018:1). This study is contextual in the sense that the phenomena is studied in its context and carefully grounded in an understanding of the nature of the investigated phenomena (Howarth, Devers, Moore, O’Cathain & Dixon-Woods, 2016:1). According to Mohajan (2018:23), context implies the conditions and situations of an event. Mohajan also states that research described as contextual when a study is made of occurrence in their immediate environment or context. Howarth et al. (2016:1) further state that a contextual design is a structured, well-defined, user-centred design process that provides methods for collecting data about users in the field and interpreting and consolidating that data in a structured way. This study is contextual and focused on the role of professional nurses in promoting the self-esteem of hospitalised pregnant women with HIV/AIDS in a public maternity antenatal unit in Cape Town.

2.3 SETTING

The study was conducted in the Cape Town Central Health District Metropolitan Region, under the City of Cape Town, in the Western Cape Province in South Africa. The site is a public sector Specialised Maternity Hospital which provides maternal and new-born care. It includes an obstetric, neonatal and midwifery service and is approximately ten kilometres from the Cape Town Central Business District (approximately fifteen minutes by car). It is part of the teaching
platform of the Department of Obstetrics and Gynaecology and Department of Paediatrics of the UCT.

The site is a referral public hospital which caters for obstetric patients living within its catchment areas (i.e. Woodstock to Claremont; Mowbray to Sawkins Road; all the avenues in Rondebosch East); however, the public hospital also accepts all obstetric patients referred to it from around the Western Cape Province who require a high level of care. This public hospital has 106 beds in the obstetrics unit and 74 neonatal beds. The majority of patients seen at the maternity hospital are blacks and coloureds. The maternity unit where the study was conducted usually allocates 15 midwives in the unit over 24 hours.

The site also provides daily antenatal clinics (Monday to Friday), a high-risk postnatal care service, a level two ultrasound service, antenatal and postnatal inpatient care and 24-hour emergency comprehensive obstetric care (which includes labour ward and obstetric theatre and the Social Work Department and a perinatal mental health program for the Liesbeek Active Birth Unit (LABU). It also performs clinical outreach and provides in-service training satellite Maternity Obstetric Unit (MOUs) with significant input from a team of medical officers. This hospital is very focused on evidence-based practice. The site is credited for Baby Friendly Hospital Initiative (BFHI) and actively pursues Building Bridges Initiatives (BBI) principles and Essential Steps in the Management of Obstetric Emergences (ESMOE) training program.

2.4 RESEARCH POPULATION AND SAMPLE

Population refers to the entire set of objects or people who are the focus of a research project and whose characteristics the researcher wants to determine (Daher et al., 2017:57). According to Young (2019:1), population is the object of research and consists, among others things, of individuals or the conditions to which they are exposed to. Young further states that population is the full set of cases from which a sample is taken. The target population is the entire set of persons (or elements) who (or that) meet the sampling criteria (Roller, 2017:1). There was an accessible population of 15 professional nurses for the study. According to Mack (2019:1), an accessible population is the portion of the target population to which the researcher has reasonable access. Mack also states that physical limitations often force a researcher to study groups that are smaller than the target population.
2.4.1 Sampling

Kumar (2018:193) defines sampling as a process of selecting a few participants from a bigger group to represent the entire population. The researcher chooses a sub-group of the population that he/she is interested in. Kumar also states that if the sampling method is carefully selected, diversity could be extensively and accurately described on the basis of information obtained, even from one individual. Young (2019:1) defines sampling as the process by which elements are drawn from the population. The process often forces researchers to limit their research to a part of the population, as it is physically impossible to obtain information from the entire population (Young, 2019:1).

In this study, the researcher used purposive sampling, also known as judgemental sampling. Creswell (2016:300) argues that purposive sampling is the primary sampling used in qualitative research.

Creswell (2016:125) further states that purposive sampling applies when the researcher uses participants who can be productive in the study and can help to answer the research problem and question. The researcher chose the participants on the basis of personal judgement, focusing on those individuals who were able to give a more detailed picture about their role as professional nurses in promoting a healthy self-esteem in pregnant women with HIV/AIDS. The researcher used homogeneous sampling, which allows researchers to collect specific participants relevant to a phenomenon, rather than a heterogeneous group, with a wider range of characteristics (Crossman, 2019:1).

2.4.2 Sample

Young (2019:1) defines a sample as a subset of the elements of the population obtained for the purpose of the study. Sim, Saunders, Waterfield and Kingstone (2018:619) argue that in qualitative research, a sample is collected to open up new theoretical insights, reveal distinctive aspects of people or social settings and deepen the understanding of complex situations, events or relationships. Lune and Berg (2017:39) state that it is advantageous to restrict the investigation to a small but well-chosen group of participants who will accurately represent a much wider group. For the purpose of this study, the sample (11 participants) was selected from
approximately 15 professional nurses working at a public maternity antenatal unit in Cape Town in the Western Cape.

All 11 participants were permanently employed by the public maternity hospital. The unit has different categories of healthcare workers; however, for the purpose of this study, the participants were professional nurses. Their years of practising in midwifery, ranged from two to more than 25 years. Some of the participants were reluctant to disclose their ages; however, their ages appeared to range between 23 to 55 years. All participants were females. Three of the participants were qualified midwives, while others were registered professional nurses with varying years of experience in the unit.

According to Pneomol (2018:1), eligibility criteria are the factors that allow someone to participate in a study (inclusion criteria) and the factors that disqualify someone from participating (exclusion criteria). Pneumol also states that eligibility of study participants is a standard, required practice when designing high-quality research protocols.

Participants who met the following criteria were considered eligible for this study:

- Have at least one year’s work experience in the public antenatal maternity unit
- Participate in examining pregnant women with HIV/AIDS on a daily basis
- Registered with the South African Nursing Council as a professional nurse

Exclusion criterion was:

- A professional nurse who work as a locum on a part-time basis

2.5 RESEARCH METHOD

The research methods involve the forms of data collection, analysis and interpretation that are proposed for the study (Creswell, 2016). In this study, the researcher made use of semi-structured individual interviews and made field notes to obtain an in-depth understanding of the phenomenon under study.

2.6 DATA GATHERING

Lune and Berg (2017:37) refer to data collection as a tool used to collect data in a way in which the information should be recorded. The researcher used data collection techniques to choose the
most appropriate method of data collection (Lune & Berg, 2017:36). According to Holloway and Galvin (2017:144), data collection is the systematic gathering of information relevant to the research purpose, or the specific objectives or questions of a study. In this study, the researcher made use of semi-structured individual interviews and field notes.

2.6.1 Pilot interview

According to Fraser, Falhman, Arscott and Guillot (2018:60), a pilot study is defined as a small-scale version or a trial conducted prior to the main study on a limited number of participants from the population at hand. The purpose of the pilot study is to investigate the feasibility of the proposed method of data collection and to detect the possible flaws in the methodology of conducting the interviews (Daher et al., 2017:57). According to Young (2019:1), a pilot study is a preliminary small-scale study that researchers conduct in order to help them decide how best to conduct a large-scale research project (Crossman, 2019:1). The researcher wanted to investigate if the research questions would result in research data that would address the objectives of the study.

The researcher could test the research questions in the pilot interview and refine them afterwards if needed. A researcher needs to identify or refine a research question, figure out what methods are best for pursuing it and estimate how much time and resources will be necessary to complete the research study, among other things (Crossman, 2019:1). In a quantitative study, a pilot study is used to determine whether the research instrument is adequately designed and to pretest it (Young, 2019:1). In this study, a pilot interview was conducted and the outcome indicated that no changes were needed to the research questions, therefore the results of the individual interview was included in the main study.

2.6.2 Preparation of the field

After ethical permission was granted from the relevant authorities, including the Department of Health and head of the institution, the researcher visited the operational manager of the unit and prospective participants at the maternity antenatal unit to invite them to participate in this research study. The researcher set up appointments on specific dates and times that were convenient to them to conduct the interviews. A private room in which to conduct the interviews was booked over a period of three months (November 2017 to January 2018). The duration of
each interview was set for 30–45 minutes. The researcher explained the objectives and aim of the study to everyone and gave each prospective participant an information letter (Annexure A), detailing this research study. The consent form was also explained to the participants (Annexure B), as written consent was required for both the interviewing process and for recording the interviews.

2.6.3 Data collection instrument

The study used semi-structured individual in-depth interviews to collect data. According to Sim, Saunders, Waterfield and Kingstone (2018:619), semi-structure interviews are commonly used to enable the researcher to probe and explore deeper and to corroborate data emerging from other data sources.

The researcher did not use unstructured interviews as they would have required that the interviewer asked questions that are not prepared in advance (Lune & Berg, 2017:36). The questions would have then arisen spontaneously in a free-flowing conversation, which would mean that participants would be not be asked the same questions (Martic, 2018:1).

According to Harvey (2019:1), one of the advantages of semi-structured individual interviews is that the participants can guide the nature of the interview, thereby reducing potential bias arising from researchers asking questions and encouraging a specific response. Harvey also states that semi-structured individual interviews enable researchers to probe and explore deeper to obtain an in-depth understanding of the phenomenon under study. Semi-structured individual interviews enable researchers to prepare questions ahead of time to allow the interviewer to be prepared and appear competent during the interview (Babich, 2018:1). According to Doyle (2018:1), semi-structured individual interviews enable researchers to phrase the questions, thereby conveying equivalence of meaning to all participants. Doyle further states that semi-structured individual interviews are flexible and enable researchers to ask in-depth questions to ensure that the questions are understood and the required information obtained. Although semi-structured individual interviews take more time than questionnaires, they are more cost-effective than questionnaires (Doyle, 2018:1).
2.6.4 Data gathering process

The researcher used an interview guide (Annexure C) for conducting interviews. Martic (2018:1) states that an interview guide is a mechanism used to help the interviewer conduct an effective semi-structured interview. The researcher developed an interview guide in order to maintain consistency during the interviews. The same questions were asked to all participants. However, the advantage was that the sequence of the questions does not have to be the same for all participants, yet similar types of data could be collected from all the individual participants (Holloway & Galvin, 2017:90). Probing, prompting and summarising was also utilised where necessary.

The following questions were asked:

- How do professional nurses influence the self-esteem of hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in Cape Town?
- How can professional nurses promote a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in Cape Town?

Each interview was conducted in a private room and recorded. The researcher made field notes, with permission from the participants, during the interviews. Phillippi and Lauderdale (2017:1) state that field notes are recorded notes by researchers in the course of field research, during or after observation of a specific phenomenon they are studying. Field notes are widely recommended in qualitative research as a means of documenting needed contextual information (Phillippi & Lauderdale, 2017:1). The researcher used field notes to ensure rich context persisted beyond the original researcher.

The field notes were taken to develop an in-depth understanding of the phenomenon, which is the role of professional nurses in promoting healthy self-esteem in hospitalised pregnant women with HIV/AIDS. Field notes were written down and were used to supplement and verify the voice recordings after the interviews.

The interview recordings were saved on a digital voice recorder and the recording device was tested prior to conducting the interviews. The interviews were dated and numbered by assigning a link to each, e.g. the first interview was coded Participant 1(P1).
Probing was used to gain an in-depth understanding of the views of the participants. According to Phillippi and Lauderdale (2017:1), probing involves asking questions in order to receive more information from participants who experience problems in expressing themselves. Probing also assists in building a common vocabulary by ensuring the clarity of terms that both the researcher and participants use; for example, if the participants use unfamiliar words or idioms, the researcher can ask them to clarify these words or idioms. It also helps the researcher to be aware of what he/she is assuming and to prevent bias which can cause the researcher to make false assumptions. Instead of assuming what the person is trying to say, it helps the researcher make the question relevant, for example, if the participant offers a response that appears to have no relevance to the question, the researcher may then be able to rephrase the question by inserting the participant’s response in the question.

An independent moderator was not used in this study, as individual interviews were conducted. According to Bredland, Soderstrom and Vik (2018:1), an independent moderator is a professional individual who is trained in conducting, managing and analysing a focus group session and leading participants through a pre-designed discussion guide by stimulating participation and facilitating useful discussion. In this study, the researcher used semi-structured, individual, in-depth interviews and acted as moderator, therefore it was not necessary to have independent moderator.

Individual interviews were conducted with participants up to the point of data saturation. Kumar (2018:213) states that data saturation is applicable to situations where the researcher is collecting information on e.g. a one-on-one basis. Kumar also states that data saturation is assumed to be reached when no new information is emerging. Moser and Korstjens (2018:1) define data saturation as a point at which no new data emerge during the data collection process. The researcher conducted interviews up to the point where no new data emerged.

2.7 TRANSCRIPTION DATA

According to Holloway and Galvin (2017:1), verbatim transcription provides fuller and richer data. In this study, a professional transcriber transcribed the recordings at the end of each interview session into a Microsoft Word document, which was printed by the researcher. The researcher furthermore listened to the recordings and compared them to the printed document. This enabled the researcher to be immersed in the data and engage with the data, while at the
same time making corrections to any words that the transcriber had misspelt or misunderstood (Holloway & Galvin, 2017). The interviews were conducted in English. The researcher used the printed copy of each recorded interview to read and make notes. Data analysis and data collection was done concurrently, with data analysis starting at the completion of the first interview. This assisted in identifying more aspects to explore in the subsequent interviews (Holloway & Galvin, 2017).

2.8 DATA ANALYSIS

Roller (2017:12) refers to qualitative analysis as a process that requires a conscious effort to accept some degree of chaos. It is a hands-on process, which requires the researcher to become immersed in the data. Roller also states that the process of data analysis requires the researcher to commit fully to a structured analytic process in order to gain an understanding of what the data convey. Data analysis allows the researcher to move deeper and deeper into the understanding of collected data and make an interpretation of the meaning of the data (Creswell, 2016:183). The data analysis allows the researcher to preserve the uniqueness of each participant’s experience, while permitting a deeper understanding of the phenomenon under investigation (Roller, 2017:12).

For the purpose of this study, the researcher transcribed the data of the interviews, together with the field notes using thematic analysis (2017:114). A thematic content analysis approach was used as a guideline for the data analysis process (Nowell, Norris, White & Moules, 2017:1). The following six steps of Maguire and Delahunt (2017:3351) for the data analysis process were followed:

a) The researcher started by reading and re-reading the transcripts to become familiar with the entire body of the data and then jotted down early ideas that came to mind in order to get clarity of the data.

The researcher then organised the data in a meaningful and systematic way by assigning initial codes to it; this was done to reduce data into small chunks of meaning. According to Maree (2017:114), it is difficult to make sense of data. Maree also states that the researcher needs to become skilled at taking words from the data and putting it in a final report. The researcher took the data from the interviews and the observations of the
moderator and combined it in a final report. Each participant was given a number in the order in which they were interviewed.

b) The researcher searched for themes by examining the codes. Some parts clearly belonged together. At the end of this step, codes were organised into broader themes that seemed to say something specific about the research question.

Coding is the process of organising and sorting data. During this process, the researcher will go through the data, summarise and synthesise what is happening and divide it into units which can be analysed (Maree, 2017:116). The responses of the participants were grouped into themes by the researcher with the assistance of the supervisor. Thematic content analysis was applied with colour coding to interpret the data.

c) Reviewing, modifying and developing the preliminary themes as identified in step three was done to make sure all themes make sense. The researcher read the data associated with each theme and considered whether the data really did support it.

d) When the researcher defined themes, the purpose was to identify the essence of what each theme was about – what the theme was saying, how subthemes interacted and related to the main theme and how themes related to one another.

e) Lastly, the report was written up and guidelines were developed.

Guidelines were developed according to the method of Muller (2001:204-205) and Muller and Bester (2018), that states that a guideline is formulated from the findings and supported literature. Each guideline is a recommendation in the form of a statement that has to indicate a rationale and actions for implementing it. Afterwards, an expert in nursing management and research (nurse educator) validated the guidelines by using the evaluation criteria of appropriateness, clarity, completeness and relevancy. No changes, additions, and omissions were recommended apart from some editorial comments to seven (7) guidelines (Chapter 4). After the analysis of the data and the refinement of the guidelines were conducted, the guidelines were finalised.
2.9 THE ROLE OF THE RESEARCHER

The role of the researcher covers all of the decisions made during the research lifecycle to handle research data: from the planning stage of the study up to the long-term preservation of data (Fellous-Sigrist, 2016:1). The researcher focused on demonstrating good interpersonal skills during conducting the interviews (Harvey, 2019:1). With the interviews, information is directly obtained from the participants, therefore the researcher has no option but to assume that the information given was their lived truth. Holloway and Galvin (2017:6) state that it is necessary that the relationship between the researcher and participants is one of trust. The researcher aimed to establish trust during the introduction phase of the interview, keeping in mind ethical issues in the research process. The researcher has been a professional nurse for seven years and has been exposed to various departments in a public hospital. According to Creswell (2016:1), the experience of the researcher might have an influence on the interpretation of the data. The researcher has been in clinical research for five years; hence he was able to be an objective observer during the study, particularly during data collection.

2.10 RIGOR IN QUALITATIVE RESEARCH

In qualitative studies, the researcher should scrutinise the trustworthiness of every phase of the analysis process, including the preparation, organisation and reporting of results in order to give a clear indication of the overall trustworthiness of the study (Fong, DeWitt & Leng, 2018:66). The researcher should be able to clarify what qualitative research is, stressing the utility of qualitative findings and addressing the quality in qualitative studies (Leung, 2015:324). The purpose of rigor in qualitative research is to ensure accurate representation of study participants (Leung, 2015:324). In this study, the following four criteria were used to measure trustworthiness of the study: credibility, dependability, transferability and confirmability.

2.10.1 Credibility

Credibility refers to consistency of the analytical procedures, including accounting for personal and research method biases that may have influenced the findings (Noble & Smith, 2015:34). According to Kumar (2018:185), credibility is an effort to establish that the interpretation of the data is credible and presented from the perspective of the participant conducting the qualitative
research. Leung (2015:324) argues that credibility can be established through prolonged engagement with the participants.

In this study, the researcher established prolonged engagement with participants to build trust. He spent more time in the field to understand the phenomenon of role of the professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS. The researcher extended engagement in the study by means of the individual semi-structured interviews conducted, each lasting 30 to 45 minutes. Prolonged engagement helped to provide in-depth experiences illustrated in the data. The data collection phase took about nine weeks.

According to Abakpa, Agbo-Egwu and Abah (2017:391), bracketing is a method, also used in this study, to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research topic and to increase the rigor of the study. This means that the researcher could experience things as new and was not prejudged, which was important for determining the essence of the phenomenon. During the interviews, the researcher excluded all prior assumptions gained through experience or literature to see the phenomenon with an open mind. He excluded all his beliefs and opinions related to the phenomenon.

For data triangulation, the researcher used different sources such as the individual semi-structured interviews, audiotapes and field notes (Brigitte, 2017:253). Reflections during the interviews were also used to clarify any misunderstanding about the data (Henry, 2015:25). The researcher determined if the research question was understood and gave participants a chance to validate and verify the conclusions of the data at the end of the interviews.

2.10.2 Dependability

Dependability is based not only on whether particular findings can be reproduced by another researcher but rather whether the findings are reasonably based on the data collected (Cruz & Tantia, 2017:79). Harel et al. (2016:104) argue that dependability of the findings lends legitimacy to the research method. In this study, a pilot individual interview was conducted that indicated that the research questions led to rich in-depth data. Hammarberg, Kirkman and De Lacey (2016:498) state that dependability establishes if the process of selecting, justifying and applying research strategies, procedures and methods were correctly done, confirmed by a moderator and an audit trail available. Hammarberg et al. (2016:498) also argue that to determine
the dependability of a qualitative study, one wants to see if the researcher has been careless or made mistakes in conceptualising the study, collecting the data, interpreting the findings and reporting results.

The researcher and an independent coder independently formulated themes and tentative conclusions from the data (Fong et al., 2018:66), after which a consensus meeting was held.

2.10.3 Transferability

According to Moon, Brewer, Januchowski-Hartley, Adams and Blackman (2016:1), transferability is the alternative to generalisation, specifically with regard to the case-to-case transfer of knowledge. Moon et al. (2016:1) also state that transferability is not only necessary for understanding the case but also allows the application of theoretical insights to a new setting and facilitates further analysis and understanding through replicative or comparative studies. Bengtsson (2016:8) argues that transferability in qualitative research refers to the ability to generalise, or the extent to which the results of the research apply to other contexts or settings. Bengtsson also states that transferability is used to provide readers with evidence that the research study’s findings could be applicable to other situations, times and populations. For the purpose of this study, the researcher provided a detailed description of how the data was collected and analysed. A record thereof is kept for audit purposes for five years. The transferability of the study was also increased by discussing the research process with the supervisor while conducting the research in the field.

2.10.4 Confirmability

According to Tobin and Begley (2004), cited in Lorelli, Nowell, Norris, White and Moules, 2017:1) confirmability reveals that the researcher’s interpretations and findings originated from the data and demonstrate how conclusions and interpretations have been reached. Bengtsson (2016:4) argues that confirmability allows an external auditor to understand how and why particular decisions were reached and to determine whether another researcher could reach similar conclusions. Bengtsson further states that the findings should be based on the analysis of the collected data and examined via an auditing process to confirm that the study findings established in the data and inferences based on the data are logical and have clarity, high utility or explanatory power.
In this study, confirmability was ensured when the researcher and independent coder met to discuss the findings and reach a consensus. The independent coder and the supervisor also read through the field notes, transcripts and the results of data analysis to confirm the categories that emerged. Data was kept and could be accessed later to confirm the results and findings if necessary.

2.11 ETHICAL CONSIDERATIONS

It is important that participant’s rights are protected throughout their participation in a research study. Further to the ethics outlined in Chapter 1, the researcher maintained a high standard of integrity, reliability and validity to demonstrate adherence to ethical principles.
2.11.1 Institution rights

The necessary permissions and support were obtained prior to the commencement of this study. Prior to interviewing participants, the researcher obtained ethical approval from the Ethics committee of the University, Cape Peninsula University of Technology Ethics Committee (REC 2017/H30), the Western Cape Department of Health and the Head of the Hospital. Only after obtaining permission from the official authorities, the researcher visited the Manager of the unit. Information on the purpose and benefits of the study was explained. A private room for interviews was requested and secured. The times of the interviews were pre-arranged with the participants in order to limit interruption to any hospital operations.

2.11.2 Informed consent

Informed consent is a major ethical issue when conducting research. According to Grady (2015:855), informed consent in principle is an authorisation of an activity based on fully understanding what that activity entails and in the absence of control by others. Grady also states that informed consent strengthens the value of respect for persons’ autonomy and their right to define their own goals and make choices designed to achieve those goals. It is an agreement by a prospective participant to participate voluntarily in a study after he or she has assimilated essential information about the study (Grady, Cummings, Rowbotham, McConnell, Ashley, Phil & Kang, 2017:856). Informed consent means that participants have adequate information regarding the research, are capable of comprehending the information and have the power of free choice, all of which enable them to consent voluntarily to participate in the research or decline participation (Grady et al., 2017:856). In this study, participants were informed about the purpose and benefits of the study before they signed an informed written consent form.

2.11.3 Beneficence

The principle of beneficence included the aspects of confidentiality about and anonymity of the participants (Bromley, Mikesell, Jones & Khodyakov, 2015:1). It refers to research benefits and to the protection of participants against discomfort and harm. According to Angell (2015:34), beneficence includes the professional mandate to do effective and significant research. The researcher explained the benefits of the study to the participants and handed out informed
consent forms. Angell suggests that researchers should protect participants from any kind of harm, such as physiological, social and economic harm and protection from exploitation. In this study, the researcher considered all possible consequences and balanced the risk of participation with proportionate benefit for participants and HIV/AIDS pregnant women. The researcher anticipated and established the harm and risk to be minimal. The exploitation of participants was avoided and they were not exposed to serious or permanent harm in any way. A psychologist as a counsellor was made available on the site to the participants if needed to be debriefed for any reason due to the interview. In such a case the interview would have been immediately be stopped; however, it was not needed in this study.

The researcher kept all information confidential (only the supervisor and independent coder had access to the details) and acted professionally at all times. The researcher furthermore ensured that the participants were comfortably seated and that the private room was in a quite environment.

2.11.4 Confidentiality and anonymity

According to Ferreira and Serpa (2018:2324), confidentiality and anonymity are closely connected to the rights of beneficence and respect for the dignity and fidelity. Confidentiality is the process of protecting an individual’s privacy pertaining to the treatment of information that an individual has disclosed in a relationship of trust, with the expectation that the information will not be divulged to others without permission (Morse & Coulehan, 2015:151). Ferreira and Serpa also state that the researcher should remain responsible for maintaining confidentiality throughout the study. In this study, similar to other types of research involving either survey or interview data, the protection of participants’ identities was critical. The information provided by study participants will not be publicly reported in a manner that identifies them and will not be made accessible to other stakeholders. Only the supervisors and the researcher will have access to the data for publication purposes (Riva, Wiederhold & Cipresso, 2016:2). Anonymity refers to the conditions in which the person’s identity cannot be linked, even by the researcher, to his or her individual responses. Hence, all digital recordings were marked as Participant 1, 2 etc. (Morse & Coulehan, 2015:151). Participation in the study was voluntary and the data collected was kept safe on Google Drive to ensure anonymity and confidentiality. Participants were informed about their right to withdraw from the study at any time. The participants received an
information sheet that explained that no names would be attached to the data obtained and interview transcripts were numbered. The participants were not linked to the research findings and the research did not harm the participants in any way.

2.11.5 Justice

According to Desposato (2016:189), the principle of justice in research includes both *procedural justice* that the procedures administered are regarded as fair, reasonable, non-exploitative and fair. *Distributive justice* is directed towards ensuring that no segment of the population is unfairly burdened with the harms of research and, on the other, towards ensuring that no individual or group is neglected or discriminated against (Desposato, 2016:189). Participants were selected according to purposive sampling and any agreements made with the participants concerning punctuality, length of the interview, privacy and method of information collected were respected (Desposato, 2016:189). During this study, no benefits or financial incentives were offered or given.

2.12 CONCLUSION

This chapter discussed the qualitative, exploratory, descriptive and contextual research design that was deemed appropriate for serving the purpose of the study. The design was in line with the method selected of conducting semi-structured individual interviews and that participants were purposively selected. The setting and population were well described for future reference if other researcher wanted to understand the scope of the study. The data gathering process – from ethical clearance, preparation of the filed, data gathering and analysis – was systematically described. The methodology followed in the study adhered to ethical principles and ensured trustworthiness.
3  CHAPTER 3: RESULTS

3.1  INTRODUCTION

A qualitative research methodology was used for the purpose of gaining an understanding of the phenomenon of the self-esteem of hospitalised pregnant women with HIV/AIDS in a natural context, rather than in a more controlled environment, as preferred in quantitative research (Mohajan, 2018:1). Data analysis in qualitative research refers to the process of preparing and organising the data for analysis, then reducing the data into themes through a process of coding and condensing the codes (Creswell, 2016:180), followed by interpretation and confirmation with literature. The purpose of doing a qualitative analysis is to interpret the data and the resulting themes in order to facilitate an understanding of the phenomenon being studied (Roller, 2017:12). The researcher transcribed the data collected during the interviews in conjunction with field notes.

This chapter describes the results from the semi-structured individual interviews, supported by field notes and addresses the main objectives which are to:

- Explore and describe professional nurses’ views on the self-esteem of hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in a public hospital in Cape Town.

3.2  PARTICIPANTS

The eleven participants (including the participant from the pilot interview) were all females between 25 and 60 years old; however, some participants were uncomfortable with disclosing their age during the recording of the interviews (Table 3.1). The participants’ years of service in the profession, their qualifications in nursing and their training in midwifery differed. The clinical experience of the participants ranged from 1 to 30 years. Data saturation was reached after the eighth interview, but the researcher continued to interview three more participants to ensure saturation was reached.
### Table 3.1: Description of participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>Description of participant</th>
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<tbody>
<tr>
<td>1 (pilot)</td>
<td>A female professional nurse. She was uncomfortable disclosing her age. She had more than 20 years’ experience in the antenatal unit. Before she moved to the antenatal unit, she worked in the labour ward. Part of her tasks in the labour ward was to provide voluntary HIV counselling and testing of patients who were about to give birth, to help them to cope with the disease. She also did her own research on pregnant women with HIV/AIDS to determine how long they have been HIV positive. She did community healthcare and she said: “The actual people who spread this HIV is men because they contain the semen, the woman is a container.”</td>
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<tr>
<td>2</td>
<td>A female professional nurse in her early thirties. She opted to keep her age confidential. She has been working in the unit for two years. She described her experience with the antenatal unit as quite hectic due to problems resulting from shortage of staff, even when everyone is on duty. She has never been exposed to any educational programs since she qualified as a professional nurse at the antenatal unit. She claims that she is one of the professional nurses who try to speak to the patients at their bedside, even if it is just for five to ten minutes.</td>
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<tr>
<td>3</td>
<td>A female professional nurse, in her late twenties, with two years’ experience at the antenatal unit. She described her experience as exciting. However, she emphasised a great need for professional nurses to go for training, such as HIV/AIDS programs. She is interested in any HIV/AIDS training. She said that professional nurses should be considered for HIV training, especially those working in hospitals, to equip them to deal with pregnant women’s poor self-esteem, in order for them to know how to act and what to say when they have to deal with these women.</td>
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<tr>
<td>4</td>
<td>A female professional nurse, in her early thirties. She started in the antenatal unit on the 16th of October 2016. She has one year and two months’ experience in the antenatal unit. When she started a year ago, she knew nothing about antenatal care, except for the knowledge she obtained as a student. She worked in a postnatal unit</td>
</tr>
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before she asked to be transferred to an antenatal unit. According to her, the antenatal unit was almost new to her, in terms of antenatal patient management. However, she made sure that she asked the professional nurses who had been there for a longer period and who were willing to help her. Now she is able to transfer that knowledge to students from the college when they ask things about pregnant women during their experiential placements. She never attended any training program on HIV/AIDS. She claims that she does not have enough information on HIV/AIDS issues, as they still need to go through training to know what happens to HIV infected patients. She still has to acquire the skills of pre- and post-test counselling, how to refer patients, how to take care of patients living with HIV and how to lower the stigmatisation and boost their self-esteem.

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<tbody>
<tr>
<td>5</td>
<td>A female professional nurse, in her late thirties. She has been at the antenatal unit for a while. She described herself as a curious professional nurse who likes to be interested and to ask patients who is supporting them at home. She also emphasised a great need for the training of professional nurses to handle pregnant women with HIV/AIDS. She said disclosure is still a huge problem among pregnant women with HIV/AIDS.</td>
</tr>
<tr>
<td>6</td>
<td>A female professional nurse, in her late fifties. She started her nursing career in 1980. She started working as a professional nurse at Groote Schuur Hospital in theatre. She also worked in various wards because they had to rotate. She did advanced midwifery for one year and then moved to Mowbray to practice as a midwife. It did not take her long to develop a love for midwifery. She was then permanently employed at Mowbray. Over the years, she became an operational manager of the antenatal and postnatal ward. During the interview, she had concerns about the lack of resources, such as private rooms for one-on-one consultations; however, at times she used her office when counselling needs arise.</td>
</tr>
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</table>
7  A 28-year-old female professional nurse. She studied nursing at the Western Cape College of Nursing in conjunction with the Cape Peninsula University of Technology. She worked at New Somerset Hospital as community service professional nurse in various wards, as they had to rotate. Then she obtained a permanent position at Tygerberg Hospital’s burns unit. A few years later, she moved to Mowbray where she worked in an antenatal unit. She has been working in the antenatal unit for three years.

8  A 27-year-old professional nurse. She studied nursing at the Western Cape College of Nursing in conjunction with the Cape Peninsula University of Technology. She worked at Tygerberg Hospital as a community service professional nurse and then obtained a permanent position at Mowbray. She has been working at Mowbray’s antenatal ward for five years. She described her experience at Mowbray as very pleasant because she enjoys midwifery and it was her favourite subject at school. She also said that when she heard the news that she was appointed to work at Mowbray, she was very happy because she enjoys and loves midwifery.

9  A female professional nurse, in her early thirties. She holds a diploma in Nursing. She started to work at Mowbray in 2014, initially by moonlighting, until she secured a permanent position in the same year. She has four years of experience. She described self-esteem as the self-confidence one has in oneself. She also said that nurses should understand all patients. She said that nurses should respect different cultures and backgrounds because we are all different. According to her, everyone must be treated in the same way.

10 A 28-year-old female professional nurse. She holds a diploma in Nursing. She worked at the Groote Schuur Hospital in the postnatal and labour wards. She has a Master’s in Advanced Midwife Neonatology. In 2017, she worked at Mowbray as a master’s student to complete her practical hours and that is how she had the opportunity to be at the antenatal unit at Mowbray for the duration of one to two years because she did not want to do her practical hours at Groote Schuur Hospital. She has been married for almost five years and has a two-year-old daughter. She
believes that all pregnant women with HIV/AIDS do not have the same self-esteem, because it depends on when they were diagnosed. She says that those who were admitted to the hospital before, might have known their status before, but they were not open to the health workers. Therefore, when they are diagnosed at the hospital, they are calm because they already know their status.

A 28-year-old female professional nurse. She completed high school at Sophumelela High School in Samora Machel. She stays in Samora Machel with her mom, dad and the rest of the family. She studied nursing at the Western Cape College of Nursing in conjunction with the Cape Peninsula University of Technology where she obtained a diploma in Nursing over a period of four years. She did her community service at New Somerset Hospital, after which she secured a permanent position at Tygerberg’s burns unit in April 2017. Then she went to Klipfontein sub-structure in the same year. She has been at Mowbray for two years, working in the antenatal unit. She said that the professional nurses at Mowbray make sure that they boost the self-esteem of HIV pregnant women by showing or telling them that it’s not the end of the world when you have this disease and that the only thing they need to do is to change their lifestyle.

3.3 FINDINGS

Seven main themes were derived from the data analysis in this study (Table 3.4). The first theme refers to the situation before an HIV/AIDS diagnosis is made. At this point, participants felt that when patients come in for the first time, their HIV status was unknown and they did not perceive themselves to be at high risk for contracting the HIV infection. They also did not know their status, with no knowledge of what the future holds for them until they fell pregnant and tested positive.

The second theme in this study deals with the issue of withdrawal, isolation and the lack of self-confidence due to stigma. Participants experienced poor self-esteem around having HIV/AIDS and being pregnant, which escalated to withdrawal, isolating themselves and eventually living in their own worlds.
The third theme links to the lack of interaction among pregnant women with HIV/AIDS and staff. These pregnant women seem to be cautious about sharing ideas with other patients or with staff.

The fourth theme addresses the issue of disclosure due to stigma. Participants felt that poor self-esteem among pregnant women with HIV/AIDS was due to the fear of disclosure, which leads to stigma among pregnant women. The fear of disclosure could be due to the fear of judgement, rejection and of losing their partners.

The fifth theme is associated with efforts by pregnant women to adapt to a new lifestyle after their HIV/AIDS diagnosis.

The sixth theme talks to the issue of the emotional state of pregnant women after a positive HIV/AIDS diagnosis. These participants experienced emotional changes, including fear and loneliness.
### Table 3.2: Themes and categories

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
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<tbody>
<tr>
<td>Discovering the unknown of a future destination</td>
<td>Self-acceptance in acknowledging a chronic disease</td>
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<tr>
<td></td>
<td>Self-respect in living your unique identity</td>
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<tr>
<td>Find themselves in their own world</td>
<td>Withdrawal into an isolated space</td>
</tr>
<tr>
<td></td>
<td>Self-confidence despite chronic condition</td>
</tr>
<tr>
<td></td>
<td>Cautious of sharing HIV status</td>
</tr>
<tr>
<td>Individuals not owning their health status</td>
<td>Lack of interaction with significant other</td>
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<td>Staff told to keep patient’s HIV status secret</td>
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<td>Stigma</td>
<td>Patients hiding their status and keeping their secret due to fear of stigma</td>
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<td>Pregnant women with HIV/AIDS become targets of judgement</td>
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<td>Community-level stigma among pregnant women with HIV/AIDS</td>
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<td>Role of cultural density on pregnant women with HIV/AIDS</td>
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<td>Fear of HIV/AIDS among pregnant women</td>
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<td>Adapting a healthy lifestyle with HIV/AIDS</td>
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<td>Moving towards a place to live with HIV/AIDS with an inspirational approach</td>
<td>Sharing information with family and community</td>
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<td>Emotionally involved through turbulences throughout the journey</td>
<td>Loneliness among pregnant women with HIV/AIDS</td>
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<td>A supportive environment for pregnant women with HIV/AIDS</td>
<td>Professional nurses’ knowledge of HIV/AIDS</td>
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<td>Acceptance of pregnant women with HIV/AIDS as human beings</td>
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<td>HIV/AIDS education for community and health professionals</td>
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The seventh theme is linked to general support in order to uplift the self-esteem of pregnant women with HIV/AIDS. The broader support includes support from partners, family and members of the community, taking into consideration the level of education.

### 3.4 THEMES AND CATEGORIES

A researcher has to show how categories link to the data from participants (Maree, 2017:116).

#### 3.4.1 Theme 1: Discovering the unknown of a future destination

New diagnoses of HIV/AIDS during pregnancy vary greatly, ranging from individuals being too shocked to comprehend the information, to immediately admitting the diagnosis and being ready to face the next steps, including engaging in medical care (Kutnick, Gwadz, Cleland, Leonard, Freeman, Ritchie, McCright-Gill, Ha & Martinez, 2017:1). HIV testing is the first step in linking HIV positive pregnant women to care and preventing new infections. The majority of infected women is unaware of their HIV status (Wilson, Kate, Kristin, Beima-Sofie, Moraa, Anjuli, Wagner, Mugo, Peter, Mutiti, Wamalwa, Bukusi, Grace, John-Stewart, Jennifer, Slyker, Pamela, Kohler & O’Malley, 2017:1).

Proudfoot (2018:323) states that women diagnosed during the antenatal stage are unfamiliar with HIV/AIDS treatment. Emphasis should be placed on preventing further spreading of HIV infections. They need to adjust to the diagnosis while dealing with new interventions. Participants felt that prior to their HIV diagnosis, they did not fit the stereotypical profile of those who were infected with HIV/AIDS and perceived that they were in a low-risk category, not being aware of what lay ahead:

“*She didn’t even know she was HIV positive until she fell pregnant and she had HIV test done.*” (P9)

“*They only find out they are HIV positive on antenatal screening.*” (P8)

This study shows that little is known about pregnant women’s reactions when they receive their HIV diagnosis. According to Kutnick et al. (2017:1), many people have strong reactions when they find out that they are HIV positive, including feelings such as fear for their future and a sense of being overwhelmed.

#### 3.4.1.1 Category 1: Self-acceptance to acknowledge a chronic disease

Schoenleber and Gratz (2018:75) define self-acceptance as demonstrating self-kindness, a feeling of satisfaction with one’s self despite deficiencies and regardless of past behaviours and choices. Yang and Mak (2016:595) argue that self-acceptance is a coping strategy that has been
associated with better health outcomes in different medical populations, including pregnant women living with HIV/AIDS.

Acceptance requires the willingness to acknowledge the cause of the HIV infection and the disposition to incorporate health-promoting behaviours into a daily routine (Schoenleber & Gratz, 2018:75). Further, acceptance requires pregnant women living with HIV/AIDS to incorporate their HIV status into their daily lives (Scrivani, 2016:1). A participant referred to self-acceptance as a coping mechanism that could result in more optimal results for pregnant women living with HIV/AIDS:

“To live positive life is to accept it.” (P1)

According to Scrivani (2016:1), the acceptance of illness is aimed at removing stressors and is a coping response that has been associated with better medication adherence, good self-esteem, positive mental health outcomes and slower disease progression. Yang and Mak (2016:595) found that self-acceptance after an HIV/AIDS diagnosis is a coping mechanism associated with a better quality of life and increased wellbeing among pregnant women living with HIV/AIDS. A participant highlighted that individuals’ acceptance of their diagnosis varied:

“HIV is everywhere and there is treatment for it and you will see they accepted already, but there will be those ones still need to accept it.” (P4)

Self-acceptance is vital for engagement in HIV/AIDS care (Kutnick et al., 2017:1). A participant mentioned that pregnant women with HIV/AIDS still do not accept the diagnosis:

“They are not accepting it.” (P8)

Kutnick et al. (2017:1) emphasise that not accepting one’s HIV infection diagnosis poses serious potential adverse public health consequences, such as the non-uptake of treatment, non-disclosure to others and not minimising the risk of transmission to sexual partners.

3.4.1.2 Category 2: Self-respect in living your unique identity

Balthip, McSherry and Nilmanat (2017:257) state that self-respect relates to the identity we attach to ourselves as integrated and autonomous individuals. Self-respect is defined as a person’s ability to see themselves as someone who has the same basic rights as others (Renger, 2018:1). Self-respect also refers to the courage to stand up for yourself when you are being treated in a manner that is less fair than what you deserve (Renger, 2018:1). A participant felt that self-respect is a fundamental part of having the self-confidence to deal with whatever life throws at you:
“Nothing stops them, especially women, they know that they must respect themselves. If they can respect themselves, no one can just walk over them. As soon, you lose self-respect no one will want to do something with you.” (P9)

Tangney, Baumeister and Boone (2018:272) state that self-respect is widely regarded as the capacity to change and adapt the self. This would allow the person to produce a better, more optimal fit between the self and the world. Self-respect is the ability to override or change one’s inner responses, as well as to interrupt undesired behavioural tendencies and to refrain from acting on them (Tangney et al., 2018:272). Therefore, self-respect should contribute to producing good self-esteem and a broad range of positive outcomes in life. Mishra (2018) argues that self-respect leads to individuals with higher self-esteem, as well as a feeling of confidence and pride in their own ability and worth.

A participant mentioned that pregnant women with HIV/AIDS need a strong sense of self-respect to fulfil their potential, develop healthy relationships and make everyone around them see them as people worthy of respect:

“HIV can be dangerous if you don’t respect yourself, but if you do the right thing, you are living the right way and the viral load is low, you sexually active and you abstaining also... you know that type of thing... you can leave a normal life.” (P2)

Another participant mentioned that if pregnant women truly want to achieve self-respect, they have to change their lifestyles and work on becoming the persons they always dreamed of becoming:

“Self-respect means the lifestyle must change, first of all, eating healthy, playing safe, use a condom all the time. We must be faithful actually because going around sleeping with different partners, that will cause infections.” (P3)

Pregnant women living with HIV/AIDS are likely to be affected by widespread stereotypes and stigmatised behaviour associated with their illness. What matters, is for them to have self-respect and a sense of personal control over their lives (Balthip et al., 2017:257).

3.4.2 Theme 2: Find themselves in their own world

According to Kalomo and Liao (2018:70), pregnant women with HIV/AIDS often experience social isolation. Despite having much activity in their lives, it is also crucial for pregnant women with HIV/AIDS to reach out to others (Kalomo & Liao, 2018:70).
Participants felt that pregnant women with HIV/AIDS are not in touch with reality. One participant mentioned that these pregnant women opt to isolate themselves and keep their distance from professional nurses, instead of engaging and discussing issues.

“People with HIV/AIDS, they not really open about it, they very like... they withdraw themselves from other patients.” (P9)

Another participant mentioned that patients isolate themselves from their family:

“Let's say they come to hospital, they always hiding, they can't phone call their family member to say: bring my tablets.” (P1)

These women have to deal with the uncertainties and the stress that usually accompany pregnancy and they have to live with the reality of having a life-threatening disease. In addition to that, they also have to deal with discriminating and stigmatising behaviours from their environment (Kontomanolis, Michalopoulos, Gkasdaris & Fasoulakis, 2017:111).

3.4.2.1 Category 1: Withdrawal into an isolated space

According to Paolilo, Tanq, Depp, Rooney, Vaida, Kaufmann, Mausbach, Moore and Moore (2018:1), pregnant women living with HIV/AIDS are a rapidly growing population of individuals who are at a significantly increased risk for social withdrawal, compared to pregnant women without HIV. Participants simultaneously felt that pregnant women living with HIV/AIDS are experiencing a high level of withdrawal due to their HIV diagnosis. They felt that these individuals find it more difficult or are less willing to interact with other people. These individuals also find it difficult to adapt to their social environment and to get involved in community life.

“You can clearly notice they are very withdrawn, they not those kinds of patients who easily chat on what so ever, so yeah the psychological side.” (P1)

“People with HIV/AIDS, they not really open about it, they very like... they withdraw themselves from other patients.” (P9)

The diagnosis of a life-threatening disease like HIV/AIDS in pregnant women can easily drive them to be socially withdrawn due to enormous stress, poor self-esteem, great anxiety and deep depression (Luo, Lin, Ji & Li, 2017:3202). Withdrawal was observed when a pregnant woman did not open up during conversations between participants:

“They not outspoken because of the stigma and... like people with HIV positive, they not really open about it, they very like... they withdraw themselves from other patients.” (P9)
“You will suspect there is something wrong after the patient comes out of the HIV counsellor’s office. She won’t interact with other patients, she will be quiet.” (P10)

Xie, Yang, Simonj, Shiu, Chen, Zha and Lu (2017:211) state that withdrawal behaviour or social isolation among pregnant women with HIV/AIDS ranges from making fewer visits to more extreme measures of sending children away, divorcing spouses, moving far from home, living alone and engaging in suicidal behaviour. A participant shared her experience of observing patients with withdrawal behaviour and isolation, however, she blamed it on nurses’ lack of time to provide support:

“You will see patient withdrawn in the whole crowd of patients, quiet, isolated, but there is nothing you can do. Because you rush over, you rush to the next patient to do a blood pressure, you had to go do Hb or patient had emergency situation, so at the end of the day when you see that patient again, the patient is on her way home.” (P10)

Xie et al. (2017:211) argue that withdrawal can go up to a point whereby pregnant women with HIV/AIDS isolate themselves because they are wary of being contagious and vigilant about keeping a safe distance between themselves and others during interpersonal interactions. Therefore, they develop strict self-discipline and continuously monitor themselves when they are interacting with people closely. They tend to avoid physical affection (Xie et al., 2017:211).

Pregnant women with HIV/AIDS are reported to withdraw and thereby distance themselves from others. Webster (2018) defined this isolation as the social separation of a person who has, or is suspected of having, a contagious disease. According to Paolillo et al. (2018:1), social isolation is associated with an increased risk for mental and physical health problems, especially among pregnant women living with HIV/AIDS. Some participants isolated themselves by not speaking:

“You will see sometimes they don’t speak to the others, they just keep quiet, just being on their phones, chatting on their phones, it’s like they alone in the room, they don’t want to speak to anyone.” (P4)

“Then we have RVD positive patients but they don’t talk as much they silence.” (P3)

Webster (2018) states that isolation could be defined as a lack of contact between persons, groups, or whole societies, as well as the failure of an individual to maintain contact with others or the lack of genuine communication where interaction with others persists. A participant describes how a pregnant woman with HIV/AIDS distances herself from others:

“People with HIV positive, they not really open about it… they withdraw themselves from other patients.” (P9)
Pregnant women living with HIV/AIDS who experience poor self-esteem, may withdraw from social relationships in an attempt to minimise potential discrimination, which would lead to social isolation and social withdrawal (Turan, Budhwani, Fazeli, Raper, Mugavero & Turan, 2017:283).

**3.4.2.2 Category 2: Self-confident, despite a chronic condition**

Self-confidence is described as a belief in one’s self and one’s ability to succeed, a feeling of being cheerful and safe (Berens, Koochek, Fielding, Gustafsson, Kim, Cederholm & Sodergrem, 2018:541). Many pregnant women living with HIV/AIDS experience a range of physical, social and psychological challenges linked to their HIV positive status (Beresa, Robinson, Welbourn & Kennedy, 2017:1079). It was mentioned that pregnant women with HIV/AIDS had too little confidence as well as poor self-esteem due to the HIV/AIDS stigma:

“They already down with stigma and self-confidence is poor.” (P2)

Self-confidence is a person’s belief in their capability to perform physical activity and in their ability to accomplish some specific goals (Berens et al., 2018:541). A participant described the importance of being strong and motivated as an individual:

“They must be informed that they must make their own choices. Self-confident, holding confident, if I have confident in myself I will do and say anything. I can jump that mountain, if possible, I will be able to do that.” (P9)

Dedicated and motivated professional nurses play a major role in delivering efficient and effective health services that improve patients’ self-confidence and their experience of healthcare (Okello & Gilson, 2015:2). A participant felt that professional nurses should take it onto themselves to build the self-confidence of pregnant women with HIV/AIDS, by motivating them:

“You can’t just make negative about the whole situation she is in. you have to build her confident, tell her there is life after HIV, whatever your dreams or hopes, where it can still continue. You can still have the life you want in future, so don’t stop trying.” (P10)

A positive approach by professional nurses allows patients to presume that they are adequately competent and to adopt the positive attitudes that benefit their healthcare needs and expectations (Okello & Gilson, 2015:2).

**3.4.2.3 Category 3: Cautious to share their HIV status**

Women who are dependent on male partners for financial support may not disclose their status for fear that partners may discontinue support, particularly during pregnancy, when it is more
difficult for them to find employment to support themselves (Kinuthia, Singa, McGrath, Odeny, Langat, Katana, Ng’ang’a, Pintye & John-Stewart, 2018:18). Participants felt that pregnant women who test HIV positive might experience anxiety when considering disclosure due to fears of being accused of bringing HIV infection into the family through extramarital partnerships or promiscuity:

“They always feel they are the one maybe infected the partner; in the mean time they didn't even know the partner could be the one.” (P1)

Some pregnant women with HIV/AIDS are able to tell their sexual partners immediately, while others may hold back because of concerns about potential negative consequences (Kinuthia et al., 2018:18). A participant mentioned that some pregnant women with HIV/AIDS are cautious to disclose because they fear losing their partners and family members:

“They are having fear of disclosing because they can be cut out of the family because the blame being put on them. Even if disease didn’t come with them maybe the partner which is the husband or boyfriend is the outgoing person who goes to parties or whatever, maybe is the one who brought disease to the mother but it won’t come out in that way if she is the first person to discover that she’s HIV positive.” (P7)

A participant also mentioned that despite some patients talking about themselves, they avoid mentioning their HIV status:

“There will be one or two, they will talk but you won’t know that she is positive. She won’t like to interact like in group activities... most of them they won’t like to interact about HIV status, they will like... what this one will think of me. What these people will think if they find out I’m HIV positive.” (P9)

Ngomzi, Godfrey, Kivunike, Julius, Salongo, Sezalio, Ronald and Francis (2017:2) argue that sharing sensitive information such as your HIV positive status, is generally thought to have beneficial effects on an individual’s health.

3.4.3 Theme 3: Individuals not owning their HIV status

Pregnant women with HIV/AIDS have the right to privacy about their health and ownership of their HIV status. The right to ownership of HIV status should not be undermined, despite good clinical outcomes, psychological adjustment and the fact that the reduction in the risk of HIV transmission requires disclosure of one’s HIV status (Arya, Huang, Kumar, Hemmige, Street & Giordano, 2018:101). According to Villela and Fraga (2016:1), the law protects HIV non-disclosure and women see it as a way to protect themselves from discrimination. Participants felt
that pregnant women with HIV/AIDS are not owning their HIV status and they often find it difficult to keep their HIV positive status a secret:

“If I do this, he must know everything, so there is not secrets kept away from the husband. That also breaking the self-esteem because she depending on the husband.” (P9)

“Because in a relationship you do things together so like, yhoo haa this one is quite difficult really because as I told you disclosing is a choice.” (P3)

According to Villela and Fraga (2016:1), pregnant women living with HIV/AIDS are under no legal obligation to disclose their status to anyone. Whether they just found out that they are HIV positive or they have known it for a while, it is entirely up to them to decide whether to disclose their HIV status or not (Arya et al., 2018:101).

3.4.3.1 Category 1: Lack of social interaction with significant other

Social interaction is one of the most important factors among people living with HIV/AIDS in predicting physical health and psychosocial wellbeing (Rzeszutek & Gruszczynska, 2018:25).

Many pregnant women with poor self-esteem related to HIV/AIDS find it hard to open their hearts and share their feelings and problems. However, social interaction is essential, where people can express their feelings and share their problems with other people (Rzeszutek & Gruszczynska, 2018:25). Participants were of the view that the social interaction of pregnant women who are HIV negative is higher than those who are HIV positive. HIV positive patients interacted less, due to poor self-esteem.

“Most of patient that interacting are ones who not positive, the ones that HIV positive they will like keep quiet. There will be one or two they will talk but you won’t know that she is positive. She won’t like to interact in group activities... most of them they won’t like to interact... .” (P9)

“Really, I can see many of these patients especially when they were told now that in this visit, they totally quiet, you see everybody interacting, they quiet.” (P1)

Another stated that interaction was less due to their mindset:

“They not those kind of patients who easily chat on what so ever, so yeah the psychological side.” (P1)
Pregnant women living with HIV/AIDS experience the lack of socially interacting with others because of their HIV status, which can be associated with a lack of self-esteem and confidence (Paolilo et al., 2018:1).

3.4.3.2 Category 2: Staff told to keep patient’s HIV status secret

Patients request staff to keep their HIV status a secret or not to tell anyone about the diagnosis. This is particularly challenging for pregnant women with HIV/AIDS, as they may choose not to disclose to their partners for fear of rejection, stigma, discrimination, or violence (Ekstrand, Heylen, Mazur, Steward, Carpenter, Yaday, Sinha, & Nyamathi, 2018:1).

Participants mentioned that pregnant women with HIV/AIDS often ask them not to disclose their health information, including their HIV positive status, to their partners during visiting times. Staff is obliged to adhere to such requests, as it is part of their ethical and professional practice to keep patients’ diagnoses private and confidential, despite the fact that they know that their patients might be putting their partners at risk.

A participant stated that the secret around the diagnosis affected record-keeping:

“It got an impact in our nursing care as well, you find yourself now you can’t write positive in the baby’s book because the partner is going to see.” (P1)

Medication had to be given in isolation:

“So you need to keep that medication or you need to call her aside and give her the medication.” (P3)

“The only thing we do its just to get close to her and give medication in a private space, we don’t get through as to say... how you got it and when did you diagnose.” (P4)

“She will immediately say ‘no sister I got my medication’ in a soft tone as if she doesn’t want me to be loud and ask: Did you took your medication or I’m going to give you medication.” (P4)

The confidentiality of medical information, including HIV status of pregnant women, is essential to the protection of their human rights, because women may find themselves abandoned, subject to domestic violence, or ostracised if their domestic partners, families, or communities discover that they are HIV positive (Villela & Fraga, 2016:1).
A participant mentioned that a secret about medication remains an issue even at home:

“So you get those kind of cases, patient ask: ‘Can’t I just come every morning with my baby so that you give this medication, because I don’t know what to say to my partner what medication is this.” (P8)

The place of medicine and management of it with children was mentioned:

“Just change the bottle to panado, nobody will check what kind of medication you giving to your child.” (P8)

Nurses needed to change their behaviour when family was nearby:

“This makes us also to be on our toes to be aware that we cannot say anything in front of their family members because they haven’t disclose yet.” (P7)

Professional nurses are aware that they have a clear ethical obligation to preserve the confidentiality of their patient’s medical information (Ekstrand et al., 2018:1). Patient confidentiality encourages patients to divulge relevant information so that healthcare professionals can make a proper assessment of a patient’s condition (Villela & Fraga, 2016:1).

### 3.4.4 Theme 4: Stigma

Stigma is a complex social process of prejudice and negative attitude towards people living with HIV/AIDS (Rasoolinajad, Abedinia, Noorbala, Morhaz, Badie, Hamad & Sahebi, 2018:1). Stigma experienced by pregnant women with HIV/AIDS can include being gossiped about, insulted or physically assaulted in communities and healthcare settings (Hargreaves, Krishnaratne, Mathema, Lilleston, Sievwright, Mandla, Mainga, Verkmaak, Piwiwar-Manning, Schaap, Donnell, Ayles, Hayes, Hoddinott, Bond & Stang, 2018:783). Despite recent advances in HIV/AIDS care, the stigma about pregnant women living with HIV/AIDS remains prevalent, with a negative impact on the quality of life and overall health (Rasoolinajad et al., 2018:1).

According to Dillingham and Darlington (2017:12), internalised HIV stigma is described as prejudice and negative attitudes towards people living with HIV/AIDS. Participants mentioned that stigma among pregnant women manifests itself in many ways:

“They shy about the fact that they HIV positive, I think that is stigma.” (P3)

“They have stigma that if you HIV you going to die.” (P8)

Pregnant women infected with HIV/AIDS are often blamed themselves for the condition, although it is treatable (Dillingham & Darlington, 2017:12). A participant mentioned that women blamed themselves for the stigma:
“They always blame themselves with the stigma attached to it.” (P8)

“HIV is a stigma.” (P3)

3.4.4.1 Category 1: Patients hiding their status and keeping their secret due to fear of stigma

According to Broderick (2018:5), hiding the status and keeping own secrets is the act of deliberately keeping information private from others. Secrets contain information that at least one individual consciously withholds from at least one other person because they do not want to or cannot reveal it to others (Broderick, 2018:5).

Participants felt that pregnant women choose to hide their status and keep their own secret due to the stigma and fear that once the husband discovered that she was positive, he would not want to see her again.

It was stated:

“They don’t want to tell the partner because they have stigma and feel like the partner will leave them if the partner knows they are HIV positive.” (P8)

“So, they fear that if the partner can find out this secret there can be a conflict within the family.” (P7)

For many pregnant women living with HIV/AIDS, the disclosure of positive status can lead to either an extension of former violence or new conflict specifically associated with HIV positive status disclosure (Colombini, James, Ndewiga & Mayhew, 2016:15). Another participant explained that pregnant women fear that their partner will accuse them as carriers of HIV/AIDS because they as partners are not sick:

“They having fear of disclosing because they can be cut out of the family, because the blame being put on them even if the disease didn’t come with them maybe the partner which is the husband outgoing.” (P7)

Despite potential preventive health benefits and care implications, disclosure of HIV status to sexual partners has been widely reported as a major source of stress for pregnant women living with HIV/AIDS, with many fearing male partner stigma, discrimination, violence, or abandonment (Colombini, James, Ndewiga & Mayhew, 2016:15).
3.4.4.2 **Category 2: Pregnant women with HIV/AIDS become a target of judgement**

Despite over thirty years into the HIV epidemic, pregnant women with HIV/AIDS are still experiencing major discrimination and stigma related to HIV/AIDS (Langeni, 2018:1). According to Earnshaw, Bogart, Courtney, Zanoni, Bangsberg, Orrell, Goggin and Katz (2018:1), judgement is a cognitive process of reaching a decision or drawing conclusions about a person. Judgement from others contribute to poor self-esteem and restricted disclosure (Watt, Dennis, Choi, Ciya, Joska, Robertson & Sikkema, 2017:3209). A participant mentioned that some of the pregnant women with HIV/AIDS do not disclose their HIV positive status due to fear of judgement from others:

“I think, because if you don't disclose obviously you got a fear that people going to judge you.” (P1)

Many pregnant women with HIV/AIDS do not tell others about their HIV positive status, thinking that they will be judged and stereotyped (Watt et al., 2017:3209).

“Actually if partner find out they going to judge them, I spoke to one of the ladies she said if family must find out she HIV positive they going to treat her different.” (P9)

Judgement plays an influential role in stigmatisation and discrimination against pregnant women living with HIV/AIDS and creates substantial barriers to the disclosure of HIV status (Langeni, 2018:1).

3.4.4.3 **Category 3: Community-level stigma among pregnant women with HIV/AIDS**

Although HIV stigma has been described as prejudice and negative attitudes towards people living with HIV/AIDS (Rasoolinajad et al., 2018:1), little is known about the contribution of community-level HIV/AIDS stigma (Kelly, Michael, Maureen, Alexander, Weiser & Sheri, 2017:399). According to Darlington and Hutson (2017:12), the community is the main arena in which pregnant women with HIV/AIDS encounter stigma, which leads to poor self-esteem. Darlington and Hutson (2017:12) also state that non-acceptance of people with HIV/AIDS by the community is linked with a lack of understanding about HIV transmission from one person to another. Community-level stigma can negatively impact individual self-esteem and less is known about the associations between pregnant women living with HIV/AIDS and stigma at the community level (Kelly et al., 2017:399).
Participants felt that community-level stigma could influence the self-esteem of pregnant women with HIV/AIDS:

“I am HIV positive and then maybe someone else in the family tells someone else in the community that I am HIV positive, then that means I am shy about the fact that I am HIV positive. I think that cause stigma.” (P3)

“Because of the pressure you getting from your community friends or the family, self-esteem drops and lead to stigma.” (P7)

Stigma can impair one’s self-esteem and motivation for self-care, while experiencing discrimination and anticipated negative interactions can limit opportunities for social connections and access to healthcare. Stigma among pregnant women with HIV/AIDS plays a role in decision-making regarding disclosure and can exacerbate isolation (Rasoolinajad et al., 2018:1).

Participants felt that pregnant women living with HIV/AIDS experienced stigma in social connections:

“HIV is a stigma, they don’t understand (the community) about HIV and then they actually see it as a stigma.” (P3)

“It’s like everybody is looking with a judging eye, so that’s how they see people who coming to visit.” (P8)

Members of the community, including family, friends, employers, even church members, often communicate stigma towards HIV positive women (Darlington & Hutson, 2017:12).

3.4.4.4 Category 4: Role of cultural density on pregnant women with HIV/AIDS

The role of cultural density has been particularly problematic in the fight against HIV/AIDS among pregnant women (Salari, 2018:88). Cultural density refers to the nature of doing things, thickness and dominance of habits and norms of practice in places (Salari, 2018:88). Therefore, it is difficult and challenging to live with a life-changing event of this kind in some cultural settings (Arrey, Bilsen, Lacor & Deschepper, 2015:1). Cultural density plays a major role in the spread of HIV/AIDS among pregnant women, especially in the patriarchal society where the control of women and male strength and power are highly valued (Arrey et al., 2015:1). Due to cultural density, many pregnant women do not want to disclose their HIV status and often keep it a secret, some even from their sexual partners (Kheswa, 2017:1445). However, a participant mentioned that some of the cultures allow the man to make all sexual decisions. Some cultures
see the man insisting on having sex with his wife, even if she is not in the mood. The participants stated:

“Women is HIV positive because she cannot refuse if husband want to sleep, we coloured can still say no, I don’t want, you not going to touch me.” (P9)

“Some cultures don’t understand about HIV and then they actually see it as a stigma.” (P3)

According to Odeny, Pfeiffer, Igonya, Kagwaini, Nduati, Kiarie and Bosire (2016:1), global opinions support breastfeeding for all babies starting from the first six months of life and continuing to partial breastfeeding for up to two years or thereafter. However, some cultures associate exclusive breastfeeding among women with HIV/AIDS (Odeny et al., 2016:1). There was consensus among some participants that culture-related HIV stigma is a barrier to exclusive breastfeeding. Exclusive breastfeeding is perceived as a practice for women who are HIV positive.

“So it’s obvious in our locations that if you breastfeed, you HIV positive.” (P9)

“I think more of what people will think, what people will say? How people will react?” (P3)

When one talks of culture, what comes to mind is the patriarchal society in which we live, as well as the gender inequalities which it has given rise to (Odeny et al., 2016:1). Participants mentioned that in some cultures HIV/AIDS is believed to be carried by women and, as a result, many women experience stress and tension on a daily basis.

“They always blame them as carrier. In the meantime, if you look really who is the... hee... I think the man... NO! NO! NO I'm not thinking when I was doing my community health and in that it shows in the research that the people actually spread this HIV is men because they contain the semen, the women is a container.” (P1)

“Maybe the partners should also go check himself then probably he will find out they are in same problem.” (P5)

Cultural density in Southern Africa prevents many pregnant women with HIV/AIDS from disclosing their positive HIV status (Langeni, 2018:1). South African traditional opinion links HIV/AIDS with sexual promiscuity and often causes HIV positive pregnant women to be rejected by their communities and households (Kheswa, 2017:1445).
3.4.4.5 Category 5: Fear of HIV/AIDS among pregnant women

HIV/AIDS diagnosis during pregnancy is a turning point in women’s sexual and emotional lives and brings traumatic experiences and fear (Arco, Rodriguez, Perez-Elías, Blanco, Cuellar, Romero, Santos, Boix, Masia, Pascual, Hernando & Coris, 2018:2).

According to Austin (2017:1), being fearful of having HIV/AIDS is natural. Austin also states that the fear of stigma and discrimination has deterred pregnant women from testing for HIV and from disclosing their HIV positive status to sexual partners, family and friends.

The diagnosis of being HIV positive is usually associated with the fear of immediate death and results in poor self-esteem (Arco et al., 2018:2). The participants tend to assume that pregnant women with HIV/AIDS, feared disclosing their HIV positive diagnosis, due to the stigma, the possible husband’s reaction, the risk of divorce and the loss of economic support.

Participants repeatedly explained that pregnant women with HIV/AIDS fear disclosing their HIV positive status because they fear that if their husbands find out, they will leave them and they will have to go home and suffer, so they decide to hide their status.

“*They do not want to disclose because they think as soon as they disclose they think their partners will going to leave them.*” (P1)

“*Fear of not having anyone, it’s a stress, it’s a general stress... I think that’s what make the people be afraid to tell their partners, that they might leave and say you accusing me... like that ... .”* (P2)

“*They fear what they will say. If they know, how they will react? They will treat me the same way?*” (P8)

Fear among pregnant women is sometimes caused by the knowledge that they are HIV positive (Chippindale & French, 2018:3). Rejection pertains to pregnant women with HIV/AIDS feeling discriminated against at home, work and in society generally, including the perception that others have less respect for them and appear to feel awkward in their presence (Barton, 2017:1).

Participants believed that fear among pregnant women with HIV/AIDS is as a result of the fear of rejection:

“*They fear to disclose because they are frightened of rejection.*” (P6)

“*They fear that they going to be judged and they also fear they going to be rejected, fear of ... yeah there's a lot of fear around this.*” (P1)
For pregnant women with HIV/AIDS, discussing their HIV status can be uncomfortable and even frightening, therefore, professional nurses should engage them with particular care, while honouring the human dignity and welfare of patients (Chippindale & French, 2018:3). Another participant mentioned that despite fears among pregnant women with HIV/AIDS, a few of them do find time to open up and discuss their fears with them:

“We sit with them and they tell us their fears.” (P7)

“I don’t think I am ready to disclose to my husband yet but I am going to continue to take my medication, do you know the time? Yes sister, I know the times.” (P3)

Barton (2017:1) argues that the lack of social support, the lack of self-esteem and agency for women in their culture and a lack of male involvement in the programs generally, contribute to fear among pregnant women with HIV/AIDS.

### 3.4.4.6 Category 6: Adapting a healthy lifestyle with HIV/AIDS

In this study, adapting a healthy lifestyle is considered analogous to coping with poor self-esteem among pregnant women with HIV/AIDS. Having been notified of an HIV positive result implies a significant emotional impact (Quiroga, Salma, Sánchez, Vivas, Villarreal, Castillo & Tueme, 2018:1). However, a strategy for living and adapting a healthy lifestyle can be possible through widely increased access to antiretroviral therapy (ART) and increased access to health support groups (O’Brien, Dagenais, Solomon, Worthington, Carusone, Ibanez-Carrasco, Hanna, Gahagan, Baxter, Robinson, James, & Yates, 2018:1). Moreover, HIV/AIDS is transitioning into a chronic illness, whereby pregnant women with HIV/AIDS have life expectancy similar to the general population (O’Brien et al., 2018:1). Participants felt that pregnant women with HIV/AIDS should adopt healthy living strategies, identify ways to help themselves deal with HIV/AIDS and promote positive self-management approaches for enhancing their health.

“HIV is not killing; it’s like other diseases, can I put it like that way.” (P5)

“You can live a healthy life if you HIV positive, there’s people who HIV positive, they live longer and what they need is to just eat healthy and obviously stop smoking and drinking and take medication, then they can live healthy longer. So it’s not like it’s a death sentence.” (P9)

In order to adapt one’s lifestyle, one has to adopt healthy living strategies, including seeking social interaction with others, maintaining a sense of control over one’s life, blocking HIV out of the mind and maintaining positive attitudes and beliefs around living with HIV/AIDS (Quiroga
et al., 2018:1). Participants felt that if pregnant women can adopt healthy lifestyles, they could live healthy lives:

“If they living healthy lifestyle, they won’t become worse, as long as they know what keeping viral load low.” (P2)

“So if they take their treatment freely and get healthy food, I think they can do better.” (P5)

Thapa, Amany, Pahari, Bam and Newman (2015:2) state that adopting a healthy lifestyle is to live a quality life as an individual, which includes a positive perception of your position in life in relation to your goals, standards, expectations and concerns. Participants were of the view that telling a partner about how they feel could enhance healthy living:

“I think telling my partner will be a good thing because it will give him that mindset that now I must leave a healthy lifestyle because there is this thing.” (P3)

“So, if maybe we can teach them the ways of approaching the partner that can boost their self-esteem because that they will be proud of themselves and walk freely and know that now my partner knows I’m HIV.” (P5)

The number of people living with HIV/AIDS is expected to increase, as individuals who were diagnosed at younger ages are now surviving into older age (O’Brien et al., 2018:1).

3.4.5 Theme 5: Moving towards a place to live with HIV/AIDS with an inspirational approach

“A life-long illness such as HIV/AIDS requires constant management in cultural situations where promotion of health is a priority” (Kabel, Teti & Zhang, 2017:221). HIV/AIDS among pregnant women is a highly stigmatised illness that could threaten their identity and social belonging (Kabel et al., 2017:221). Participants were of the view that moving towards a place to live with HIV/AIDS with an inspirational approach could benefit pregnant women with HIV/AIDS by improving their self-esteem:

“Move to new place with different behaviour, especially newly diagnosed and people who are not coping with the fact that they are HIV.” (P3)

“A place where they can do everything freely and be away from scary of doing things.” (P5)
3.4.5.1  **Category 1: Sharing information with family and community**

Pregnant women with HIV/AIDS not only have to deal with the challenges of living with an incurable disease but also with the dilemma of whether or not to share their HIV information with their families and community (Arrey et al., 2015:1). Participants felt that the concern about negative reactions from family members and their community affects many HIV positive pregnant women’s decisions regarding the sharing of their HIV status:

“You will find out they will say no one knows at home, sister, I don’t want my partner to know about this.” (P5)

“We always ask that kind of a question that who you are going to tell? So most of the time they are like to indicate that they not going to share with nobody for now. They indicate they just want to deal with it.” (P8)

Sharing information is critical to the healthy development and functioning for all pregnant women, especially those living with HIV/AIDS (Lee, Yamazaki, Harris, Harper & Allen, 2015:73). The sharing of information about their HIV positive status might lead to much needed social support from close people, such as family and the community, which can impact pregnant women’s self-perception and self-esteem. This will allow them to reach a point where they would share information willingly (Lee et al., 2015:73).

3.4.6  **Theme 6: Emotional involvement throughout the turbulent journey**

According to Mayer, Caruso and Salovey (2016:304), emotions play a crucial role in human lives and in human affairs, as part of psychological and cognitive sciences. Receiving an HIV/AIDS diagnosis can be an emotionally challenging time for newly diagnosed individuals, especially for mothers and pregnant women who must assimilate HIV into their identities (Proudfoot, 2018:323). Ashraf and Sitwat (2016:364) state that people with HIV, as a group, experience emotional difficulties more than those seen in the general population. Being diagnosed or living with a serious illness like HIV/AIDS is likely to have a significant emotional impact. Ashraf and Sitwat (2016:364) also state that, to ensure safe patient care, it is necessary to deliver emotional support to pregnant women with HIV/AIDS. This was demonstrated in the following quotation:

“Because, these mothers are more emotionally traumatised... sometimes they don’t get the support they supposed to get in their family.” (P8)
An HIV positive individual may experience emotional turbulence which adversely affect self-esteem and treatment outcomes (Brittain, Mellins, Phillips, Zerbe, Abrams, Myer & Remien, 2017:274). A participant mentioned the support needed:

“Nursing, it’s not only about giving medication, doing vital signs, but talking to a patient, zooming in, trying to probe and see what is bothering the patient, nursing, it’s about healing patient emotional state.” (P7)

Participants expressed more concerns with regard to emotional turbulences in pregnant women with HIV/AIDS while they were hospitalised:

“HIV patients sometimes, you see the patient is been quiet, not communicating with other patients or change to become aggressive when you talk to them or we can see that she is aggressive to other patients.” (P7)

“Sometimes they laugh, sometimes they cry, don’t want this around, you don’t eat this, you don’t eat that.” (P9)

Pregnant women with HIV/AIDS need ongoing emotional support from their communities, friends and from professional nurses to cope with their illness. Without such support, the challenge of emotional difficulties could cause patients to suffer from physical fatigue (Mothi & Tappuni, 2016:19).

3.4.6.1 Category 1: Loneliness among pregnant women with HIV/AIDS

Pikhartoya, Bowling and Victor (2016:543) define loneliness among pregnant women with HIV/AIDS as the discrepancy between one’s desired and achieved levels of social interaction. This sometimes becomes a long-lasting feeling of having no alternative to turn to in times of distress and depression. Loneliness is generally classed as a period of heightened cognitive discomfort and uneasiness of being on your own (PikhartoYa et al., 2016:543). A participant felt that pregnant women living with HIV/AIDS are lonely and socially isolated due to their HIV status having become known to others:

“I think she is lonely because they scared if the husband must find out that she is HIV positive.” (P9)

Pregnant women with HIV/AIDS with loneliness, have feelings about a lack of connections with other people and can be present even in the presence of social networks (Valtorta, Kanaan, Gilbody & Hanratty, 2016:1). Different emotions could be involved:

“I don’t know how can I put it, but they have that feeling of loneliness, sorrow, alone.”
A positive diagnosis of HIV/AIDS could lead to a number of psychological problems among pregnant women with HIV/AIDS, such as loneliness, isolation, low self-esteem, identity crises and lack of interest in the prevention of HIV/AIDS (Dahlui, Azahar, Bulgiba, Zaki, Oche, Adekunjo & Chinna, 2015:1).

3.4.7 Theme 7: A supportive environment for pregnant women with HIV/AIDS

According to Lifson (2015:1382), a supportive environment enhances self-esteem in pregnant women with HIV/AIDS. Given that patients who became aware of their diagnosis during pregnancy and then entered care may be an especially vulnerable group, programs to help identify and address social support needs can provide multiple benefits in facilitating the best possible physical, emotional and functional quality of life for pregnant women living with HIV/AIDS (Lifson, 2015:1382).

Professional nurses are trained to provide guidance and support to pregnant women. Emotional support is when one human being displays appreciation, benevolence and an absolute interest in another human being (MIR, 2018:1). As human beings, we have a continuous and essential need for genuine, original, worthwhile relations with our fellow human beings. Generally, “people with healthy friendships and relationships have greater emotional wellbeing, live healthier lives and even have longer life expectancies” (MIR, 2018:1). The lack of social support for patients in need necessarily has negative consequences for a hospital. The nursing profession, like any other profession, is not exempt from the negative effects of a lack of support in the work environment. Professional nurses should have time allocated to attend to the psychological needs of pregnant women with HIV/AIDS to strengthen the women’s self-esteem (Kontomanolis et al., 2017:111). Participants in this study felt that they should give more support to patients with HIV/AIDS. However, due to staff shortage and busyness in the unit, they do not have enough time to cover all health aspects. It was expressed as follows:

“We don’t do anything, because you see brother, this maternity is understaff and sometimes you just do... you actually work just for survival, you haven’t got that deep intense nursing care for the patient. I think if we had enough staff, yeah, at times when you come upon this patient who is withdrawal of whatsoever, you can take this patient aside and ask her why she so quiet and blah, blah, maybe she will tell you but as I said we only work for survival.” (P1)

According to Kontomanolis et al. (2017:111), pregnant women with HIV/AIDS face constant psychological difficulties, including low self-esteem. A participant stated:
“We just doing nursing care, we don’t really get to the real support. Sometimes you see the patient is crying, we just ask quickly, we ask if we need to refer and then you refer. Because of the busyness and shortage of staff we don’t follow-up. I think we can do more or we failing because of the shortage of staff, that is where the problem comes in because we don’t really get the emotions of the patient, we just do the basic nursing care because that’s what we going to answer for.” (P8)

Professional nurses should integrate giving support to pregnant women living with HIV/AIDS within their duties in order to assist these women in uplifting their self-esteem (Arco et al., 2018:2).

3.4.7.1 Category 1: Professional nurses’ knowledge of HIV/AIDS

Knowledge is described as knowing a fact or a condition which was learned through experience or association. It can also be the acquaintance with or understanding of a science, art or technique or to be aware of something (Webster, 2018). Marimon et al. (2017) state that knowledge is a relevant understanding in which employees diffuse relevant information to others across and outside the institution. Participants felt that they needed training and skills development to understand how to support pregnant women with HIV/AIDS and how to promote the healthy self-esteem of hospitalised patients:

“I actually think I need to go for a course, HIV course... I really think I don’t know much about this, otherwise, if I went already I would give more for patients. Also I lack information somewhere somehow, yes, I know the basics such as taking meds, adhering, but going deeper I think I still need training.” (P4)

“Lot of us are not even trained in PMTCT clinics, our staff are not staffed in that field of diagnosis, our role is basically in health education from the basics we know.” (P2)

Professional nurses should be able to provide information and support after a positive HIV/AIDS diagnosis (Arco et al., 2018:2).

It was expressed that participation of professional was essential:

“HIV/AIDS program or NGO’S, they must also involve us as professional nurses, no matter whereby you not working for the HIV NGO, they must give us studies, skills, take us to training.” (P3)

According to Naidoo, Ngcobo, Ncama and Brysiewicz (2017:1), professional nurses remain a crucial part in the management and care of pregnant women with HIV/AIDS, especially in resource constrained settings where they fulfil a variety of roles and functions. Naidoo et al.
(2017:1) state that professional nurses need to achieve optimal clinical outcomes for pregnant women living with HIV/AIDS.

### 3.4.7.2 Category 2: Acceptance of pregnant women with HIV/AIDS as human beings

Acceptance in human psychology is a person’s assent to the reality of a situation, recognising a process or condition without attempting to change it (Fish 2014:1). According to Bauer, Giblon, Coleman, Aykroyd, Fraser and Pugh (2017:7), acceptance of people with HIV/AIDS as human beings refers to the sense of recognising the sovereignty and dignity of individuals, despite the HIV/AIDS diagnosis. Recognising someone’s suffering as a human being does not occur in isolation, but is intimately interconnected with others and inherent to the nature of life (Yang & Mak, 2017:55). Seeing pregnant women living with HIV/AIDS as normal human beings remain a challenge, as discrimination occurs on the basis of their status (Yang & Mak, 2017:55). Living with HIV/AIDS can affect pregnant women in many different ways. Darlington and Hutson (2017:12) argue that being accepted by the community where you live can have a positive effect on the self-esteem, while feelings of rejection can lower your self-esteem.

The acceptance of an individual with HIV/AIDS involves help and support from the patient’s social network, including friends, family and the community at large (Ford, Lam, John & Mauss, 2018:1). A participant focused on the role of nurses:

> “Sometimes they are thinking that when you have this disease people won’t accept you … So we trying making them feel accepted.” (P11)

Despite the greater acceptance of pregnant women living with HIV/AIDS than before, high levels of stigma and discrimination against them remain (Parsons, Bond & Nixon, 2015:1). A participant mentioned that in many instances the self-worth of an individual with HIV/AIDS as a human being depended on the social approval:

> “I think it depends on how they accepted in the environment, because if people accept you, you can also feel comfortable to handle challenges and whatever, but if people going to point a finger?” (P9)

A participant mentioned that HIV/AIDS among pregnant women is viewed, “as a process of the dying of a human being”:

> “HIV positive, it’s like it’s a death sentence in some people.” (P1)

Participants repeatedly spoke about instances where they felt that family members and friends tend to discriminate against pregnant women with HIV/AIDS:
“They think whether they will want to eat with you? Do you know that type of thing?”

(P2)

Darlington and Hutson state that rejection felt by pregnant women with HIV/AIDS over time negatively effects how they see themselves. Recognising one’s suffering as a human being does not occur in isolation, but is intimately interconnected with others and inherent to the nature of life (Yang & Mak, 2017:55). HIV/AIDS is a disease that continues to stigmatise across the globe, mostly due to the lack of knowledge. Most people lack information about HIV/AIDS and, therefore, they tend to react negatively towards people living with HIV/AIDS (Dutra, Cordova & Avant, 2018:226).

3.4.7.3 Category 3: HIV/AIDS education for community and health professionals

Webb (2017:1) defines education as knowledge acquired by an individual after studying a particular subject matter or experiencing life lessons that provide an understanding of something. There is an urgent need to promote the awareness that the disease does not affect only pregnant women, but that it has a broader impact on the community and healthcare system (Dutra et al., 2018:226). It is widely believed that constant exposure to new ideas and skills makes people better workers, thinkers and societal contributors (Webb, 2017:1). Most participants believed that the lack of knowledge about HIV/AIDS results in negative attitudes towards pregnant women with HIV/AIDS:

“My father on other day he said... (Name of participant) I went to the toilet at work, do you think I’m going to get HIV because I sat on the same toilet where.... I said no Papa you can’t. It’s only through blood and if you have sexual intercourse with that person and body fluids. So that is what they don’t know.” (P9)

Health professionals and society at large must take a stand to promote mindfulness about the negative effect of the oppression of pregnant women living with HIV/AIDS (Dutra et al., 2018:226).

“They need more education, I think they take it lightly, some of the people they have lack of education.” (5)

“We need to educate about HIV positive, so that they know that it’s not the end of life.” (P5)

People around the world place a high value on educating all people, whether formally or informally (Ashipa, Ofili, Onakewhor & Adejumo, 2017:2). Participants mentioned that education is not only needed for patients, friends and communities but for professional nurses as
well. Hence, a lack of educational programs remains a challenge among professional nurses, especially in the antenatal unit.

“Most of staff lack information concerning HIV/AIDS, that we can’t dispute, sometimes they will give this information for certain people but doesn’t give for everybody. I don’t know how many times did I go to HIV/AIDS workshop where you find some people doesn’t know much about it.” (P1)

Participants felt that the training of professional nurses could help them improve the nursing care of patients with HIV/AIDS:

“We need to be informed with regard to HIV; we need to be informed continually about new things and developments.” (P3)

“...Give us training, training to be updated of the studies, of like how to tackle as for now we get different behaviour, especially with newly diagnosed and people who are not coping with the fact that they are HIV positive, so we need to be well equipped in order to know how to tackle those kinds of situations.” (P3)

Professional nurses’ knowledge of the self-esteem of pregnant women with HIV/AIDS should be assessed in order to identify training needs to inform the content of future training programs (Ashipa et al., 2017:2).

3.5 CONCLUSION

This chapter presented the findings of the semi-structured individual interviews and field notes. The findings indicated that there is a need to equip professional nurses with knowledge and experience with regard to the self-esteem of patients with HIV/AIDS, so that they can play their role in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS. Results indicated that professional nurses need to be empowered with more skills in order to be able to deal with pregnant women’s poor self-esteem after a positive HIV/AIDS diagnosis.
4 CHAPTER 4: CONCLUSIONS, GUIDELINES, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

In this chapter, guidelines based on the findings are described and presented, each with its rationale and related actions. Recommendations for professional nurses, research and practice, as well as limitations of the study will also be discussed.

4.2 CONCLUSIONS

The major conclusions linked with the themes of the study. Firstly, participants explained that they were unknown of their future destination. This study shows that little is known about pregnant women’s reactions when they receive their HIV/AIDS diagnosis. It was reported that self-acceptance was a coping mechanism that could assist in reaching optimal results for pregnant women living with HIV/AIDS. The battle for these women was to accept the diagnosis. It came to the fore that it mattered for these pregnant women to have self-respect and a sense of personal control over their lives to contribute in a positive way in their home and work environment.

Secondly, it seemed that pregnant women with HIV/AIDS were not in touch with their reality. They had to deal with the uncertainties and the stress that usually accompany pregnancy while living with the reality of having a life-threatening disease. Participants felt that pregnant women living with HIV/AIDS were experiencing a high level of withdrawal due to their HIV/AIDS diagnosis. Pregnant women with HIV/AIDS withdraw and thereby distance themselves from others, thereby isolating themselves from others.

Thirdly, the confidentiality of the HIV/AIDS status of pregnant women was found to be essential to protection of their human rights. These rights should be respected and professional nurses are obliged to adhere to the standards set for their ethical and professional practices. Patients with a HIV status seemed to refuse to disclose their diagnosis, and rather behaved secretly around it. Specifically, pregnant women with HIV/AIDS seems not to be eager to disclose their HIV/AIDS positive status, to their partners, and this put their partners at risk. These women with HIV/AIDS were concerned about their right to privacy around their health and ownership of their health status. The findings indicated that the pregnant women battled with a low self-esteem, and found it hard to talk openly about their condition, also sharing related feelings and problems. It seemed that the social interaction of these women should be encouraged to socialise more in the community, to improve their self-confidence and esteem.
Fourthly, participants mentioned that stigma among pregnant women manifests itself in many ways. They often blamed themselves for the condition, feeling judge and stigmatised by others, the risk of becoming a divorcée and the possible loss of economic support. The participants indicated that patients indicated that the disclosure of their HIV/AIDS status to sexual partners put them under major stress and indicated being afraid of being abandoned by their partners. Participants indicated that due to cultural density, many pregnant women did not want to disclose their HIV/AIDS status. Participants felt that pregnant women with HIV/AIDS should adopt healthy living strategies, identify ways to help themselves deal with HIV/AIDS and promote positive self-management approaches for enhancing their health.

Fifthly, participants were of the view that pregnant women with HIV/AIDS could benefit from improving their self-esteem through a positive mind shift, towards a place to live with HIV/AIDS, with an inspirational approach. Challenges that pregnant women could face was negative reactions from family members and their communities when they decided to share their HIV status. The sharing of information about their HIV positive status might lead to much needed social support from close friends and family.

Sixth, women with HIV/AIDS were described as being emotional challenged with emotional turbulences when being diagnosed with a positive status, therefore staff needs to ensure the delivery of emotional support to these pregnant women. Pregnant women living with HIV/AIDS should be supported, as they could be very lonely and socially isolated due to their HIV status having become known to others.

Lastly, participants in this study felt that they should give more support to patients with HIV/AIDS during patient visits. However, due to staff shortage and busyness in the unit, they do need to focus on time management to cover all the relevant health aspects, such as psychological difficulties of the pregnant women with HIV/AIDS. On the other hand, participants uttered that they needed pertinent training and development in understanding how to effectively support pregnant women with HIV/AIDS. Participants repeatedly spoke about instances where they felt that family members and friends tend to discriminate against pregnant women with HIV/AIDS. The need for support from the community was explored as found to be accepting individuals with HIV/AIDS as human beings, to have a sense of recognising the dignity of individuals.
4.3 GUIDELINES

The following seven guidelines were developed from the themes generated by the data analysis (Table 4.1).

**Table 4.1: Themes and guidelines**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Guidelines</th>
</tr>
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<tbody>
<tr>
<td><strong>Theme 1: Discovering the unknown of a future destination</strong></td>
<td>Guideline 1: Professional nurses should place emphasis on preventing further spreading of HIV infections by educating patients about health and ensuring treatment compliance.</td>
</tr>
<tr>
<td>Newly diagnosed and unaware of the implications of an HIV status. Testing positive for HIV often leaves a person overwhelmed with questions and concerns.</td>
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<tr>
<td><strong>Theme 2: Find themselves in their own world</strong></td>
<td>Guideline 2: Professional nurses should find time to reach out to pregnant women with HIV/AIDS in order to support and protect them against social isolation.</td>
</tr>
<tr>
<td>After HIV/AIDS diagnosis, some patients just want to crawl under a blanket and hide. Concerned about how people might react to their diagnosis.</td>
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</tr>
<tr>
<td><strong>Theme 3: Individuals not owning their HIV status</strong></td>
<td>Guideline 3: Professional nurses should honour the patients’ privacy and rights – disclosure of a HIV status should be the patient’s decision.</td>
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<tr>
<td>Experience difficulties in exercising their rights to privacy about their health and HIV status. Decision about HIV/AIDS diagnosis disclosure should remain with patients.</td>
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<tr>
<td><strong>Theme 4: Stigma</strong></td>
<td>Guideline 4: Professional nurses should provide pregnant women with HIV/AIDS with information with which to manage their health status.</td>
</tr>
<tr>
<td>Stigmatisation of pregnant women living with HIV/AIDS remains common, which negatively impacts their quality of life and overall health. HIV/AIDS stigma could make people more vulnerable to HIV.</td>
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**Theme 5: Moving towards a place to live with HIV/AIDS, as an inspirational approach**

Some places discriminate against people living with HIV/AIDS, while others have a better understanding.

In some places people can be forced to leave their home and change their daily activities.

**Guideline 5:** Professional nurses should advice pregnant women with HIV/AIDS on effective living to improve their self-esteem.

**Theme 6: Emotional involvement throughout the turbulent journey**

People diagnosed with HIV are more likely to be depressed than people without the virus.

These people may withdraw from friends and family as a way of hiding their emotions.

**Guideline 6:** Professional nurses should be able to diagnose depression in pregnant women with HIV/AIDS to ensure adequate patient care and emotional support.

**Theme 7: Supportive environment for pregnant women with HIV/AIDS**

A supportive environment may be helpful in assisting patients to navigate complex care processes and achieve optimal outcomes.

A supportive environment may enhance adherence to ART.

**Guideline 7:** Professional nurses should conduct programs facilitating a supportive environment and enhancing the quality of life of pregnant women living with HIV/AIDS.

### 4.3.1 Guideline 1: Professional nurses should place emphasis on preventing further spreading of HIV infections by educating patients about health and ensuring treatment compliance

Being confronted with an unknown future can be very difficult. According to Wilson et al. (2017:1), many pregnant women living with HIV/AIDS do not know that they have the virus. Wilson et al. (2017:1) state that the context of a patient stands in the way of making informed decisions on treatment, preventing the spread of HIV infections and receiving supporting services.

**Rationale:** Pregnant women who have just found out about their HIV/AIDS status should be assured by professional nurses that despite having been diagnosed with HIV/AIDS, they could
still live a long and healthy life if they focus on among other things, “self-acceptance to acknowledge a chronic disease” and “self-respect in living their unique identity” (Huang et al., 2019:1).

Being diagnosed with HIV during pregnancy could allow a pregnant woman to receive effective antiretroviral therapies for her own health and preventive drugs (e.g. ARTs) to improve the chances that HIV will not be transferred to her infant. Early knowledge of maternal HIV status is also important for decision-making regarding obstetrical management.

The following actions should be taken by professional nurses to address Guideline 1:

Professional nurses should help pregnant women with self-acceptance and acknowledging their disease by doing the following:

- Talking to them about how important it is to accept their diagnosis, meet with doctors to come up with a treatment plan and start medication, if appropriate (Kutnick et al., 2017:1).
- Reminding patients that there are many effective treatments which could keep people with HIV healthy for a long time and to delay the progression to AIDS.
- Informing patients that an HIV diagnosis may mean making some life changes but that it is still possible to live a long and healthy life thanks to new medications.
- Telling them that they should not shoulder this burden alone and the longer they deny accepting and acknowledging this illness, the more difficult and frustrating it will be for them.
- Encouraging patients to deal with the situation by accepting and acknowledging the condition. The longer they delay treatment and becoming educated about how to take care of themselves and avoid contracting other infections (Christ & Debyser, 2015:1), the longer their agony about their situation will be.

Professional nurses could support and encourage pregnant women living with HIV/AIDS to develop self-respect despite having been diagnosed with HIV/AIDS in pregnancy by doing the following:

- Explaining to patients that self-respect can help them fulfil their potential, develop healthy relationships and make everyone around them see them as people who are worthy of respect, even if they are living with HIV/AIDS (Renger, 2018:1).
- Encouraging patients to take steps to know how to feel happy with who they are and make the society treat them as they deserve to be treated.

- Forgiving themselves for things they have done wrong in the past; things that they are not proud of. Thereafter, they can respect themselves and move on with their lives.

- Advising them not to compare themselves with others because that might be a reason for their lack of self-respect.

- Encouraging patients to maintain their own standard of living and working on achieving the goals they want to achieve (Mishra 2018:1).

- Encouraging patients to be true to themselves and to those whom they love through disclosure.

Both self-respect and self-acceptance are the cornerstones of future endeavours of a person. According to Kutnick et al. (2017:1), HIV/AIDS diagnosis during pregnancy may lead to a sense of denial, anger and confusion. However, pregnant women with HIV/AIDS should be told that there is support available to assist them to cope with a positive diagnosis (Kutnick et al., 2017:1).

4.3.2 Guideline 2: Professional nurses should find time to reach out to pregnant women with HIV/AIDS in order to support and protect them against social isolation

Patients could find themselves in their own world. Professional nurses should support pregnant women to be less lonely. Wherever possible, pregnant women should be offered opportunities to reach out to others, so that they remain actively involved in society, rather than sitting passively waiting for something to happen (Kutnick et al., 2017:1). Pregnant women living with HIV/AIDS may need encouragement and guidance from professional nurses on how to be creative and how to have a positive approach to meeting other people with whom they can socialise with or relate to.

**Rationale:** It could be detrimental to the health and wellbeing of pregnant women living with HIV/AIDS if they are very isolated from society and could impair their quality of life and wellbeing (Kalomo & Liao, 2018:70).

The following actions should be taken by professional nurses to address Guideline 2:

- Supporting and motivating pregnant women who find themselves in their own world to find ways to be less lonely by encouraging them to do the following:
  - Join support groups in their communities
o Become involved in community actions such as sporting activities and community debates
o Participate in local organised outings to for e.g. the theatre or cinema
o Join smaller gatherings of three or four people who are also living with HIV/AIDS

Nurses should furthermore talk more openly about the disease to create an environment in which the pregnant women with HIV/AIDS feels comfortable talking about both the physical and emotional aspects of HIV/AIDS (Kalomo & Liao, 2018:70).

Professional nurses should play a role in providing various types of support for pregnant women who withdraw and become isolated. It is important for professional nurses to work closely with pregnant women living with HIV/AIDS in order to identify their needs for emotional support.

Professional nurses could support pregnant women and prevent isolation by doing the following:

- Provide psychosocial interventions, such as monitoring attendance of support groups, in enhancing the quality of life of pregnant women with HIV/AIDS.
- Ask feedback on participation in social structures, such as church attendance, to provide individuals with meaningful support, encouragement for the expression of relevant emotions and a buffer from stress (Luo, Lin, Ji & Li, 2017:3202).
- Arrange to get pregnant women with HIV/AIDS together to talk about HIV, share their experiences and listen to the stories of others who are in a similar position.
- When possible, arrange one-on-one sessions to provide pregnant women with support they might not get from family and friends within their community.
- Provide information to enhance their insight into HIV/AIDS.
- Empower patients to make positive changes in their lives, such as changes related to their sexual behaviour and nutritional habits, through referring them to relevant radio talks.

Professional nurses should encourage pregnant women living with HIV/AIDS to develop self-confidence, despite their chronic condition. The following actions could assist in the attainment of self-confidence:

- Encourage pregnant women to develop confidence and face their fears head-on, despite living with HIV/AIDS (Berens et al., 2018: 541).
- Empower patients to know that no matter what HIV/AIDS-related obstacles come their way, they should have the ability to deal with it amicably.
Influence them to view their lives in a positive light, even when things are not going well with their health.

Encourage patients to stay away from negativity and focus on being positive when interacting with others. Pregnant women living with HIV/AIDS are often cautious to share their HIV status to partners, employers, landlords, school officials or family members. From a legal perspective, these pregnant women are not required to tell any of the aforementioned persons that they are HIV positive. The only people they might share their status with, are the people with whom they have sex, or share needles with. Professional nurses should protect the rights of patients pertaining to HIV/AIDS disclosure. However, patients with courage to speak out about their HIV status, should be commended.

The following actions should be taken by professional nurses to address patients’ reluctance to share their HIV status:

- Encourage pregnant women to share their HIV status if it is safe to do so.
- Counsel patients and allow them to decide when it is safe to disclose their HIV status.
- If patients choose to remain silent about their HIV status for their own reasons, such patients should not be scorned for doing so.
- From a public health perspective, encourage patients to share their HIV status with their sexual partner(s), primarily because it will reduce the risk of HIV transmission.
- Encourage patients to share their HIV status to reduce HIV stigma in the community.
- Respect the patient’s decision not to disclose their HIV status if they have fear of discrimination.

4.3.3 Guideline 3: Professional nurses should honour the patients’ privacy and rights - disclosure of a HIV status should be the patient’s decision

Individuals who do not own their HIV status face difficulties in exercising their rights to privacy regarding their health and HIV status. According to Arya et al. (2018:101), it is still perceived to be socially dangerous for pregnant women to disclose their HIV status, as disclosure could result in violence and many other collateral consequences. Professional nurses should support pregnant women living with HIV/AIDS to own their HIV status.

Rationale: Patients’ medical information, including their HIV status, is protected by strict confidentiality laws and should never be released without the patient’s permission (Villela &
Fraga, 2016:1), especially when such release could result in harm to the person living with HIV/AIDS (Arya et al., 2018:101).

**Actions:** The following actions should be taken by professional nurses to address Guideline 3:

- Tell pregnant women with HIV/AIDS that family and friends do not have to know their test results or HIV status; they are at liberty to tell them themselves (Arya et al., 2018:101).

- Educate pregnant women living with HIV/AIDS to be firm in not allowing family members, friends or partners to take charge of their HIV status, as they are the owners of their HIV status.

- However, discuss the benefits associated with sharing the ownership of their HIV status with significant others, who includes sexual partners. Such benefits include:
  - Talking with people whom they can trust can help them to deal with an HIV diagnosis.
  - These people can support patients with the longer-term issues of treatment and disclosing their status to others.
  - These people can assist them by acting as advocates for them and speaking for them in case of an emergency, helping them navigate the medical system.

Professional nurses could support HIV pregnant women with limited social interaction with significant others. People living with HIV/AIDS, including pregnant women, have fundamental needs for inclusion in group activities and for close relationships. It is easier to stay motivated, to meet the varied challenges of life, when one has someone to interact with. Rzeszutek and Gruszczynska (2018:25) state that there is growing evidence indicating that when the need for social relationships is not met, people living with HIV/AIDS are likely to fall apart mentally and even physically.

Professional nurses should pay attention to the following to achieve social interaction for pregnant women with HIV/AIDS:

- Provide supportive communication and avoid breaches in confidentiality between pregnant women with HIV/AIDS and nursing staff.

- Address the stigma about HIV/AIDS in pregnant women with HIV/AIDS.

- Encourage patients to participate in programs aimed at enhancing social interaction (Paolilo, Tanq, Depp, Rooney, Vaida, Kaufmann, Mausbach, Moore & Moore, 2018:1).
Emphasise the importance of establishing trusting relationships between professional nurses and patients.

Address social relations between pregnant women with HIV/AIDS and themselves to ensure that integrated delivery of HIV counselling and services encourage women’s care seeking and in turn improve maternal and child health.

Pregnant women with HIV/AIDS often ask staff not to disclose their HIV status. Professional nurses are not allowed to reveal any medical information about their patients or their circumstances without patients’ permission (Villela & Fraga 2016:1). Therefore, if pregnant women living with HIV/AIDS are not feeling ready to divulge her secret, professional nurses should not automatically step in to disclose the patient’s status without permission.

The following actions should be taken by professional nurses to address the issue of staff being asked not to divulge the patient’s HIV status:

- Encourage patients to tell their partners about their HIV status.
- Link patients to support groups and promote the use of condoms.
- Counsel the patient to understand that if one wants to cope with the disease, you should be prepared to disclose.

4.3.4 Guideline 4: Professional nurses should provide pregnant women with HIV/AIDS with information with which to manage their health status

The stigma associated with pregnant women living with HIV/AIDS remains common and has a negative impact on their quality of life and overall health. Professional nurses should take it upon themselves to assess the patient’s physical, psychological and social status to ensure that there is less HIV-associated stigma among pregnant women (Hargreaves et al., 2018:783).

**Rationale:** The stigma associated with pregnant women living with HIV/AIDS plays an important role in their lives and is likely to hinder them from accessing the treatment (Saki, Kemanshahi, Mohammead & Mohraz, 2015:1). This could also be viewed as one of the greatest challenges in living with HIV/AIDS during pregnancy.

**Actions:** The following actions should be taken by professional nurses to address Guideline 4:

- Consult with patients about their care plan, evaluate the outcome of care and work closely with other members of the healthcare team (Saki, et al., 2018:783).
- Treat patients equally and fairly, whether they living with HIV/AIDS or not.
• Remind patients of their human rights and that they should not let the HIV stigma delay their treatment or make them refuse treatment or hide their disease from others.

Professional nurses should support HIV pregnant women who choose not to divulge their HIV status due to fear and stigmatisation.

Professional nurses should play a role in supporting pregnant women with HIV/AIDS who become a target of judgement. These pregnant women are often experiencing widespread judgement, which leads to stigmatisation and discrimination (Langeni, 2018:1). Professional nurses should help pregnant women living with HIV/AIDS to protect themselves against such behaviours.

The following actions should be taken by professional nurses to address judgement against pregnant women with HIV/AIDS:

• Embark on teaching programs and focus on the attitude of fellow health workers towards patients living with HIV/AIDS.

• Avoid to convey messages of HIV judgement, understand HIV/AIDS and have a positive attitude towards the nursing of pregnant women living with HIV/AIDS.

• Educate the community about HIV/AIDS judgement of pregnant women with HIV/AIDS, thereby providing opportunities to professional nurses to build trusting relationships with pregnant women living with HIV/AIDS.

• Educate patients about laws protecting people living with HIV/AIDS.

Professional nurses should support pregnant women with HIV/AIDS to deal with social stigma. The necessary support and advice from professional nurses can assist the pregnant women living with HIV/AIDS to stand up against discrimination and stigmatising in their environment (Rasoolinajad et al., 2018: 2018:1).

The following actions should be taken by professional nurses to assist in coping with social stigma:

• Conduct campaigns to prepare and educate communities to integrate pregnant women living with HIV/AIDS into their societies.

• Whenever possible, professional nurses should encourage society and medical professionals to respond to and provide all the necessary support and advice to pregnant women living with HIV/AIDS.
- Encourage the community to establish teamwork in their communities and to form support groups that underscore mutual respect.

- Inform members of society who are unaware of HIV/AIDS about the need to support patients with HIV/AIDS.

Professional nurses should support HIV pregnant women suffering from stigmatisation. Community-level stigmatisation can negatively impact the self-esteem of pregnant women living with HIV/AIDS (Kelly et al., 2017:399).

Community-level stigmatisation of pregnant women living with HIV/AIDS could be addressed in the following ways:

- Professional nurses should provide HIV/AIDS education in order to prevent patients from relying on their community members for HIV/AIDS education, which might mean that their attitudes are based on those of their community (Darlington & Hutson, 2017:12).

- Encourage community networking and exposure to information about HIV stigmatisation management through participation in educational programs and media.

- It is important to address HIV-related community stigmas in order to encourage behaviour change, which should consider the social, economic and cultural environments in which pregnant women with HIV/AIDS live.

In support of pregnant women with HIV/AIDS, professional nurses should attend to the role of cultural sensitivity. The cultural density has been particularly problematic in the fight against HIV/AIDS and stigmas associated with HIV/AIDS in pregnant women.

The following actions should be taken to assist professional nurses to address cultural sensitivity among pregnant women living with HIV/AIDS:

- Professional nurses should not support individuals who blame witchcraft, spirits and supernatural forces for the transmission of HIV/AIDS. The proportion of pregnant women with such beliefs is small, but these individuals were found to be more likely to sanction stigmatising beliefs and practices against people with HIV/AIDS (Arrey et al., 2015:1).

- They need to find time to conduct one-on-one sessions to discuss the patient’s cultural beliefs and attitudes towards persons with HIV/AIDS and use this session to educate them about HIV/AIDS as a disease in various cultures, resulting in stigmas associated with HIV/AIDS.
Professional nurses should never underestimate the power of cultural beliefs. Therefore, the role of cultural beliefs about pregnant women with HIV/AIDS should be explored and advice and education should be given.

The level of understanding of HIV/AIDS from a cultural or spiritual viewpoint should be assessed to provide the necessary support.

Professional nurses should support pregnant women who fear their HIV/AIDS status. An HIV/AIDS diagnosis during pregnancy is a turning point in a women’s sexual and emotional life. The diagnosis is often associated with a fear of an immediate death, poor self-esteem and the feeling of social isolation (Arco et al., 2018:2).

The following actions should be taken to assist professional nurses to address HIV/AIDS positive pregnant women’s fears:

- Explain to pregnant women that being diagnosed with HIV/AIDS is initially devastating. However, it is not necessary a death sentence, nor something they need to cope with on their own.
- Reassure patients that being fearful or being anxious of having HIV/AIDS during pregnancy is absolutely normal.
- Advise them to seek help, as there are many sources of help available to people diagnosed with HIV/AIDS, such as Global information and education on HIV/AIDS (2019).
- At all times nurses should respect confidentiality during treatment, as this sometimes could be a source of fear.
- Professional nurses should be place HIV positive people in separate queues or specific cubicles, as this can easily reveal the HIV status of patients.

Professional nurses should encourage pregnant women with HIV/AIDS to adopt a healthy lifestyle. The following actions should be taken to assist professional nurses to teach healthy lifestyle strategies to pregnant women living with HIV/AIDS:

- Motivate patients to seek social interaction with others, maintain a sense of control over their life, block HIV out of their minds and maintain positive attitudes and beliefs about living with HIV/AIDS (Quiroga et al., 2018:1).
- Encourage patients to remain healthy, despite their HIV diagnosis. They can achieve this by taking in adequate nutrition which helps to boost the immune system.
Encourage patients to start antiretroviral treatment as soon as possible and to sustain it as part of their everyday routine. This will ensure that their immune system stays strong.

Emphasise the roles of regular exercise, eating well, getting enough rest and quality sleep in maintaining their health.

Focus on quitting alcohol and joining support groups for substance abuse (if relevant).

4.3.5 Guideline 5: Professional nurses should advise pregnant women with HIV/AIDS on health living to improve their self-esteem

Professional nurses should advise pregnant women with HIV/AIDS to consider living in places where there is less pressure on them in order to improve their self-esteem. According to Kabel et al. (2017:221), the HIV/AIDS epidemic among pregnant women has devastating effects on families and communities where these pregnant women live and come from. It also affects social relationships, forcing people to move away from their families and communities that they are used to, to places where they are less likely to experience pressure (Kabel et al., 2017:221).

Rationale: In order for HIV/AIDS positive pregnant women to experience less stigmatisation, it might be required that they move to a place where individuals living with HIV/AIDS could experience a sense of belonging (Kabel et al., 2017:221).

Actions: The following actions should be taken by professional nurses to address Guideline 5:

- Encourage patients to move to nearby relatives where they can live comfortably if they are unable to endure HIV stigmatisation in their current homes or communities.
- Prepare patients for some of the physical symptoms they may feel by referring them to a counsellor, as this may have some social pressures on them in the communities where they live.
- It is important to explain to them that by sharing their HIV positive status, they can feel part of a worldwide group of people living with HIV/AIDS.

4.3.6 Guideline 6: Professional nurses should be able to diagnose depression in pregnant women with HIV/AIDS to ensure adequate patient care and emotional support

A HIV/AIDS diagnosis in pregnant women causes emotional turbulence throughout their journey. According to Ashraf and Sitwat (2016:364), emotional turbulence does not solely refer to the turbulent feelings of the pregnant women with HIV/AIDS, but it also refers to the holistic wellbeing and the individual’s capacity to maintain a positive mindset. All of these effects lead to turbulence and disorganisation, which have a deep-seated effect on the individual’s sense of
personal identity (Proudfoot, 2018:323). Professional nurses should support pregnant women living with HIV/AIDS to cope with these emotional turbulences.

**Rationale:** HIV/AIDS diagnosis can be an emotionally challenging time for newly diagnosed individuals, especially for mothers and pregnant women, who must assimilate HIV into their identities (Proudfoot, 2018:323).

**Actions:** The following actions should be taken by professional nurses to address Guideline 6:

- Encourage patients to become involved with their own care to allow them to feel in charge of their own health.
- Explain to patients that anger, fear and worry are not diseases and that can learn to deal with emotional turbulences of any kind.
- Encourage them to create good life strategies that can help them to withstand any amount of stress that could arise due to their HIV positive status.

Loneliness among pregnant women with HIV/AIDS or a lack of connection with other people remains a major concern (Valtorta et al., 2016:1). The following actions could assist professional nurses to address loneliness in pregnant women with HIV/AIDS:

- Encourage the patients to participate in family events and other activities in the area.
- Expand the network of the patient by seeking out opportunities for connecting with others such as entertainment and socialising activities and workforce training.
- Talk about social networks and links to reduce loneliness among pregnant women with HIV/AIDS.

4.3.7 **Guideline 7:** Professional nurses should conduct programs facilitating a supportive environment and enhancing the quality of life of pregnant women living with HIV/AIDS

A supportive environment that facilitates the best possible physical, emotional and functional quality of life for pregnant women living with HIV/AIDS can provide multiple benefits (Lifson, 2015:1382).

**Rationale:** Pregnant women with HIV/AIDS face constant psychological difficulties, including low self-esteem (Kontomanolis et al., 2017:111).
**Actions:** The following actions should be taken by professional nurses to address Guideline 7:

- Professional nurses should remain knowledgeable about HIV/AIDS as it is a crucial part in the management and care of HIV/AIDS pregnant women (Naidoo et al., 2017:1). The following actions could enhance professional nurses’ knowledge about HIV/AIDS in pregnant women:
  
  - Professional nurses should request capacity building training to improve their midwifery competency and to ensure that they have efficient knowledge and skills to care for pregnant women living with HIV/AIDS (Ali, Lakhani, Jan, Shahid & Baig, 2015:1).
  
  - Professional nurses should seek guidance and feedback from their management as they can offer educational support and guidance with regard to supporting pregnant women with HIV/AIDS.
  
  - Professional nurses should apply to participate in various courses offered by NGOs that review professional nurses’ knowledge of and skills in the care and management of patients with HIV/AIDS.
  
  - They also should attend in-service training to further their knowledge and develop new skills.

Diagnosis of HIV/AIDS can affect pregnant women in many different ways. Being accepted by the community where they live can boost their self-esteem, while feelings of rejection can lower their self-esteem (Darlington & Hutson, 2017:12). The following actions could assist professional nurses to facilitate acceptance of pregnant women HIV/AIDS:

- Be available for open, honest conversations about HIV/AIDS, thereby indicating acceptance.

- Encourage family members to believe in the patient, do things they did together before patients were diagnosis and talk about things they talked about before their diagnosis.

- Family members should be educated about the importance of looking at the patient in the same way than they did before and to remember that a person has more value than their diagnosis.

- Reassuring patients with HIV/AIDS that HIV is a manageable health condition and that they are still the same person as they were before diagnosis.
Encouraging patients to believe in their own unique talents and their contribution to the broader society and their family.

HIV/AIDS education is needed in communities and among healthcare professionals. The disease does not only affect pregnant women, but it has a broader impact on the community and healthcare system, therefore health professionals and society must take a stand to promote mindfulness about the negative effect of the oppression of pregnant women living with HIV/AIDS (Dutra, Cordova & Avant, 2018:226).

The following actions could assist professional nurses to promote HIV/AIDS education for community and health professionals:

- They should educate patients and the community about how the virus is transmitted so that they are able to protect themselves from infection.
- At the same time, the professional nurses should also educate patients on how the virus is not transmitted, as people need to know that they cannot become infected from such things as sharing food, towels or toilets.

Adherence to these guidelines by professional nurses could ensure a positive support system, which will lead to feelings of a strong self-esteem and self-confidence in pregnant women with HIV/AIDS (Darlington & Hutson, 2017:12).

4.4 RECOMMENDATIONS FOR RESEARCH, NURSING EDUCATION AND PRACTICE

4.4.1 Research

Overall, there are very few research studies on the role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS. It would, therefore, be of benefit to all stakeholders if more studies were conducted in this field.

- A quantitative survey could be conducted to investigate the self-esteem challenges pregnant South African women with HIV/AIDS face.
- A further study can be conducted to explore the awareness of professional nurses in their role of supporting families of pregnant women with HIV/AIDS in the Western Cape.
- An in-depth study on the perceptions of the health officials and managers about professional nurses’ role in promoting healthy the self-esteem of hospitalised pregnant women with HIV/AIDS could be conducted, with a view to change negative perceptions around being HIV positive.
A comparison of the role of professional nurses vs the role of medical doctors in promoting a healthy self-esteem of hospitalised pregnant women with HIV/AIDS would be of interest.

Further studies regarding the promotion of a healthy self-esteem in woman with HIV/AIDS should be conducted in public health institutions.

4.4.2 Nursing education

Nurse educators need to take cognizance of the challenges that lead to poor self-esteem of pregnant women with HIV/AIDS in order to implement the necessary changes to accommodate these women while hospitalised and in their communities. The following aspects should be integrated into the nursing curricula:

Psychological support:

- Psychological support should include instilling hope, teaching, sharing information and creating a sense of empowerment in pregnant women with HIV/AIDS to address poor self-esteem and stigmatisation issues.

- Pregnant women experiencing stress associated with HIV/AIDS stigmatisation in the society where they live should be referred to support networks to help them cope and to instil a sense of belonging and positive feelings in them.

Community meetings:

- Meetings should include consultations with pregnant women with HIV/AIDS to help them to develop coping strategies and to strengthen their self-esteem.

- The meeting environment should be friendly and accommodating of all pregnant women with HIV/AIDS to give them a sense of inclusion.

Accepting healthcare environment:

- Nurse managers and senior professional nurses should condemn any form of stigmatisation when dealing with pregnant women with HIV/AIDS.

- Management should re-visit the unit routine policy in the care of patients to make time for professional nurses to attend to the psychological needs of their patients.
Family involvement:

- By encouraging partners and family members to accept pregnant women with HIV/AIDS, improved self-esteem and self-confidence and decreased stigmatisation could be facilitated.

4.4.3 Nursing practice

The active and educational support from professional nurses and nurse managers could give pregnant women with HIV/AIDS a sense of belonging.

- Professional nurses should not display harshness towards the pregnant women with HIV/AIDS in their care; they should rather be professional in their conduct since they are the role models for patients.
- Professional nurses should practice sensitivity and offer nurturing support to pregnant women with HIV/AIDS to enhance their self-esteem.
- Professional nurses could also strengthen the support system of pregnant women with HIV/AIDS by making time for them, despite the shortage of staff and heavy workload.
- The multi-disciplinary team should be encouraged to treat all patients with care and compassion to ease their stress and worries.

4.5 LIMITATIONS OF THE STUDY

As with any study, this study also has limitations that could not be controlled by the researcher. Limitations include influences, shortcomings and conditions that tend to limit the extent to which a study can go and sometimes affect the end results and the conclusions that can be drawn (Barongo, 2018:1). This study was limited in scope because only a small sample of professional nurses working in one hospital in the maternity unit was involved. The study was furthermore conducted in only one of South Africa’s eleven official languages (English).

Shortage of staff significantly affected the collection of data. This led to re-scheduling of interviews with recruited participants. Logistics also proved to be challenging, due to the researcher’s work schedule and the availability of professional nurses. This required repeated re-scheduling of appointments and rebooking of the venue at the hospital. The interviews were conducted at only one maternity unit in Cape Town. Hence, the findings cannot be generalised to other units.
4.6 CONCLUSION

The focus of this research was on the role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town. The research question was answered by the findings of this study. The objectives of the study were met by an in-depth study that generated themes from the individual semi-structured interviews during data collection. Further research into self-esteem of pregnant women with HIV/AIDS and the challenges faced by pregnant women with HIV/AIDS, were suggested. This study could be extended to a larger study or replicated in other public or private hospitals and in other provinces of South Africa.

The findings of the study indicate that poor self-esteem among pregnant women with HIV/AIDS does indeed exist and that the professional nurses have a vital role in supporting hospitalised pregnant women with HIV/AIDS. It is evident pregnant women living with HIV/AIDS are still stigmatised, which has a negative impact on their quality of life and overall health. The findings also imply that professional nurses remain a crucial part in the management and care of HIV/AIDS pregnant women, especially in resource constrained settings where they fulfil a variety of roles and functions.

The general recommendations for nurse managers is that they should equip professional nurses with knowledge, skills and experience that will enable them to play a significant role in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS.
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ANNEXURES

ANNEXURE A: PARTICIPANT’S INFORMATION SHEET

Project Title: The role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town

Dear Participant

Introduction
My name is Zama Mfundisi and I am a registered Masters student in the Department of Nursing Science at the Cape Peninsula University of Technology. I would like to ask you to afford me an opportunity to explain the research that I wish to undertake and to ask you to kindly participate in an individual interview. Please note that you are allowed to stop me any time and ask any question you may have.

Purpose of the research study
South Africa is one of the countries where HIV/AIDS among pregnant women remains a major challenge that requires combined efforts of healthcare professionals including midwives for the global fight against the epidemic. While fighting for HIV/AIDS, one of the aspects also to be taken into consideration is the self-esteem of pregnant women. Midwives work close with HIV/AIDS pregnant woman and can provide useful and insightful information that is required for this study. The purpose of the study is to explore and describe the role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in Cape Town.

Description of study procedures
As part of the research study, I will conduct individual semi-structured interviews in a quiet private room at the maternity unit. I will set appointments with every participant as agreed on at
a specific date and time to conduct the interviews. You will be asked for at least 45 minutes of your time to participate in a research. Each interview will be tape-recorded with your permission. The reason for recording is to allow researcher to analyse interviewee’s responses to gain insight, to listen to the interview more than once and share the data obtained with only the supervisor. I will also take notes so that at the end of interview I can reflect on the interview to identify gaps that might need to be explored in a follow-up interview. The interview schedule will include questions such as: What is the role of midwives in promoting self-esteem of hospitalised HIV/AIDS pregnant women in a maternity unit? How can hospitalised HIV/AIDS pregnant women be supported by midwives in promoting a healthy self-esteem?

**Risks or discomfort**

Should you decide to participate in the study, you may feel emotional about what patients are going through during their pregnancy, however there will be no physical risk. In the event of any unforeseen circumstance, the interview will be stopped and necessary assistant will be offered by a psychologist that will be available near the unit.

**Benefits to the participant or others**

The outcome of the study may contribute to routine management of HIV/AIDS pregnant woman. The guidelines may also provide insight for midwives to support hospitalised HIV/AIDS pregnant women in promoting healthy self-esteem.

**Privacy and confidentiality**

Participant’s information will remain strictly confidential. Interviews will be conducted in a private room. The researcher will not record your name anywhere during the interview session (will be numbered) on the informed consent form and the audio recording will not be linked to your name. Only the researcher and supervisors will have access to the information. Your information will be kept in a locked office for five years after the report has been published.

**Conditions of participation**

Please understand that taking part in this study is voluntary and you are not being forced to participate. The decision to participate is entirely up to you. However I would appreciate it if you share your views with me. If you make a decision not to participate in the study you will not be affected in any way at work. You will not lose any benefits which you are entitled to by not taking part. If you agree to participate and later decide to change minds or decide to withdraw at any stage of the interview or study you will be allowed to do so.

**Expenses**

You will not pay anything and you will not be paid by participating, the researcher is self-funding in this research study.

**Contact details**
This research is being conducted by Zama Mfundisi, a professional nurse now working as research officer/ surveillance officer here at Mowbray Maternity Hospital.

If you have any questions about the research study itself, please contact:
Researcher: Zama Mfundisi
Professional Nurse
Mowbray Maternity Hospital,
Horsey Road,
Mowbray, 7700
Cell: 0732176444/0739392954
Email address: zama.mfundisi@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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ANNEXURE B: CONSENT FORM

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WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Project Title: The role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered after reading the information sheet. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant’s name………………………..
Participant’s signature………………………………

I further agree that the interview be voice recorded.

Participant’s signature………………………………
I further agree that the researcher takes field notes.

Participant’s signature………………………………
Witness………………………………
Date……………………….
ANNEXURE C: INTERVIEW SCHEDULE

Interview schedule

➢ Tell me around your background, qualifications and work experience in the unit?
➢ What is the role of professional nurses in promoting self-esteem of hospitalised pregnant women with HIV/AIDS in a maternity unit in Cape Town?
➢ How can professional nurses promote a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in Cape Town?

Probing

- How can patient be supported to develop self-esteem (ego) when she successfully resolves her crises around having HIV/AIDS?
- How can the patient be supported to use a wider and integrated set of life skills and abilities that function together within her as an autonomous individual.
- How can the patent develop a sense of identity in her society and help other HIV/AIDS persons in becoming well.
- How can the professional nurse support patient to establish a sense of trust in others, such as the midwife in an unit while being hospitalised.

➢ What did you mean by stating……
➢ Tell me more?
➢ Do I understand that ….
➢ Can you give me an example of that?”
Letter of permission to Department of Health

August 2017

Prof C Househam
Head of Health
Department of Health
4 Dorp Street
Cape Town
8001

Dear Prof Househam

**Request for permission to conduct research investigation**

I hereby request to conduct a research study at the maternity unit in the Western Cape. The study is entitled: The role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town. This study is part of the requirements for acquiring a Masters Degree in Nursing. The study will be done under the supervision and guidance of Professor K. Jooste of the Cape Peninsula University of Technology.
The purpose of the study is to explore and describe the role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in Cape Town.

Data collection will be obtained by:
- Individual semi-structured interviews which will be held at an maternity unit at a public hospital in the Western Cape. Participants invited to partake will be professional nurses who perform midwifery duties. Interviews will be held in a private room as arranged and it will take around 45 minutes for individual interviews.

The researcher will adhere to the rights of participants to privacy and confidentiality. In this study no names will be attached to the data obtained and interview transcripts will be numbered. The participants will in no way be linked to the research findings. The research will not harm the participants in any way. Before interviews will be conducted, participants will be informed that they can withdraw from the study at any time they wished to. In this study, the researcher will make use of semi-structured individual interviews and field notes to develop a comprehensive understanding of the phenomenon. The researcher and participants will agree upon a convenient time to conduct the interviews. The interviews will take around 45 minutes in a private room at the maternity unit in the research setting. While conducting the interviews, the researcher will tape-record the views shared by the participants with their permission. The transcribed data of the interviews, together with the field notes will be triangulated for analysis. Open coding will be used to organise data collected in the semi-structured individual interviews and an independent coder (experienced researcher and supervisor) will assist in this regard.

I am also attaching the proposal, information sheet to participants as well as the informed consent sheets for your information.

Researcher: Zama Mfundisi
Professional Nurse
Mowbray Maternity Hospital,
Horsey Road,
Mowbray
7700
Cell: 0732176444/0739392954
Email address: zama.mfundisi@gmail.com
Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

**Research Supervisor/ Head of Department of Nursing Science, in the Faculty of Health and Wellness Sciences:**

Prof. K. Jooste  
Cape Peninsula University of Technology  
P O Box 1906, Bellville, 7535  
Telephone : (021) 959 2271  
Email: kjooste@cput.ac.za

**Research Co-Supervisor / Senior Lecture Post Basic Nursing**

Dr. H. Vember  
Cape Peninsula University of Technology  
P O Box 1906, Bellville, 7535  
Telephone: (021) 9596183   Email: vemberH@cput.ac.za

This research has been approved by the Senate Ethics Committee of the Cape Peninsula University of Technology.
Ms JC Joemat  
Chief Executive Officer  
12 Hornsey Road  
Mowbray, 7700  
Cape Town  
South Africa  
Tel: +27 21 685 3026  Fax: +27 21 685 2991

Dear Ms Joemat

Letter of request to conduct the research

I hereby request to conduct a research study at the maternity unit in your facility. The study is entitled: The role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town. This study is part of the requirements for acquiring a Masters of Nursing Science. The study will be done under the supervision and guidance of Professor K. Jooste of the Cape Peninsula University of Technology.

The purpose of the study is to explore and describe the role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in Cape Town.

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I am also attaching the proposal, information sheet to participants as well as the informed consent sheets for your information.

Researcher: Zama Mfundisi
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Mowbray Maternity Hospital,
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Prof. K. Jooste
Cape Peninsula University of Technology
P O Box 1906, Bellville, 7535
Telephone : (021) 959 2271
Email: kjooste@cput.ac.za

Research Co-Supervisor / Senior Lecture Post Basic Nursing
Dr. H. Vember
Cape Peninsula University of Technology
P O Box 1906, Bellville, 7535
Telephone: (021) 9596183 Email: vemberH@cput.ac.za

This research has been approved by the Senate Ethics Committee of the Cape Peninsula University of Technology.
Dear Mr Zama Mfundisi

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC on 14 September 2017 to Mr Mfundisi for ethical clearance. This approval is for research activities related to student research in the Department of Nursing at this Institution.

TITLE: The role of professional nurses in promoting a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town

Supervisor: Prof K Jooste and Dr H Vember

Comment:

Approval will not extend beyond 26 October 2018. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorised to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an annual progress report that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.
Kind Regards

Mr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences
REFERENCE: WC_201710_016
ENQUIRIES: Ms Charlene Roderick

Cape Peninsula University of Technology
Cnr. Keizersgracht and Tennant Street
Science Building
Cape Town
8001

For attention: Mr Zama Mfundisi

Re: The role of professional nurses to promote a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Mowbray Maternity Hospital
Mrs Karin Moore
021 659 5550

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report.
(Annexure B) to the provincial Research Co-ordinator
(Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

[Signature]

A T HAWKRIDGE

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 7/11/2017
Mowbray Maternity Hospital

Mr Z Mfundisi
Researcher
Cape Peninsula University of Technology

Dear Mr Zama Mfundisi

Re: The role of professional nurses to promote a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity antenatal unit in Cape Town.

Your request received on the 27 November 2017 in the abovementioned regard refers.

Please be advised that permission has been granted for you to do research at Mowbray Maternity Hospital.

Thank you for your interest shown and choosing our Hospital. It is part of the vision of this hospital to make it a place “Where leaders are born and leaders are made”.

Hope that the time you spend with us will be a fruitful experience and contribute positively to your academic progress.

Kind Regards

Mrs. K Moore
Deputy Manager: Nursing
Date: 11 December 2017

KM/Is
Dear Mr Zama Mfundisi

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC on 14 September 2017 to Mr Mfundisi for ethical clearance. This approval is for research activities related to student research in the Department of Nursing at this Institution.

TITLE: The role of professional nurses to promote a healthy self-esteem in hospitalised pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town

Supervisor: Prof K Jooste and Dr H Vember

Comment:

Approval will not extend beyond 8 May 2020. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorised to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an annual progress report that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards
Dr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences
To whom it may concern

Confirmation of language editing

This letter is to record that I have completed a language edit of The role of professional nurses in promoting a healthy self-esteem in hospitalised, pregnant women with HIV/AIDS in a maternity unit in a public hospital in Cape Town by ZAMA MFUNDISI.

The edit that I carried out included the following:

• Correct grammar, punctuation, spelling and usage
• Attend to the consistency of style, tone and voice
• Point out confusing sentence structures, wrong word choices and ambiguous passages
• Point out incomplete sentences or phrases
• Query or eliminate redundancies and verbosity
• Identify any problems in matters of substance or structure

I did not:

• Add, remove or reorder content
• Check bibliographical information for accuracy
• Rearrange sentences, paragraphs or sections to ensure that the argument is logically constructed
• Verify the accuracy of citations
• Verify the accuracy of mathematical or statistical calculations, or specific formulae or symbols, or illustrations
• Verify the correctness or truth of information (unless obvious)

Helena Johanna van Niekerk

M.Diac. (University of South-Africa); Post-graduate Diploma in Editing and Translation (Stellenbosch University)