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A STUDY TO DETERMINE THE RELATIONSHIP BETWEEN LEVEL OF WOMAN EMPOWERMENT AND
THE LEVEL OF SELF-CARE AMONG HIV POSITIVE PREGNANT WOMEN AGED 15-49 YEARS AT
MORGENSTER MISSION HOSPITAL IN MASVINGO PROVINCE.

BY

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ABSTRACT

Human immunodeficiency virus (HIV) continues to be a major public health problem locally, regionally and internationally (Arron, 2007). Global UNAIDS 2013 report stated that 35, 5-38, 8 million people were living with HIV by December 2012 and approximately 60% of them being women. HIV prevalence among women aged 15-49 years in Zimbabwe is 16.4%, Avert Zimbabwe (2014) reported. Zimbabwe like any other countries which adopted the June 2013 WHO new integrated HIV treatment guidelines recommending lifelong antiretroviral therapy Option B+ for all HIV positive pregnant women and lactating mothers for their own health and prevention of mother to child transmission. Culture, socioeconomic status, and religion have left HIV positive pregnant women vulnerable to inability in accessing health care services. The purpose of this research was to determine the relationship between empowerment and self-care among HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital Antenatal Clinic in Masvingo Province. The study utilised Orem's self care model. A quantitative descriptive correlation design was used in the study, which describes the relationship between variables only without exploring cause and effect relationships. A sample of 96 HIV positive pregnant women aged 15-49 years was selected conveniently. A structured interview schedule was used for data collection after a pre-run of the study instrument for validity and reliability. The questionnaire had closed and open ended questions which took 15 to 20 minutes to answer. Data was analysed using the statistical package for Social Science (SPSS -PC). The research questions were analysed using descriptive and inferential statistics. Linear regression analysis was used to test the strength of the relationship between empowerment and self care. Only 32 (33.3%) were empowered and 31 (31.3% could self care.

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DEDICATION

This document is dedicated to my sweetheart Enock Mudhefi my parents Mr and Mrs Gwekwe, Atidaishe, Anopaishe and Charity.

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Chapter One

Background and organizing framework

Human immunodeficiency Virus /Acquired Immune Deficiency Syndrome continue to be a major public health problem. According to UNAIDS global report (2013), 35, 3-38, 8 million people were living with HIV by the end of December 2012, approximately 60% of them being women. About 15 million people have been infected with HIV since the beginning of the HIV epidemic. Worldwide 2,3million people were newly infected with HIV in 2012. In 2013, 2 million people were enrolled on antiretroviral therapy, the largest ever increase in the epidemic (UNAIDS 2013).

In Africa, several countries have been ravaged with HIV/AIDS burden which accounts for 2/3 of the world's HIV infection (UNAIDS, 2013). Around 1, 2 million people in Sub-Sahara alone died as a result of HIV related complications (Bertrand, 2012). As in the rest of sub-Saharan Africa, the epidemic in South Africa affects women disproportionately. Young women 15 to 24 years, are four times more likely to be HIV-infected than are young men. Multiple factors increase women's vulnerability to HIV acquisition including biological, behaviour, socioeconomic, cultural and structural risk (WHO, 2013). Data and statistics for 2013, postulates that 67% of all pregnant women living with HIV in low and middle income countries received medicines to prevent transmission to their babies in 2012. HIV testing among pregnant women increased significantly from 29% in 2005 to 90% in 2010 and, in 2011, 78% of pregnant women with HIV received ARVs for PMTCT. Zimbabwe just as any other sub-Saharan country has been ravaged with HIV/AIDS with high numbers of infection in women and children (UNAID 2013). In the last quarter Avert Zimbabwe 2014 reported that HIV prevalence by December was 14, 7% and in women aged 15to 49 years it was 16%.

Morgenster Mission Hospital lies 35 km South of Masvingo town has a catchment population 8904 including women of child bearing age constituting 2390.

From January to November 2014 the hospital delivered 1 643 of which 184 were HIV positive. Pregnant women tested during the year from Morgenster catchment area were 207 and 33 were HIV positive constituting 17.1% .Dominant patriarchal, cultural and society exacerbates women's inferiority and their disparate health status. Thus the needs and desires of women are not considered significant and often women play no part in decision making nor are they allowed to express their sexual advances (WHO, 2011).

Problem Statement

A multitude of factors increased women's vulnerability to HIV acquisition including behavioural, socioeconomic, cultural and decision making among women of child bearing age in low income countries (UNAIDS, 2013). In Sub-Saharan Africa women have most decisions made for them by males due to gender inequalities (WHO, 2011). HIV positive pregnant women are a vulnerable group who need empowerment to promote self-care through information giving, about decision making, family planning, safe sex to curb sexually transmitted infection, optimal nutrition and being economically empowered. The reasons conveyed on the delay in coming for early antiretroviral initiation and booking antenatally were due to lack of economic empowerment and self-care. Zimbabwe being a patriarchal nation, women cannot make decisions of their own even what pertains to their health (Ministry of Women Affairs and Gender 2011). Women have to consult the spouse and in-laws to go to hospitals as they are treated like minors (Ministry of Women Affairs, Gender & Community Development, 2011). Some HIV positive pregnant women presented with sexually transmitted infections and narrated that their spouses deny them condom use. Family planning was also one of those problems observed in HIV positive women who

attended antenatal care at Morgenster Mission Hospital. The writer had observed that pregnant HIV positive women reported very late for ART initiation and subsequent care after testing HIV positive during PMTCT to attain good health and optimal pregnant outcomes.

Purpose of the Study

The purpose of this study was to assess the relationship between women empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital in Masvingo Province.

Research Objective

The study sought to:

1. To determine the level of women empowerment in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital.
2. To determine the level of self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital.
3. To examine the relationship between the level of women empowerment and the level of self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital.

Research Question

The study sought to answer the following questions:

1. What is the level of women empowerment in HIV positive pregnant women aged 15-49 years attending antenatal clinic at Morgenster Mission Hospital?
2. What is the level of self-care in HIV positive pregnant women aged 15-49 years attending antenatal clinic at Morgenster Mission Hospital?

3. What is the relationship between the level of women empowerment and the level of self-care in HIV positive pregnant women aged 15-45 years at Morgenster Mission Hospital in Masvingo Province?

Significance to Nursing

This research study will be a systematic inquiry designed to establish baseline information about the relationship between women empowerment and self-care in HIV positive pregnant women aged 15-45 years. One of the nurses' roles is to preserve and promote health among individuals, families and communities (Polit and Hungler, 2009). The significance of the study to nursing is to improve in rendering evidence based care to HIV positive pregnant women. Nurses would utilize expert opinions from basic scientific information obtained from the study. Evidence based care from research findings would also add to the body of knowledge in nursing, provide opportunities for individualized nursing care, more effective, streamlined and dynamic(Wallin, Gustavsson, Enbreberg, and Rudman, 2014). Women empowerment can be facilitated by involving and encouraging individuals, groups and communities to address their own problems thus improving the quality of life. People who are empowered to come up with their own plans and solutions are more likely to implement effective HIV prevention programs and self-care. Individuals, (especially women in disadvantaged positions, and young people) should be empowered by being taught communication skills, negotiation skills assertiveness in decision-making strategies, self-esteem, safe sexual behaviour, and problem solving and conflict resolution. Personal and social disempowerment of women in Africa is often emphasized and is indeed sometimes a serious problem. The inherent strength and autonomy of African women, especially in women's groups, should not be overlooked by health care professionals working in Africa. Self-care significance to nursing is the individual's ability or power to engage in foundational

capabilities or general abilities allowing any deliberate action and power components related specifically to self-care for example maintaining attention, control of available energy motivation, ability to make decisions and order discrete self-care actions (Orem, 1991). Thus, self-care agency refers to a set of human abilities for meeting self-care requisite, such as acquiring knowledge, decision making and taking action for optimal health (Van Dyk, 2007).

Theoretical Framework Self -Care Theory

Orem's General Theory of Nursing

Dorothea Orem began developing her self-care model in 1959 and she refined it several times. It is used in many nursing curricula and guides studies of a variety of settings. Orem's (1991) theory defined self-care as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health and well-being". Orem's complex theory includes three interrelated constructs, each with a central emphasis and set assumptions: the theory of self-care, self-care deficits, and nursing systems (Nursing Theories, 2012).

Self-care agency is the HIV positive pregnant women who is to engage in self-care, and include both foundational capabilities (general abilities allowing any deliberate action) and power components related to specifically to self-care.

Whereas nursing system refers to the supportive educative system through empowerment by information giving, counselling on safe sex and the importance of early booking. Thus actual activity of helping the HIV positive pregnant women meet their self-care needs, nursing agency refers to the ability to know and help others to know and meet their therapeutics self-care demands. The agency refer to a set of human, in this study, the HIV positive pregnant women's abilities for meeting self-care requisites, such as acquiring knowledge, decision

making, and taking action for change. The nurse/midwife assesses the HIV positive pregnant women's self-care deficits and provides the care needed by teaching the women. The assessment revealed lack of empowerment and self-care among HIV positive pregnant women. Nurses would help the HIV positive pregnant women assume responsibilities for self-care. With the exception of the supportive-educative nursing systems, it might appear that the nurse alone determines the other's self-care needs. This emphasis might devalue the HIV positive pregnant women's ability to do self-assessment and planning.

In this study, three concepts of Orem's theory were used to guide the study. These were self-care deficit, which in this study was the lack of empowerment and self-care in HIV positive pregnant women, supportive education which in this study corresponded to education and counselling of HIV positive pregnant women to promote self-care. The third was self-care which in this case resulted in HIV positive pregnant women being able to make decisions, being empowered to negotiate safe sex through consistent correct use of condoms. Information to demand their rights to optimal reproductive health to curb sexually transmitted infections was given to the study subjects. Orem expected HIV positive pregnant women to be responsible for themselves and to seek help when they cannot maintain therapeutic self-care or dependent care. Orem's self-care model was used as in figure1 below.

OREMS SELF-CARE AND ITS RELATIONSHIP WITH THE STUDY

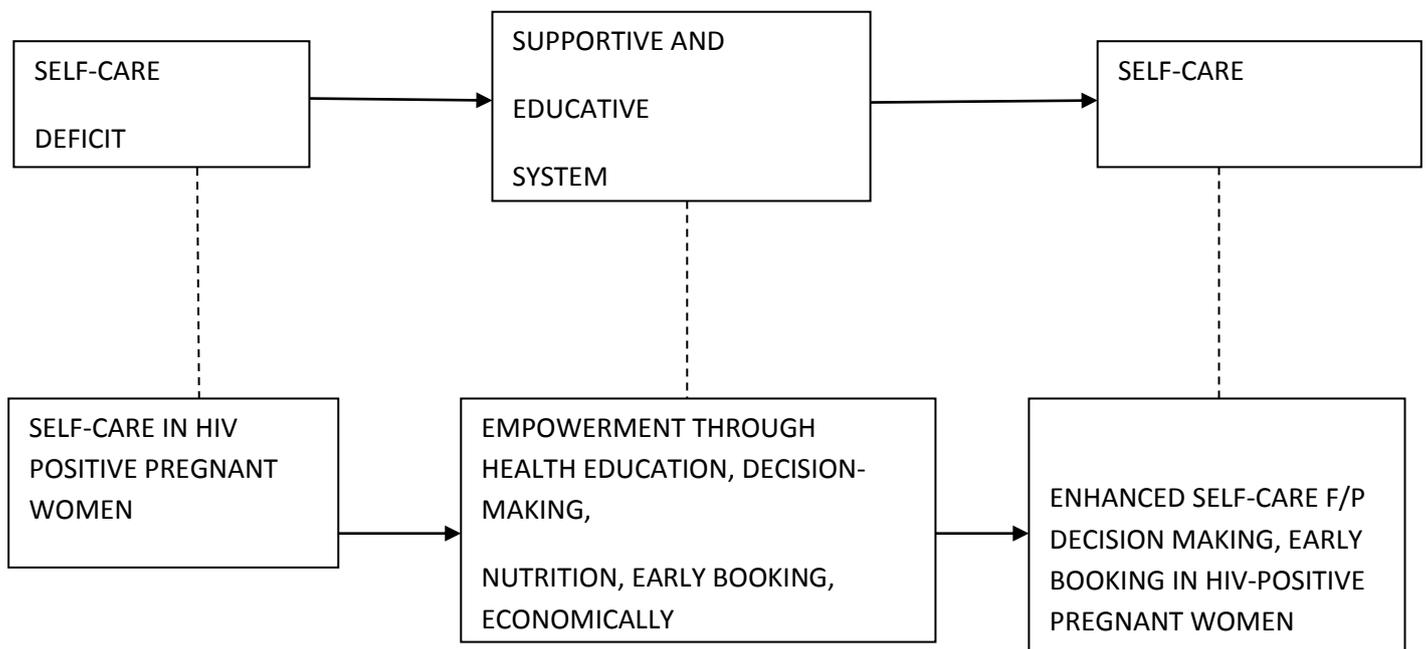


Figure 1 Orem’s self-care model (1991) (Modified).

DEFINITION OF TERMS

Self-Care: is the performance or practice of activities that individuals initiate and perform on their own behalf to maintain life, health and wellbeing (McEwen & Wills, 2011).

Self-Care Agency: is the human’s ability or power to engage in self-care. The individual’s ability to engage in self-care is affected by basic conditioning factors, duration in order to meet known self-care requisites by using valid methods and related sets of operations and actions.”

Developmental Self Care Requisites: are “either specialized expressions of universal self-care requisites that have been particularized for developmental processes or they are new requisites derived from a condition or associated with an event.”

Health Deviation Requisites: is a result from illness, injury, or disease or its treatment. They included actions such as seeking health care assistance, carrying out prescribed therapies and learning to live with the effects of illness or treatment.

Self-Care Deficit: results when a self-care agency is not adequate to meet the known self-care demand (<http://nanda> nurse dairy, BlogSpot. (George, 2012).

Nursing System

Wholly Compensatory: systems are required for individuals who are unable to control and monitor their environment and process information

Partly Compensatory: systems are designed for individuals who are unable to perform some (but not all) self-care activities.

Supportive-educative (developmental): systems are designed persons who need to learn to perform self-care measures and need assistance to do so.

Empowerment: defined as a process of awareness throughout which women recognize their capacity to achieve individual and social changes. The process involves a mental and spiritual awareness that enables them to gain greater control of the physical, psychological and social dimensions of the healing process (George, 2012).

Decision making: is the ability to make choices in ones' live about health, sexual partner, or profession and the like.

Self-efficacy: confidence in one's ability to successfully take an action (Croyle, 2005).

Cues to action: those internal or external factors and strategies that activate readiness to change (Croyle, 2005).

Child bearing refers to age group between fifteen and forty nine years (Cooper and Fraser, 2009).

CHAPTER TWO

LITERATURE REVIEW

Introduction

The literature review would put the research problem in context. According to Polit and Beck; 2014 literature review indicates what knowledge is well verified, what should be considered tentative, and what is without any foundation. It points to the unknown that would benefit from further research. It suggest methodologies for research and addressing those unknown, and data collection method for this study (Emerson, 2007) The review also give a provision of conceptual context for the study (Polit and Hungler, 2009).

Literature review is a critical summary of research on the relationship between empowerment and self-care in Human Immunodeficiency Virus (HIV) positive pregnant women aged 15 to 49 years. Literature search in this section is based on the focused areas as follows: HIV trends internationally, regionally and locally .Educational empowerment in (HIV) positive pregnant women in regards to decision making, nutrition, safe sex, family planning and adherence to their drugs, Self-care in HIV positive pregnant women in relation to prenatal care, intranatal care and post natal care and the relationship between empowerment and self-care in (HIV) positive pregnant women.

Empowerment

Community empowerment is characterized by capacity building so that community members become their own change agents. With community empowerment programs, external agents are still involved but can develop themselves (Bhuyan et al, 2004).

According to Domitilla et al (2013) in their study in United States of America defined empowerment as a process of awareness throughout which women recognize their capacity to achieve individual and social changes. The process involves a mental and spiritual awareness that enables the woman to gain greater control of the physical, psychological and social dimension of the healing process.

Empowerment influences pregnant women to go for HIV testing without first consulting their spouses in Tanzania according to Demographic Health Survey, (2010).

It's assumed that empowerment stimulates women's desire for HIV testing despite that all pregnant women should test for HIV that serves as both critical prevention and treatment in the control of the epidemic (WHO, 2004).

Another study done in Tanzania socioeconomically empowered women sought for health care and HIV testing (Demographic Health Survey 2010).

In Tehran women did not attend health care centres for prenatal services. After providing the necessary information on the importance of antenatal care the rate of attendances increased (Banaem et al, 2008).

A study on women empowerment in fighting stigma in Guyana revealed that stigma often hindered women from disclosing their status to their husband and to access services making mother to child transmission very risky for HIV positive women (Cameron, 2010).

Access to proper information on issues related pregnancy delivery and empowering HIV positive pregnant women to make positive changes in health care behaviours are among the main challenges for health care providers (Wallace, et. al, 2009).

Empowering pregnant women through educational intervention in Greece on dietary intake and weight gain antenatally showed that the rate of low birth weight among women in the intervention group was lower (Kafatos, Vlachnikolis and Codrington, 2009).

In a study conducted in Zimbabwe showed that women need to be economically empowered so that they can be assertive to be able to negotiate safe sex and responsible sexual practice including use of condoms (Mutowo, 2014).

According to International Centre for Research (2010) women are better poised to improve their lives when they own land and other assets. Just 1% of the world's women own land. Although laws to protect women's property rights exist in most countries many women still cannot realize their rights. Discrimination against women lack of information, consent, stigma and social exclusion Suffered by women living with HIV impede their lives and often result in the violation of their human rights (Hope, 2011).

Some studies have indicated that maternal education is the most important social factor that can affect outcomes of pregnancy and birth (Grandes, et. al, 2008).

A study done on African culture in Cameroon indicated that in most cases a woman is not allowed to talk or make decisions when men are there or disagree with decisions made by men (Okin, 2013).

Miller 2011 in a study to determine women empowerment and HIV status in Sub Saharan Africa reported increased female vulnerability to HIV stems from limited access to health care and lack of autonomy to make decisions regarding sexual health education.

In a study conducted in South Africa among women living with HIV who encountered numerous obstacles in preventing unwanted pregnancies such as lack of information on most appropriate contraceptive methods. There was limited access to contraceptives in the postnatal period and minimal condom promotion for pregnant women. Despite the relatively high increased risk of becoming infected during pregnancy and denying women to access sterilization services was noted (Ramkission, et. al, 2012).

Issues having a bearing on women living with HIV's reproductive decision making include religious beliefs that militate against abortion acceptability, negative attitudes of peers, sexual partners and family members (Lang, Salazar, Wingood, DiClemente and Mikhaili, 2007).

Counsellors often have to counsel women or couples on pregnancy issues to support them emotionally. These issues usually fall into one of the following three categories: HIV-positive pregnant women are concerned about the health of their babies. According to the Bill and Rights in the South African Constitution (2001), HIV-positive women have the same rights to health care services, including reproductive health care. HIV-positive women have the right to plan pregnancies or to terminate pregnancies if they wish to do so. The role of the counsellor is to guide the woman to make the right decision for her circumstances. Empowering HIV positive pregnant women help them to tell their story in such a way that they will have a clearer picture of the road ahead and the decision to take (Blom, 2001).

However more needs to be done we need to get the government more involvement to improve HIV positive women's economic empowerment opportunities (Cameron, 2010). Women's social-economic vulnerability and gender inequalities also lie at the root of their painful experiences associated with HIV infection. HIV positive women bear a double burden, being infected and being women. In many societies women are socially ostracized,

marginalized and even killed are very real potential consequences of exposing one's HIV status. Yet HIV testing is critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child. Women's economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women make it more likely that they will exchange sex for money or favours, less likely that they will succeed in negotiating protection and less likely that they will leave a relationship that they perceive to be risky.

In another study conducted in South Africa by Pronky (2006) gender equality and economic empowerment are key development goals in themselves, as asserted in international conventions and in Millennium Development Goals. There is also evidence that promoting women's economic empowerment can make a positive impact on the response to HIV. In some regions obstacles posed by unequal access to credits and market information drive women into the economy with little access to social protection. Lack of economic empowerment increases the vulnerability of women to HIV and hampers impact mitigation

In a study among HIV positive women in Tanzania 44% of economically empowered women could make decisions and disapproved wife beating and having sexual intercourse with an infected husband or partner with a sexually transmitted infection (Tanzanian Demographic Health Survey (TDHS, 2010).

Taking action through the world of economic empowerment increases the bargaining power of women to negotiate safer opportunity to create a group identity separate from that of the family.

Self –care

Self-care is defined as the practices of those activities that maintain health and wellbeing (Caetano et al, 2006). In Sub-Saharan Africa, men are the decision makers in a family or in a relationship so at times, it becomes difficult for a woman to practice positive self-care practices. In fact women are told what to do and what not to do (Chamisa, 2004)

Self-care agency – a human capability to engage in actions that fulfil the self-care needs as well as care needs for dependent members of the family. Self-care reproductive rights sexual reproductive health and Family Planning (McEwen & Wills, 2011)

In a pilot self-care group intervention for low income HIV positive women in United States where 80% of the women of child bearing age were HIV positive. Findings were that those HIV positive women need to actively participate in the management of their physical and emotional health to experience positive health outcome. Several other researchers have successfully used group interventions to enhance positive health behaviours in persons living with HIV including reduction in potential HIV transmission behaviour among women living with HIV/AIDS (Kalichman, Rompa and Cage, 2005).

Financial limitations, family demands and emotional stress may contribute to lack of self esteem, social support which can be barriers to healthful self-care (Eller; Corles; Bunch; et al, 2005)

Decision making in HIV positive women over one's health in self care depends on the prevailing socio-cultural setting. In many developed countries, efforts to exercise self-care and more control over one's health and health matters are gaining momentum. Studies and data collected over time show how self-care can make a difference in terms of health care effectiveness, including the health care cost aspect (McEwen & Wills, 2011).

In another study in Tanzania it is believed that a woman who is empowered politically or culturally and professionally has confidence to decide to go for HIV testing as she does not depend on her husband or partner to make decision to seek medical care or not (Tacaïd et al 2013)

In a study in United States of America among low income HIV positive women who are economical disabled, HIV prevalence continue to increase among low income women. Interventions are needed that successfully engage women in positive self-care management through elimination of the health disparities that currently face poor women particularly women living in smaller cities who are greatly affected by HIV/AIDS (Chiou; Kuo; Lee; and Chen (2004).

In a study by Anaya (2008) to assess on self-care educational program based on the Health Belief Model on reducing low birth weight among a sample of pregnant Iranian women, . The intervention group received an educational program to promote self-care behaviour during pregnancy. The control group received routine antenatal care. Birth weight presenting theory and evidence based educational programs for women during prenatal care helps to solve health care problems related to pregnancy. Low birth weight decreased and risky behaviours improve resulting in optimal outcomes of pregnancy.

According to the Demographic health survey (DHS, 2000); a great number of pregnant women in Tehran had not attended any health care centre for prenatal care (Banaem et al, 2008). It seemed that providing the necessary information might increase the rate of antenatal clinic attendance

The educational content towards self-care in pregnancy included several items on physical activity, wise eating for their health and the health of the baby (WHO and Food and

agriculture organization of United Nations, 2009). Oral health, side effects of substances, illegal drug abuse and smoking during pregnancy, the risk signs of pregnancy complications, sexually transmitted infections, and ways of preventing toxoplasmosis and exposure to X-rays, prevention of traffic accidents. Women in the intervention group received the educational package in addition to the usual antenatal care and education during each visit throughout their pregnancy by the health care staff including family health staff.

According to (Granders, et. al, 2008) during the last few decades various health care education models have been applied to achieve large scale changes in behaviours. Access to proper information on issues related to pregnancy, delivery and empowering them to positive changes are the main challenges for health-care providers (Wallace 2009). Some studies have indicated that maternal education is the most important social factor that can affect self-care, outcomes of pregnancy and birth (Grjibovsk, 2005)

Moderate exercise during pregnancy has many advantages including improving cardiovascular fitness, limited weight gain, an improved attitude and mental state, an easier and less complicated birth and speed postnatal recovery (Fraisier and Cooper, 2005). HIV positive pregnant women need this empowerment in order to take care of their health through self-care.

There are strong correlation between malnutrition and immune depression. Research findings suggest that a healthy diet, vitamin and mineral supplementation and defensive eating may enhance the immune response to HIV infections (Piscitelli, 2000). Vitamins and Minerals enhance the immune system.

It is believed in some cultures that a married woman should trust her husband and is not allowed to use a condom for sex with him or partner whom she suspects to have an STI

(Hasbullh, 2013). This belief put women in a web of silence and denied decision making power.

According to Van Dyk (2007) sex releases stress and provides much needed human contact HIV positive people should therefore learn to rediscover their enjoyment of sex with practices that protect themselves from re-infection with HIV and other sexually transmitted infection.

According to World health Organisation, (2013) integrated HIV treatment guidelines:

.Disclosure can ease access to medical services, care and support, including access to antiretroviral therapy. Disclosure can help people protect themselves and others. Openness about their HIV positive status may help women to negotiate safe sex practices. Disclosure may help to reduce the stigma, discrimination and denial that surrounded HIV /AIDS. Disclosure promotes responsibility. It may encourage the person's loved ones to plan for the future.HIV positive pregnant and lactating mothers should take lifelong ART for their own health and prevention of MTCT of HIV. Male involvement prenatally, intranatally and postnatal services are also recommended for prevention of mother to child transmission of HIV babies.

According to Multiple Indicator Cluster Survey, 2014 Zimbabwe breast feeding is nearly universal at 98.1% regardless of their HIV status. Bottle feeding is at 10.3%

Maman and colleagues (2002) in their study in South Africa found that lack of financial autonomy, control of household income inability to negotiate condom use and lower education, lower income are factors that hampered self-care among HIV positive pregnant women. In another study

The relationship between empowerment and self-care

Orem's self-care deficit theory explains when nursing is necessary as it defines the relationship balance between self-care agency and therapeutic self-care demand (McEwen & Wills, 2011).

Within the context of Primary Health Care (PHC) self-care can be primarily viewed as the translation of community participation in health development. To elicit active community participation, the community, with the emphasis on women, has to be empowered. Information is an important component to empower people in making informed decisions. Access to the information, the quality of information, as well as skill in interpreting and applying important information are important to support self-care promotion process. Empowerment is an important concept and should be a continuum with inter-related, overlapping stages with information and consultation with communities by professionals at end, to collaboration and assuming full responsibility by communities at the other (WHO, 2009).

A study on the effects empowerment among HIV positive women showed that patients reported greater decision making; involvement had higher levels of communication with their care providers. Patients received more information and a positive affect from their care providers. Health care providers of HIV positive women are encouraged to culminate empowered behaviours in their patients (Marelich and Muph; 2013).

Brouard, 2002, Oosthuizen, 2002; Skovholt, 2001; UNAIDS, 2000a, in their studies in South Africa on HIV- positive patients, caregivers and counsellors they noted that it was important for the self-preservation in health. Care providers just like HIV positive people/pregnant woman are responsible for their own physical and mental health.HIV positive pregnant women just like care givers and counsellors should look after themselves in the following

way: Develop and maintain a healthy lifestyle in order to build up resistance to stress. A balanced diet and sufficient exercise, rest and sleep are important. Also try to change harmful habits such as smoking and heavy drinking. Nurture self and take time out to do things that one enjoys like walking, listening to music or reading. Actively search for ways to cope with stress that work for them and use those methods of coping. Relaxation exercises, breathing exercises, visualization, imagery and meditation work very well in coping with stress. Spend time with one's family and try not to think HIV status and pregnancy at all. Work on relationships. Learn to be assertive but not aggressive, communicate effectively, resolve conflicts and solve problems constructively.

According to Pronky, et al., (2006) there is evidence that promoting women's economic empowerment make an impact on the response to HIV. In some regions, obstacles posed by unequal access to credit and market information drive women into the economy with little access to social protection. Promote gender equality and women economic empowerment increase the bargaining power of women to negotiate safer sex. This may also help women afford and access counselling testing services and ART (WHO, 2011).

An empowered individual will change his or her belief about his or her own self efficacy when they have achieved mastery of a task by effectively performing it (Zorrilla, et al., 2005). Increased efficacy leads to behavioural change, which it turn results in improved outcomes (Autumn, 2005). As Staveteig et al., (2013) have observed HIV testing is an essential part in providing medical care to persons living with HIV and key to prevention of HIV transmission. Studies by (NBS and Macro, 2011) revealed that women are justified to refuse sexual intercourse with her husband or partner if she knows he has a sexually transmitted infection (STI).

Relationship between empowerment and self-care in a study conducted in Tanzania 2012, it is believed that a woman who is empowered , culturally or politically or professionally has confidence to decide to go for HIV testing as she does not depend on her husband or partner to make decisions for her weather to test or not (WHO, 2004). Women’s empowerment includes participating in decision making, attitudes towards beating and towards refusal of intercourse with an infected partner or spouse. The assumption that women aged 15-49 years are empowered to decide to for voluntary testing not just if they attend antennal clinic. The determinants under this assumption are women taking major decisions at the household level, having the ability to refuse unsafe sex and not approving wife beating (Yang, et al., 2005). Empowerment influences HIV testing was considered to compare women who have given birth in the five years preceding the Tanzanian Demographic Health Survey, 2010 with women who did not give birth in the last five years.

A study done in Tanzania has explored the relationship between socio-economic characteristics and HIV testing. It’s assumed that empowerment stimulates women’s desire for HIV testing, despite that all pregnant women should test for HIV that serves as both critical prevention and treatment in the control of HIV epidemic (WHO, 2004). To measure women’s empowerment, three variables have been developed; women’s attitude participation in household decision-making, women’s attitude towards a wife’s right to refuse intercourse with partner or husband. High scores on decision-making indicated high empowerment levels among women (NBS &ICF Marco, 2011). HIV positive pregnant women should always use condoms to prevent re-infection. A newly HIV infection during pregnancy or breast feeding is likely to result in an increase in the viral load, and this will increase the likelihood of mother-to-child transmission. Re-infection may also cause mother’s diseases to progress more rapidly (Evian, 2003).

Empowered women know that condoms are the best choice for contraception because they also prevent HIV transmission during sexual intercourse (WHO, 2011). HIV-positive mothers who breastfeed should be encouraged to use condoms to prevent re-infection with new strains of the virus, and to prevent an increase in their viral load (WHO, 2013). In this way the use of condoms will reduce the chance of transmitting the virus to the baby through breast milk. Empowered HIV-positive women go to the pharmacy and ask the pharmacist for the inserts (or information pamphlets) for some of the antiretroviral drugs available. Read the information on the pamphlet and write a summary that includes: The name of the drug, the class or category of the medication like Nucleoside, Non-nucleoside and Protease Inhibitors. The contraindications, can this drug be taken by pregnant women, by patients with renal failure or with liver disease. The dosage and direction for use; the possible side effects of the medication; The special precautions or does the manufacturer discuss negative interactions with other medication or herbal products? The special requirements like alcohol be avoided, should certain foods be avoided. Vitamins and Minerals enhance the immune system. The relationship between empowerment as it reinforces HIV positive pregnant women's self-efficacy by making sure that they possess required communication, negotiation and problem solving skills to carry out desired action and that they know exactly how to apply their newly acquired behaviour for example how to use condoms, eat a nutritious diet and self-care.

A study on the effects of empowerment among HIV positive women showed that patients reported greater decision making; involvement had higher levels of communication with their care providers. Patients received more information and a positive affect from their care providers. Health care providers of HIV positive women are encouraged to culminate empowered behaviours in their patients (Marelich and Muph, 2013)

According to Pronky, et al., (2006) there is evidence that promoting women's economic empowerment make an impact on the response to HIV. In some regions, obstacles posed by unequal access to credit and market information drive women into the economy with little access to social protection. Promote gender equality and women economic empowerment increase the bargaining power of women to negotiate safer sex. This may also help women afford and access counselling testing services and (ART).

Summary

In all the articles read similar findings were noted. Empowerment has been found to be the most important predictor to self-care. Imparting of accurate information packages result in optimal pregnant outcomes and longevity in life of women on Option B +. Through empowerment self-management of conditions like diabetic mellitus in pregnancy lead to optimal health outcomes of the mother and foetus likewise HIV positive pregnant women need to be empowered. Belief Model has been noted to have a bearing on how individuals perceive health and health seeking behaviours. Empowerment can be economically, culturally, religiously or educationally that yield self-care (Mutowo, 2014). All modes of empowerment yield good pregnancy outcomes. With empowerment HIV positive pregnant women will have the ability to make life style changes learn new behaviours to reach their desired health goals. Empowerment is the ability to make decisions, autonomy in self-care, and negotiation for safe sex result in optimal maternal and child health hence reducing morbidity and mortality of HIV positive pregnant women. Without empowerment in HIV positive pregnant women they remain vulnerable to be re -infected, transmit HIV to their unborn babies as they cannot access health services as long as men maintain their bossy at

CHAPTER THREE

RESEARCH METHODOLOGY

INTRODUCTION

Research methodology refers to overall plan to obtain answers to research questions. It is a blueprint for collecting, measuring underlying data (Polit and Beck, 2010).

This chapter looked at the methods which includes the research design, sampling plan, sampling procedures, sample size, variables, instruments, data collection plan, ethical considerations and data analysis of the study.

Research Design

This study utilized a descriptive correlation and design. This quantitative non-probability study design enabled the investigator to examine the relationship between empowerment and self-care among HIV positive pregnant women at Morgenster Mission Hospital attending antenatal clinic or staying in the waiting mother's shelters. This design allowed data to be collected passively, thus the researcher did not manipulate the variables which were being investigated on (Polit & Beck, 2014). This approach allowed the researcher to describe and document the relationship between level of women empowerment and level of self care in HIV positive pregnant women as it occurred naturally Polit & Hungler (2009). It also enhanced the ethical soundness of this research study due to absence of manipulation of variables which were investigated (Burns & Grove, 2013). This approach was very strong in terms of feasibility and was not artificial, thus it was helpful in looking for practical solutions of many problems.

Research design maximises control over factors that may interfere with the validity of a study finding whilst guiding the researcher in planning and implementing the study in a way that will achieve the intended goal (Burns & Grove, 2014). It is related to the problem to be investigated, the aim of the investigation and the resources at the researcher's disposal. Research design provides the glue that holds the research project together. A design is used to structure the research, to show all of the major parts of the research project. The samples or groups, measures, treatments or programs and methods of assignment work together to try to address the central research questions. A lot of nursing research has been done using empirical research which is the collection of material, relevant to the problem being investigated, from the "real" world using methods such as descriptive, experimental (Polit and Beck, 2014). It is a science of studying how research is to be carried out, addressing all the procedures by which researchers use in describing, explaining and predicting phenomena of concern (Polit and Beck, 2014). Research methodology is also defined as the way and procedures by which knowledge is attained. It aims to provide the overall work plan for carrying out a research study (Houser, 2011). The chapter focuses on components of the research methodology used including the research design, the population sample, the sampling procedures, data collecting instruments and the pilot plan and analysis procedures. Ethical considerations were also included this chapter.

Target Population

Target population is the total group of subjects about whom a researcher is interested and to whom results could be reasonably generalized (Polit & Beck, 2014). This research study targeted a population of 440 women aged 15-49 years of child bearing at Morgenster Memorial Hospital in Masvingo Province (Zim Stat, 2014).

Accessible Population

A population is an aggregate of individuals, objectives or cases with some common characteristics (Polit & Hungler, 2008). Accessible population is the aggregate of all cases that conform to designated criteria and that are accessible to the researcher as a pool of the study subjects (Polit & Hungler, 2008). It meets the criteria established and is also accessible, considering constraints of time, finances, researcher availability (Houser,2011). The accessible population for this study was a population of pregnant women aged 15-49 years attending their sessions at Morgenster Mission Hospital in Masvingo Zimbabwe.

Sampling Plan

Sampling plan is a formal plan that specifies the sampling method, the sample size, and the procedures involved in recruiting subjects (Polit & Beck, 2014). Sampling is a process of selecting a sub-section of a population that will participate in research study, representing the entire population in order to obtain information on the subject of interest

(Moule & Goodman, 2009). That sub-set of the population, which is selected to participate in a study, is known as a sample (Polit & Beck, 2004). In this study, participants represented a population of Zimbabwean HIV positive pregnant women in Masvingo Province Morgenster Mission Hospital

Sampling Procedures

The participants of this study were invite using a non- probability sampling method. According to Polit and Hungler (2009) Non- probability sampling refers to selection of sampling units (participants) from a population using non-randomized procedures. This means that the probability of each member of a population to be included in a sample is different. This method involves convenience selection of participants to be included in the search study (Houser, 2011) thus only HIV positive pregnant women within the age of 15-49

years visiting the Morgenster Mission Hospital for prenatal care during the time of data collection were eligible for the study sample.

The sampling procedure was conducted at Morgenster Mission Hospital in Masvingo Province, Zimbabwe. The researcher sought for permission from the responsible authorities to go through the antenatal records of the available pregnant HIV positive women, and then conveniently selected the subjects suitable to be in the study sample. Those who were absent during the data collection period due to various reasons did not participate in the research study. Non-probability method was used because it provided an easy access to respondents (Moule and Goodman, 2009). Non probability sampling is very simple, practical, economical and quick (Polit and Beck, 2014). Convenience sampling design presents the investigator with the opportunity of easy access to participants thus allowing to meet deadlines for data collection as a student.

Inclusion and Exclusion criteria

Sampling criteria is a reference point or a set of population characteristics against which the members of a population will be evaluated for eligibility to participate in a study (Polit & Hungler, 2008).

The inclusion criteria specify the characteristics that the participants should possess in order to be part of the study (Polit & Beck, 2014). The exclusion criteria define characteristics the participants must not possess, thus it provide a guideline on selection of appropriate participants of the study (Burns & Grove, 2009). Inclusion criteria were those HIV positive pregnant women aged from 15-49 years will be studied. They also had to be either Shona or English speaking, of any level of education and visiting Morgenster Mission Hospital Antenatal Clinic on their routine antenatal care during their data collection period.

Exclusion criteria

Exclusion criteria refers to the characteristics the investigator does not want in the study, hence in this study those woman HIV positive pregnant, younger than 15 years or older than 49 years who did not speak Shona or English were excluded. HIV positive pregnant women aged 15 to 49 years absent, HIV negative pregnant women aged 15 to 49 years and those who declined to take part in the study were excluded to avoid extraneous variables.

Sample Size

The sample size is an important parameter in determining representation of the target population (Houser, 2011). The size of a sample is directly proportional to its representatives of the population, thus the bigger the size, the better the sample in representing the population (Pollit & Beck, 2012). An adequate sample size is good in describing the phenomena of interest, detecting relationships of variables being studied (Houser, 2011). This is the capacity to accept or reject the null hypothesis. Power also increases and the needed sample size decreases. The smaller effect size would be .2, a medium effect size is .5 and a large effect size is .8. A medium effect size of .5 was used in this study. The research has related nursing as having small to medium .5 effects (Burns & Grove, 2012). Depending with the nature of a study, a sample small may be excellent in describing phenomena of interest or can be inappropriate and can lead to misleading conclusions (LoBoindo-Wood & Haber, 2004). Quantitative researchers use formal statistical procedures to test hypothesis hence they require larger samples if higher representativeness and generalizability is to be guaranteed (Polit & Beck, 2012). Basing on Dobson formula to calculate the sample size, for this study was obtained.

The sample size calculation was based on the relationship between empowerment and self-care in HIV positive pregnant women. The sample size was based on the proportion of empowerment and self-care in HIV positive pregnant women. Using the formula by A. Dobson calculations were done as follows:

$$n = \frac{(z \div \Delta)^2 p (1-p)}{}$$

In the equation n is the sample size, z is table values for standard deviation (1,96), delta is 0,05 which is standard deviation at 95% level and p is the proportion of self care in HIV positive pregnant women attending ANC at Morgenster Mission Hospital in Masvingo Province. The proportion n is derived from ZDHS statistical report of woman of child bearing age in our catchment area was 4440 basing on the 2013 ZDHS report.

Where: Z is 1, 96 (based on 95% confidence interval)

$$P = 0, 5 \text{ (variance)} \quad \Delta = 0, 05 \quad z = 1, 96$$

$$n = (1, 96/0, 05)^2 (0, 5) (1-0, 5)$$

$$n = (1536, 64 \times 0,25) = 384, 16$$

Basing on power of .80 = 384.16/0, 80

$$481, 25 = 482 \text{ Adjustment from } 482/1/4=120$$

The sample size of the study was $\frac{3}{4}$ of 120 subjects constituting 96 participants. Due to time factor and lack of funds to carry out the study using a large sample $\frac{3}{4}$ of this sample was finally recruited and 96 participants were registered in this study.

Power refers to the ability of the researcher to detect differences among variables. Power tries to control the likelihood of making a type 11 error. This arises when a researcher accepts the

null hypothesis when it should be rejected. The researcher can directly affect power by increasing the sample size or relaxing inclusion criteria of the test. For example power decreases when criteria are 0.01 than 0.05. Power is therefore subject to the researcher's control. In the study a power analysis of 0.80 was used which results in 20% chance of not being able to find a relationship between variables. A significance level of 0.05 was used which has a smaller sample size than 0.01 significance level.

Study Site

The study was conducted at Morgenster Mission Hospital Antenatal Clinic in Masvingo, Zimbabwe. Data was collected from appropriate participants visiting this ANC for their routine antenatal care. Data was collected before or after the antenatal care service had been rendered to participants, without disturbing the procedures. The pilot study was conducted at Nemamwa Antenatal Clinic using a pilot sample of 5 participants.

Variables

(Burns & Grove, 2013) described a variable as an empirical property that is capable of assuming two or more values. These characteristics or attributes of an individual, group, or the environment are of interest in a research study (Moule & Goodman, 2009). The relationship between empowerment and self-care in HIV-positive pregnant women aged 15-49 years at Morgenster Mission Hospital in Masvingo Province were the study variables in this study.

Conceptual and Operational Definitions of Variables

Conceptual definition is the abstract or theoretical meaning of the concepts being studied (Polit and Beck, 2014). A conceptual definition uses words to define the properties of a

concept, thus conveying the general meaning of that concept (Moule and Goodman, 2009). Operational definition ascribes meaning to a concept or construct by specifying the operations that must be performed in order to measure or manipulate the concept under investigation (Moule and Goodman, 2009). Conceptual and operational definitions give meaning to a variable under investigation by specifying out what the investigator does to measure it (Polit and Beck, 2014).

Demographic Variables

In this study, demographic variables were conceptually defined as independent and dependent variables. They are quantifiable statistics of the population that provide regarding research participants (Houser, 2011). Independent variables are the variables that the investigator manipulates or introduces into the situation, sometimes called the “manipulated variables” (Polit and Beck, 2014). Dependent variables are ones that are under observation by the investigator in order to note the effect on it on the introduction of an independent variable. It is sometimes called the criterion variable (Polit and Beck, 2014). Demographic variables were operationalized using the demographic section of the data collecting instrument that was designed by the researcher. Data was collected using structured interviews. Demographic variables among the study participant included age, sex, religion, educational level and employment status, in HIV-positive pregnant women aged 15-49 years. Knowledge acquired on empowerment and self-care in HIV-positive pregnant women was recorded.

Study Hypothesis

There is a relationship between empowerment and self-care among HIV positive pregnant women aged 15 to 49 years.

Instrument

Research instrument is a tool used for data collection. Several tools for data collection are employed for instance questionnaires, interviews, focus group discussion and observations (Polit and Beck, 2014). A structured interview was used to collect information from HIV-positive pregnant women aged 15 -49 years at Morgenster Mission Hospital. According to Houser, (2011) an interviews scheduled is a formal written instrument with questions which are asked verbally in either face-face or telephone interviews. Respondent anonymity is interfered with hence result in interview bias. Study subjects tend to give answers that are socially acceptable (Polit and Beck 2014). Interview schedules were feasible with most people, even the illiterate and the blind utilized them and its response rate was high in face-to-face interviews and less likely to have left unanswered questions. The researcher had control over questions such that no bias resulted in the study (Moule & Goodman, 2009). The study instruments consist of 3 sections that are demographic data and other two variables in the study. The level of empowerment consisted of a scale 0-42. A self determined score rating of 0-42 was used to deduce the level of empowerment. Three (3) was the highest score allocated to a participant who was empowered economically, in decision making and information wise/educationally. A two (2) was allocated to a participant who alluded that all aspects of empowerment were met as a couple. Lowest level of empowerment had a zero (0) where the participant had everything done by the spouse/partner or relatives. The lowest score ranged from 0-14, moderate empowerment was scored at 15-28 points and the highest score rate was 29-42 points.

Validity

Refers to the degree or extent to which an instrument measures what it purports to measure (Polit & Hungler, 2008). To attain this validity a structured interview was carefully designed

to determine the relationship between empowerment and self-care in HIV-positive pregnant women. Instrument items were deduced from the literature review findings.

Reliability

Reliability of an instrument relates to its accuracy and precision in measuring the attribute of concern (Polit and Beck, 2004). Thus the instrument should yield similar results if used on a different sample of participants from a similar target population in a similar context, (Burns & Grove, 2010). Hence each item was successfully and acutely phrased to guard against ambiguity to guarantee maximum reliability of the study instrument. The researcher carefully prepared an alternative Shona research instrument for those in the Pilot study who preferred to give answers in Shona.

Pilot study

A pilot study is a small scale version or trial run done in preparation for the major study (Polit and Beck, 2014). The pilot study was conducted at Nemamwa Antenatal Clinic using a pilot sample of 5 participants and the instrument was amended accordingly to ensure maximum validity and reliability. A pilot study was conducted at a different site from the major study site, (Burns & Grove, 2009).

Data collection plan

This was a series of steps that the researcher used to carry out during the process of gathering data on phenomena of concern in a systematic way that enabled the researcher to evaluate the outcomes and to accurately answer the research question (Houser, 2011). Due to constraints of resources and need to maintain consistency throughout the study, the researcher herself conducted the interviews after obtaining the necessary clearances from the responsible

authorities involved. The data was collected from suitable participants at Morgenster Memorial Hospital Antenatal Clinic. A structured interview schedule was used. A well prepared structured interview schedule, with items which the researcher ticked or filled in the information from the participants was availed. The researcher first asked for a quiet environment for the study from relevant authorities in charge. She then introduced herself and explained about the study (its importance and how it was going to be carried out) to suitable participants. After they get fully informed, the researcher then will issue the participant an informed consent forms to read and sign without being coerced. The researcher then took them individually into a private room and administered the instrument. The researcher orally asked participants in order to gather their demographic data and information about their knowledge of medical benefits of empowered HIV-positive pregnant women aged 15-45 years and filled the information on the research instrument. Upon finishing the session, the researcher sincerely thanked the participants for their cooperation.

Ethical Considerations

Ethics refers to philosophical study of moral values and rules (LoBoindo-Wood & Haber, 2006). Polit and Beck (2004) defined ethical considerations as the quality and extent to which the decisions and research procedures adhere to professionals, social and legal obligations to the study subjects. The researcher made sure that the participants are aware of their rights and that they are well protected. In this study the researcher observed ethical principles and rules including the right to anatomy and confidentiality, right to privacy, justice, beneficence and respect for persons (Burns & Grove, 1993).

The researcher respected participants as autonomous individuals by allowing them to choose either to participate or not without any form of coercion. The investigator ensured that all participants gave informed consent to participate in the research study fully explained to them

the purpose of the study using the language they understood. She alluded to the implications of their voluntary participation and that they were free to refuse or withdraw should they so wish without compromising their entitlement to health services. The participants were given a chance to ask questions and after they were fully informed, they then signed an informed consent form which was a legal document which served as proof that the participants voluntarily agreed to participate without being coerced after they were fully informed (Moule & Goodman, 2009).

The researcher maintained participant's confidentiality and ensured them anonymity by not putting their names on the coded data collecting tool. The researcher protected the participants' identity by not giving their names, or any information which would reveal their identity during presentation of the research result. Even the researcher herself could not link any information to any study participant at the end of the research. The interviews were conducted in a private setting where no other persons heard the conversation.

Another principle of importance which was observed in this study was the principle of beneficence-doing more good than harm to the participants (Polit & Beck, 2012). It was the researcher's responsibility in this study to safeguard the participants from social, physical, financial, psychological and emotional harm through minimizing waiting periods and maintaining privacy, anonymity and confidentiality (Burns & Grove, 2013).

The principle of justice which points to impartiality (Burns & Grove, 2013) was also observed in ethical consideration. In this study, the researcher treated the participants fairly by gave them an option of volunteering or refusing to participate or to withdraw from the study at any time if they so wished to withdraw from the study without their right to health services being compromised.

To ensure adequate ethical soundness of this research, the researcher sought permission from Joint Research Ethics Committee (JREC), appropriate hospital administrations where the study was carried out and relevant department authorities and other health professionals. Their approval meant that this study was ethically sound and the researcher proceeded to the required hospital premises.

Summary

This chapter focused on various areas of research methodology used in this study, that include the research design, sampling procedures, data collecting instrument, pilot stud and ethical consideration. The purpose of this study was to determine the relationship between empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital. Participants were recruited using convenience sampling method from accessible population with in the 440 women of child bearing age in the catchment area. The participants were Shona or English speaking HIV positive women attending ANC at Morgenster Hospital. A structured interview schedule was used for data collection in this research study. The variables in this study were empowerment, self-care and demographic factors. The researcher made sure that the study subjects knew their rights like anonymity confidentiality, right to privacy, principle of justice and the principle of beneficence and respect of person (Burns&Grove, 2013).

CHAPTER 4

RESULTS

The purpose of this study was to describe and examine the relationship between empowerment and self care among HIV positive pregnant women aged 15 to 49 years attending antenatal clinic at Morgenster Mission Hospital. The data sought to answer the following questions:

1. What was the proportion of empowerment among HIV positive pregnant women aged 15 to 49 years attending antenatal clinic at Morgenster Mission Hospital?
2. What was the proportion of self care among HIV positive pregnant women aged 15 to 49 years attending antenatal clinic at Morgenster Mission Hospital?
3. What was the relationship level of empowerment and level of self care among HIV positive pregnant women attending antenatal care at Morgenster Mission Hospital?

The data was collected from April to May 2015 using face to face interview schedules. Ninety six participants in this study were recruited. The response rate was optimal at 100%. Data was analyzed using the Statistical Package for Social Sciences (SPSS). Descriptive statistics using frequencies, percentages, mean and standard deviation were used to describe empowerment and self care among HIV positive pregnant women aged 15 to 49 years attending antenatal clinic at Morgenster Mission Hospital. Inferential statistics specifically the Pearson Product Moment correlation test was used to determine the relationship between empowerment and self care. Simple regression was used to determine the strength of the relationship between the independent variable and dependent variable. Data was presented in tables.

Respondents' Demographic Characteristics

Table 1 shows mothers age ranging from 15 to 45 years, with a mean age of 29.45 and a standard deviation of 6.65 years. Table 1 shows the marital status of HIV positive pregnant mothers. Four (4.2%) were single and ninety two (95.8%) were married. Table 1 shows the HIV positive pregnant women's level of education. Five (5.2%) had received no education, twenty five (26.0) had attained primary education, sixty four (66, 7%) received secondary education and two (2, 1%) had reached tertiary level. Table 1 show HIV positive pregnant women's monthly income. Eighty eight (91.7%) earned less than \$50.00, two earned between \$300 and \$550.00 per month and seven earned \$551 .00 and above per month. Table 2 shows the religions the HIV positive pregnant women belonged. One (1.0%) had no church affiliation, twelve (12.5%) belonged to the Roman Catholic Church, while eighteen (18.8%) were Protestants, sixteen (16.7%) were Pentecostals, thirty five belonged to the Apostolic Sect and fourteen (14.6%) were Zionists.

Table 1 Sample Graphic Characteristics (1) (N=96)

	Variables	Frequencies	Percentages %
Age	16	1	1.0
	17	4	4.2
	18	2	2.1
	19	1	1.0
	20	2	2.2
	21	3	3.1
	22	3	3.1
	23	1	1.0
	24	9	9.4
	25	5	5.2
	26	2	2.1
	27	2	2.1
	28	8	8.3
	29	5	5.2
	31	4	4.2
	32	7	7.3
	33	10	10.4
	34	3	3.1
	35	6	6.3
	36	7	7.3
	37	3	3.1
38	8	8.3	
39	1	1.0	
41	1	1.0	

	44	1	1.0
	45	1	1.0
Total		96	100%
<u>Marital status</u>	Single	4	4.2
	Married	92	95.8
<u>Total</u>		96	100%
<u>Level of Education</u>	None	5	5.2
	Primary	25	26.0
	Secondary	64	66.7
	Tertiary	2	2.1
Total		96	100%
<u>Religion</u>	None	1	1.0
	Methodist	4	4.2
	RCZ in Zimbabwe	14	14.6
	Roman Catholic	12	12.5
	Pentecostals	16	16.7
	Apostolic Sect	35	35.5
	Zionists	14	14.6
Total		96	100%

Empowerment

Table 2 shows results of empowerment of HIV positive pregnant women. The interview schedule sought information on empowerment among HIV positive pregnant women attending Antenatal Clinic at Morgenster Mission Hospital. The empowerment items were economical, information, psychosocial support and decision making. Table 3 shows results of empowerment through social information an HIV positive has to know for empowerment towards self-care. On spouse tested ten (10.4%), married to the HIV positive pregnant women were not tested and eighty six (89.6%) spouses/partners of the HIV positive pregnant women interviewed were tested. Concerning spouse/partner's HIV status thirteen (13.5%) HIV positive pregnant women did not know their spouse's status and eighty three (86.5%) knew their spouses/partner's HIV status. Table 3 also show spouse support to the HIV positive pregnant women where seventeen (17.7%) never support the women, one (1.0%) rarely support the wife, three (3.1%) sometimes support the HIV positive pregnant women and seventy five (78, 1%) had always supported their HIV positive pregnant women. Table 3 shows results on women's knowledge on empowerment as their right thirty two (33.3%) did not know they had that right two (2.1%) were not sure of their right to empowerment and sixty two (64.6%) knew that HIV positive pregnant women had the right to empowerment. Table 3 also shows results on who else know the HIV positive pregnant women's status .Forty (41.7%) had not told anyone their HIV status and fifty six 958 had told a close relative or friend.

Table 2 Empowerment through support and knowledge of spouse's HIV status

	Variable	Frequencies	Percentages
<u>Was your spouse tested ?</u>	No	10	10.4
	Yes	86	89.6
Total		96	100%
<u>What is your spouse/partner's HIV status?</u>	HIV positive	0	0
	HIV negative	83	86.5
	Did not disclose	0	0
	Do not know	13	13.5
Total		96	100%
<u>Is your spouse supportive?</u>	Never	17	17.7
	Rarely	1	1.0
	Sometimes	3	3.1
	Always	75	78.1
		96	100%
<u>Is empowerment a women's right?</u>	No	32	33.3
	Not sure	2	2.1
	Yes	62	64.6
Total		96	100%
<u>Who else know your HIV status?</u>	Nobody	40	41.7
	Relatives	56	58.3
Total		96	100%

Table 3 shows findings on socioeconomic empowerment, eighty eight (91.7%) were not employed and eight (8.3%) were employed. On payment of drugs and any investigations,

eighty seven (90.6%) could not afford and nine (9.3%) could pay for their medical care. Table 4 shows results of ANC payments on booking eighty seven (90.6%) could not pay for antenatal booking and nine (9.3%) could afford antenatal registration. Seventy eight (81.3%) of the HIV positive pregnant women could not access any financial loans from local financing and clubs and eighteen (18.8%) pregnant women could access financial loans. Table 4 shows information on income generating projects where fifty seven (59.4%) had nothing to sustain them financially and thirty nine (40.4%) had projects like poultry keeping, market gardening or venting. Table 5 shows empowerment of HIV positive mothers through information. On knowledge of modes of HIV transmission from mother to child twenty three (24.0%) of the HIV positive pregnant women could not state anything, thirty two (33.3%) stated only one mode, fourteen (14, 6%) stated two ways of HIV transmission and twenty seven (28.1%) knew very well modes of HIV spread from mother to child. Table 5 shows HIV positive pregnant mothers' knowledge on feeding options for an HIV exposed baby. Twenty eight (29.2%) had no information, thirty eight (39.6%) knew one option, eleven (11.5%) stated two options and nineteen constituting 19.8% could state all types of feeding options. Table 5 also shows response results on knowledge on properties of breast milk which is recommended in low income countries like Zimbabwe. Forty five did not know any culminating 46.9% of the study subjects, fifteen (15.6%) could state one property, eight (8.3%) mentioned two and twenty seven (28.4%) knew all that constitutes breast milk. The HIV positive pregnant women were also asked about ART administered to an HIV exposed baby. Thirty two women hardly knew any drugs given to an HIV exposed baby, twenty one could elaborate one, two women stated two drugs and forty one stated the ARV drugs given to an HIV exposed baby.

Table 3 Socioeconomic empowerment N=96

	Variables	Frequencies	Percentages
<u>Are you employed?</u>	Yes	8	8.3
	No	88	91.7
Total		96	100%
What is your monthly income?	\$0-\$50.00	88	91.7
	\$51-\$150	0	0
	\$151-\$250	0	0
	\$251-300	1	1.0
	\$301- \$400	0	0
	U\$550 and above	7	7.3
Total		96	100%
<u>Can you afford to pay for drugs and investigations?</u>	Yes	9	9.3
	No	87	91.7
Total		96	100%
<u>Can you afford Antenatal booking fees?</u>	Yes	9	9.3
	No	87	90.7
Total		96	100%
<u>Can you access any finance loan?</u>	Yes	18	18.6
	No	78	81.4
Total		96	100%
What income generating project do you have?	Chicken breeding	9	9.4
		25	26.0

	Market garden	5	5.2
	Venting	57	59.4
	Nothing		
Total		96	100%

Table 4 shows results of empowerment through decision making, with the current pregnancy, fifty four (56.3%) conceived because the spouse/partner wanted a child, thirty four (35.4%) took the decision as a couple and eight (8.3%) of the women decided on their own to fall pregnant. Table 6 shows results on who decides on condom use during sexual intercourse. Forty nine (51.0%) of the HIV positive pregnant women had the decision on condom made by spouses, thirty three (34.4%) had decisions on condom as a couple and fourteen (14.6%) of the women decided on condom use during sexual intercourse. Table 4 show results on decision making on antenatal booking for the HIV positive pregnant women. Fifty six (58.3) had decision to register antenatally made by spouses, thirty (31.3%) made the decision as a couple and ten (10.4%) women made the decision to book at ANC. Table 6 also reveals results on decision made by HIV positive pregnant women on place of delivery. Thirty four (35.4%) had the spouse's decision, thirty (30%) made the decision on place of delivery as a couple while thirty two HIV positive pregnant women made their own decision on place of delivery. Decision on feeding option had to be drawn, thirty three (34.4%) were made by the spouse, forty four (45.8%) were made by the couple and nineteen were made by the HIV positive pregnant women.

Table 4 Empowerment through decision making N=96

	Variable	Frequencies	Percentages
<u>Who decided on current pregnancy?</u>	Spouse/partner	54	56.3
	Couple	34	35.4
	Self	8	8.3
<u>Total</u>		96	100%
<u>Who decides on condom use during sexual intercourse?</u>	Spouse/partner	49	51.0
	Couple	33	34.4
	Self	14	14.6
<u>Total</u>		96	100%
<u>Who decided on antenatal booking?</u>	Spouse/partner	56	58.3
	Couple	30	31.3
	Self	10	10.4
<u>Total</u>		96	100%
<u>Who decided on place of delivery?</u>	Spouse/partner	34	35.3
	Couple	30	31.3
	Self	32	33.3
<u>Total</u>		96	100%
<u>Who decided on feeding options?</u>	Spouse/partner	33	34.4
	Couple	44	45.8
	Self	19	19.8
<u>Total</u>		96	100%

Self care among HIV positive pregnant women

Table 5 shows results on disclosure among HIV positive pregnant women. Five (5.2%) had not disclosed their HIV statuses to their spouses and ninety one (94.8%) had disclosed. Sixty nine (71.9%) HIV positive pregnant women had not registered with any support group and twenty seven (28.1%) had registered with local support groups. Table 7 shows results on other persons the HIV positive pregnant women had registered with antenatally. Thirty nine (40.6%) had not brought any other persons to register they had come alone, seven (7.3%) had brought either friends or other relatives not spouses and fifty (52.1%) had registered with their spouses antenatally .Asked about when the HIV positive pregnant women had started Option B+ or ART, Six (6.3%) were still on Cotrimoxazole, four (4.2%) had started ART before the current pregnancy and eighty six were initiated on Option B+ with the current pregnancy.

Table 5 Self- care among HIV positive pregnant women N=96

	Variable	Frequencies	Percentages
<u>Did you disclose your status to your spouse?</u>	Yes	91	94.8
	No	5	5.2
Total		96	100%
<u>Do you belong to any support group?</u>	Yes	27	28.1
	No	69	71.9
Total		96	100%
<u>When did you start ART?</u>	Not yet	6	6.2
	Before current		

	pregnancy	4	4.2
	With the current pregnancy	86	89.6
Total		96	100%
<u>State the ART drugs you are taking?</u>	Zero	42	43.8
	One	8	8.3
	Two	5	5.2
	All	41	42.7
Total		96	100%
<u>At what gestational age did you register?</u>	Below 12/40 weeks	38	39.5
	After 12/40 weeks	58	60.4
<u>Total</u>		96	100%
<u>Who else was registered with you antenatally?</u>	Spouse/partner	39	40.6
	Relative	7	7.3
	nobody	50	52.1
Total		96	100%

Table 6 shows results of the ART the HIV positive pregnant women are currently taking. Forty two (43.8%) could not name any, eight (8.3%) stated one drug, five (5.2%) mentioned two and forty one (42.7%) knew all the drugs they were taking. Table 8 shows results on recommended booking gestational age. Thirty eight (39.6%) had late booking and fifty eight (60.4%) had booked at 12 weeks and below as expected.

Table 6 Empowerment through knowledge/information N= 96

	Variables	Frequencies	Percentages
How is HIV transmitted from mother to child?	Zero	23	24.0
	One mode known	32	33.3
	Two modes known	14	14.6
	All modes known	27	28.1
Total		96	100%
<u>State infant feeding option</u>	None	28	29.2
	One	38	39.6
	Two	11	11.4
	All	19	19.8
Total		96	100%
<u>State properties of breast milk</u>	Zero	45	46.9
	One	15	15.6
	Two	8	8.3
	All	27	28.4
<u>Total</u>		96	100%

Table 7 Pearson's Correlation output for empowerment and self care

Variable	Y
	1.000
X	.481

*p< 0.05 **p< 0.01 ***p< 0.01

Key

Y (Empowerment)

X (Self care)

Table 8 Regression Analysis of self care

Variance	B	SEB	Beta
X	.399	1.355	.481
Constant	9.685	.075	
R²	.231	F= 28.260	0

*p< .05 **p<.01 ***p<.001

Key

X= Empowerment in self care among HIV positive pregnant women

CHAPTER Five

DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This chapter presents discussion, study findings; implications, conclusions, recommendations and limitations. Implications of study results to the field of nursing and research and the conceptual framework will be discussed.

Summary

The purpose of this study was to describe and examine the relationship between empowerment and self care in HIV positive pregnant women aged 15 to 49 years attending routine ANC at Morgenster Mission Hospital in Masvingo Province. Ninety six respondents were interviewed utilising a questionnaire with operationalized definitions and Orem' Self Care Model. Data analysis was done using descriptive statistics using frequencies, percentages and averages to describe empowerment and self care in HIV positive pregnant women aged 15 to 49 years attending routine antenatal clinic at Morgenster Mission Hospital in Masvingo Province. Inferential Statistics utilizing the Pearson Product Moment test was used in order to examine the relationship between independent variable of

empowerment and self- care among HIV positive pregnant women. Simple regression analysis was used in order to examine the strength of the relationship between the independent variable and the dependent variable. The highest score on empowerment was 33 out of 42 with a mean score of 16.5 points and a standard deviation of 7.4691. Those respondent poorly empowered attained 0 to 14 were twenty four (25%) moderate empowered was a score of 15 to 28 were fifty five (57, 3) points and highest empowerment score was 29

to 42 points where seventeen (17.7%). On self care the highest score was 39 out of 42, with a mean score of 16, 4583 and a standard deviation of 7,446912. The respondents who poorly self cared scores from 0 to 14 constituted twenty (20.8%), moderate self care scored 15 to 28 points were sixty four constituting (66.6%) and those participants who could highly self care scored between 29 and 42 points were 12 (12.5%). The majority of the participants in both independent and dependent variables are moderately empowered and can moderately self care meaning there is moderate correlation between empowerment and self care in HIV positive pregnant women.

Discussion and implication

Sample demographics

Ninety five participants belonged to some religious sect as indicated except one (1.0%) who was none Christian, Roman Catholic 12 (12.5%), Protestants 18 (18,8%), Pentecostals 16 (16.7%), Apostolic 35 (35.5%) and Zionists 14 (14.6%). There is an increase in Apostolic sect and Zionists due to the upcoming ministries and prophetic based churches in Zimbabwe. The majority of the participants were married 92 (95.8%) and four (4.2%) were single. The majority of the participants were unemployed eighty eight constituting (91.7%) and eight (8.3%) were employed. There is also high unemployment rate currently at 90% according to (ZDH 2015). The unemployment in most of the respondents concurs with the study findings in Zimbabwe that women showed that women need to be economically empowered to be assertive in self care (Mutowo, 2014).

Five (5.2%) had never been to school, twenty five (26.0%) attained primary education. According to Zimbabwe Health Demographic Survey (2010-2011) Primary level is grade 1 to 7. The implications are that with such low educational level of almost one third of the

participants will not be able to read and understand information given on HIV and even call the name of the drugs they are taking. Sixty four (66.7%) attained secondary education and two had gone to tertiary institutions which means the majority of the participants could read and understand information on pamphlets and news papers about HIV. According to Multiple Indicator Cluster Survey of 2014 Zimbabwean literacy level is at 92% while those who have attained primary education constitute 99.3% and secondary education is at 57.5%. This was noted in this study that most of the participants got secondary level up to form three the majority did not write O-level examinations.

Those who attained secondary education could articulate information as stated by Wallace et al (2009) that access to proper information by pregnant women on issues related to pregnancy and delivery would empower them to positive changes in health care behaviours. Granders et al, (2008) in their study indicated that maternal education was the most important social factor that could affect pregnancy and birth outcomes.

Empowerment

According to Domitilla et al (2013) in their study in United States of America defined empowerment as a process of awareness throughout which women recognize their capacity to achieve individual and social change. The process involves a mental and spiritual awareness that enables the HIV positive pregnant women to gain control of their physical, psychological and social dimension of health which was inquired among the participant On spouse HIV test ten (10.4%) had not tested and eighty six had been tested. Thirteen (13.5%) of the participants did not know their spouse's HIV results and eighty three (86.5%) knew their spouse or partner's HIV test results. World Health Organization (2010) postulates that HIV testing despite that all pregnant women should test for HIV that serves as both critical prevention and treatment in control of the epidemic. The fact that some spouses are reluctant

to be tested might mean a big problem in having a free HIV generation. Concerning support from spouses seventeen (17.7%) never supported their wives, one (1.0%) rarely cared, three (3.1%) sometimes supported and seventy five (78.1%) did support their wives. In a study conducted in South Africa by Van Dyk's (2007) he noted that 44.4% were not supported by friends and family members and (21.7%) were harassed by their husbands who also refused to have sexual intercourse with them. Same was noted in this study as alluded to by the participants. Some husbands were said to have abandoned their families while others got into polygamous lives. Eller, Corles and Bunch (2005) noted that financial limitations, family demands and emotional stress may contribute to lack of self esteem, social support which can be a barrier to healthful self care. Regarding knowledge on rights to empowerment thirty two (33.3%) did not know they had rights, two (2.1%) were not sure and the majority sixty two (64.6%) knew they had rights. According to Ministry of Women Affairs and Community Development (2011) women have rights similar to men. It has been noted that even when the HIV positive pregnant women knew their sexual reproductive and health rights, social and family pressures, lack of confidence and economic dependence on husbands and their families are the main reasons why women do not defend their interests. Hope (2011) in her study in Zimbabwe noted that sexual reproductive health rights emphasized equitable access to preventive care. This proves that the findings in this study has revealed the truth of the matter that inequalities that prevail hinders women's protection from being re infected by their spouses or partners who are neither tested or disclose their HIV results to their wives.

Eighty eight (91.7%) participants were not employed and eight (8.3%) were employed meaning the majority of the study subjects had no source of income or salary. Current employment rate in Zimbabwe is at 10% according to the Zimbabwe Demographic Survey (2015). The majority of the participants depended on their spouses or partner for financial

support. Hope (2011) in her study in Zimbabwe stated that the socio –economic and political inequality that prevail between men and women revealed that there is unequal access to HIV prevention education. According to Zimbabwe National Aids Council (2011) women are likely to be poorer and less educated than men, predisposing them to HIV infection and making it harder for them to access treatments, care and information. On access to financial loans, seventy eight (81.3%) the majority of the participants could not afford any loan and seventeen (17.7%) could afford because they had working spouses or they were working. On income generating projects fifty nine (59.4%) had none and thirty nine (40.6%) had projects like market gardening, poultry keeping or venting for a living. In this study most of the HIV positive pregnant women had no income generating projects neither were they employed. In an All Africa Com. Report of 15 January (2008) it was noted that as income for rural households tends to be low and women often relied upon husbands working in urban areas for financial support women cannot afford the costs of drugs According to International Research Centre (2010) women are better poised to improve their lives when they own land and other assets. Just 1% of the world’s women land own land. This has been the case in this study where the majority of the participants had no income and no land but barely lived in poverty. (Cameron, 2010) in her study among HIV positive women in Guyana, noted that more needed to be done and that there was need to get the government more involved to improve the HIV women’s empowerment opportunities. Women’s socio-economic vulnerability and gender inequalities also lie at the root of their painful experiences associated with HIV infection. In another study in South Africa it was noted that gender equality and economic empowerment were the key developmental conventions (Pronky, 2006). It was also evident that promoting HIV positive’s economic empowerment can make a positive impact on the response to HIV. In some regions obstacles posed by unequal access to credits and market information drive HIV positive women into economy with little access to

social protection. Lack of economic empowerment increases the vulnerability of women to HIV and hampers impact of mitigation. This was noted in this study as only 8.3% were economically empowered on a salary.

On knowledge or information empowerment twenty three (24%) did not know the modes of HIV transmission to the baby, thirty two (33.3%) knew one mode, fourteen (14.6%) knew two ways of MTCT of HIV and twenty seven (28.1%) knew all the modes of HIV transmission, generally the participants did not know how they could infect their babies.

Grandes, et al (2008) indicated that maternal education is the most important social factor that can affect outcomes of pregnancy and birth. In their study they also noted that various health care education models have been applied to achieve large scale changes in behaviour. Access to proper information on issues related to pregnancy and delivery empower HIV positive pregnant women. Likewise this was denoted in this study that HIV positive need a lot of information on their status so as to empower them towards optimal health and life. Regarding baby ART, thirty two (33.3%) did not know, twenty one (21.9%) knew one drug, two (2.1%) knew two drugs and forty one (42.7%) knew all the ART drugs they would give to their babies. Just as previously noted there is need to intensify in information giving to HIV positive pregnant women for continuous support and care. WHO and Food and Agricultural Organization,(2009) stated that HIV positive pregnant women in their educational content towards self care in pregnancy nurses included to several items on physical activities, wise eating and in addition to the usual antenatal care on each visit throughout pregnancy. Knowledge on feeding options was asked and sixty six (68.8%) knew one option, (11.5%) knew two and nineteen (19.8%) stated three options on infant feeding. The majority knew about breast feeding which was the most appropriate for low income persons. According to Multiple Indicator Cluster Survey (2014) breast feeding is almost

universal in Zimbabwe constituting 98.1% and bottle feeding at 10.3%. In this study findings are similar to the (MICS, 2014) that in Zimbabwe with or without HIV breast feeding is ideal. The majority of the participants choose to breastfeed their babies. On properties of breast milk, forty five (46.9%) did not know, fifteen (15.6%) stated one, eight (8.3%) stated two and twenty seven (28.4%) knew all the properties of breast milk. The lack of knowledge may be attributed to the rural dwelling such that the midwives have to really give emphasis on every health talk to the women. Pittiglio and Hough (2009) stated that HIV positive pregnant women, if they become informed about HIV they develop more attitude towards their future. The same attitude should prevail among rural health personnel to empower the HIV positive pregnant women with information. Asked on who else knew the participant's status forty (41.7%) had not told anyone else, one (1.0%) was not allowed to tell anyone of the spouse's relative and she chose to tell her sister fifty five had disclosed to all their parents and their in-laws. The majority knew the importance for telling other people for social and material support. Discrimination against women, lack of information, consent, stigma and social exclusion suffered by HIV positive women impede their life often resulting in the violation of their human rights (Hope, 2011). The same was revealed when some HIV positive pregnant women were barred from telling anyone their HIV status but to keep to the couple.

Regarding current pregnancy, fifty four (56.3%) had decision made by the spouse to conceive, thirty four (35.4%) made the decision as a couple to have a baby and eight (8.3%) decided on their own to fall pregnant. Majority did not conceive by own choice.

According to Chamisa (2004), in her study in Zimbabwe, in Sub Saharan Africa, men are decision makers in the family or in a relationship, so at times it becomes difficult for a woman to practice positive self care practices. In fact women are told what to do and what not to do. The study participants in this research had decisions made by spouses or partner

they could not make their own decisions. Decision on antenatal booking fifty six (58.3%) had the decision to go for ANC booking made by their spouses, thirty four (31.3%) and ten (10.4%) decided on their own when to book antenatally. In a study conducted in United States of America by Chiou, Kuo, Lee and Chen (2004) among low income women HIV positive women who were economically disabled, HIV prevalence continued to increase. The same high HIV prevalence rate has been noted among the study participants. Interventions were needed that successfully engaged women in positive self care management through elimination of health disparities that currently face poor women living in smaller cities who were greatly affected by HIV/AIDS. This study has seen the HIV positive pregnant women equally suffering as they had for their spouses to decide everything for them.

Self care

Self care is defined as the performance or practice of activities that individuals initiate and perform on their own behalf to maintain life, health and wellbeing (McEwen & Wills, 2011). Disclosure had these responses five (5.2%) had not disclosed their statuses to their spouses or partners and ninety one (95.8%) had told their spouses. Participants showed some culture of mutual trust to enable self care. According to Marelich and Muph, 2013 disclosure in HIV positive women encourage them to culminate empowered behaviours in their lives. Secrecy and no-disclosure with in a community sounds very dangerous. On the issue of support groups, sixty nine (71.9%) had not registered with any support group and twenty seven (28.1%) belonged to the local support group. Majority of the participants did not have social support other than just having support care once a mother or when they came for drug supply. Van Dyk (2007) in his study in South Africa stated that support groups in HIV are very powerful and allows colleagues to share concerns problems and fears. A social support system relieves stress, loneliness, depression and anxiety. Support groups strengthens the

sense of self worth, trust and life direction hence there is need to initiate one in Morgenster catchment area. Several researchers have successfully used group interventions to enhance positive health behaviours in persons living with HIV including reduction in potential HIV transmission behaviour among women living with HIV/AIDS, (Kalichman, Rompa and Cage, 2005).

Regarding current pregnancy, fifty four (56.3%) had decision made by the spouse to conceive, thirty four (35.4%) made the decision as a couple to have a baby and eight 98.3%) decided on their own to fall pregnant. Majority did not conceive by own choice. According to Chamisa 2004, in Sub Saharan Africa, men are decision makers in the family or in a relationship, so at times it becomes difficult for a woman to practice positive self care practices. In fact women are told what to do and what not to do. Decision on antenatal booking fifty six (58.3%) had the decision to go for ANC booking made by their spouses, thirty four (31.3%) had decision made as a couple and ten (10.4%) decided on their own when to book antenatally. Interventions were needed that successfully engaged women in positive self care management through elimination of health disparities that currently face poor women living in smaller cities who were greatly affected by HIV/AIDS. This study has seen the HIV positive pregnant women equally suffering as they had to wait for their spouses to decide everything for them. On condom use among HIV positive pregnant women forty nine (51%) had their spouses deciding on condom use during sexual intercourse, thirty three (34.4%) decided on condom use as a couple and fourteen (14.6%) decided independently on condom use during sexual intercourse.

Majority of the participants had no say regarding consistent correct condom use. Maman and colleagues (2002) in their study in South Africa found that lack of financial autonomy, control of household income, inability to negotiate condom use, lower education and lower

income were factors that hampered self care among HIV positive pregnant women. The above statement concurs with the WHO, 2011 statement that promoting gender equality and women empowerment economically would increase the bargaining power to negotiate safer sex. This may also help women afford and access counselling testing services and ART. Miller, (2011) in a study in Sub Saharan Africa reported an increase in female vulnerability to HIV that stemmed from limited access to health care and lack of autonomy to make decisions regarding sexual reproductive health education and only 65% could make their own decisions. Marston and Gwyther 2003 stated that sex release stress and provides much needed human conduct and intimacy in HIV positive persons. Safer sex should be practiced at all times to protect sex partners from infection and themselves from re-infection with HIV and other sexually transmitted infections. These participants needed that protection since they would be vulnerable to infect their unborn babies. Ministry of Women Affairs Gender and Community Development of Zimbabwe 2011 state that the relationship between husband and wife is based on respect for each other rather than husband's power over the wife. Hasbullh, 2013 states that it is believed that a married woman should trust her husband and is not allowed to use a condom for sex with her spouse or partner even when she suspects him to be infected with an STI.

Same belief could be prevalent among the study participants since the majority were not able to decide on condom use during sexual intercourse. (WHO, 2011) states that empowered women know that condoms are the best choice for contraception because they also prevent HIV transmission during sexual intercourse. According to WHO (2013) HIV positive mothers who breast feed should be encouraged to use condoms to prevent re-infection with new strains of the virus and prevent an increase in the viral load. Optimal sex practices, use of condoms will reduce the chances of transmitting the virus to the baby through breast milk.

Decision on place of delivery in thirty four (35.4%) was made by the spouse, thirty one (31.3%) was made as a couple and thirty two (33.3%) was made by the participant revealing that almost everything the HIV positive pregnant women does, has the spouse's approval. The health of the HIV positive pregnant women is determined by their spouses yet their health is their right and responsibility. There is need for nurses/midwives to impart information on sexual reproductive health rights to all women of child bearing age and the girl child during health education talks. (Grjibovsk, 2005) states that some studies indicated that maternal education is the most important social factor that can affect self care and outcomes of pregnancy and birth. The HIV positive pregnant women alluded that hospital delivery was the best and safe for them and management of pregnancy complication. ZIMSTAT 2014 revealed that hospital deliveries in Zimbabwe were at 80% and maternal mortality 614 per 100 000 live births hence the need for all pregnancies to deliver in hospitals to attain 100%.

Enquiring on ability to self care eighty seven (90.6%) could not pay for antenatal booking relatives or working husbands, partners or children had to pay the \$25.00 for the participants, nine (9.6%) paid their booking fees. Eighty seven (90.6%) and nine (9.4%) of the participants could not pay for any form of investigations and drugs revealing economic disability that prevail among HIV positive pregnant women as already discussed. This was noted in Tanzania 2010 that women who are empowered politically, culturally or professionally had confidence to decide to go for HIV testing as she did not depend on her husband or partner to make decisions to seek medical care or not. On booking period thirty eight (39.6%) had late booking after 12 weeks of conception while fifty eight (60.4%) registered before 12 weeks gestationally. According to Copper and Fraser (2009) optimal antenatal booking period is from the time a woman notices that she has missed a period or suspects that she is pregnant.

The majority in this study had observed that and booked early for early HIV diagnosis and ART initiation. Concerning partner or spouse registration antenatally thirty nine (40.6%) came alone as spouses declined, seven brought relatives and fifty had their spouses or partners also registered at MCH department till 24 months post delivery. According to WHO 2013 integrated HIV treatment guidelines recommended lifelong ART for all HIV positive pregnant and lactating mothers for their own health, prevention of MTCT of HIV and male involvement which is currently 10%.

Regarding ART initiation six (6.2%) were on Cotrimoxazole only, four (4.2%) had started ART before the current pregnancy and eighty six (89.6%) started option B + with the prevalent pregnancy. The majority had started ART at booking and well early to prevent mother to child transmission of HIV. Asked to state the drugs HIV positive pregnant women were on forty two (43.8%) stated none, eight (8.3%) knew only one drug, five (5.2%) named two drugs and forty one (42.7%) could state all the drugs they were taking. Most of the women did not know their ART drugs though they are supposed to. Literate rate which was measured by assessing one's ability to read in full a short simple statement about everyday life save for the participants who had attended at least secondary education was 1.01% for primary level and 1.17% for secondary level (MICS,2014) could have attributed to the lack of knowledge of ART drugs.(WHO, 2013) stated that empowered HIV positive women go to pharmacy and asks the pharmacist for the inserts or information pamphlets, for some of the antiretroviral drugs available. Read the information on pamphlets and write a summary: the name of the drug, the class or category of medication like Nucleoside, Non-nucleoside and Protease Inhibitors. The contraindications can this drug be taken by pregnant women, by patients with renal failure or liver disease .The direction, dosage for use and the possible side

effects of the medication. The special precautions or does the manufactures discuss negative interactions with other medications or herbals should be known.

The special requirements like should alcohol be avoided, should certain foods be avoided. Such empowerment reinforces the HIV positive pregnant women's self efficacy by making sure that the participants posses required information, negotiation and problem solving skills to carry out desired actions and that they know exactly how to apply their newly acquired behaviour for example how to use condoms, eat nutritious diet and self care. Generally from the study findings it was noted that HIV positive pregnant women need a lot of empowerment socio-economically, in decision making and educationally though information giving if they are to exercise optimal self care towards pregnancy good outcomes and good health with more male involvement.

Relationship between empowerment and self care

Pearson correlation coefficient test

The results of Pearson correlation revealed that empowerment was positively correlated to self care in HIV positive pregnant women ($r=.481$, $p=0.01$). This implies that an increase in empowerment should lead to an increase in self care among HIV positive pregnant women. This relationship is moderately positive. Orem, (1991) postulates that self care comprises of the ability of an individual to independently perform activities that promote and maintain personal health throughout life.

Regression analysis

The strength of the relationship between empowerment and self care in HIV positive pregnant women is indicated by ($R^2 =.231$) ($F = 28.260$, $p<0.01$ $b =.399$ $B=.481$).This

means that the independent variable empowerment explains a 23.1% of variance in self care among HIV positive pregnant women.

Maman and colleagues (2002) in their study in South Africa found that lack of financial autonomy, control of household income, inability to negotiate condom use, lower education and income factors that hampered self among HIV positive pregnant women. In this study findings were the same with the above as 88 (91.7%) were unemployed, 14 (14.6%) could negotiate condom use, lower education 25 (26.0%) and no education 5 (5.2%) really hampering self care in HIV positive pregnant women at Morgenster Mission Hospital.

Theoretical Framework

Orem's self care model was used to direct and guide this study. The focus on the model is self care. The concepts chosen from self care were self care deficit, which in this study corresponded to self care in HIV positive pregnant women, supportive and educative systems corresponded with empowerment through health education on importance of early booking, disclosure, drug adherence, safe sex through condom use, economic empowerment and decision making to enhance self care.

Orem (1991) proposed that self care agency's capability enables an individual to institute self care.

The supportive educative theory was chosen because it explains how nursing agency used education to empower the HIV positive pregnant women to care for self. Orem's self care model can be utilized to give and direct health education delivery to clients having noted lack of empowerment on self care to improve clients' health and pregnant outcomes.

Implications on Maternal Child Health, Midwifery and Nursing Practice

Findings in this study noted that 32 (33.3 %) participants were empowered in self care and 30 (31,3%) could institute self care. These findings called for massive empowerment in HIV positive pregnant women if they have to self care. Empowerment through information giving, socio-economically and decision making was seen as hampering factors to self care among HIV positive pregnant women. Culture, religion and male dominant patriarchal ideologies were noted to hinder self care in HIV positive pregnant women. Male involvement as suggested by WHO (2013) guidelines would enhance self care in HIV positive pregnant women. Women need to be informed about their sexual reproductive health rights and making sound decisions on self care. In this study the investigator noted that poor socio-economic status, stigma, lack of social support, disclosure and gender inequalities hampered self care among HIV positive pregnant women. The study findings also portrayed that the male counterparts are not responsible enough in supportive care to their wives deterring self care.

As a measure to reduce maternal and child mortality there is need for the government to improve HIV positive women's socio-economic status and intensification in information giving during antenatal, intranatal and postnatal care by midwives to enhance self care. Family care services should be rendered all the time. Spouse or partner support and addressing of gender inequalities would promote empowerment and self care among HIV positive pregnant women. For example spouses or partners should allow their wives to make decisions in ANC booking, use of condoms, and choice on disclosure and delivery place that promote self care for optimal pregnancy outcomes for child survival.

Implications to Nursing and Midwifery Education

Findings in this study revealed 31, 3% of those HIV positive pregnant women who could self care meaning the majority were not empowered. The solution is that the health personnel

have to capitalize on health education talks during antenatal, intranatal and postnatal care with male involvement. Nursing curricular should also incorporate nursing research and promote utilization of validated research findings in the day to day care at all levels of care. For example effects of gender inequalities and male involvement in empowerment and self care in HIV positive pregnant women. Health education is a vital tool midwives and general nurses should appreciate right from the beginning of their training. Health education talks should include minor and common things to patients as it could be taken for granted that people know yet clients would have inadequate information.

Implications to Research

The study findings have possible shortcomings of nursing and midwifery practice in terms of imparting information to the public, clients and patients. The varied responses given by the participants on empowerment and self care could have been a result of midwives and nurses' lack of knowledge of their community's health values, norms and behaviours. There is need for midwives and nurses to make a community diagnosis of the people they are serving so as to work on what they know about empowerment in relation to self care among HIV positive pregnant women. Their findings may provide a platform for midwives /nurses to design appropriate programmes to meet the HIV positive pregnant women's empowerment and self care health education talk.

Recommendations

- 1 Basing on the study findings it is recommended that HIV positive pregnant women need to be empowered Socio-economically, educationally and in decision making.
- 2 The government needs to do more about the welfare of HIV positive pregnant women in improving their socio-economic wellbeing and decision making on their health.
- 3 Male involvements should be mandatory in HIV positive pregnant women prenatally, intranatally and postnatally from the current 10% of 2013.
- 4 Another study aspect to be investigated on is how much information is given to HIV positive pregnant women decision making, economic empowerment and sexual reproductive health rights publicly to enhance self care.
- 5 Further studies should be carried out to determine male involvement in empowering HIV positive pregnant of child bearing age to attain self care.

Limitations

Limitations are restrictions in the study that may decrease generalizability of the study findings (Burns and Grove, 2009). The two limitations are theoretical and methodological limitations

- 1 The results of the study cannot be generalized because the study was done on a small sample which was supposed to be 384 but due to the short study time and financial problems it was not feasible.
- 2 The instrument was designed by the investigator and has never been subjected to validity tests it was used for the first time.

3 The participants were sampled through convenience sampling which is a weak method of data collection; anyhow this method was used because of the short duration given for data collection.

4Some critical areas of self care such as nutrition in pregnancy, early booking, adherence to ART and early treatment in infections were not addressed in this study.

Summary

HIV is a major problem globally regionally and in Zimbabwe it is currently 18.4% among women of child bearing age. It is one of the causes of child and maternal mortality the world over. The purpose of this study was to determine the relationship between empowerment and self care among HIV positive pregnant women aged 15 to 49 years. The study utilised Orem's self care model. A non-probability sampling comprising of 96 HIV positive pregnant women were individually interviewed while the researcher filled the questionnaire. Data was coded and entered into the computer and analyzed using the Statistical Package of Social Science (SPSS-PC). Descriptive statistics such as frequencies, percentages mean, mode and median were used to describe empowerment scores and self care scores among HIV positive pregnant women. Pearson correlation test and linear regression analysis test were used to show the type of relationship that exists between the variables. The result showed that there was significant moderately positive relationship between empowerment and self care among HIV positive pregnant women.

The results of the study showed that empowerment was positively correlated to self care in HIV positive pregnant women ($r=.481$, $p=<0.01$). The relationship was significant.

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APPENDIX A

INFORMED CONSENT FORM

PROTOCOL TITLE: The relationship between empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital in Masvingo province.

NAME OF RESEARCHER: SARAH MUDHEI

PHONE : 0775 365 425

PROJECT DESCRIPTION:

A research study that will be carried out in partial fulfilment of the requirements of the Masters' Degree in Nursing Science at the University of Zimbabwe.

PURPOSE OF THE STUDY

You are being asked to participate in a research study to determine the relationship between empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital. The purpose of the study is to assess the proportion of empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital. The study will recruit 120 participants.

PROCEDURES AND DURATION

If you decide to participate, you will be asked a few questions for approximately 10-30 minutes in order to assess the proportion of empowerment and self-care in HIV positive pregnant women. No further information is required from you after this session.

RISKS AND DISCOMFORTS

There is no physical or financial harm associated with this study. However some of the questions may you feel less comfortable as they are likely to invade your private sexual experience.

You are free to withdraw from the study at any time.

POTENTIAL BENEFITS OR COST OF PARTICIPATING

The researcher cannot and do not guarantee or promise that you will receive any benefits from this study. However, the information gathered in this study might be used to help empower HIV positive pregnant women in self-care. You will not be paid for participating in this study.

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, the information that you provide will remain confidential, being accessible only to the investigator and his supervisor. Any information that is obtained in connection with this study that can be identified with you will be disclosed only with your permission.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your access to health care services or your future relations with the nurses/midwives at Morgenster Mission Hospital. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty

QUESTIONS

Before you sign this consent form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION/ENGLISH CONSENT FORM

I have read this paper about this study. I understand the possible risks and benefits of this study. I know being in this study is voluntary. I choose to be in this study and I know I can withdraw from the study and that I will not lose any benefits entitled to me. (Initial all the previous pages of the consent form).

Participant Name (Print)_____Date.....

Participant 'signature_____Time.....

Investigator's signature

Witness signature (optional)

YOUR PARTICIPATION IS GREATLY APPRECIATED.

If you have any issue as research-related injuries or violation of your rights as a research participant that requires attention by someone other than the researcher, please feel free to contact:

Mr A.P.G Charumbira The chairman of University of Zimbabwe at the Department of Nursing Science

P.O BOX A178 Avondale, Harare

[Tel:\(04\)79163ext2221](tel:(04)79163ext2221)

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

APPENDIX B

Gwaro retenderano

ZITA RETVSAKURUDZO: Tsvakurudzo yekuronga hukama kana kudyidzana kwe kugona kuzvimiririra pakuzvizivira nezveutano kana kuzvirapisa kwe madzimai anorarama nehutachiwana hwe (HIV) shuramatongo ane nhumbu ane makore kubva pegumi nemashanu kusvika pamakumi mana nemapfumbamwe paMorgenster Mission Hospital Antennal Clinic.

ZITA REMUTSVAKURUDZI: SARAH MUDHEFI

NHAMBANDA DZENHARE: 0775365425

TSANANGURO YETSVAKURUDZO: Iyi tsvakurudzo irikuitwa nemudzidzi ari mugore rechina paUniversity yeZimbabwe.

CHINANGWA CHETSVAKURUDZO IYI.

Muri kukumbirwawo kuti mubatanidzwewo mukuita tsvakurudzo yekuona kuti madzimai akazvitakura ane makore kubva pegumi nesere kusvika pamakumi matatu nemashanu aneruzivo rwakadzama zvakadini pamusoro pezvakanakira kuchecheudzwa kuhutano. Mapiwa mukana wokupinda mutsvakurudzo iyi nechikonzero che kuti makazvitakura uye mune makore ari pakati pegumi nesere kusvika pamakumi matatu nemashanu uye hamusi kurwara. Tsvakurudzo iyi inoda madzimai akazvitakura anosvika makumi matatu kuti igopera.

UREFU HWENGUVA YEZVICHAITWA MUTSVAKURUDZO IYI

Kana mukazvipira kupinda mutsvakurudzo iyi, muchabvunzwa mibvunzo mishomanana inechokuita neruzivo rwenyu pamusoro pevzakanakira kuchecheudzwa kwemaminitsi ari pakati pegumi negumi nemashanu. Mushure mebvunzurudzo iyi, hapana zvimwe zvamuchazobvunzwa pane imwe nguva.

Kubatanidzwa kwenyu mutsvakurudzo iyi hakuiti kuti murasikirwe nemari yenyu kana kukuvadzwa nenzira ipi zvayo. Kunyange zvakadaro, mimwe mibvunzo inogona kuita kuti munyore sezvo iine chekuita nehupenyu hwenyu hwakavanzika neshamwari yenyu yepabonde.

MUBAIRO KANA MURIPO WEKUBATANIDZWA MUTSVAKURUDZO IYI.

Mutsvakurudzi haatsidze kana kukuvimbisai kuti pane zvamuchawana kuburukidza kuzvipira kubatanidzwa mutsvakurudzo iyi. Kunyange zvakadaro, ruzivo ruchabuda nekuda kwe tsvakurudzo iyi runogona kushandiswa mukuderedzwa kupomerwa kwe vana vanozvarwa nemadzimai ane hutachiwana hweHIV uyewo muri kuwedzera ruzivo rwevana Mukoti. Kubatanidzwa kwenyu mutsvakurudzo iyi hakuiti kuti murasikirwe nemari yenyu nenzira ipi zvayo.

KUCHENGETEDZWA KWAMAGWARO ACHASHANDISWA.

Kana mukaratidza chido chenyu chekubatanidzwawo mutsvakurudzo iyi kuburidza nekusaina Gwaro iri, zvamuchataurirana nemutsvakurudzi zvicharamba zviri pakati penyu muri vaviri. Muchakumbirwa mvumo yekutendera kuti ose mashoko anotaridza kuti akabva kwamuri anogoonekwawo nevamwe vasiri vatsvakurudzi.

KUZVIPIRA KUBATANIDWZAWO

Kubatanidzwa kwenyu mutsvakurudzo iyi ndekwezvipira. Kana mukasarudza kusabatanidzwa mutsvakurudzo iyi, kurapwa kwenyu uye ukama hwenyu nevashandi vepachipatara che Parirenyatwa Antennal Clinic haukanganisike. Zvakare, makasungunuka kubuda musarudzo iyi kana maona zvakakodzera.

MIBVUNZO PAMUSORO PETSVAKURUDZO IYI.

Kana muine mibvunzo pamusoro pezvamunoda kunzwisisa nezvetsvakurudzo iyi musati masaina Gwaro iri makasungunuka kubvunza henyu uye kutora nguva yamunoda yekufunga nezvavzo.

TENDERO/MVUMO

Ndanyatsoverenga Gwaro iri rinechokuita netsvakurudzo. Ndanyatsonzwisisa nezvemubairo kana zvakashata zvinogona kundiwira mutsvakurudzo iyi. Ndinoziva kuti kubatanidzwa mutsvakurudzo iyi ndekwekuzvipira. Ndiri kusarudza kubatanidzwa musarudzo iyi uye ndinoziva kuti ndakasununguka mairi pasina matongo kana kurasikirwa nekodzero dzangu (nyora mavara okutanga ezita renyu nechepasi pamapepa ose egwaro rino)

Zita Renyu _____ Date _____

Rutaratadzo _____ Time _____

Rutaratadzo rwemutsvakurudzi _____

Rutaratadzo rwechapupu _____

KUBATANIDZWAWO KWENYU MUTSVAKURUDZO IYI KUNOTENDWA ZVIKURU.

Kana muine dzimwe nhau dzakaita sekutyorwa kwe kodzero dzenyu netsvakurudzo iyi uye muchinzwa kuda kukurukura nemumwe munhu asiri mutsvakurudzo, makasungunuka kutaura nemukuru wedhipatimende reNursing:

Mr. A. P. G Charumbira vari chairman ku University of Zimbabwe Department of Nursing Science P.O BOX A178 Avondale, Harare Tel (04)79163ext2221

MUCHAPIWAWO RENYU GWARO RETENDERANO IYI KUIT MUGOCHENGETA

APPENDIX C

Serial number:

ENGLISH STUCTURED INTERVIEW

Topic: A study to determine the relationship between empowerment and self-care in HIV positive pregnant women aged 15-49 years at Morgenster Mission Hospital.

Section A: Demographic Data

Instructions: Tick in the provided box and fill in the blank space provided

1) What is your age?

2) Marital status

a. Single Yes No

b. Married Yes No

3) Educational levels

a. Primary

b. Secondary

c. Tertiary

d. No education

4) Religion

a. Tradition

b. Methodist

c. Reformed Church in Zimbabwe

d. Pentecostal

e. Roman Catholic

f. Apostolic Faith Church

g. Zionists

Section B Empowerment

5. Did you disclose your HIV status?

a) Yes

b) No

6. Is your spouse/partner tested for HIV?

a) Yes

b) No

7. What is your spouse/partner's HIV status?

a) HIV positive

b) HIV negative

c) Did not disclose

d) Do not know

8. Is your spouse/partner supportive?

e) Never

f) Rarely

g) Sometimes

h) Always

9. Do you belong to any support group?

a) Yes

b) No

10. Who else know your HIV status?

a) In-law

b) Your mother

c) Friend

d) None

Section C Empowerment in decision making

11. Decision making is one of women rights

a) Yes

b) No

c) Not sure

12. Who made the decision on the current pregnancy

a) Self

b) Spouse/partner

c) Significant others

d) Was unintended

13. Who decided on when to register antenatally?

a) Self

b) Spouse/partner

c) Other

14. Who decides/initiates condom use when you have sexual intercourse?

a) Self

b) Spouse/partner

a) No condom use

15. Who makes decisions on where to deliver?

a) Self

b) Spouse/partner

c) Others

16. Who decides on feeding options for the baby?

a) Self

b) Spouse

c) Others

Section D: ECONOMIC EMPOWERMENT

17. Are you employed?

a) Yes

b) No

18) Salary/Income

a) \$50.00 and below

b) 100 -150

c) \$200-250

d) \$300-350

e) \$400-450

f) \$500-550

g) \$600 and above

19. Do you have a Medical Aide Policy?

a) personal

b) Family Medical Aide policy

20. Can you afford health care, drugs and investigations?

a) Yes

b) No

21. Who paid for your antenatal/maternity booking?

a) self

b) spouse/partner

- c) Relatives
- d) Social welfare+

22. Can you access funds from local financial institution?

- a) Yes
- b) No

23. What income generating project do you have?

- a) Poultry
- b) Market gardening
- c) Vending
- d) None

SECTION E SELF CARE: KNOWLEDGE/INFORMATION ON ART/PREGNANCY

24. What is the recommended gestational age for initial ANC booking?

- a) 12 weeks
- b) 16 weeks
- c) Do not know

25. When is ART/Option B+ initiated in HIV positive pregnant women?

.....

26. State any one of ART given to HIV positive pregnant women

.....

27. Who else is registered at ANC for ART?

.....

28. What treatment is administered to an HIV exposed baby at birth?

.....

.....

29. State which ways can HIV be transmitted to the baby?

.....

.....

30. What does breast milk offer to the baby?

.....

.....

.....

Appendix D

Questionnaire in Shona

Serial Number.....

Musoro- Tsvakurudzo pamusoro pekudyidzana / ukama hwekugona kuzvimiririra nekuzvichengetedza kwamadzimai ane pamuviri achirarama neutachiona hweshuramatongo vane makore gumi namashanu kusvika makumi mana nemapfumbamwe pachipatara che Morgenster kuMasvingo.

Chikamu Chekutanga

Hurukuro pamusoro pamai vanorarama neutachiona.

Zvekuita: Zadzisa mitsara yakapiwa kana kutsvunha mubhokisi remhinduro yamasarudza pane dzakapiwa.

1. Mune makore mangani?

2. Parizvino makaroworwa here uye muri mese here newamakaroorwa naye?

a) Ndakawanikwa

b) Handina kuroorwa

3. Makadzidza kusvika chinhanho chipi?

a.O-level

b.Handina kumboenda kuchikoro

c Primary

d.ZJC

f .level

4. Chitendero chenyu ndechipi?

a. ChiKristu

b. ChiVanhu

c. Methodist

d. Roman Catholic

e. Reformed Church in Zimbabwe

f. Pentecostals

g. Apostolic Faith Church

h. Zionists

SHONA Chikamu chechipiri

Kugona kuzvimiririra munhaurirano kwemudzimai ane nhumbu achirarama neutachiwana hweshuramatongo

5. Makaudza Murume kana shamwari rume yenyu here pamumire maererano nedudziro dzeropa ramakatorwa dzeshuramatongo?

a) Hongu

b) Kwete

6) Murume wenyu kana shamwari rume yenyu yakatorwa ropa rekuziva pavamire here nezvechirwere cheshuramatongo?

a) Hongu

b) Kwete

7) Dudziro dzeropa remurume wenyu kana shamwari rume yenyu maererano neshuramatongo dzakadini?

a) Aneutachiwana

b) Haana utachiwana

c) Haana kundiudza

d) Handizivi

8) Murume wenyu kana shamwari rume wenyu inokutsigirai here pamararamire enyu nechirwere che shuramatongo?

a) Haatombonditsigiri

b) Nenguva dzirikure

c) Dzimwe nhambo anombonditsigira

d) Unonditsigira nguva dzose

9) Mune boka revanorarama neshura matongo here ramunosanganavo navamemwe?

a) Hongu

b) Kwete

10) Ndiyani mumwe wapedyo nemi unoziva pamumire maererano nemamiriro enyu ekurarama neutachiwana hweshuramatongo?

a) Mai wenyu

b) Vabereki vemurume wenyu

c) Shamwari

d) Hapana wandakaudza

Chikamu Chetatu

KUGONA KUZVIMIRIRIRA PAKUITA SARUDZO KWEMADZIMAI ANORARAMA NEUTACHIWANA ANE NHUMBU

11. Kuita sarudzo dzezvaunoda ndeimwe yekodzero dzamadzimai

a) Hongu

b) Kwete

c) Handina chokwadi nazvo

12. Ndiani akakusarudzirai kuita nhumbu yamunayo?

a) ndini ndakazvidira

b) Murume wangu/ishamwari rume yangu

c) Isarudzo yedu tose nemurume wangu/ne shamwari rume yangu

d) Ndevamwe ve mhuri

e) Tanga tisina kuronga kuita nhumbu iyoyi

13. Ndiani akaita sarudzo yekundonyoresa nhumbu iyoyi Kuchipatara?

a) Ndini

b) Murume wangu/shamwari rume

c) Ndevamwe vemhuri

d) Ndini nemurume/neshamwari rume

14. Ndiani apnopa sarudzo yekushandisa kondomu pabonde renyu?

a) Ndini

b) Murume/ishamwari rume

c) Tose tinotenderana

d) Hatitoshandisi kondomu pabonde redu

15. Ndiani noita sarudzo yekwamuchasunungukira nhumbu yamunayo?

a) Ndini

b) Murume wangu/shamwari rume

c) Tose

d) Ndiwanavamwene

16. Ndiani anosarudza marererwo achaitwa mwana azvarwa?

a) Ndini

b) Murume/shamwari rume

c) Tose tinotaurirana

d) Ndevamwe vemhuri

Chikamu cheshanu

KUGONA KUZVIMIRIRIRA KWEMAIDZIMAI ANEMARI ANENHUMBU
ANORARAMA NEWUTACHIWANA HWESHURAMATONGO

17. Munoshanda here?

a) Hongu

a) Kwete

18. Mugove wenyu pamwedzi ndeupi pane yakapiwa iyi

a) \$50.00 zvichidzira

b) \$100-\$150

c) \$200-\$250

d) \$300-\$450

e) \$500-\$550

f) \$600 zvichikwira

19. Munokwanisa kubhadhara here zvose zvamunoitirwa kana mishonga

Kuchipatara?

a) Hongu

b) Kwete

20. Ndiani akakubhadharirai mari yekunyoresa nhumbu yenyu Kuchipatara?

a) Ndakanyoresa ndoga

b) Murume wangu/shamwari rume yangu

c) Ihama dzangu

d) Ndakanyoresa nechikwereti

21. Munzwimbo yekwenyu mu kwamunogona kukweretane mari here?

a) Hongu

b) Kwete

22. Mune mibato yemaoko inogona kukuitisai mari here yamunoita? Sei iyi

a) Kupfuya huku

b) Kurima mirivo yokutengesa

c) Kufamba muchitengesa

d) Handina

KUGONA KUZVIMIRIRIRA NEKUDA KWERUZIVO PAKATI
PEMADZIMAI ANENHUMBU ACHIRARAMA NEUTACHIWANA

23. Nhumbu inonyoreswa yava nemasvondo mangani pane akapiwa awa?

a) Masvondo gumi nemaviri

b) Masvondo gumi nematanhatu

c) Handizivi

24. Mishonga yeART/Option B + inotanga kumwiwa papi nemadzimai anenhumbu aneutachiwana?

.....
.....

25. Ndeapi mazita amunoziva Eart/Option B + amunoziva?

.....
..
.....
.....

26. Ndiani mumwe anonyorwa kuANC kana mudzimai anenhumbu awanikwa ane utachiwana hweshuramatongo?

.....
.....

27.Ndeipi mishonga inopiwa kumwana azvarwa namai vanorarama neutachiwana?

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29. Ndiudzeivo nzira dzinogona kuti mwana abatire uachiwana kubva kuna mai vake?

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30. Ndedzipi nzira dzekurera nadzo azvarwa namai vanorarama neutachiwana hweshuramatongo?

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31. Mumukaka wamai munowanikwa chii chakanakira mwana?

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APPENDIX VIII: BUDGET FOR THE STUDY

ITEM	QUANTITY	UNIT COST	TOTAL COST
a)Stationary- Bond paper	1x4 rims	\$5,00/rim	\$20-00
Tonner	1x2	\$100,00/tonner	\$200-00
Exercise Books	1x10	\$0.20	\$2.00
Ball-points	1 x 10	\$0,20	\$2
e)Lunch Researcher	1x18 days	\$20x18 x1	\$400-00
f)Communication costs	1x50	\$1x50	\$50-00
g)Permission fees for MRCZ & JREC	1x2	\$50X2	\$100-00
Total cost	-	-	\$1 463-00

Proposed Budget and Time –Table

ITEM	JAN 2015	FEB- 2015	MARCH- 2015	APRIL- 2015	MAY- 2015
Topic selection	✓				
Literature review	✓	✓	✓		
Research proposal		✓			
Designing data collection instrument		✓			
Pilot study			✓		
Data collection			✓		
Data Presentation and analysis				✓	
Report writing				✓	
Typing of the report				✓	
Proof reading				✓	
Binding				✓	
Submission of the project					✓