

UNIVERSITY OF KWAZULU- NATAL

**EXPLORING THE NURSES' PERCEPTIONS ABOUT THEIR
PROVISION OF MENTAL HEALTH CARE TO PEOPLE LIVING
WITH HIV/AIDS IN BLANTYRE DISTRICT, MALAWI**

GENESIS CHORWE-SUNGANI

2010

**EXPLORING THE NURSES' PERCEPTIONS ABOUT THEIR PROVISION OF
MENTAL HEALTH CARE TO PEOPLE LIVING WITH HIV/AIDS IN
BLANTYRE DISTRICT, MALAWI**

A dissertation submitted to:
Faculty of Health Sciences, School of Nursing, University of KwaZulu-Natal
in partial fulfillment of requirements for

MASTERS DEGREE IN MENTAL HEALTH NURSING

By:

GENESIS CHORWE-SUNGANI

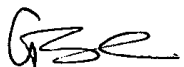
SUPERVISOR : Ms. N. C. SHANGASE

AUGUST, 2010

Declaration

I, Genesis Chorwe-Sungani, declare that this dissertation is my own original piece of work and that it has never been submitted in part or whole for any other award or purpose before. All resources utilised in this piece of work have been fully acknowledged by means of referencing. This original piece of work is submitted for a Masters of Mental Health Nursing degree.

Student: Genesis Chorwe-Sungani (Mr.)

Signature: 

Date: 23/12/2010

This thesis has been examined and approved for submission

Supervisor: Ms. N. C. Shangase

Signature: _____

Date: _____

Dedication

This is a special dedication to Dalitso, my daughter and my beloved wife, Allena.

Acknowledgements

Many thanks should go to the Most High for making it possible that I produce this original piece of work.

This work would not be accomplished without the unfailing guidance and support from my supervisor, Ms. N. C. Shangase. I pray that she may receive many blessings.

The spirit of ingratitude will trouble me forever if I do not acknowledge the following people who were instrumental from behind the scenes:

- The love of my life, Allena, for single handedly bringing up our daughter while I was away studying. Allena, you are the ever flowing fountain of my inspiration and hope.
- The Principal of Kamuzu College of Nursing and the Government of Malawi for providing me with the much needed financial support.
- Dr. Mwangalawa, for lifting me up and helping me feel at home in Durban when I was down.
- Mrs Daza for the emotional, material and psychological support rendered to me during the data collection period.

To all those who raised their finger to make this work a success, God bless you and may you continue doing the same for others.

Abstract

Background

People living with HIV/AIDS (PLWHA) are not always cared for by nurses who are competent to deal with mental health problems (MHP) in Blantyre district, Malawi. Little is known regarding nurses' perceptions about their ability to provide mental health care in the district's general settings.

Purpose

The purpose of the study was to explore nurses' perceptions about their provision of mental health care to PLWHA in Blantyre district.

Methodology

A quantitative study was conducted to explore nurses' perceptions about their provision of mental health care to PLWHA in Blantyre. Permission was granted by relevant authorities to conduct the study. Between March and April 2010, 165 nurses were randomly sampled from all wards and other departments at a central hospital and five selected health centres. They gave a written consent before joining the study. 151 questionnaires which were completed at participant's convenient time were personally collected. Descriptive statistics were used to analyse data and nonparametric tests were also used to explore associations amongst variables.

Findings

This study found that nurses' perceptions about their provision of mental health care to PLWHA vary. Most nurses reported positive perceptions about caring for PLWHA who have MHP in general settings although some had negative perceptions. It was apparent that a relationship exists between nurses' willingness to deal with MHP and perceptions about their knowledge, skills and access to support from mental health specialist. The perceived lack of knowledge, skills and support from mental health specialists were identified as reducing nurses' ability to provide relevant mental health care to PLWHA.

Conclusion

Conclusively, it is logical to say that the more support nurses receive from mental health specialists, the more knowledgeable and skilled they will become in dealing with MHP and, consequently, these nurses may demonstrate more willingness to deal with MHP of PLWHA.

Table of contents

Content	Page
List of figures.....	v
List of tables.....	vi
Acronyms.....	vii
Chapter One: Introduction.....	1
1.0 Introduction and background information.....	1
1.1 Statement of the problem.....	5
1.2 Definition of terms.....	6
1.3 Purpose of the study.....	8
1.4 Study objectives.....	8
1.5 Research questions.....	8
1.6 Significance of the study.....	9
Chapter Two: Theoretical framework and literature review.....	10
2.0 Introduction.....	10
2.1 Theory of Therapeutic Commitment.....	10
2.2 Unfolding of the theoretical framework in this study.....	12
2.3 Literature review.....	13
2.3.1 Introduction.....	13
2.3.2 Mental health problems and PLWHA in Malawi	14
2.3.3 The mental health care delivery system in Malawi.....	15
2.3.4 Nurses and the provision of mental health care in Malawi.....	16
2.3.5 Perceptions of nurses about their provision of mental health care.....	17
2.3.6 Summary of literature review.....	20
2.4 Conclusion.....	21
Chapter Three: Methodology.....	22
3.0 Introduction.....	22
3.1 Design.....	22
3.2 Study place.....	23

3.3 Study population.....	23
3.4 Sample size.....	24
3.5 Instrumentation.....	25
3.5.1 Validity and reliability of instrument.....	26
3.6 Data collection procedure.....	27
3.7 Data management.....	28
3.8 Data analysis.....	29
3.9 Strengths and limitations of the study.....	29
3.10 Ethical considerations.....	30
3.11 Conclusion.....	31
Chapter Four: Findings of the study.....	32
4.0 Introduction.....	32
4.1 Sample realisation.....	32
4.2 Demographic data of participants.....	33
4.2.1 Age.....	33
4.2.2 Gender	34
4.2.3 Professional qualification	34
4.2.4 Work experience	35
4.2.5 Workplace.....	36
4.2.6 Whether mental health lectures had been received during training.....	37
4.3 Therapeutic commitment.....	38
4.4 Role competency.....	39
4.5 Role support.....	39
4.6 Levels of therapeutic commitment, role competency and role support for participants.....	43
4.7 The relationship between therapeutic commitment and role competency.....	43
4.8 The relationship between therapeutic commitment and role support.....	45

4.9 The relationship between role competency and role support.....	46
4.10 The relationship between age and levels of therapeutic commitment, role competency and role support.....	47
4.11 The relationship between gender and levels of therapeutic commitment, role competency and role support	47
4.12 The relationship between professional qualification and levels of therapeutic commitment, role competency and role support.....	48
4.13 The relationship between work experience and levels of therapeutic commitment, role competency and role support.....	49
4.14 The relationship between workplace and levels of therapeutic commitment, role competency and role support.....	50
4.15 The relationship between mental health lectures received in training and levels of therapeutic commitment, role competency and role support.....	50
4.16 Summary of study findings.....	51
4.17 Conclusion.....	53
Chapter Five: Discussion and recommendations.....	54
5.0 Introduction.....	54
5.1 The relationship between demographic characteristics and therapeutic commitment, role competency and role support.....	54
5.1.1 Age.....	55
5.1.2 Gender.....	55
5.1.3 Professional qualification	55
5.1.4 Work experience	56
5.1.5 Workplace.....	56
5.1.6 Received mental health lectures in training	57
5.2 Discussion of findings according to objectives of the study.....	57
5.2.1 Nurses' self perceptions of their knowledge and skills in relation to providing mental health care to PLWHA.....	57

5.2.2 Nurses' self perceptions about the support they receive from mental health specialists when providing mental health care to PLWHA.....	60
5.2.3 Nurses' self perceptions about their commitment to providing mental health care to PLWHA.....	61
5.3 Summary of discussion.....	63
5.4 Recommendations.....	65
5.4.1 Practice.....	65
5.4.2 Policy.....	65
5.4.3 Nursing education.....	66
5.4.4 Research.....	66
5.5 Conclusion.....	66
References.....	68
Appendices.....	77
Appendix 1: Instrument for the study	77
Appendix 2: Request to use MHPPQ.....	81
Appendix 3: Permission to use MHPPQ.....	82
Appendix 4: Information and informed consent sheet.....	83
Appendix 5: Ethical clearance letter.....	85
Appendix 6: Ethical Approval letter.....	86
Appendix 7: Clearance letter to Queen Elizabeth Central Hospital.....	87
Appendix 8: Clearance letter from Queen Elizabeth Central Hospital.....	88
Appendix 9: Clearance letter to Blantyre District Health Office.....	89
Appendix 10: Clearance letter from Blantyre District Health Office.....	90

List of figures

	Page
Figure 1.1: Map of Malawi showing the geographical location of Blantyre district.....	4
Figure 2.1: Diagrammatic presentation of Theory of Therapeutic Commitment.....	10
Figure 4.1: A graph showing age distribution of participants.....	33
Figure 4.2: A graph showing distribution of participants according to professional qualification.....	35
Figure 4.3: A graph showing distribution of participants according to work experience.....	36
Figure 4.4: A graph showing the distribution of participants according to whether mental health lectures had been received during training.....	38
Figure 4.5: Scatter plot showing the relationship between therapeutic commitment and role competency.....	44
Figure 4.6: Scatter plot showing the relationship between therapeutic commitment and role support.....	45
Figure 4.7: Scatter plot showing the relationship between role competency and role support.....	46

List of tables

	Page
Table 3.1: Relationship among conceptual framework, questionnaire and objectives.....	27
Table 4.1: Table showing distribution of participants according to gender.....	34
Table 4.2: Table showing distribution of participants according to their workplace.....	37
Table 4.3: Responses to therapeutic commitment scale items.....	40
Table 4.4: Responses to role competency scale items.....	41
Table 4.5: Responses to role support scale items.....	42
Table 4.6: Mean scores of participants indicating levels of therapeutic commitment, role competency and role support.....	43
Table 4.7: The relationship between age and levels of therapeutic commitment, role competency and role support.....	47
Table 4.8: The relationship between gender and therapeutic commitment.....	47
Table 4.9: The relationship between gender and role competency	48
Table 4.10: The relationship between gender and role support	48
Table 4.11: The relationship between professional qualification and levels of therapeutic commitment, role competency and role support.....	49
Table 4.12: The relationship between work experience and levels of therapeutic commitment, role competency and role support.....	49
Table 4.13: The relationship between workplace and levels of therapeutic commitment, role competency and role support.....	50
Table 4.14: The relationship between mental health lectures received in training and therapeutic commitment.....	51
Table 4.15: The relationship between mental health lectures received in training and role competency.....	51
Table 4.16: The relationship between mental health lectures received in training and role support.....	51

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BMJ	British Medical Journal
CINAHL	Cumulative Index to Nursing and Allied Health Literature
COMREC	College of Medicine Research and Ethics Committee
ENM	Enrolled Nurse Midwife
EPN	Enrolled Psychiatric Nurse
HIV	Human Immunodeficiency Virus
IBM	International Business Machines
MAPP	Maudsley Alcohol Pilot Project
MHP	Mental Health Problems
MHPPQ	Mental Health Problems Perception Questionnaire
MOHP	Ministry of Health and Population
NMCM	Nurses and Midwives Council of Malawi
NMT	Nurse Midwife Technician
NSO	National Statistics Office
PLWHA	People Living With HIV and AIDS
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
SPSS	Statistical Package for Social Sciences
UKZN	University of Kwazulu Natal
WHO	World Health Organisation

Chapter One

INTRODUCTION

1.0 Introduction and background information

The Mental Treatment Act provides for the provision of mental health care and control of mental hospitals in Malawi (Harris, 1968). The provision of mental health care is further explicated by the National Mental Health Policy of Malawi. This policy, among other things, stipulates that mental health services must be incorporated into the general health care delivery system (Ministry of Health and Population [MOHP], 2001). However, mental health specialists are rarely found in general settings because Malawi is faced with a scarcity of these professionals. There are 2.5 mental health nurses per 100 000 of the population (World Health Organisation [WHO], 2005) and only one psychiatrist is employed by the Ministry of Health to cater for a population of fourteen million people (<http://www.nyypct.nhs.uk/aboutus/zombalink/index.htm>). The few mental health professionals who are available are mostly working at the mental hospitals and there are very few deployed in primary care settings across the country. Health care professionals who have not specialised in mental health are expected to provide mental health services to people living with HIV and AIDS (PLWHA) as well as the rest of the population.

The majority of health care professionals who care for PLWHA in Malawi are nurses, both at outpatient and inpatient settings, and they are expected to deal with the mental health problems (MHP) of these patients. The provision of mental health care to PLWHA is vital because apart from the physical illnesses associated with the virus, these people are also affected by MHP (Freeman, Nkomo, Kafaar, & Kelly, 2007; Freeman, Patel, Collins, & Bertolote, 2005; Mellins, Kang, Leu, Havens, & Chesney, 2003; Mwale, 2006; Myer et al., 2008; WHO, 2008; Wright, Lubben, & Mkandawire, 2007). MHP are disturbing human emotional and psychological experiences (Angus, Lauder, & Reynolds, 2001) and, as such, it is very important that nurses provide holistic care by dealing with the MHP of PLWHA. This is in line with the recommendations of the World Health Organisation which promotes the integration of mental health services with general

health services, where non-mental health specialists should take part in the provision of mental health care (WHO, 1999). However, it has been documented that nurses working in general hospital settings do not provide adequate mental health care due to their lack of knowledge and skills in dealing with MHP (Mavundla, 2000). This not only compromises the care of PLWHA, but also poses a challenge to the success of HIV and AIDS intervention programmes. According to Freeman et al. (2005), HIV and AIDS intervention programmes must include mental health care if they are going to be successful.

Literature suggests that the self perceptions of nurses have an influence on their mental health care interventions (Angus et al. 2001; Mavundla, 2000). This may mean that the quality of mental health care received by PLWHA depends on the nurse's self perceptions at any particular moment. This is consistent with Lauder, Reynolds, Reilly, & Angus (2000), who asserted that there is a direct link between the self perceptions of nurses and the effectiveness or success of their mental health nursing interventions. These authors categorised nurse's self perceptions about their provision of mental health care as role competency, role support and therapeutic commitment. They further described role competency as nurses' self perceptions of having the necessary knowledge and skills to provide mental health care, and role support as their perceived level of access to mental health specialists. They argued that role competency and role support influence therapeutic commitment, which they described as the nurses' self perceptions about their willingness to deal with MHP. Hence, it is necessary for nurses to have adequate knowledge, skills and support for them to have positive perceptions about dealing with MHP.

Reed & Fitzgerald (2005) alleged that nurses who have positive self perceptions about MHP may be enthusiastic in dealing with MHP and may consider mental health care as an integral part of nursing. These two authors claimed that negative self perceptions, on the other hand, may influence nurses to believe that caring for people with MHP in general hospital settings is difficult, unrewarding and threatening. It may be that the lack

of knowledge, skills and support may create negative self perceptions about MHP in nurses. This is corroborated by Mavundla (2000), who claimed that nurses who feel that they are inadequately prepared to care for people with MHP have negative self-perceptions about dealing with MHP.

Although some studies have found that negative perceptions about MHP exist amongst nurses (Mason, Hall, Caulfied, & Melling, 2010; Woollaston & Hixenbaugh, 2008), others have found the opposite. For instance, predominantly positive self perceptions about providing mental health care in general hospital settings were found among nurses at a Gauteng Hospital (Lethoba, Netswera, & Rankhumise, 2006). Despite these disparities in nurses' self perceptions, literature suggests that self perceptions of nurses could influence their mental health care interventions (Ito, Kishi, & Korosawa, 1999; Lauder et al., 2000; Lauder, Reynolds, Reilly, & Angus, 2001; Mavundla, 2000; Reed & Fitzgerald, 2005). For this reason, it can be argued that the interventions of nurses who care for PLWHA who have MHP in Blantyre district, Malawi, may be influenced by their self perceptions. Nonetheless, little is known about nurses' self perceptions about the mental health care they provide to PLWHA in this district because the topic has never previously been researched in Malawi. Therefore, a study will be conducted to explore the self perceptions of nurses about their provision of mental health care to PLWHA in Blantyre district. The map below shows the geographical location of Blantyre district in Malawi (Figure 1.1).

Figure 1.1: A map of Malawi showing the geographical location of Blantyre district



Retrieved April, 1, 2010 from <http://www.sdn.org.mw/undp/Mlwinf/maps/Malawi1.jpg>

1.1 Statement of the problem

There is a preponderance of literature suggesting a rise in global recognition of the interrelationship between mental health and HIV/AIDS (Freeman et al., 2005; Freeman et al., 2007; Mellins et al., 2003; Prince et al., 2007; RAND corporation, 2007; WHO, 2008; Wright et al., 2007). The trend sets the pace for mental health care services for PLWHA because it is evident that HIV/AIDS intervention programmes must include mental health care if they are going to be successful (Freeman et al., 2005). This partly implies that health professionals dealing directly with PLWHA must effectively manage the MHP related to HIV/AIDS. However, there is very little reference to mental health care in the HIV/AIDS programmes that are being implemented across the country in Malawi (MOHP, 2001) although the National HIV/AIDS Policy does recognise that PLWHA are affected by MHP (MOHP, 2003).

The majority of health care professionals who constantly come in contact with PLWHA in Blantyre are the nurses, and it is these nurses who are expected to deal with the MHP of their clients. It is clear that nurses' self perceptions may influence their mental health care interventions (Ito et al., 1999; Mavundla, 2000; Reed & Fitzgerald, 2005). What remains unclear, however, is how the nurses themselves perceive their provision of mental health care to PLWHA in Malawi with regard to role competency, role support and therapeutic commitment, because no studies have been conducted in this area. Therefore this study will be conducted to answer the question: What are the self perceptions of nurses about caring for PLWHA who have MHP?

1.2 Definition of terms

Perceptions refer to nurses' feelings about their level of knowledge and skills in dealing with MHP, their access to support from mental health specialists and their willingness to deal with MHP (Lauder et al., 2000).

For the purpose of this study, the term **nurse** refers to all cadres of nurses in Malawi according to the Nurses and Midwives Council of Malawi [NMCM] (2009), as described below.

A Registered Nurse (RN) is a person who has completed a four year degree in nursing, a three year diploma in nursing or a two year bridging diploma, and has passed the relevant NMCM examinations.

A Registered Psychiatric Nurse (RPN) is a registered nurse who has completed a two years postgraduate degree in psychiatric nursing and has passed the relevant NMCM examinations.

An Enrolled Nurse Midwife (ENM) is a person who has completed a two year certificate programme in nursing plus a one year certificate in midwifery and has passed the relevant NMCM examinations.

An Enrolled Psychiatric Nurse (EPN) is an enrolled nurse who has completed one year post basic certificate training in psychiatric nursing and has passed the relevant NMCM examinations.

A Nurse Midwife Technician (NMT) is a person who has completed a three year integrated certificate training programme in nursing and midwifery and has passed the relevant NMCM examinations.

Mental health care refers to the care of clients with mental health problems and includes screening, assessment, pharmacotherapy, counselling and psychosocial support (Lazarus & Freeman, 2009).

1.3 Purpose of the study

The purpose of this study was to explore the self perceptions of nurses regarding their provision of mental health care to PLWHA in Blantyre district, Malawi.

1.4 Study objectives

The objectives of this study were to:

1. Describe nurses' self perceptions of their knowledge and skills in relation to providing mental health care to PLWHA.
2. Identify nurses' self perceptions about the support they receive from mental health specialists when providing mental health care to PLWHA.
3. Determine nurses' self perceptions about their commitment to providing mental health care to PLWHA.

1.5 Research Questions

Research objective one:

1. What do nurses perceive is their level of knowledge regarding provision of mental health care to PLWHA?
2. What do nurses believe is their level of skill in providing mental health care to PLWHA?

Research objective two:

3. How much support do nurses report receiving from mental health specialists?

Research objective three:

4. What is the perceived level of commitment reported by nurses about providing mental health care to PLWHA?

1.6 Significance of the study

The study is significant because it is the first of its kind to reveal that PLWHA in Blantyre district are often attended to by nurses who do not have the adequate knowledge or skills to deal with the MHP of these people. The study findings give an insight to the nurses' levels of competency, their commitment and the support they receive when dealing with MHP of PLWHA in Malawi. The findings, therefore, may be useful in nursing practice to make recommendations about the mental health care of PLWHA. They may also be used by policy makers to ensure that nurses deal effectively with MHP affecting PLWHA. Nurse educators may utilise the findings of this study when formulating, reviewing or implementing their curricula in an effort to prepare nurses who can effectively respond to the mental health care needs of PLWHA. The information from this research study may also be used as a baseline for further research.

Chapter Two

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

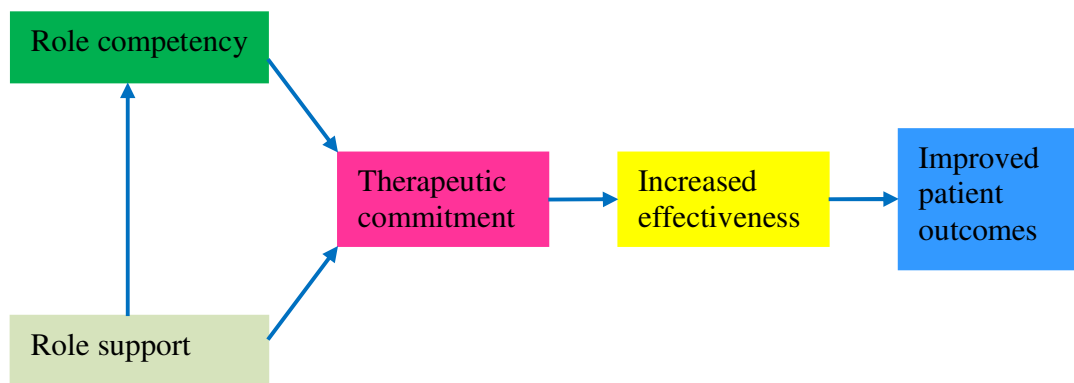
2.0 Introduction

This chapter presents the theoretical framework that guided this study and a review of the literature that was consulted in order to provide a context for the study.

2.1 Theory of Therapeutic Commitment

The study draws on the Theory of Therapeutic Commitment that was developed by psychosocial researchers at Stirling University as its theoretical underpinning (Figure 2.1).

Figure 2.1: Diagrammatic presentation of Theory of Therapeutic Commitment



From Lauder et al. (2000)

It is a revised version of the Maudsley Alcohol Pilot Project (MAPP) model which was originally developed by Shaw, Cartwright, Spratley and Harwin (1978) to explain the factors which influence the therapeutic commitment of unspecialised health professionals

in dealing with alcohol and alcohol related problems. The model linked the perceived levels of knowledge and skills of health professionals with their ability to establish effective therapeutic relationships. The core concepts of the original MAPP model included role legitimacy, therapeutic commitment and role adequacy.

Shaw et al. (1978) described these concepts in the following way: role adequacy was defined as the health professionals' confidence in their capacity to respond effectively to clients problems; role legitimacy as the extent to which health professionals perceive that they have the right to intervene in clients problems; and therapeutic commitment as behaviours and attitudes that qualify health professionals. The MAPP model proposed that health professionals feel insecure in their roles if they do not have the adequate knowledge and skills to deal with the MHP of their clients. This is consistent with the revised model, the Theory of Therapeutic Commitment, by Lauder et al. (2000).

Unlike the original MAPP model, whose focus was only on alcohol and alcohol related problems, the focus of revised version, the Theory of Therapeutic Commitment, is on MHP in general and can thus be used in the context of all mental health problems.

The core concepts of this revised theory are therapeutic commitment, role competency and role support, which are similar to those of the original MAPP model. Role competency is a combination of both role adequacy and role legitimacy in the original MAPP model (Lauder et al., 2000) and can be described as nurses' self-perception that the work they are engaged in is a legitimate part of their role and that they have the required knowledge and skills to discharge this responsibility effectively (Lauder, Reynolds, Reilys, & Sharkey, 2002). Role support is a concept which was not part of the original MAPP model, but it was later added to the revised Theory of Therapeutic Commitment. It includes the access to support from mental health specialists and other colleagues which influences both nurses' role competency and their therapeutic commitment (Lauder et al. 2000). This is corroborated by Shaw et al. (1978).

Therapeutic commitment is described as a predisposition for working therapeutically with clients and a prerequisite for effective therapeutic intervention (Lauder et al., 2002). The level of therapeutic commitment is dependent upon the degree of role competency perceived by the nurses, which in turn depends on the amount of support they have received in their tasks (Albery et al., 2003). This implies that therapeutic commitment, role competency and role support are all interrelated. Angus et al. (2001) argued that the suggested relationship among role support, role competency and therapeutic commitment remains a reasonable proposition.

It is evident that the health professionals, who perceived that they did not have adequate knowledge and skills (role competency) and who had not received sufficient support from more experienced colleagues in dealing with alcohol related problems, were found to have low levels of therapeutic commitment (Cartwright, 1980). This may possibly mean that health professionals who have low levels of role competency may avoid engaging with clients suffering from MHP for fear that they may fail to successfully deliver the services required of them. This was supported by a recent study that was conducted in fourteen countries across the world (Anderson et al., 2003). The study found that health professionals who receive more education on MHP, who perceive that their working environment is supportive, who express higher role security in working with MHP and who report greater therapeutic commitment in working with MHP, are more likely to successfully manage clients with MHP. Hence, it would only be logical to suggest that nurses may be more likely to deal successfully with MHP of PLWHA if they feel that they have high levels of role competency, role support and therapeutic commitment.

2.2 Unfolding of the theoretical framework in this study

The Theory of Therapeutic Commitment purported that role competency and role support have a direct influence on the therapeutic commitment of nurses (Angus et al., 2001; Lauder et al., 2000). It is also apparent that perceived low levels of role support or role competency may have a negative influence on the nurses' levels of therapeutic commitment to dealing with MHP of PLWHA (Lauder et al., 2001). The theory predicts

that interventions by nurses who are not specialised become more effective if their levels of therapeutic commitment are high (Cartwright, 1980). As such, it can be argued that the same variables may influence the success of nursing interventions for PLWHA who are experiencing MHP.

Nurses who display high levels of therapeutic commitment are able to reduce feelings of insecurity in their clients and achieve successful outcomes (Lauder et al., 2000). This is supported by Cartwright (1992). He stated that health professionals who are not therapeutically committed to their clients affectively withdraw and do not provide the necessary environment for creating a therapeutic relationship and hence fail to achieve successful outcomes. On the other hand, the creation of a therapeutic nurse-client relationship facilitates the nurse's understanding of the client's needs and, consequently, the planning of appropriate interventions. For these reasons, it can be said that successful outcomes are closely associated with the attitudes of the health professionals.

This study proposes to explore and describe the three core concepts of the model: role competency, role support and therapeutic commitment; and the relationships that may exist between each. The extent to which role competency, role support and therapeutic commitment increase the nurses' effectiveness, as measured by client outcomes, is not within the domains of this study.

2.3 Literature review

2.3.1 Introduction

The review of literature intends to provide a context for the study and give an insight into the depth of the existing body of knowledge on the topic under study. It illustrates how the topic has previously been researched and identifies gaps and disparities within findings of similar studies that were conducted elsewhere. The literature search focused on English language articles that were dated between 1999 and 2010. However, several research articles and books dated as far back as 1968, 1978, 1980, 1991 and 1992 have

been cited because they contain relevant information which was not available in the more recent publications.

An extensive search of research articles from reputable electronic data bases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), Proquest, Science Direct, PubMed, EBSCOHOST, British Medical Journal (BMJ) online and Wiley InterScience was conducted. It is acknowledged that relevant articles might have been available in other data bases. The key words that were used when looking for the research articles included mental health, HIV and AIDS, nurse, self perceptions, mental health problems, PLWHA, psychiatric disorders, mental health care and mental illness. While numerous articles relating to the topic under study were retrieved from the data bases, the literature search yielded very little on research that had been conducted in Malawi.

The reviewed literature will be presented under the following subheadings: mental health problems and PLWHA in Malawi; the mental health care delivery system in Malawi; nurses and the provision of mental health care in Malawi; and perceptions of nurses about their provision of mental health care. This will be followed by a summary of the literature review and conclusion.

2.3.2 Mental health problems and PLWHA in Malawi

It is clear that PLWHA worldwide are affected by MHP (Brandt, 2009, Collins, 2006; Myer et al., 2008). Of the 13 077 160 people in Malawi (National Statistics Office [NSO], 2008), there are almost 900 000 adults (14%), between the ages of 15 and 49, living with HIV/AIDS in Malawi (WHO, 2005). This shows that the country is grossly affected by the HIV/AIDS pandemic. Considering the established relationship between MHP and HIV/AIDS, it is likely that some of the PLWHA in the country are affected by MHP. It is apparent that HIV/AIDS is associated with the etiology of MHP in PLWHA and also that the mental attitude of PLWHA would influence their prevention or treatment of the virus (Freeman et al., 2007; Prince et al., 2007; Wright et al., 2007). However, there is scanty data on the magnitude and nature of how MHP affect PLWHA

and the entire population of Malawi (Skuse, 2008). An isolated study that was conducted by Mwale (2006) found a prevalence rate of 14.4% of MHP amongst PLWHA who attended Antiretroviral Therapy (ART) clinics in Mzuzu. The findings of this particular study are of value because they highlight the prevalence of MHP affecting PLWHA in the country.

Providing mental health care to PLWHA may be helpful in preventing further spread of the infection and improving the quality of life of those affected. However, in many developing countries like Malawi, mental health issues are not usually considered as important aspects of HIV/AIDS intervention programmes (Lazarus & Freeman, 2009). Nurses play a vital role in addressing the mental health needs of PLWHA and it is apparent that their mental health care interventions are influenced by their self perceptions (Lauder et al. 2001). Little is known, however, about the self perceptions of nurses in Blantyre, Malawi, with regard to their provision of mental health care to PLWHA.

2.3.3 The Mental health care delivery system in Malawi

In Malawi, mental health care is largely provided by the government. The country has two mental hospitals, one of which is run by the government and the other by missionaries (Kauye, 2008). PLWHA and the rest of the population can also access mental health services in general health care settings (Central Hospitals, District Hospitals, Community Hospitals, Health Centres and Outreach Clinics) as stipulated in the National Mental Health Policy of Malawi (MOHP, 2001). Although the policy provides for the integration of mental health services in the general health care system, the country does not have enough mental health specialists (WHO, 2005) and, as a result, other health professionals, who have not specialised in mental health, are expected to provide mental health services as well.

The drawback with this set-up is that most health workers in Malawi, including nurses, feel neither confident nor competent when dealing with the MHP of their clients (Kauye,

2008). Hence, it poses a serious challenge in the provision of adequate mental health care to the population. According to WHO (2004), mental health is a state of emotional, psychological well being, which gives individuals the ability to work productively and contribute to community development. It follows then, that health care professionals, who are equipped with the necessary skills to diagnose and manage the MHP of PLWHA, are crucial in the pursuit of treating PLWHA and the rest of the population who are in need of mental health care.

2.3.4 Nurses and the provision of mental health care in Malawi

In Malawi, nurses are the majority of all health care workers and provide the bulk of health care services. They also provide most of the mental health services to clients in the country (Skuse, 2008). Enrolled Psychiatric Nurses (EPNs) and Registered Psychiatric Nurses (RPNs) are nurses who have specialised in mental health care. ENPs receive a one year post basic certificate training in psychiatric nursing (Herzig, 2003) and RPNs undergo a 2 year postgraduate degree programme in psychiatric nursing (NMCM, 2009). Both EPNs and RPNs are in short supply in Malawi (Kauye, 2008; Skuse, 2008). There are only 3 RPNs and 18 EPNs at Zomba Mental Hospital, the only state owned referral facility, which has a bed capacity of 332 (<http://www.nyypct.nhs.uk/aboutus/zombalink/index.htm>).

Despite being in short supply, it is usually the EPNs who run most of the mental health services in the country (Herzig, 2003; Kauye, 2008; Skuse, 2008). It has also been alleged that some EPNs are not providing the specialist psychiatric care they have trained for because they have been redeployed to general nursing duties (Muula, 2005). From another perspective, this may imply that some physically ill people, such as PLWHA, do come in contact with mental health specialists in the general health care settings.

The other cadres of nurses available in the country include Registered Nurses (RNs), Nurse Midwife Technicians (NMTs) and Enrolled Nurse Midwives (ENMs). RNs are general nurses who have studied at diploma or degree level and who are autonomous in

that they supervise the NMTs and ENMs. NMTs and ENMs are trained at a certificate level and are general nurses who can conduct selected nursing and midwifery procedures under the supervision of a Registered Nurse (NMCM, 2009). Currently, the training programmes of all nurses in Malawi include modules on mental health nursing. The Bachelor of Science in Nursing and Midwifery curriculum of University of Malawi, for example, has both theory and practical modules which introduce students to mental health nursing (University of Malawi, 2008).

2.3.5 Perceptions of nurses about their provision of mental health care

Nurses are the group of health workers who frequently come in contact with people who have MHP in low income countries such as Malawi (Ghebrehiwet & Barrett, 2007; Collins, 2006; Kauye, 2008; Skuse, 2008). Since no such studies have previously been conducted in Malawi, the self perceptions of nurses about the mental health care they provide to PLWHA are not well documented. Studies related to the topic have been carried out elsewhere, however, and some previous studies from other parts of Africa and the world at large will be used to highlight what is already known about the topic.

In Australia, a study was conducted by Clark, Parker and Gould (2005) to explore the perceptions of rural generalist nurses about the effectiveness of their mental health care interventions. In the study, 70% of the respondents reported that their perceived limited knowledge of MHP hindered the provision of optimum care to clients with MHP. Some also reported that they were not given sufficient support when dealing with the MHP of their clients. The findings showed that most nurses had low levels of role competency and some had low levels of role support. Reed and Fitzgerald (2005) postulated that nurses with low levels of role competency became anxious when dealing with MHP and ended up either not addressing, or ignoring, the mental health needs of their clients. It also became apparent that low levels of role support had a negative influence on the commitment of nurses towards the provision of mental health care (Lauder et al., 2001). Based on the aforementioned facts, it is clear that role competency and role support affect the nurses' willingness to deal with MHP.

The findings by Clark et al. (2005) and Reed & Fitzgerald (2005) are corroborated by Wynaden, O'Connell, McGowan and Popescu (2000) who found that most nurses had low levels of role competency since they did not perceive themselves as being adequately prepared to care for a person with MHP. Sixty percent (60%) of the nurses who participated in their study reported that they felt that they lacked the knowledge and skills required to provide care to people with MHP. Low levels of role competency or role support negatively influence nursing actions and nurses' enthusiasm in providing mental health care to clients (Lauder et al., 2001). Conversely, a study by Wynaden et al. (2000) found that general nurses had positive perceptions about being able to provide mental health care, regardless of having low levels of role competency. It may be assumed that negative self perceptions of nurses may be detrimental to the mental health care of PLWHA attending general health care settings. On the other hand, it is evident that positive self perceptions about their mental health care interventions are essential in the management of MHP (Ito et al., 1999).

On the African continent, Mavundla (2000) conducted a study on professional nurses' self perceptions of nursing mentally ill people in a South African general hospital setting. The study found that the nurses generally had negative self perceptions about caring for people with MHP as the nurses considered themselves as being inadequately prepared to provide mental health care. These findings are supported by Clark et al. (2005), Lauder et al. (2001), Reed & Fitzgerald (2005) and Wynaden et al. (2000) who also found low levels of role competency among nurses. The findings of Mavundla (2000) further revealed that some nurses who had negative self perceptions felt that clients who had co-morbidity of physical illnesses and MHP should not be nursed in the general wards.

Nurses who perceive that providing mental health care is not their role do not like to care for people with MHP (Reed & Fitzgerald, 2005). It is clear that such self perceptions can have a negative influence on their provision of holistic care in general health settings. This has a negative impact on the recommendations of the World Health Organisation which advocates the integration of mental health care with general health services and the involvement of non-mental health specialists in the provision of mental health care

(WHO, 1999). In addition to this, the views of such nurses would be contrary to the spirit of the National Mental Health Policy of Malawi which also advocates the integration of mental health care and general health services. The negative self perceptions of nurses may result in them denying PLWHA who have MHP access to mental health services when they seek help in general health settings. This is supported by Suominen et al. (2010) who purported that negative attitudes towards MHP of PLWHA exist amongst nurses due to the nurses' lack of knowledge and skills and it negatively affects their willingness to provide care to these people.

Literature indicates that both positive and negative attitudes towards MHP prevail amongst health professionals in South Africa (Foster, Usher, Baker, Gadai, & Ali, 2008). As already mentioned, Mavundla (2000) found that most nurses in a general hospital setting had negative self perceptions about caring for people with MHP. Lethoba (2005), on the other hand, found that most nurses had positive perceptions about their ability to nurse people with MHP in general hospitals and were willing to provide mental health care. However, Lethoba (2005) and Mavundla (2000) at least agree that some nurses perceive themselves as being inadequately prepared and lacking the support they require to provide relevant mental health care to clients. Thus, these nurses have low levels of role competency and role support which have a negative effect on their levels of therapeutic commitment (Angus et al., 2001). This could mean that the nurses' self perception of their predisposition to working therapeutically with clients who have MHP is negatively affected when nurses have low levels of role competency and role support. This is supported by Albery et al. (2003) who affirmed that therapeutic commitment relies on the levels of role competency and role support nurses perceive in their task of providing mental health care.

Therapeutic commitment is a prerequisite for effective therapeutic intervention (Lauder et al., 2002). There is increase in success of outcomes when nurses are therapeutically committed to dealing with the MHP of their clients (http://www.code-a-text.co.uk/training_concepts.htm). Consequently, it can be argued that nurses who have high levels of therapeutic commitment may provide quality mental health care to

physically ill people such as PLWHA with co-morbidity of MHP. It may be that higher levels of therapeutic commitment increases the ability of nurses to deal with MHP of PLWHA and also helps the nurses to create therapeutic relationships with these people and provide client centred care.

2.3.6 Summary of literature review

The review of literature revealed that some PLWHA are also affected by MHP in Malawi. In this country, the majority of health care workers who come in contact with PLWHA are the nurses. As frontline care providers, nurses are expected to deal with the MHP of PLWHA, apart from addressing the physical illnesses of these people. It is clear that nurses' self perceptions influence their provision of mental health care to clients. It is evident that many nurses are not able to detect and treat MHP and some studies have attributed this to the negative self perceptions they have about their provision of mental health care.

Nurses who have low levels of role competency perceive that they are not competent enough to attend to the MHP of their clients, while those who have low role support perceive that they do not have adequate support from mental health specialists. The low levels of role competency and role support have been seen to reduce the motivation of nurses in meeting the mental health care needs of their clients. Conflicting results from other studies have found positive self perceptions amongst nurses about their willingness to care for people with MHP.

Since no studies on this topic have, as yet, been conducted in Malawi, study findings from other parts of the world were of value in giving an insight about nurses' self perceptions of their provision of mental health care. However, these studies might not be a true representation of the self perceptions of nurses in Blantyre, taking into consideration their uniqueness. In addition, the reviewed studies did not focus on the mental health care of PLWHA.

It is therefore important to explore the perceptions of nurses about their provision of mental health care to PLWHA in Blantyre. The study may help in clarifying some of the inconsistencies found in literature about nurses' self perceptions of their provision of mental health care. A clear understanding of the phenomenon may help to influence the provision of mental health care offered to PLWHA in Malawi.

2.4 Conclusion

The philosophical underpinning and context of this study has been presented in this section. This was based on a literature review which revealed that although similar studies have been done elsewhere, a study of this nature has never been conducted in Malawi.

Chapter Three

METHODOLOGY

3.0 Introduction

Methodology refers to the steps, procedures and strategies for gathering and analysing data in a research study (Polit & Beck, 2004). This section gives an overview of the research process that was followed to investigate the topic under study. It gives an account of the research design, study place, study population, sample size, instrumentation, validity and reliability of the instrument, data collection procedures, data management, data analysis, limitations of the study and ethical considerations.

3.1 Design

This study adopted a quantitative, non-experimental, descriptive survey design. The design is the blue print for a study that guides a researcher in planning and implementing the study (Gillis & Jackson, 2001, p.703). This study was underpinned by a positivist paradigm which is a traditional model underlying a scientific approach which assumes that there is a fixed, orderly reality that can be predicted or objectively studied.

The researcher was independent to the phenomenon of interest and hence did not engage with the phenomenon or participants being researched. According to Gillis & Jackson (2001), positivists believe in value free research so that personal values have no influence on the results of a study. In addition, they stated that positivists rely on numerical analysis of data. Thus, the researcher only collected numerical and ordinal data that was subjected to statistical analysis.

The study design is considered valid because the results from this study can be generalised to other settings, since the study utilised a data collection tool that was previously used in similar studies elsewhere (Clark et al., 2005; Lauder et al., 2000). Threats to the validity of this study design included reactive effects whereby participants

may have under-reported some behaviours which they deem socially unacceptable. The use of a self reporting questionnaire may have helped in minimising this threat because it was less confronting to participants. Ensuring the anonymity of participants by not collecting their identification details may also have helped to minimise this threat because participants were assured that their responses could not be traced back to them.

3.2 Study place

The study was conducted at a central hospital and five selected health centres in Blantyre district. The hospital setting included a psychiatric unit, a gynaecological ward, an orthopaedic ward, 2 medical wards, 2 surgical wards, 4 paediatric wards, an under-five clinic, a maternity ward, Antiretroviral Therapy (ART) clinic, a Family Planning Clinic and the Outpatient Department. The settings at the health centres included a maternity ward, an outpatient department, ART clinic and an under-five clinic in each facility. These settings were chosen because they are the places where the nurses mostly encounter PLWHA who have MHP. The settings were suitable for the study because the researcher is a resident of Blantyre district and hence, had easy access to them.

3.3 Study population

The target population included all nurses working in the psychiatric unit, gynaecological ward, orthopaedic ward, medical wards, surgical wards, paediatric wards, under-five clinics, maternity ward, ART clinic, Family Planning Clinic and Outpatient Department at the hospital and those working in maternity wards, outpatient departments, ART clinics and under-five clinics at the five selected health centres. These were registered nurses, enrolled nurse midwives and nurse midwife technicians who had two years of work experience or more. There were 194 nurses at the central hospital and about 117 nurses working under the Blantyre District Health Office. As such, there were 311 nurses working in Blantyre district altogether. The target population of nurses in the district was big enough to suffice the sample size of the study.

3.4 Sample size

The sample size was calculated based on the percentage of role competency of nurses from a recent study that was conducted in Australia by Clark et al. (2005). They found that 70% of their study participants perceived that their limited knowledge of MHP hindered the provision of optimum care to clients with MHP. The formula for calculating sample size for a survey by Lwanga and Lemeshow (1991) was used to calculate the sample size as below:

$$\text{Estimated sample size} = \frac{(Z)^2 PQ}{d^2}$$

The confidence interval was set at 95%. As such Z was 1.96, where Z was the normal variate corresponding to the level of significance; P was the anticipated proportion having low levels of role competency, while Q was the proportion having high levels of role competency ($1-p$). Then d was the relative precision on both sides of anticipated proportion (10% of P).

Therefore,

$$n = \frac{(Z)^2 PQ}{d^2} = \frac{(1.96)^2 \times .7 \times .3}{.07 \times .07} = 165$$

The researcher drew a random sample of 165 participants from the population of about 311 nurses through simple random sampling. Simple random sampling ensured that all the nurses had an equal chance of being selected for participation in the study. Nurses' registers and duty rosters, sourced from charge nurses, were used as sampling frames when selecting study participants. The researcher assigned random numbers from a table

against names of nurses on the registers and duty rosters in order to draw a random sample.

The researcher achieved the sample size of 165 by personally approaching nurses whose names were randomly selected from a register or duty roster in each setting and explaining the study to them. Those who agreed to participate in the study were asked to sign a written consent. The sample size of 165 was more than half the population and was large enough for the study. According to Burns and Grove (2005), the quantitative study sample size should be at least 30.

The inclusion criteria were:

- Agreeing to participate in the study after the study had been explained
- A minimum of 2 years post graduation working experience as a nurse
- Verbal confirmation of exposure to PLWHA who have MHP
- Currently at work on the dates of data collection and not on vacation or sick leave.
- Giving a written consent to participate in the study

3.5 Instrumentation

Instrumentation refers to the application of specific rules to the development of a measurement instrument (Burns & Grove, 2005). The collection of data was done using a self administered questionnaire. Questionnaires are used to gather a broad spectrum of information from participants and are presented in a consistent manner providing less opportunity for bias while they also facilitate analysis (Polit & Beck, 2004).

The questionnaire, Appendix 1, had two sections, A and B. Section A requested demographic data, which included the following: age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received during training. Section B requested data regarding the self perceptions of the participants about their role competency, role support and therapeutic commitment. It was composed in the form of a five point likert scale which was adapted from the Mental Health Problems

Perception Questionnaire (MHPPQ). The researcher was granted permission by Professor Lauder to use the MHPPQ for this study (Appendices 2 & 3).

The researcher added PLWHA to the statements on the scale to ensure that the focus was on MHP of PLWHA. The participants possible responses on the scale items ranged from strongly disagree (1) to strongly agree (5). According to Pallant (2007), a likert scale must have at least five exclusive possible responses from which a participant will only choose one.

The questions in the questionnaire were aimed at eliciting a link between role competency, role support and role commitment of nurses in dealing with MHP of PLWHA. The instrument was in English because all participants were able to read, speak and understand English. Quantitative data, which was ordinal on the five point likert scale about role competency, role support and therapeutic commitment, was collected using the tool. The tool was also used to collect numerical and nominal data on demographic characteristics of the participants.

3.5.1 Validity and reliability of the instrument

Burns and Grove (2005) describe the validity of the instrument as the determination of the extent to which the instrument reflects the phenomenon under study. They also describe the reliability of the instrument as the consistency of measure obtained by the instrument.

The demographic data requested in this study included age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received during training. These were requested because the content validity of this demographic data was established through the extent to which the variables were central to previous studies on the three core concepts; role competency, role support and therapeutic commitment (Clark et al., 2005; Lethoba et al., 2006; Lauder et al., 2001; Mavundla, 2000; Wynaden et al. 2000). Table 3.1, below, identifies the items within

section B of the instrument and their association to the conceptual framework and the research objectives.

Table 3.1: Relationship among conceptual framework, questionnaire and objectives

Conceptual framework	Questionnaire item	Objectives
Therapeutic commitment	1-12	3
Role competency	13-24	1
Role support	25-30	2

The MHPPQ has proven to be a valid and reliable instrument. Its reliability is supported by its use in several research studies (Clark et al., 2005; Lauder et al., 2001). The adapted instrument was reviewed by experts in the field at the School of Nursing, University of KwaZulu-Natal, to assess its relevance, content and face validity. Angus et al. (2001) computed a reliability coefficient using Cronbach's alpha to test for internal consistency of the sections of the instrument: therapeutic commitment scale ($\alpha=0.84$), role support scale ($\alpha=0.89$) and role competency scale ($\alpha=0.87$).

For this study the calculated Cronbach's alpha for the instrument were: therapeutic commitment scale ($\alpha=0.7$), role support scale ($\alpha=0.75$) and role competency scale ($\alpha=0.78$). These results indicate good stability of the instrument. Pallant (2007) asserts that a stable and reliable instrument must have a Cronbach's alpha of at least 0.7. Prior to data collection, the instrument was tested on 5 nurses in Blantyre district in order to establish whether there was any need to amend it. Although the results from the test were taken into consideration, they did not form part of this main study.

3.6 Data collection procedure

Data collection is a systematic process of gathering information in order to answer research questions or objectives (Burns & Grove, 2005). Firstly, the researcher reported

to the Blantyre District Nursing Officer at the Blantyre District Health Office and the Chief Nursing Officer at the central hospital in Blantyre to personally introduce himself, explain the study and express his intention to commence data collection during the first week of March 2010. With the blessings of both these officers, the researcher approached the Unit Matrons of each study setting to explain the study and seek consent for recruiting participants from their respective units.

After getting permission from the Unit Matrons, he approached the Charge Nurses of each ward/clinic/department to explain the study and seek consent for recruiting participants from the areas under their jurisdiction. Once consent was granted by the Charge Nurses, the researcher employed a face to face recruitment procedure by personally inviting and explaining the study to nurses who were randomly selected from registers or duty rosters to participate in the study. Those who agreed to participate were asked to give a written consent (Appendix 4). Having returned the written consent, participants were handed a self reporting questionnaire which they completed at their convenience. The researcher personally collected the completed questionnaires from the participants at an agreed time. Data collection was completed during the first week of April 2010.

3.7 Data management

The researcher controlled factors that could have led to data contamination by personally distributing and collecting the questionnaires. This was done to limit access of collected data to the researcher only and to ensure the highest level of confidentiality. During the research period, the hard copies of collected data were kept secured in a locked cabinet, accessible only to the researcher. Each questionnaire was given a code for its identification. The researcher coded the data, entered it on the computer and analysed it using IBM SPSS, version 15.0 (Pallant, 2007). Soft copies of data were secured with a password known only to the researcher. At the end of the study, both soft copies and hard copies of data were stored in a secure place that was arranged together with the supervisor at the School of Nursing of University of KwaZulu-Natal. They will be kept

secure for a period of five years after which the hard copies will be destroyed by incineration and the soft copies will be deleted from the storage device.

3.8 Data analysis

Data analysis is the process of summarising, organising, interpreting and numerically communicating study findings (Burns & Grove, 2005). Data was analysed using IBM SPSS, version 15.0. Prior to analysis, coded data was entered in the SPSS package on a computer. Data entry was done simultaneously with data collection and it was finished a week after completion of data collection. Descriptive statistics (means, medians, standard error of means, percentages and frequencies) were used to summarise, describe and synthesise data, and to calculate parameters in the form of graphs, frequency distributions, variability as well as contingency tables.

Scatter plots were used to explore relationships of scores on therapeutic commitment, role competency and role support scales. It was decided to also make use of nonparametric tests to explore associations amongst variables. Spearman's rho correlation coefficients was utilised to explore associations amongst core concepts of therapeutic commitment, role competency and role support and both the Kruskal-Wallis Test and the Mann-Whitney *U* test were also used to investigate associations between demographic data and the three core concepts of therapeutic commitment, role competency and role support.

3.9 Strengths and limitations of the study

One of the strengths of the study was that its design made it possible for the researcher to collect data at one point in time without causing much inconvenience to participants. Another strength was that the findings from this study may be generalised to other settings since it used a reliable data collection tool that has already been used in previous studies of this nature. A potential limitation to the study, however, was that it used a self reporting questionnaire to collect data. Respondents might have been tempted to present

themselves in a more favourable way in their responses. Also, the study failed to establish the issues underpinning the nurses' self perceptions regarding MHP since the tool collected quantitative data only.

3.10 Ethical Considerations

The researcher explained the nature and benefits of the study to the nurses (Appendix 4). He ensured that the participants were not harmed in any way. Their names did not form part of the demographic data, thus respecting their privacy and maintaining confidentiality. Participants were informed that they would not benefit directly from the study, but that the information which they provided could be utilised in making recommendations about the mental health care of PLWHA. Participants were informed that only aggregated data would be analysed and presented. They were informed that all hard copies of data collected would be locked in a cabinet in the researcher's place of residence and would be incinerated at the end of the study. They were also informed that any electronic data would be secured by a password known only to the researcher and that it would be deleted at the end of the study.

The study proposal was presented to the Research Committee of the School of Nursing at the University of KwaZulu-Natal (UKZN) before it was reviewed by the Ethics Committee of UKZN for ethical clearance (Appendix 5). Later, it was presented to the Research and Publications Committee of the Kamuzu College of Nursing and thereafter submitted to the College of Medicine Research and Ethics Committee (COMREC) for ethical approval (Appendix 6). Permission and clearance were sought from the District Health Office for Blantyre district and the Director of the central hospital in Blantyre to carry out the study in their respective facilities (Appendices 7, 8, 9, 10). A written informed consent (Appendix 4) was obtained from participants who were randomly sampled and who agreed to participate in the study. The participants were informed that they were free to withdraw at any time if they felt uncomfortable about any aspect during the course of the study. They were also made aware that refusal to participate would have

no effect on their employment status, since the researcher was not an employee of the Ministry of Health and Population.

3.11 Conclusion

This chapter has presented a description of the study design, setting, study population, sample size, instrument, and the strengths and limitations of the study. It has also given an overview of the methodology and procedures which were followed and utilised to collect, manage and analyse data for this study. Furthermore, it has highlighted the ethical considerations that were followed to ensure that neither the study participants nor the researcher were harmed in any way.

Chapter Four

FINDINGS OF THE STUDY

4.0 Introduction

The findings of the study are presented in this chapter. Quantitative data about demographic characteristics of the participants will be presented first. This will be followed by descriptive statistics on the participants' responses regarding their self perceptions about their provision of mental health care to people living with HIV/AIDS. All the data was collected using a self administered questionnaire which had two sections (Appendix 1). Section A focused on the demographic characteristics of participants while Section B consisted of an adapted version of the MHPPQ. This questionnaire was in the form of a likert scale that was used to measure the levels of therapeutic commitment, role competency and role support in nurses regarding their provision of mental health care.

Data was analysed using IBM SPSS, version 15.0. The analysis of data was guided by both the theoretical framework and the research questions for the study. The relationships among therapeutic commitment, role competency, role support and participants' demographics were tested using the following nonparametric tests: Spearman's rho correlation coefficients, the Kruskal-Wallis Test and the Mann-Whitney *U* Test. The study findings in this section are presented in form of narratives, tables and graphs.

4.1 Sample realisation

The study participants comprised of 151 nurses working at the central hospital and five health centres in the Blantyre district. The researcher achieved the sample size by personally distributing 165 self administered questionnaires to nurses who had agreed to participate in the study. Out of the 165 questionnaires that were handed out, 151 completed questionnaires were returned and 14 were not returned. This represented a 91.5% response rate.

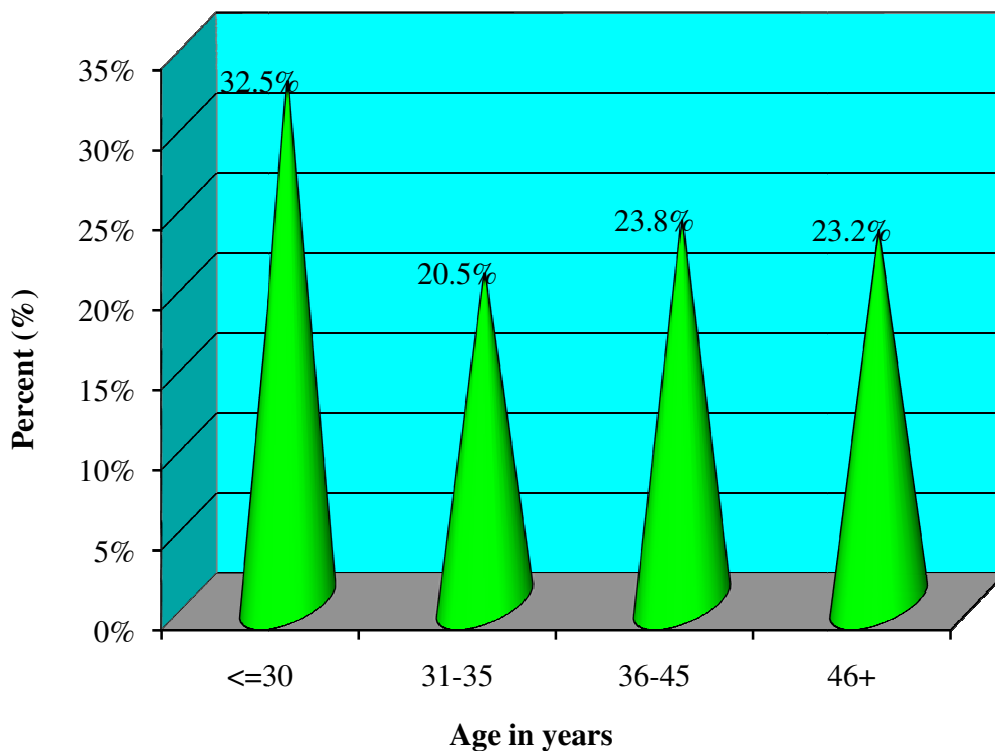
4.2 Demographic data of participants

This section presents the findings of the study regarding the following demographic characteristics of participants: age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received in training.

4.2.1 Age

The age of participants ranged from 24 to 67 years old with the majority (32.5%, $n=49$) being younger than 30 years old. The mean age was 38.18 years old with a standard error of 0.852. This small standard error of mean ($SEM=0.852$) indicates that the sample was representative of the population since there was very little variation in the age of participants. The participants were then categorised into four groups to facilitate further analysis (Figure 4.1).

Figure 4.1: A graph showing age distribution of participants



4.2.2 Gender

The study findings show that 86.1% ($n=130$) of participants were female with only 13.9% ($n=21$) being male (Table 4.1).

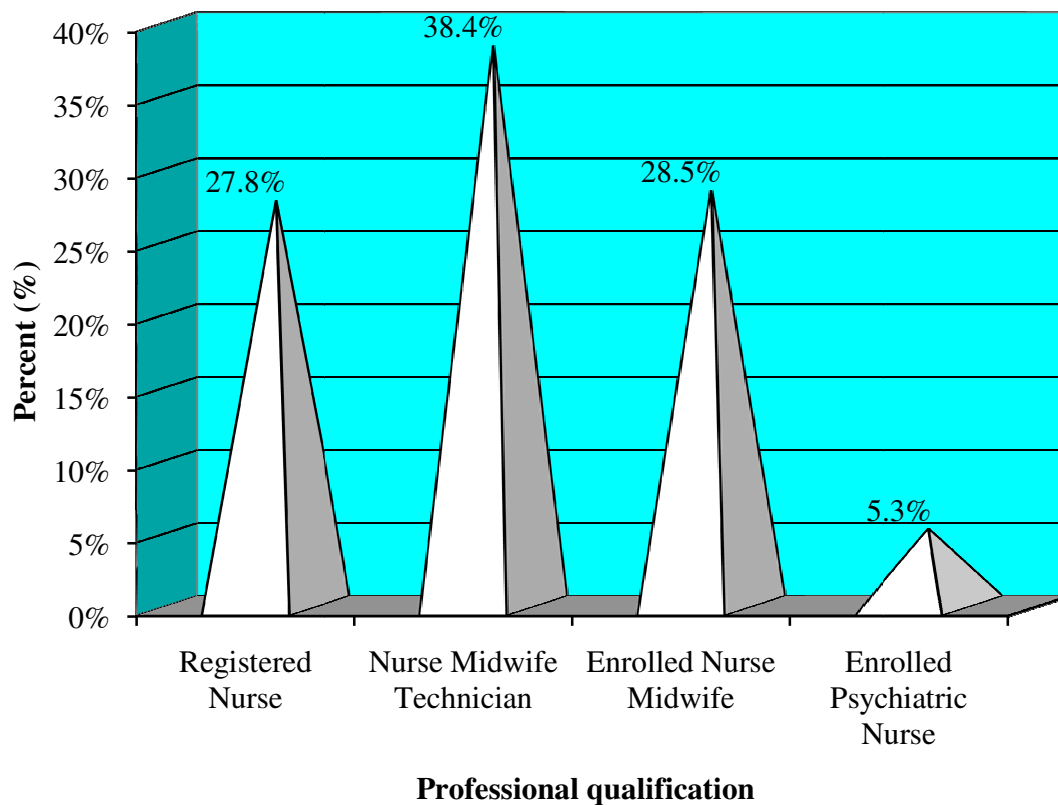
Table 4.1: Table showing distribution of participants according to gender

Gender	<i>n</i> (%)
Male	21(13.9)
Female	130(86.1)

4.2.3 Professional Qualification

The majority of the study participants were NMTs (38.4%, $n=58$) followed by ENMs (28.5%, $n=43$). Forty two (27.8%) RNs and eight EPNs (5.3%) also participated in the study. There were no RPNs who participated in this study (Figure 4.2).

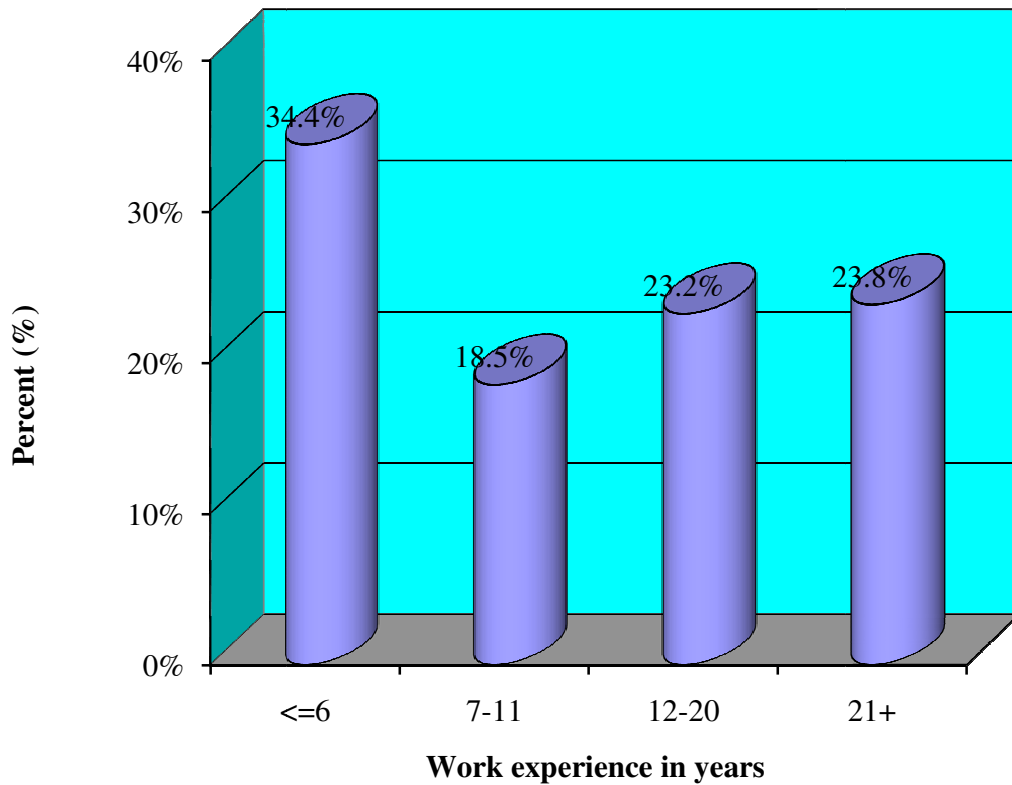
Figure 4.2: A graph showing the distribution of participants according to professional qualification



4.2.4 Work experience

The study findings show that although 34.4% ($n=52$) of participants had been working for six years or less, none of them had worked for less than two years. The mean number of years of work experience was 13.62 years with a standard error of 0.808. The small standard error of mean ($SEM=0.808$) shows that the sample was representative of the population. The years of work experience were then categorised into four groups in order to facilitate further analysis (Figure 4.3).

Figure 4.3: A graph showing the distribution of participants according to work experience



4.2.5 Workplace

The results of the study indicate that the majority of participants (24.5%, $n=37$) were working in the maternity wards. There were only two participants (1.3%) who were working in the psychiatric unit. Table 4.2, below, shows the distribution of the rest of participants according to their work place.

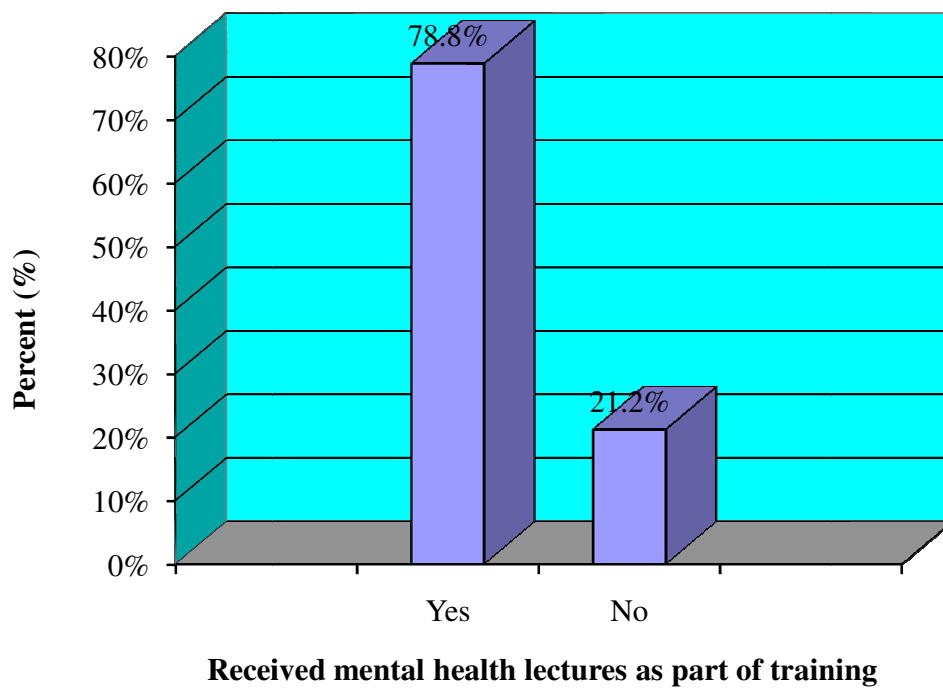
Table 4.2: Table showing the distribution of participants according to their workplace

Workplace	<i>n</i> (%)
Psychiatric unit	2(1.3)
Maternity ward	37(24.5)
Outpatient	5(3.3)
Paediatric ward	27(17.9)
Surgical ward	26(17.2)
Medical ward	34(22.5)
Other	20(13.3)

4.2.6 Whether mental health lectures had been received during training

The study findings show that most of the participants (78.8%, $n=119$) had received mental health lectures as part of their training. Nonetheless, 21.2% ($n=32$) of participants reported that they had not received any mental health lectures as part of their preparation (Figure 4.4).

Figure 4.4: A graph showing the distribution of participants according to whether mental health lectures had been received during training.



4.3 Therapeutic Commitment

The findings revealed that the vast majority of participants (94%, (n=142) agreed with the statement that “Caring for PLWHA who have MHP is an important part of a nurse’s role”. Conversely, the results also reveal that some nurses (12.6%, n=19) lack willingness to care for PLWHA who have MHP. They disagreed with the statement, “I want to work with PLWHA who have MHP”. Table 4.3, on page 40, provides a summary of individual responses to individual questionnaire items on therapeutic commitment scale.

4.4 Role competency

The study findings show that there are variations in nurses' self perceptions of their knowledge and skills to care for PLWHA who have MHP. Some nurses felt that they had the necessary knowledge and skills to care for PLWHA who have MHP while others did not. For instance, 45% ($n=68$) of participants agreed with the statement, "*I have the skills to work with PLWHA who have MHP*", while 26.5% ($n=40$) disagreed with the same statement. The lack of knowledge and skills among nurses was also revealed by 23.2% ($n=35$) of participants who agreed with the statement, "*I often have difficulty knowing how to communicate with PLWHA who have MHP*". The findings further show that 43% ($n=65$) of participants agreed with the statement, "*I feel that I know enough about the factors that put PLWHA at risk of MHP*", while 36.4% ($n=55$) disagreed. The summary of individual responses to individual questionnaire items on role competency scale has been presented in Table 4.4 on page 41.

4.5 Role support

The study findings indicate that nurses do not always receive the necessary support when working with PLWHA who have MHP. Of all the study participants, 49.7% ($n=75$) disagreed with the statement, "*When working with PLWHA who have MHP, I receive adequate support from other agencies*". In contrast, 48.3% ($n=73$) of participants agreed with the statement, "*When working with PLWHA who have mental health problems, I receive adequate support from colleagues*". The summary of individual responses to individual questionnaire items on role support scale has been presented in Table 4.5 on page 42.

Table 4.3: Responses to therapeutic commitment scale items.

Statement	Disagree (1, 2) <i>n</i> (%)	Neutral (3) <i>n</i> (%)	Agree (4, 5) <i>n</i> (%)
I am interested in the nature of mental health problems of PLWHA and the treatment of them	10(6.6)	23(15.2)	118(78.2)
I feel I am able to work with PLWHA who have mental health problems as effectively as other patients who do not have mental health problems	13(8.6)	23(15.2)	115(76.2)
I want to work with PLWHA who have mental health problems	19(12.6)	50(33.1)	82(54.3)
I feel that there is nothing I can do to help PLWHA who have mental health problems	129(85.4)	11(7.3)	11(7.3)
I feel that I have something to offer PLWHA who have mental health problems	11(7.3)	17(11.3)	123(81.4)
I feel that I have a number of good qualities for working with PLWHA who have mental health problems	15(9.9)	29(19.2)	107(70.9)
Caring for PLWHA who have mental health problems is an important part of nurse role	4(2.6)	5(3.3)	142(94.1)
In general, one can get satisfaction from working with PLWHA who have mental health problems	20(13.3)	46(30.5)	85(56.2)
I often feel uncomfortable when working with PLWHA who have mental health problems	97(64.2)	30(19.9)	24(15.9)
In general, I feel that I can understand PLWHA who have mental health problems	18(11.9)	27(17.9)	106(70.2)
On the whole, I am satisfied with the way I work with PLWHA who have mental health problems	45(29.9)	55(36.4)	51(33.7)
In general I find working with PLWHA who have mental health problems difficult	68(45)	38(25.2)	45(29.8)

Table 4.4: Responses to role competency scale items.

Statement	Disagree (1, 2) <i>n</i> (%)	Neutral (3) <i>n</i> (%)	Agree (4, 5) <i>n</i> (%)
I feel that I know enough about the factors that put PLWHA at risk of mental health problems	55(36.4)	31(20.6)	65(43)
I feel that I know how to treat PLWHA who have long term (or chronic) mental health problems	41(27.2)	48(31.7)	62(41.1)
I feel that I can appropriately advise my patients who are infected with HIV/AIDS about mental health problems	17(11.2)	27(17.9)	107(70.9)
I feel I have clear idea of my responsibilities in helping PLWHA who have mental health problems	19(12.5)	37(25)	95(62.5)
I feel I have the right to ask my patients who are infected with HIV/AIDS about their mental health status	11(7.3)	31(20.5)	109(72.2)
I feel that my patients who are infected with HIV/AIDS believe I have a right to ask them questions about their mental health problems	30(19.9)	47(31.1)	74(49)
I feel that I have the right to ask PLWHA for any information that is relevant to their mental health problems	10(6.6)	25(16.5)	116(76.9)
I have the skills to work with PLWHA who have mental health problems	40(26.5)	43(28.5)	68(45)
I feel I have the skills to assess and identify PLWHA who have mental health problems	24(15.9)	42(27.8)	85(56.3)
I often have the difficulty knowing how to communicate with PLWHA who have mental health problems	67(44.3)	49(32.5)	35(23.2)
I feel I know how to treat PLWHA who present in a crisis with signs of mental health problems	36(23.9)	52(34.4)	63(41.7)
I often have difficulty knowing how to assess PLWHA who have mental health problems	69(45.7)	46(30.5)	36(23.8)

Table 4.5: Responses to role support scale items.

Statement	Disagree (1, 2) <i>n</i> (%)	Neutral (3) <i>n</i> (%)	Agree (4, 5) <i>n</i> (%)
If I felt the need when working with PLWHA who have mental health problems			
I could easily find someone who would help me clarify my professional difficulties.	35(23.2)	27(17.9)	89(58.9)
If I felt the need I could easily find someone who would be able to help me			
formulate the best approach to PLWHA who have mental health problems	24(15.9)	25(16.6)	102(67.5)
When working with PLWHA who have mental health problems, I receive adequate			
support from other agencies	75(49.7)	48(31.8)	28(18.5)
When working with PLWHA who have mental health problems, I receive adequate			
support from colleagues	34(21.9)	45(29.8)	72(48.3)
When working with PLWHA who have mental health problems, I receive			
adequate support from mental health services within my district	59(39.1)	51(33.8)	41(27.1)
When working with PLWHA who have mental health problems, I receive adequate			
support from other mental health services outside my district	79(52.2)	49(32.5)	23(15.3)

4.6 Levels of therapeutic commitment, role competency and role support for participants

The mean and standard deviation were calculated to indicate the levels of therapeutic commitment, role competency and role support across the study population (Table 4.6). The total scores on each scale were calculated by adding up all items within each scale so that scales could be treated as continuous variables. Before calculating the total scores on each scale, the following negative statements were reversed: “*I feel that there is nothing I can do to help PLWHA who have mental health problems*” and “*I often feel uncomfortable when working with PLWHA who have mental health problems*”. The reversal of negative statements was done by changing participants scores on the scale so that 1=5, 2=4, 3=3, 4=2 and 5=1.

Table 4.6: Mean scores of participants indicating levels of therapeutic commitment, role competency and role support.

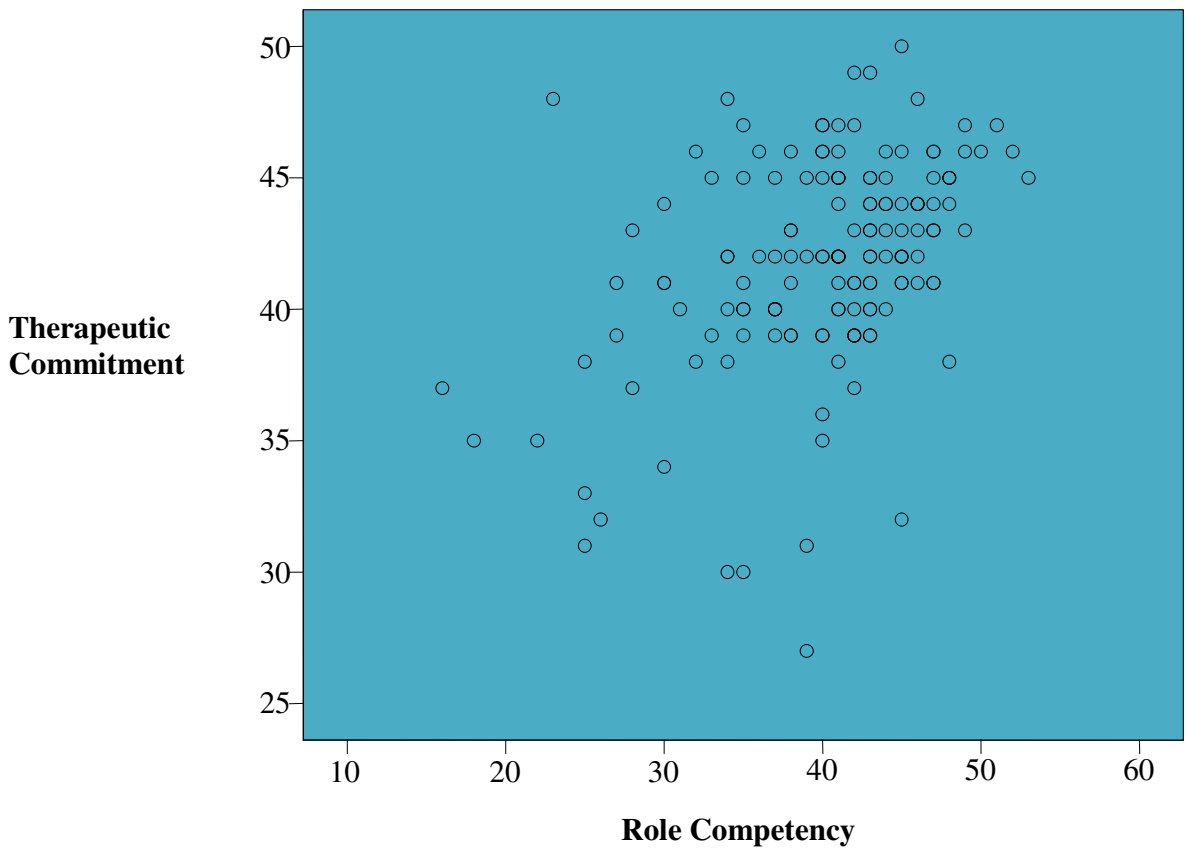
Scale	<i>n</i>	Range	M	SD
Therapeutic commitment	151	28-51	42.8	3.86
Role competency	151	18-53	38.9	6.21
Role support	151	6-26	16.94	4.56

4.7 The relationship between therapeutic commitment and role competency

The relationship between therapeutic commitment as measured by the therapeutic commitment scale and role competency as measured by the role competency scale was investigated using Spearman’s rho correlation coefficients. Preliminary analyses such as scatter plots were performed to ensure that there was no violation of the assumptions of normality, linearity and homoscedacity (Figure 4.5). There was a medium positive linear correlation between the two variables, $r=.42$, $n=151$, $p< .0005$, with higher levels of role

competency associated with higher levels of therapeutic commitment within the population understudy.

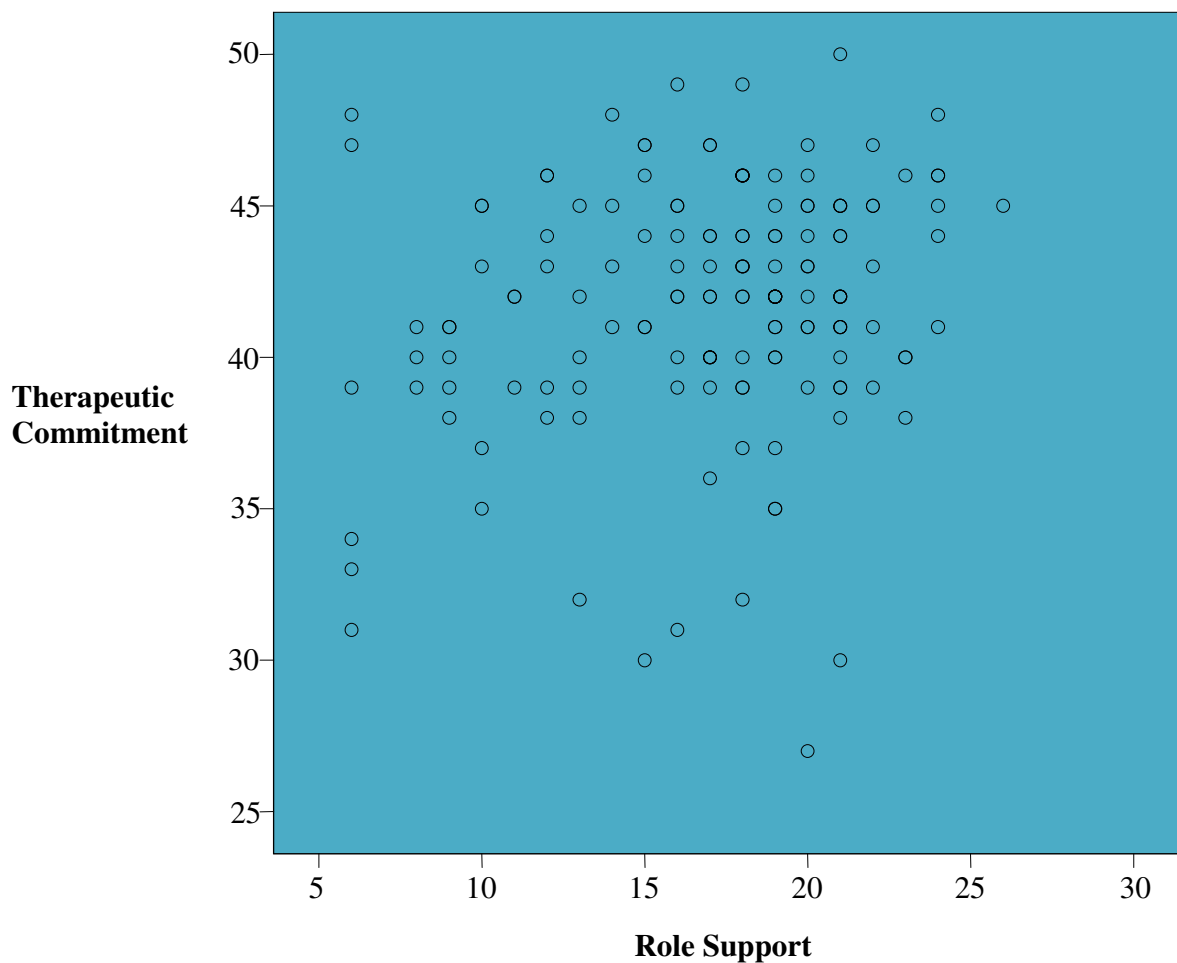
Figure 4.5: A scatter plot showing the relationship between therapeutic commitment and role competency



4.8 The relationship between therapeutic commitment and role support

The relationship between therapeutic commitment as measured by a therapeutic commitment scale and role support as measured by a role support scale was examined using Spearman's rho correlation coefficients. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedacity (Figure 4.6). There was a small positive linear correlation between the two variables, $r=.2$, $n=151$, $p<.0005$, with higher levels of role support associated with higher levels of therapeutic commitment within the population under study.

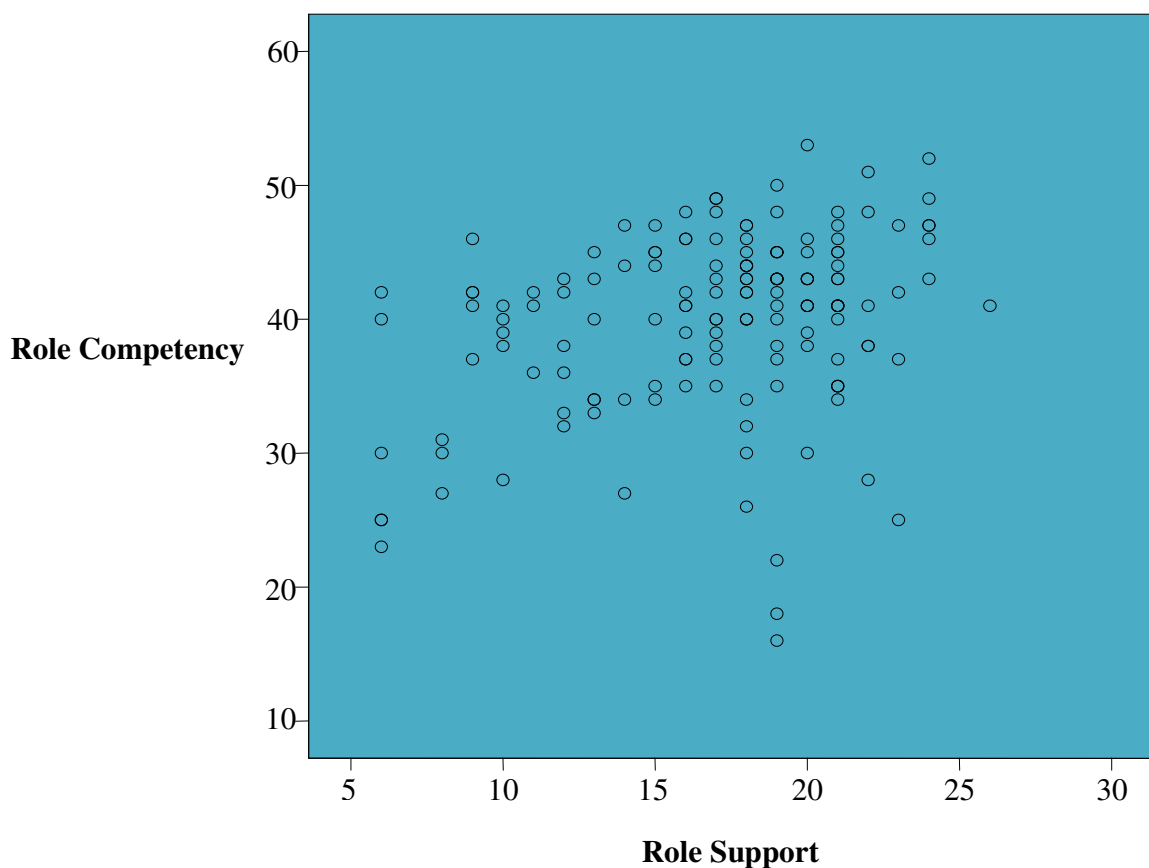
Figure 4.6: A scatter plot showing the relationship between therapeutic commitment and role support



4.9 The relationship between role competency and role support

The relationship between role competency as measured by a role competency scale and role support as measured by a role support scale was explored using Spearman's rho correlation coefficients. Prior to the test, preliminary analyses were performed to ensure that there was no violation of the assumptions of normality, linearity and homoscedacity (Figure 4.7). The calculated Spearman's rho correlation coefficients showed that there was a medium positive linear correlation between the two variables, $r=.34$, $n=151$, $p<.0005$, with higher levels of role support associated with higher levels of role competency within the population under study.

Figure 4.7: A scatter plot showing the relationship between role competency and role support



4.10 The relationship between age and levels of therapeutic commitment, role competency and role support

The Kruskal-Wallis Test showed that there was no significant association between age and the levels of therapeutic commitment, role competency and role support amongst participants of the study. This is so because the calculated p values were greater than 0.05 (Table 4.7).

Table 4.7: The relationship between age and levels of therapeutic commitment, role competency and role support

Variable response categories	Therapeutic commitment		Role competency		Role support	
	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>
Years						
<=30	43	.31	43	.22	18	.74
31-35	42		41		16	
36-45	42		41		18	
46+	41		40		18	

4.11 The relationship between gender and levels of therapeutic commitment, role competency and role support

The Mann-Whitney U test revealed no statistically significant differences in the levels of therapeutic commitment, role competency and role support between males and females. The p values were all greater than 0.05 (Tables 9-11).

Table 4.8: The relationship between gender and therapeutic commitment

Variable response categories	Therapeutic commitment			<i>z</i>	<i>p</i>	<i>r</i>
	<i>Md</i>	<i>n</i>	<i>U</i>			
Female	42	130	1273.5	-.49	.62	.04
Male	42	21				

Table 4.9: The relationship between gender and role competency

Variable response categories	Role competency			z	p	r
	Md	n	U			
Female	41	130	1272	-.50	.62	.04
Male	42	21				

Table 4.10: The relationship between gender and role support

Variable response categories	Role support			z	p	r
	Md	n	U			
Female	18	130	1232.5	-.72	.48	.06
Male	18	21				

4.12 The relationship between professional qualification and levels of therapeutic commitment, role competency and role support

A Kruskal-Wallis Test revealed statistically significant differences in levels of role competency across the four different professional qualifications (RNs, NMTs, ENMs and EPNs), $\chi^2(3, n=151) = 9.85, p = .02$. The EPNs recorded the highest median score ($Md = 43$) followed by NMTs ($Md = 42$). RNs were third with a recorded median score of 40.5. ENMs recorded the lowest median value of 40 compared to the other three professional groups. The Kruskal-Wallis Test also showed that there were no significant differences in the levels of therapeutic commitment and role support across the four professional qualification groups (Table 4.11).

Table 4.11: The relationship between professional qualification and levels of therapeutic commitment, role competency and role support

Variable response categories	Therapeutic commitment		Role competency		Role support	
	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>
Registered Nurse	42	.64	40.5	.02	18	.36
Nurse Midwife Technician	42		42		19	
Enrolled Nurse Midwife	42		40		17	
Enrolled Psychiatric Nurse	44		43		17	

4.13 The relationship between work experience and levels of therapeutic commitment, role competency and role support

The Kruskal-Wallis Test showed that there was no significant association between work experience and the levels of therapeutic commitment, role competency and role support amongst study population. The *p* values were all greater than 0.05 (Table 4.12).

Table 4.12: The relationship between work experience and levels of therapeutic commitment, role competency and role support

Variable response categories	Therapeutic commitment		Role competency		Role support	
	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>
Years						
<=6	43	.92	41	.52	18	.62
7-10	42		42		17	
11-20	42		41		18	
21+	41		41		18	

4.14 The relationship between workplace and levels of therapeutic commitment, role competency and role support

The Kruskal-Wallis Test showed that there were no significant differences in the levels of therapeutic commitment, role competency and role support amongst participants who worked in different departments. This was evident by the value of p which was greater than 0.05 in all cases (Table 4.13).

Table 4.13: The relationship between workplace and levels of therapeutic commitment, role competency and role support

Variable response categories	Therapeutic					
	commitment		Role competency		Role support	
	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>	<i>Md</i>	<i>p</i>
Psychiatric unit	43	.08	43.5	.96	9.5	.44
Maternity ward	41		41		18	
Outpatient	47		40		18	
Paediatric ward	43		41		18	
Surgical ward	42		41		17.5	
Medical ward	42.5		41		18	
Other	42		41		17	

4.15 The relationship between mental health lectures received in training and levels of therapeutic commitment, role competency and role support

The Mann-Whitney U test revealed no statistically significant differences in the levels of therapeutic commitment, role competency and role support of participants who had received mental health lectures during training and those who had not. The p values were all greater than 0.05 (Tables 15-17).

Table 4.14: The relationship between mental health lectures received in training and therapeutic commitment

Variable response categories	Therapeutic commitment					
	<i>Md</i>	<i>n</i>	<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
Received mental health lectures						
Yes	42	119	1815	-.41	.68	.03
No	42	32				

Table 4.15: The relationship between mental health lectures received in training and role competency

Variable response categories	Role competency					
	<i>Md</i>	<i>n</i>	<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
Received mental health lectures						
Yes	42	119	1502.5	-1.83	.07	.15
No	40	32				

Table 4.16: The relationship between mental health lectures received in training and role support

Variable response categories	Role support					
	<i>Md</i>	<i>n</i>	<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
Received mental health lectures						
Yes	42	119	1502.5	-1.83	.07	.15
No	40	32				

4.16 Summary of study findings

In summary, the study findings revealed that majority of participants (32.5%, $n=49$) were 30 years old or younger. 13.9% of the participants ($n=21$) were male and 86.1% ($n=130$) were female. These participants were RNs (27.8%, $n=42$), NMTs (38.4%, $n=58$), ENMs (28.5%, $n=43$) and EPNs (5.3%, $n=8$). Most of these participants (65.6%, $n=99$) had

been working for more than six years. They were drawn from the psychiatric unit, maternity wards, outpatients, paediatric wards, surgical wards, medical wards and other departments. It is clear from the findings that most of the participants (78.8%, $n=119$) had received mental health lectures during training, while only a few (21.2%, $n=32$) had not.

The study findings showed that there were variations in participants' self perceptions about their willingness to provide mental health care to PLWHA. A large majority of participants (94%, $n=142$) reported that they perceived caring for PLWHA who have MHP is an important part of nurse role. Conversely, 12.6% ($n=19$) of participants indicated that they did not want to work with PLWHA who have MHP. In addition to this, 13.3% ($n=20$) of participants disagreed with the statement "*In general one can get satisfaction from working with PLWHA who have MHP*". Overall, the findings revealed differing levels of therapeutic commitment amongst the participants.

With regard to role competency, the results indicated that there were variations in participants' self perceptions of their knowledge and skills in caring for PLWHA who have MHP. Some participants (45%, $n=68$) felt that they had the necessary knowledge and skills to care for PLWHA who have MHP while others, 26.5% ($n=40$), on the contrary, responded that they did not. Of all the participants, (36.4%, $n=55$) indicated that they perceived themselves as not having enough knowledge about factors that put PLWHA at risk of MHP. Nevertheless, 44.3% ($n=67$) of participants reported that they do not often have difficulty knowing how to communicate with PLWHA who have MHP. Taking into consideration the aforementioned statistics, the findings suggest that some nurses had higher levels of role competency while others had lower levels of the same.

It is apparent from the study findings that nurses do not always receive adequate support when working with PLWHA who have MHP. Almost half of the participants (49.7%, $n=75$) reported that they do not receive adequate support from other agencies when working with PLWHA who have MHP. On the other hand, less than half of the participants (48.3%, $n=72$) indicated that they receive adequate support from colleagues

when working with PLWHA who have MHP. As such, the findings indicate that levels of role support varied among the study participants.

The Kruskal-Wallis Test showed that there were significant differences in the levels of role competency across the professional qualifications $\chi^2 (3, n=151) = 9.85, p = .02$. The EPNs had the highest median score ($Md= 43$) while ENMs recorded the lowest median score of 40. However, the Kruskal-Wallis Test revealed no significant differences in the levels of role support and therapeutic commitment across professional qualification groups since the calculated p values were $>.05$.

The findings also revealed that there were no significant differences in the levels of therapeutic commitment, role competency and role support in relation to age, gender, work experience, workplace and whether mental health lectures had been received during training. This was evident by the calculated p values of the Kruskal-Wallis Test and the Mann-Whitney U Test, which were $>.05$.

It is evident from the calculated Spearman's rho correlation coefficients that a medium positive linear correlation exists between therapeutic commitment and role competency, $r= .42, n=151, p<.0005$, with higher levels of role competency associated with higher levels of therapeutic commitment. The same test also indicated that a small positive linear correlation exists between therapeutic commitment and role support, $r=.2, n=151, p<.0005$, with higher levels of role support associated with higher levels of therapeutic commitment. Spearman's rho correlation coefficients further revealed the existence of a medium positive linear correlation between role competency and role support, $r=.34, n=151, p<.0005$, with higher levels of role support associated with higher levels of role competency.

4.17 Conclusion

This chapter presented the findings of this study in form of tables, bar graphs, scatter plots and narratives. A discussion of these findings will be presented in chapter five.

Chapter Five

DISCUSSION AND RECOMMENDATIONS

5.0 Introduction

The chapter presents a discussion of the study findings and the interpretation of the same in relation to reviewed literature and the Theory of Therapeutic Commitment which guided the study. Demographic characteristics (age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received during training) will be discussed first in relation to the dependent variables in the study (therapeutic commitment, role competency and role support). The discussion will then centre on the following three objectives of the study: (1) to describe nurses' self perceptions of their knowledge and skills in relation to providing mental health care to PLWHA; (2) to identify nurses' self perceptions about the support they receive from mental health specialists when providing mental health care to PLWHA; and (3) to determine nurses' self perceptions about their commitment in providing mental health care to PLWHA. Finally, a summary of the discussion will be made and it will be followed by the recommendations and conclusion.

5.1 The relationship between demographic characteristics and therapeutic commitment, role competency and role support

The following demographic characteristics: age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received during training were chosen and their association with therapeutic commitment, role competency and role support was tested because previous studies in Australia and South Africa had found significant relationships (Clark et. al., 2005; Lethoba et al., 2006).

5.1.1 Age

The vast majority of the study participants (32.5%, $n=49$) were ≤ 30 years old and the mean age was 38.18 years (Figure 4.1). It was clear from the findings that there was no significant association between age and therapeutic commitment, role competency and role support with p values $>.05$ (Table 4.7). Lethoba et al. (2006), on the contrary, found a relationship between age and role competency. This may be partly attributed to the fact that generally, nurses in Blantyre district, regardless of their age, do not have access to ongoing in-service mental health education and support from mental health specialists. Hence, the findings revealed no differences in the levels of therapeutic commitment, role competency and role support across the age groups.

5.1.2 Gender

The study participants consisted of 86.1% ($n=130$) females and 13.9% ($n=21$) males (Table 4.1). There was no significant associations between gender and therapeutic commitment, role competency and role support because $p >.05$ (Tables 9-11). This is in contrast with Lethoba et al. (2006), who found that many male nurses had more positive perceptions about MHP than their female counterparts. It may be possible that this study found no association between gender and the dependent variables because male participants were under-represented in the study.

5.1.3 Professional qualification

Most of the participants (38.4%, $n=58$) in the study were NMTs (Figure 4.2). It is apparent that there was a significant difference in the levels of role competency across the professional qualification groups, $\chi^2(3, n=151) = 9.85, p = .02$ (Table 4.11). EPNs had the highest levels of role competency in comparison to NMTs, RNs and ENMs. The results clearly showed that nurses who had not specialised in mental health nursing had lower levels of role competency. In support of these findings are Clark et al. (2005) and Lethoba et al. (2006). It is alleged that nurses who have not specialised in mental health

feel that they do not have adequate knowledge and skills to care for people who have MHP (Sharrock & Happell, 2006). Despite of the aforementioned findings, it was also revealed that there was no significant association between professional qualification and therapeutic commitment and role support with p values $>.05$ (Table 4.11).

5.1.4 Work experience

It is clear from the study findings that most of the participants (34.4%, $n=52$) had been working for ≤ 6 years (Figure 4.3). The mean number of years of work experience was 13.62 years. There was no significant association between work experience and therapeutic commitment, role competency and role support since $p >.05$ (Table 4.12). This is supported by Clark et al. (2005). On the contrary, dissimilar results from Svediene, Jankauskienė, Kušleikaitė, & Razbadauskas (2009) found that work experience positively influenced the competency of nurses in dealing with MHP. This may possibly mean that the nurses' levels of knowledge and skills to deal with MHP increase as their work experience increases. However, this may not be true for the nurses in Blantyre because they do not always have opportunities for ongoing in-service mental health education and support from mental health specialists.

5.1.5 Workplace

The study participants were drawn from a psychiatric unit, maternity wards, outpatients, paediatric wards, surgical wards, medical wards and other departments (Table 4.2). The findings revealed that there was no significant association between workplace and therapeutic commitment, role competency and role support with p values $>.05$ (Table 4.13). The findings are partly supported by Clark et al. (2005) who also found that there was no significant relationship between workplace and role competency and role support. These researchers did find, however, a significant relationship between the workplace and therapeutic commitment.

5.1.6 Received mental health lectures in training

It is clear that many participants (78.8%, $n=119$) had received mental health lectures during training while a few (21.2%, $n=32$) had not (Figure 4.4). The study findings revealed that there was no significant association between whether mental health lectures had been received during training and therapeutic commitment, role competency and role support, $p >.05$ (Tables 15-17). This is in contrast with Munro, Watson, & McFadyen (2007). However, it may be partly attributed to the lack of opportunities for nurses to access mental health specialists and ongoing in-service mental health education in Blantyre district.

5.2 Discussion of findings according to objectives of the study

The section presents a discussion of the study findings in accordance with the study objectives.

5.2.1 Nurses' self perceptions of their knowledge and skills in relation to providing mental health care to PLWHA.

The findings revealed that nurses' self perceptions of their knowledge and skills regarding their provision of mental health care to PLWHA who have MHP are diverse. This was demonstrated by the varied responses of the participants on the role competency scale (Table 4.4). Some nurses (45%, $n=68$) perceived themselves as having necessary knowledge and skills to care for PLWHA who have MHP, while others (26.5%, $n=40$) perceived themselves as lacking such knowledge and skills. More than one third of participants (36.4%, $n=55$) reported that they perceived themselves as not having enough knowledge about the factors that put PLWHA at risk of MHP. Similar results were found by Clark et al. (2005) in Australia where 62% of the participants felt that they lacked adequate knowledge and skills for them to provide mental health care.

Nurses have a higher frequency of contact with PLWHA than most other health care providers (Delobelle et al., 2009). Notwithstanding this fact, nurses are not usually competent enough to deal with MHP (Atkin, Holmes, & Martin, 2005; Svediene et al., 2009). This is consistent with the study findings. In Blantyre district, nurses provide the majority of health care in general settings and many nurses perceived that they lacked knowledge and skills to deal with MHP. As such, the findings suggest that PLWHA are not always attended to by nurses who are competent enough to deal with MHP. In support of these findings, other previous studies have indicated that nurses must have adequate knowledge and skills to deal with MHP of PLWHA (Freeman et al., 2005; Freeman & Thom, 2006) because they are usually the frontline health care providers in general settings (Atkin et al., 2005; Lauder et al., 2000).

It is clear from the findings of this study that there are variations in the nurses' self perceptions about their having adequate knowledge and skills (role competency) to care for PLWHA who have MHP. Some contributors to nursing literature have stated that nurses' self perceptions in this regard have an influence on their nursing interventions (Clark et al., 2005; Lauder et al., 2002; Lethoba et al., 2006). This may probably mean that the quality or standard of mental health care received by PLWHA may vary according to the nurses' levels of role competency. Previous studies have shown that having knowledge and skills evokes positive self perceptions about MHP in a nurse and this helps in the therapeutic interaction and understanding of the client needs (Mavundla, 2000). However, issues regarding the measurement of client therapeutic outcomes are beyond the scope of this study.

It is vital that nurses are adequately equipped with knowledge and skills to care for people who have MHP. In this study, the majority of the participants (78.8%, $n=119$) reported that they had received mental health lectures during their training, while 21.2% ($n=52$) indicated that they had not (Figure 4.4). Despite the fact that many nurses had received mental health lectures in training, there was a significant number who demonstrated low levels of role competency. This was confirmed by the participants individual responses on the role competency scale (Table 4.4). Nevertheless, the results

showed that most of the nurses have at least some knowledge and skills, though not sufficient, to care for PLWHA who have MHP. The prevailing low levels of role competency in some nurses may be attributed to lack of access to ongoing training and in-service education in the field of mental health. This is corroborated by Munro et al. (2007) who proposed that effective and appropriate training helps nurses to improve their knowledge, skills and attitudes regarding mental health care.

By and large, training in mental health promotes confidence in nurses dealing with MHP in general settings (Moxham et al., 2010). Conversely, it is clear that nurses who have not received training in mental health perceive themselves as being inadequately equipped to deal with MHP and may not be willing to help (Lethoba et al., 2006; Sharrock & Happell, 2006; Wynaden et al., 2000). It may be argued that the low levels of role competency have a negative influence on the nurses' willingness to deal with MHP and this is consistent with the Theory of Therapeutic Commitment (Lauder et al., 2000). Therefore, nurses who have low levels of role competency may not be willing to deal with MHP of PLWHA. Consequently, PLWHA who have MHP may end up not having ready access to relevant mental health care in general settings. The fact that PLWHA may not always access relevant mental health care defeats the very purpose of the National Mental Health Policy of Malawi (MOHP, 2001) which advocates for the provision of mental health care in general settings.

It was interesting to note that although some PLWHA may receive substandard mental health care due to lack of knowledge, skills and confidence on the part of the nurses, the nurses who participated in this study demonstrated some enthusiasm in caring for PLWHA who have MHP (Table 4.3). Their willingness to deal with MHP may have provided nurses the opportunity of building therapeutic relationships with PLWHA who have MHP, which is fundamental to the provision of holistic care.

5.2.2 Nurses' self perceptions about the support they receive from mental health specialists when providing mental health care to PLWHA.

The results of this aspect of the study were mixed, showing that some nurses perceive that they do not always receive adequate support from other agencies when working with PLWHA who have MHP (Table 4.5). Almost half of the participants (49.7%, $n=75$) reported that they did not receive such support, which is in line with a similar study that was conducted in Australia, which found that nurses did not feel adequately supported when dealing with MHP (Clark et al., 2005). Nonetheless, the findings also revealed that almost the same percentage (48.3%, $n=72$) of nurses perceived that they did receive adequate support from colleagues when working with PLWHA who have MHP.

Nurses usually get support from fellow nurses (Sharrock & Happell, 2006). As such, there is strong likelihood that the nurses who participated in this study get support from fellow general nurses because of the gross shortage of mental health specialists in the country. This could mean, however, that sometimes the support nurses receive when providing mental health care to PLWHA in general settings may be neither relevant nor adequate. It has been reported that nurses in general settings are often unable to provide appropriate support because they have not been adequately trained themselves to deal with MHP (Mavundla, 2000). Therefore, it is imperative that nurses who provide mental health care to PLWHA have ready access to support from mental health specialists. Nurses may access appropriate support by establishing active inter-professional relationships with mental health specialists, which is in agreement with Collins et al. (2006). Unfortunately, there are very few such specialists in Malawi.

Collins and colleagues (2006) asserted that there is a need to have a smooth collaboration between HIV services and mental health services. This is important because nurses will have somewhere to turn for support when dealing with PLWHA who have MHP. The statement is supported by a large body of literature which indicates that nurses in general settings require support from mental health specialists when dealing with MHP (Arnold & Mitchell, 2008; Haddad et al., 2005; Sharrock & Happell, 2006). The support which

nurses receive helps them to experience increased comfort and encourages their interest in dealing with MHP (Reed & Fitzgerald, 2005). It appears that the self perceptions of nurses who are receiving adequate support have an influence on their knowledge and skills to work with people who have MHP. This is in line with the propositions of the Theory of Therapeutic Commitment (Lauder et al., 2000) that there is a relationship between role support and role competency.

The existence of a medium positive linear correlation between role support and role competency, $r=.34$, $n=151$, $p<.0005$ was found in this study. The increase in levels of role support can be associated with the increase in levels of role competency (Figure 4.7). For this reason, it can be inferred that the more support nurses receive from mental health specialists, the more likely it is that they will acquire the necessary knowledge and skills they need to provide the relevant mental health care. Consequently, this may help the nurses to be more enthusiastic and competent in their dealing with MHP of PLWHA. This is consistent with Reed and Fitzgerald (2005) who stated that access to support from mental health specialists helps nurses to overcome their anxieties and increases their competence in caring for people who have MHP.

5.2.3 Nurses' self perceptions about their commitment in providing mental health care to PLWHA.

The findings of the study show that most of the participants (78.2%, $n=118$) had positive self perceptions about their provision of mental health care to PLWHA, although several of them (12.6%, $n=19$) expressed a lack of interest in caring for PLWHA who have MHP (Table 4.3). These findings are similar to Chambers et al. (2010) who found that nurses generally had positive attitudes towards MHP. On the contrary, dissimilar results were found by Mavundla (2000) in South Africa where the nurses' perceptions about dealing with MHP in general settings were mostly negative. All the same, these findings are consistent with other previous studies (Lethoba et al., 2006; Reed & Fitzgerald, 2005; Sharrock & Happell, 2006).

It is evident from the study findings that both positive and negative self perceptions exist among nurses (Tables 4, 5, 6). Reed and Fitzgerald (2005) postulated that negative self perceptions of nurses towards people who have MHP lead to discrimination which reduces the ability of the nurse to provide relevant mental health care. They further stated that positive self perceptions increase the desire in a nurse to provide mental health care in general settings. Thus, the findings suggest that nurses who have positive self perceptions about MHP may be willing to provide mental health care to PLWHA. This is supported by Sharrock & Happell (2006), who purported that nurses who have positive self perceptions towards MHP acknowledge mental health care as part of their nursing role and are willing to help. However, the nurses' positive or negative self perceptions towards MHP are influenced by their perceived levels of knowledge, skills and access to relevant support (Angus et al., 2001; Clark et al., 2005). It follows that nurses who perceive themselves as having adequate knowledge, skills and support may have positive self perceptions towards MHP and may usually be willing to care for PLWHA who have MHP and the other way around. This is supported by the Theory of Therapeutic commitment (Lauder et al., 2000).

In this study, it was revealed that there is a relationship between role competency and therapeutic commitment. The results showed that a medium positive linear correlation exists between role competency and therapeutic commitment, $r=.42$, $n=151$, $p<0005$. The increase in levels of role competency was associated with an increase in levels of therapeutic commitment (Figure 4.5). Similarly, the findings also revealed that there is a relationship between role support and therapeutic commitment. It was found that a small positive linear correlation exists between role support and therapeutic commitment, $r=.2$, $n=151$, $p<0005$. The increase in levels of role support was associated with an increase in levels of therapeutic commitment (Figure 4.6). It can be inferred that improving role support for nurses may also increase their levels of role competency and therapeutic commitment. Hence, it is logical to say that the more support nurses receive from mental health specialists, the more knowledgeable and skilled they become in dealing with MHP and consequently, these nurses may demonstrate more willingness to deal with MHP of PLWHA.

5.3 Summary of discussion

The study found no significant differences in the levels of therapeutic commitment, role competency and role support in relation to age, gender, work experience, workplace and whether mental health lectures had been received during training. There were, however, significant differences in the levels of role competency across the professional qualification groups. Of all nurses, EPNs had the highest levels of role competency which showed that nurses who had specialised in mental health nursing displayed higher levels of role competency. Most of the participants had received mental health lectures during their training while a few had not received any mental health training at all.

It is clear that the nurses had differing self perceptions regarding their knowledge and skills in caring for PLWHA who have MHP. This was demonstrated by the diverse individual responses on the role competency scale. Some nurses perceived themselves as having necessary knowledge and skills to care for PLWHA who have MHP while others did not.

Although, nurses form the majority of health care providers who come in contact with PLWHA who have MHP, they are usually not skilled enough to deal with MHP. As such, PLWHA are not always attended to by nurses who are competent enough to deal with their MHP. Nurses who lack knowledge and skills are said to have lower levels of role competency and may not be willing to deal with MHP of PLWHA. This is consistent with Clark et al. (2005), Lauder et al. (2002) and Lethoba et al. (2006).

It is clear from the study findings that nurses do not always receive adequate support when working with PLWHA who have MHP. It is crucial, however, that nurses who provide mental health care to PLWHA should have ready access to support from mental health specialists because access to such support helps nurses to improve their competence in caring for people who have MHP (Reed & Fitzgerald, 2005). Consequently, this may help the nurses to portray an increased willingness to care for PLWHA who have MHP.

The majority of nurses in this study had positive self perceptions about their provision of mental health care to PLWHA, although a number of them expressed a lack of interest in caring for these people. The nurses who perceive themselves as having adequate knowledge, skills and support usually have positive self perceptions towards MHP and may be more willing to care for PLWHA who have MHP.

It is clear from the study findings that there is a relationship between role support, role competency and therapeutic commitment. The increase in levels of role support was associated with an increase in role competency. The increase in both role support and role competency was also associated with an increase in therapeutic commitment. This implies that improving role support for nurses may lead them to having higher levels of role competency and therapeutic commitment. Therefore, it follows that the more support nurses receive from mental health specialists, the more knowledgeable, skilled and willing they will become in dealing with MHP of PLWHA.

5.4 Recommendations

The study findings have shown that in Malawi, a significant number of nurses in general settings lack knowledge and skills to care for PLWHA who have MHP. Further to that, these nurses do not always receive adequate support from mental health specialists when working with PLWHA who have MHP. It is clear from the findings of this study that there is a link between nurses' levels of knowledge, skills and support, and their willingness to deal with MHP. Hence, the following recommendations were made in view of these findings:

5.4.1 Practice

There is a need for nurses in general settings to have opportunities for obtaining the much needed knowledge and skills through training and in service education so that they may become competent enough to care for PLWHA who have MHP. This can be achieved through the implementation of the recently launched mental health Gap intervention guide for mental, neurological and substance use disorders in non-specialised settings (WHO, 2010). Nurses in general settings must also have ready access to mental health specialists to support them when dealing with MHP. This may be achieved through an active collaboration relationship between mental health specialists and nurses who are working in general settings. Nurses and mental health specialists need to liaise more effectively and become more familiar with each other's roles in the care of PLWHA. In this regard, nurses need to be well-versed about the roles of all health professionals and agencies involved in mental health care in order to ensure that they utilise their powers of referral in the best interests of PLWHA who have MHP. Thus, the use of a multidisciplinary approach in dealing with PLWHA who have MHP may also be helpful.

5.4.2 Policy

The government may consider the introduction of liaison mental health nurses or mental health nurse consultants in the general settings. The mental health nurses who are already

deployed in general settings could be utilised for this purpose (Sharrock & Happell, 2006). They may be a valuable resource for providing support to general nurses who care for PLWHA who have MHP. There is also a need to develop guidelines for caring for PLWHA who have MHP in general settings in order to support nurses in their work.

5.4.3 Nursing education

Nurse educators, together with the government, need to intensify the training of mental health specialists so that they can be readily available to support nurses who are caring for clients with MHP in general settings. Nurse educators also need to ensure that their curricula adequately prepare nurses to deal with MHP so that nurses may be able to respond effectively to the mental health care needs of PLWHA. It would seem logical to educate nurses on how to identify and manage MHP affecting PLWHA during their training and practice. Ross and Goldner (2009) affirm that improving basic nursing education regarding mental health from entry to practice, and providing supplementary clinical mental health education to nurses who are practicing, may improve their competencies in dealing with MHP. Therefore it is important that nursing educators must include the just launched mental health Gap intervention guide for mental, neurological and substance use disorders in non-specialised settings (WHO, 2010) in their curricula.

5.4.4 Research

Further qualitative research needs to be undertaken to uncover the complexities underlying nurses' self perceptions regarding their provision of mental health care to PLWHA in order to have an in-depth understanding of the subject matter.

5.5 Conclusion

Overall, the study reveals a remarkable opportunity for improving the mental health care of PLWHA in general settings in Blantyre, Malawi. Nurses are potentially an essential human resource for dealing with MHP of PLWHA because of their frequent contact with

these people in general settings. Unfortunately, nurses usually lack knowledge and skills to address MHP of PLWHA. They also lack support from mental health specialists. This has a negative influence on their willingness to care for PLWHA who have MHP in general settings. Nurses who feel that they lack knowledge, skills and support may be unwilling to engage themselves with MHP of PLWHA for fear of uncovering problems which they may find themselves unable to deal with. Therefore, it is essential that better supervision and support networks for nurses who deal with MHP of PLWHA in general settings are developed. The access to ongoing training and in-service education by nurses, the use of a multidisciplinary approach and the establishment of effective professional collegial relationships between nurses and mental health specialists may provide nurses with an opportunity of improving their role competency, role support and consequently their therapeutic commitment in dealing with MHP of PLWHA.

References

- Albery, I. P., Heuston, J., Ward, J., Groves, P., Durand, M. A., Gossop, M. et al. (2003). Measuring therapeutic attitude among drug workers. *Addictive Behaviours*, 28, 995-1005.
- Anderson, P., Kaner, E., Wutzke, S., Wensing, M., Grol, R., Heather, N. et al. (2003). Attitudes and management of alcohol problems in general practice: Descriptive analysis based on the findings of a World Health Organisation international collaborative survey. *Alcohol & Alcoholism*, 38(6), 597-601.
- Angus, N. J., Lauder, W., & Reynolds, W. (2001). Further testing of the Mental Health Problems Perception Questionnaire. *Journal of Advanced Nursing*, 33(5), 638-643.
- Arnold, M., & Mitchell, T. (2008). Nurses' perceptions of care received by older people with mental health issues in an acute hospital environment. *Clinical Research*, 20(10), 28-34.
- Atkin, K., Holmes, J., & Martin, C. (2005). Provision of mental health care to people with co-morbid mental illness in general hospitals: General nurses' perceptions of their training needs. *International Journal of Geriatric Psychiatry*, 20, 1081-1083.
- Brandt, R. (2009). The mental health of people living with HIV/AIDS in Africa: A systematic review. *African Journal of AIDS Research*, 8(2), 123-133.
- Burns, N., & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique and utilisation*. (5th ed). St. Louis: Elsevier Saunders.

- Cartwright, A. (unpublished book chapter). *Key Concepts in the Training of Psychotherapists*. Retrieved July, 23, 2009 from http://www.code-a-text.co.uk/training_concepts.htm
- Cartwright, A. K. J. (1980). The attitude of helping agents towards the alcoholic client: The influence of experience, support, training and self esteem. *British Journal of Addiction, 75*, 413-431.
- Cartwright, A. K. J. (1992). Implication of training of studies using the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ). Conference paper, University of Kent, United Kingdom.
- Chambers, M., Guise, V., Valimaki, M., Botelho, M. A. R., Scott, A., Staniuliene, V. et al. (2010). Nurses' attitudes to mental illness: A comparison of a sample of nurses from five European countries. *International Journal of Nursing Studies, 47*, 350–362.
- Clark, C., Parker, E., & Gould, T. (2005). Rural generalist nurses' perceptions of the effectiveness of their therapeutic interventions for patients with mental illness. *Australian Journal of Rural Health, 13*, 205-213.
- Collins, P. (2006). Challenges to HIV prevention in psychiatric settings: Perceptions of South African mental health care providers. *Social Science & Medicine, 63*, 979-990.
- Collins, P. Y., Holmand, A. R., Freemane, M. C., & Patel, V. (2006). What is the relevance of mental health to HIV/AIDS care and treatment programs in developing countries? A systematic review. *AIDS, 20*, 1571-1582.

- Delobelle, P., Rawlinson, J. L., Ntuli, S., Malatsi, I., Decock, R., & Depoorter, A. M. (2009). HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa. *Journal of Advanced Nursing*, 65(5), 1061-1073.
- Foster, K., Usher, K, Baker, J. A., Gadai, S., & Ali, S. (2008). Mental health workers' attitudes toward mental illness in Fiji. *Australian Journal of Advanced Nursing*, 25 (3), 72-79.
- Freeman, M., & Thom, R. (2006). Serious mental illness and HIV/AIDS. *South African Journal of Psychiatry*, 12(1), 4-8.
- Freeman, M., Nkomo, N., Kafaar, Z., & Kelly, K. (2007). Factors associated with prevalence of mental disorder in people living with HIV/AIDS in South Africa. *AIDS Care*, 19(10), 1201-1209.
- Freeman, M., Patel, V., Collins, P., & Bertolote, J. M. (2005). Integrating mental health in global initiatives for HIV/AIDS. *British Journal of Psychiatry*, 187, 1-3.
- Ghebrehiwet, T., & Barrett, T. (2007). Nurses and mental health services in developing countries. *The Lancet*, 370, 1016-1017.
- Gillis, A., & Jackson, W. (2001). *Research for nurses: Methods and interpretation*. Philadelphia: F. A. Davis Company.
- Haddad, M., Plummer, S., Taverner, A., Gray, R., Lee, S. Payne, et al. (2005). District nurses' involvement and attitudes to mental health problems: A three-area cross-sectional study. *Journal of Clinical Nursing*, 14, 976-985.
- Harris, F. O. C. (1968). *Laws of Malawi*. London: Waterlow & Sons Ltd.

- Herzig, H. (2003). Teaching psychiatry in poor countries: Priorities and needs. A description of how mental health is taught to medical students in Malawi, Central Africa. *Education for Health, 16*(1), 32-39.
- Ito, H., Kishi, Y., & Kurosawa, H. (1999). A preliminary study of staff perception of psychiatric services in general hospitals. *General Hospital Psychiatry, 21*(1), 57-61.
- Kauye, F. (2008). Management of mental health services in Malawi. *African Journal of Psychiatry, 5*(2), 29-30.
- Lauder, W., Reynolds, W., Reilys, V., & Angus, N. (2000). The development and testing of the Mental Health Problems Perception Questionnaire. *Journal of Psychiatric and Mental Health Nursing, 7*, 221-226.
- Lauder, W., Reynolds, W., Reilys, V., & Angus, N. (2001). The role of district nurses in caring for people with mental health problems who live in rural areas. *Journal of Clinical Nursing, 10*, 337-344.
- Lauder, W., Reynolds, W., Smith, A., & Sharkey, S. (2002). A comparison of therapeutic commitment, role support, role competency and empathy in three cohorts of nursing students. *Journal of Psychiatric and Mental Health Nursing, 9*, 483-491.
- Lazarus, R., & Freeman, M. (2009). *Primary-level mental health care for common mental disorder in resource-poor settings: Models & practice. A literature review.* Pretoria: Medical Research Council.
- Lethoba, K. G. (2005). *Perceptions of professional nurses of nursing mentally ill people in general hospital setting.* University of South Africa.

Lethoba, K. G., Netswera, F. G., & Rankhumise, E. (2006). How professional nurses in general hospital setting perceive mentally ill patients. *Curationis*, 29(4), 4-11.

Lwanga, S. K., & Lemeshow, S. (1991). *Sample size determination in health studies*, Geneva.

Map of Malawi. Retrieved April, 1, 2010 from

<http://www.sdn.org.mw/undp/Mlwinfomaps/Malawi1.jpe>.

Mason, T., Hall, R., Caulfield, M., & Melling, K. (2010). Forensic nurses' perceptions of labels of mental illness and personality disorder: Clinical versus management issues. *Journal of Psychiatric and Mental Health Nursing*, 17, 131-140.

Mavundla, T. R. (2000). Professional nurses' perception of nursing mentally ill people in a general hospital setting. *Journal of Advanced Nursing*, 32(6), 1569-1578.

Mellins, C. A., Kang, E., Leu, C., Havens, J., & Chesney, M. A. (2003). Longitudinal study of mental health and psychosocial predictors of medical treatment adherence in mothers living with HIV disease. *AIDS Patient Care and STDs*, 17(8), 407-416.

MOHP. (2001). *National mental health policy for Malawi*. Lilongwe: Ministry of Health and Population.

MOHP. (2003). *National HIV/AIDS Policy*. Retrieved July, 29, 2009 from

http://data.unaids.org/Topics/Human-Rights/malawi_national_policy_en.pdf.

Moxham, L., Dwyer, T., Happell, B., Reid-Searl, K., Kahl, J., Morris, J., et al. (2010). Recognising our role: Improved confidence of general nurses providing care to young people with a mental illness in a rural paediatric unit. *Journal of Clinical Nursing*, 19, 1434-1442.

- Munro, A., Watson, H.E., & McFadyen, A. (2007). Assessing the impact of training on mental health nurses' therapeutic attitudes and knowledge about co-morbidity: A randomised controlled trial. *International Journal of Nursing Studies*, 44, 1430–1438.
- Muula, A. (2005). Shortage of health workers in Malawian public health services system: How do parliamentarians perceive the problem? *African Journal of Health Sciences*, 12(3-4), 101-107.
- Mwale, C. M. (2006). *The prevalence of psychological distress and associated factors among people living with Aids attending antiretroviral therapy clinics In Mzuzu, Malawi: A cross sectional descriptive study*. University of Malawi, Blantyre.
- Myer, L., Smit, J., Leroux, L., Parker, S., Stein D. J., & Seedat, S. (2008). Common mental disorders among HIV-infected individuals in South Africa: Prevalence, predictors, and validation of brief psychiatric rating scales. *AIDS Patient Care and STDs*, 22(2), 147-158.
- National Statistical Office. (2008). *Main Census Report*. Retrieved on December, 6, 2010 from <http://www.nso.malawi.net/>
- Nurses and Midwives Council of Malawi. (2009). *Scope of practice for all cadres of nursing and midwifery*. Mzuzu: Katoto Printing Press.
- Pallant, J. (2007). *SPSS survival manual: A step by step guide to data analysis using SPSS version 15*. Berkshire: McGraw-Hill Company.
- Polit, D. S., & Beck, C. T. (2004). *Nursing research: Principles and methods*. (7th ed). Philadelphia: Lippincott.

- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., et al. (2007). No health without mental health. *The Lancet*, 370, 859-877.
- RAND Corporation. (2007). Mental health and substance abuse issues among people with HIV. *Research Highlights*, 1-5.
- Reed, F., & Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing*, 14, 249-257.
- Ross, A. C., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 16, 558-567.
- Sharrock, J., & Happell, B. (2006). Competence in providing mental health care: A grounded theory analysis of nurses' experiences. *Australian Journal of Advanced Nursing*, 24(2), 9-15.
- Shaw, S., Cartwright, A., Spratley, T., & Harwin, J. (1978). *Responding to drinking problems*. Croom-Helm, London.
- Skuse, D. (2008). Mental health services in sub-Saharan Africa. *African Journal of Psychiatry*, 5(2), 28-29.
- Suominen, T., Koponen, N., Mockiene, V., Raid, U., Istomina, N., Vänskä, M. et al. (2010). Nurses' knowledge and attitudes to HIV/AIDS-an international comparison between Finland, Estonia and Lithuania. *International Journal of Nursing Practice*, 16, 138-147.

- Svediene, L., Jankauskienė, L., Kusleikaite, M., & Razbadauskas, A. (2009). Competence of general practice nurses caring for patients with mental health problems in the somatic departments. *Medicina (Kaunas)*, 45(10),822-829.
- University of Malawi. (2008). *Bachelor of Science in Nursing and Midwifery Curriculum*. Lilongwe.
- WHO. (1999). *The introduction of mental health component into primary health care*. Geneva.
- WHO. (2004). *Promoting Mental Health*. Geneva. Retrieved May, 25, 2009 from http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
- WHO. (2005). *Mental Health Atlas*. Geneva. Retrieved May, 12, 2009 from http://www.who.int/mental_health/evidence/mhatlas05/en/index.html
- WHO. (2005). *Summary country profile for HIV/AIDS treatment scale-up*. Lilongwe. Retrieved May, 8, 2009 from <http://www.who.int/hiv>
- WHO. (2008). *HIV/AIDS and mental health* (Report). Retrieved June, 19, 2009 from http://apps.who.int/gb/ebwha/pdf_files/EB124/B124_6-en.pdf
- WHO. (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialised settings*. Retrieved November, 20, 2010 from http://www.who.int/mental_health/mhgap
- Woollaston, K., & Hixenbaugh, P. (2008). Destructive Whirlwind: Nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 15, 703–709.

Wright, J., Lubben, F., & Mkandawire, M. (2007). Young Malawians on the interaction between mental health and HIV/AIDS. *African Journal of AIDS Research* 6(3), 297-304.

Wynaden, D., O'Connell, B., McGowan, S., & Popescu, A. (2000). The educational needs of nurses in the area of mental health. *The Australian Electronic Journal of Nursing Education*, 6(1), 1-13.

Zomba Mental Health Link. Retrieved July, 25, 2009 from
<http://www.nypct.nhs.uk/aboutus/zombalink/index.htm>

Appendices

Appendix 1

Instrument for the study

CODE _____

SECTION A

Demographic Characteristics

1. What is your age in years?
2. Indicate the number of years you have been practicing as a nurse?

Please circle the option which applies to you

3. Gender:
 1. Male
 2. Female
4. Which nursing cadre do you belong to?
 1. Registered Nurse
 2. Nurse Midwife Technicians
 3. Enrolled Nurse Midwife
 4. Enrolled Psychiatric Nurse
 5. Other specify _____
5. Indicate your department
 1. Psychiatric unit
 2. Maternity
 3. Outpatient
 4. Paediatrics
 5. Surgical
 6. Medical
 7. Other specify _____
6. Did you receive mental health lectures as part of your training?
 1. Yes
 2. No

SECTION B

Indicate whether you **strongly disagree (SD)**, **disagree (D)**, **neutral (N)**, **agree (A)** or **strongly agree (SA)** with the statements below by ticking (✓) in the corresponding box.

		SD	D	N	A	SA
1	I am interested in the nature of mental health problems of people living with HIV/AIDS (PLWHA) and the treatment of them					
2	I feel I am able to work with PLWHA who have mental health problems as effectively as other patients who do not have mental health problems					
3	I want to work with PLWHA who have mental health problems					
4	I feel that there is nothing I can do to help PLWHA who have mental health problems					
5	I feel that I have something to offer PLWHA who have mental health problems					
6	I feel that I have a number of good qualities for working with PLWHA who have mental health problems					
7	Caring for PLWHA who have mental health problems is an important part of nurse role					
8	In general, one can get satisfaction from working with PLWHA who have mental health problems					
9	I often feel uncomfortable when working with PLWHA who have mental health problems					
10	In general, I feel that I can understand PLWHA who have mental health problems					
11	On the whole, I am satisfied with the way I work with PLWHA who have mental health problems					
12	In general I find working with PLWHA who have mental health problems difficult					
13	I feel that I know enough about the factors that put PLWHA at risk of mental health problems					

		SD	D	N	A	SA
14	I feel that I know how to treat PLWHA who have long term (or chronic) mental health problems					
15	I feel that I can appropriately advise my patients who are infected with HIV/AIDS about mental health problems					
16	I feel I have clear idea of my responsibilities in helping PLWHA who have mental health problems					
17	I feel I have the right to ask my patients who are infected with HIV/AIDS about their mental health status					
18	I feel that my patients who are infected with HIV/AIDS believe I have a right to ask them questions about their mental health problems					
19	I feel that I have the right to ask PLWHA for any information that is relevant to their mental health problems					
20	I have the skills to work with PLWHA who have mental health problems					
21	I feel I have the skills to assess and identify PLWHA who have mental health problems					
22	I often have the difficulty knowing how to communicate with PLWHA who have mental health problems					
23	I feel I know how to treat PLWHA who present in a crisis with signs of mental health problems					
24	I often have difficulty knowing how to assess PLWHA who have mental health problems					
25	If I felt the need when working with PLWHA who have mental health problems I could easily find someone who would help me clarify my professional difficulties.					
26	If I felt the need I could easily find someone who would be able to help me formulate the best approach to PLWHA who have mental health problems.					
27	When working with PLWHA who have mental health problems, I receive adequate support from other agencies					
28	When working with PLWHA who have mental health problems, I receive adequate support from colleagues					

		SD	D	N	A	SA
29	When working with PLWHA who have mental health problems, I receive adequate support from mental health services within my district					
30	When working with PLWHA who have mental health problems, I receive adequate support from other mental health services outside my district.					

THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN THIS STUDY

Appendix 2

Request to use Mental Health Problems Perceptions Questionnaire

School of Nursing
Desmond Clarence Building
University of Kwazulu Natal
4041
Durban
South Africa
Email: genesischorwe@yahoo.co.uk
or 208503010@ukzn.ac.za
29th September 2009

W. Lauder
Department of Nursing and Midwifery
University of Stirling
Old Perth Road
Inverness
UK

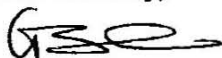
Dear Professor

REQUEST TO USE YOUR MENTAL HEALTH PROBLEMS PERCEPTION QUESTIONNAIRE (MHPPQ) FOR MY STUDY.

I am a Malawian pursuing a Master of Mental Health Nursing programme at University of Kwazulu Natal. I am currently working on the proposal for my research project entitled "*Exploring Perceptions of Nurses about Mental Health Care of People Living with HIV/AIDS in Blantyre District.*" I would like to request if I could use the MHPPQ for my study.

I trust that this request is going to receive your favourable consideration and I look forward to hear from you.

Yours faithfully,


Genesis Chorwe-Sungani

Appendix 3

Permission to use Mental Health Problems Perceptions Questionnaire

WL/lmb

7 October 2009

Mr Genesis Chorwe-Sungani
School of Nursing
Desmond Clarence Building
University of Kwazulu Natal
4041
Durban
South Africa



**UNIVERSITY OF
STIRLING**

DEPARTMENT OF
NURSING AND MIDWIFERY

Email: nursingmidwifery@str.ac.uk
Web: www.nm.str.ac.uk

Professor William Lauder
Head of Department
Department of Nursing & Midwifery
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 46 6345
Fax: +44 (0) 1786 46 6344
Email: william.lauder@str.ac.uk

Dear Mr Chorwe-Sungani

Mental Health Problems Perception Questionnaire (MHPPQ)

Thank you for your letter of 29 September 2009.

I confirm that I am happy for you to use the MHPPQ in your research project "Exploring Perceptions of Nurses about Mental Health Care of People Living with HIV/AIDS in Blantyre District". I wish you every success with your research.

Yours sincerely

PROFESSOR WILLIAM LAUDER
Head of Department

Highland Campus:
Centre for Health Science
Old Perth Road
Inverness IV2 3JH
HS1 2AF
Tel: +44 (0) 1463 259655
Fax: +44 (0) 1463 259654

Stirling Campus:
Stirling
FK9 4LA

Tel: +44 (0) 1786 466340
Fax: +44 (0) 1786 466333

Western Isles Campus:
Western Isles Hospital
MacAulay Road
Stornoway Isle of Lewis

Tel: +44 (0) 1851 706243
Fax: +44 (0) 1851 706070

The University of Stirling is recognised as a Scottish Charity with number SC011159

Appendix 4

Information and informed consent sheet

Welcome to this study and I would like you to know the following about the study:

Purpose of the Study: I am a master student at the University of Kwazulu Natal conducting a study to explore nurses' perceptions of the mental health care they provide to People Living with HIV/AIDS (PLWHA) in Blantyre district, Malawi. The study is in partial fulfillment of the Master of Mental Health Nursing programme which I am pursuing.

Study objectives: The objectives of this study are the following: (i) to describe nurses' self perceptions of their knowledge and skills in relation to providing mental health care to PLWHA (ii) to identify nurses' self perceptions about the support they receive from mental health specialists when providing mental health care to PLWHA (iii) to determine nurses' self perceptions about their commitment to providing mental health care to PLWHA.

Procedures: If you consent, you will be asked to complete a questionnaire about your perceptions about mental health care of PLWHA.

Risks and benefits: You will not be punished in any way for refusing to take part in the study. You are free to decline to answer questions without giving reasons whenever you feel uncomfortable to do so. However, it is important that you know that the information given may help in making recommendations about mental health care for PLWHA.

Confidentiality: All information given will be kept confidential and only used for research purposes. Your name will not appear in any report of the research.

Participation is voluntary: Participation in the study is entirely voluntary and you can choose to withdraw from the study at any time without giving reasons for doing. If you have any questions please do not hesitate to contact:

Genesis Chorwe-Sungani, Kamuzu College of Nursing, P.O. Box 415, Blantyre. Tel: 01 823 673, Mobile: 0999 682 073, Email: genesischorwe@yahoo.co.uk or Principal, Kamuzu College of Nursing, P/Bag 1, Lilongwe. Tel: 01 751 622, Email: principal@kcn.unima.mw or Chairperson, COMREC, College of Medicine, Mahatma Ghandi Road, Blantyre.Tel: 01 877 245/291

CONSENT STATEMENT:

I..... (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

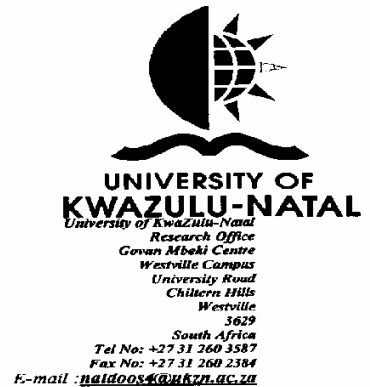
I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of participant.....Date.....

Signature of witness.....Date.....

Appendix 5

Ethical clearance letter



12 December 2009

Mr G Chorwe-Sungani
Louis Botha Residence
Room D2
HOWARD COLLEGE CAMPUS

Dear Mr Chorwe-Sungani

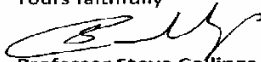
PROTOCOL: Exploring Nurses Perceptions of their provision of Mental Health Care to People Living with HIV/AIDS in the Blantyre District, Malawi
ETHICAL APPROVAL NUMBER: HSS/0960/2009: Faculty of Health Sciences

In response to your application dated 20 November 2009, Student Number: 208503010 the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

SC/sn

cc: Ms N C Shangase
cc: Mr S Reddy

Appendix 6

Ethical Approval letter



UNIVERSITY OF MALAWI

Principal
Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:
Your Ref.: P.01/10/856

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 877 245
01 877 291
Fax: 01 874 700
Telex: 43744

5th March 2010

Mr. Sunganani Chorwe
Kamuzu College of nursing
P.O Box 415
Blantyre 3

Dear Mr. S. Chorwe,

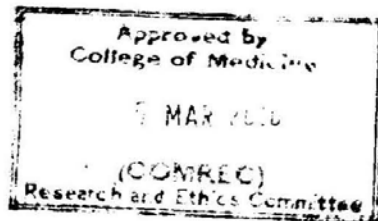
P.01/10/856 – Exploring Nurses Perceptions of their provision of Mental Health Care to people living with HIV/AIDS in Blantyre District

I write to inform you that COMREC reviewed your proposal which you resubmitted for expedited review. I am pleased to inform you that your proposal was approved on 5th March 2010 after considering that you addressed all the queries which were raised during the previous review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours sincerely,

Prof. J. M Mfutso-Bengo
CHAIRMAN – COMREC.



JMMB/ck

Appendix 7

Clearance letter to Queen Elizabeth Central Hospital


Kamuzu College of Nursing,
P. O. Box 415,
Blantyre
2nd November 2009

The Hospital Director,
Queen Elizabeth Central Hospital,
Chipatala Avenue
Blantyre.

Dear Sir/Madam,

CLEARANCE REQUEST TO CONDUCT A RESEARCH STUDY

I write to request for permission to conduct a study at your institution in partial fulfillment of my studies. I am a Master of Mental Health Nursing student at the University of Kwazulu Natal intending to conduct a study entitled "Exploring nurses perceptions of their provision of mental health care to people living with HIV/AIDS in the Blantyre District, Malawi." I intend to ask nurses who will be randomly selected to complete a questionnaire starting from 1st March 2010 to 31st March 2010. Participation in the study will be entirely voluntary.



Genesis Chorwe-Sungani

Appendix 8

Clearance letter from Queen Elizabeth Central Hospital

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director



In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref No. QE/CNO/10

16th November 2009

Genesis Chorwe-Sungani
Kamuzu College of Nursing
P.O. Box 415
BLANTYRE

Dear Sir,

**PERMISSION TO CONDUCT RESEARCH AT QUEEN ELIZABETH
CENTRAL HOSPITAL**

With reference to your letter dated 2nd November, 2009 in which you requested for permission to conduct a study on "**Exploring nurses perceptions of their provision of mental health care to people living with HIV/AIDS in the Blantyre District, Malawi.**", I would like to inform you that we have no objection for you to conduct the mentioned study.

We will appreciate if a copy of your findings is shared with the hospital.

All the best in your studies.

Yours faithfully,

A handwritten signature in black ink, appearing to be 'T.N. Soko'.

T.N. Soko (Mrs)
CHIEF NURSING OFFICER

Appendix 9

Clearance letter to Blantyre District Health Office

Kamuzu College of Nursing,
P. O. Box 415,
Blantyre.
2nd November 2009

The District Health Officer,
Chipatala Avenue,
Blantyre.

Dear Sir/Madam,

CLEARANCE REQUEST TO CONDUCT A RESEARCH STUDY

I write to request for permission to conduct a study the following health centres: Bangwe, Chilomoni, Limbe, Ndirande and Zingwangwa in partial fulfillment of my studies. I am a Master of Mental Health Nursing student at the University of Kwazulu Natal intending to conduct a study entitled "Exploring nurses perceptions of their provision of mental health care to people living with HIV/AIDS in the Blantyre District, Malawi." I intend to ask nurses who will be randomly selected to complete a questionnaire starting from 1st March 2010 to 31st March 2010. Participation in the study will be entirely voluntary.



Genesis Chorwe-Sungani

Appendix 10

Clearance letter from Blantyre District Health Office

Telephone: (265) 01 877 401

All communications should be addressed to:
The district health officer



In reply quote No.

Blantyre district health office
P/Bag 66
Blantyre
Malawi

Ref No.

13th November 2009

Genesis Chorwe-Sungani (Mr.)
Kamuzu college of Nursing
P. O Box 415
Blantyre

Dear Sir,

PERMISSION TO CONDUCT A RESEARCH STUDY

With reference to your letter on the above subject, I write to authorize you to conduct a study on "Exploring Nurses perceptions of their provision of mental health care to people living with HIV/AIDS in Blantyre District, Malawi."

A handwritten signature in black ink, appearing to read 'L. Chunda'.

L. Chunda (Dr.)
District Health Officer