

**EXPLORING HOW PLWHA WITH CO-MORBID
DEPRESSION PERCEIVE DEPRESSION AND
MENTAL HEALTH SERVICES**

By

Nkanyiso Madlala

(209501912)

A short dissertation submitted in partial fulfillment of the
Requirements for the degree of:

MASTERS IN CLINICAL PSYCHOLOGY

In the

School of Applied Sciences, Psychology discipline

At the

University of KwaZulu-Natal, Howard College

Research supervisor: Professor I. Petersen

Declaration:

I, **Nkanyiso Lionel Madlala** declare that this research thesis titled: Exploring how PLWHA with co-morbid depression perceive depression and mental health services is my original work except where otherwise stated. I declare that this thesis has not previously been submitted for any qualification at any other university. I have acknowledged all sources in the reference list.

Nkanyiso Lionel Madlala

December 2015

ACKNOWLEDGEMENTS

To **God** be the glory great things He has done! This thesis, as part of the psychology masters requirement, for me, marks the great accumulation of all the learning and hard work through all the years I have been at the University of KwaZulu Natal. Thus I acknowledge and thank the Almighty God who has seen me through all these years and who has not failed to see me through this thesis.

I would also like to extend my most sincere gratitude to the following people for their invaluable contribution:

I will remain forever indebted to Professor **I. Petersen** who has played a great role in making this thesis a success. I am truly grateful for the encouragement, support and patience that you have shown me and I commend you for your diligence and superior work ethics.

To my Family for their steadfast love, support and encouragement that empowered me to work diligently on this thesis.

To my pastor and spiritual father, **Ps. Nkhoma and the Zululand Christian Mission Outreach** church, for your faithful prayers and motivation.

To all my friends, particularly **Zama Kunene and Londiwe Nyandeni**, thank you for your support and motivation and importantly for containing me during trying times. Your jokes and humor never failed to make me laugh.

To the UKZN psychology staff and Centre for Applied Psychology clinic staff, thank you for your encouragement and support.

To my colleagues and supervisors from my internship sites – thank you for your guidance and support.

To the participants who participated in this study, without your involvement this thesis would not have existed.

To the Primary Health Clinic where the study was conducted in and all the staff as well as all those who were involved in the data collection process, I am truly grateful.

DEDICATION

To my late grandmother T.C. Makhunga – you were all a parent can be. To my lovely mother D.N. Makhunga, your support and encouragement saw me through, to my cousin and brother S.E. Makhunga, your teachings and guidance were my pillars and to Mam Pat Mthethwa and the UKZN psychology staff, you made university a home away from home!

ABSTRACT

Background: South Africa, like many low and middle income countries (LMICs) continue to bear the excessive burden of HIV/AIDS. This problem has been further compounded by the growing prevalence of common mental disorders such as depression, which are often co-morbid with HIV/AIDS. There is growing recognition of the seriousness of the co-morbidity of common mental disorders, primarily depression with HIV/AIDS. Literature suggests that co-morbidity between depression and HIV leads to reduced adherence to Anti- Retro-Viral Therapy (ART) and Accelerate the progression of HIV. In the context of a scarcity of mental health services, this is of particular concern.

Aim: The aim of this study is to explore how PLWHA with co-morbid depression perceive depression and mental health services. The secondary aim of the study is to learn about their perceptions of acceptable interventions.

Method: This study used a qualitative design. Qualitative data was obtained from 15 participants attending a large primary health facility through semi-structured interviews. The participants were recruited through a two stepped process with initial inclusion criteria being that participants were HIV-positive and had to meet the diagnostic criteria for major depressive disorder (MDD) using the Structured Clinical Interview for DSMIV Diagnosis (SCID). Thematic analysis, specifically the Framework approach was used to analyze the collected data.

Results: Findings from the study attest to the lack of mental health services for PLWHA who suffer from depression. It emerged from the findings that all the participants had no knowledge of any mental health services that might be available. A factor that stood out was that of low levels of mental health literacy as a strong barrier to seeking or even inquiring about mental health services. With regard to appropriate interventions, participants expressed a strong preference for support groups as compared to being helped as individuals.

Conclusion: The scarcity of mental health services for people suffering from mental illness continues to be a pressing challenge in South Africa. Depression co-morbid with HIV poses numerous challenges that continue to threaten the wellbeing of PLWHA with co-morbid depression. Further, some determinants of depression such as poverty also pose a great threat to the ART programme by interfering with ART medication adherence. In attempts to address the problem of the shortage of specialized mental health personnel, many writers and

researchers have advocated and called for task shifting as a possible relief to the scarcity of these vital services. However more studies are needed that demonstrate the effectiveness and feasibility of task shifting.

Keyword: PLWHA, HIV, Depression, Co-morbidity, Mental Health Services, Task Shifting.

TABLE OF CONTENTS

Content	Page
DECLARATION	2
ACKNOWLEDGEMENTS	3
DEDICATION	4
ABSTRACT	5
CHAPTER 1: INTRODUCTION	
1.1 Background of the study	11
1.2 Problem statement	12
1.3 Aim of the study	13
1.4 Significance of the study	13
1.5 Outline of chapters	13
1.6 Acronyms	14
1.7 Definition of terms	16
CHAPTER2: LITERATURE REVIEW	
2.1Depression: An overview	17
2.1.1 Depression and Quality of Life	18
2.1.2 Depression and gender	19
2.2 HIV/AIDS stigma and mental health	22
2.3 HIV/AIDS and depression	24
2.4 HIV disease progression	26
2.5 Depression and poor ART treatment adherence	26
2.6 Mental health services in Africa and South Africa	28
2.7 Proposed pathways for the effective provision of mental health services	33
2.8 HIV/AIDS and depression co-morbidity: Health related outcomes	36
2.9 Theoretical framework: Kleinman’s Explanatory model of illness	36

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Aim of the study and objectives	40
3.2 Research design	41
3.3 Study site	41
3.4 Sample demographics	41
3.5 Recruitment and sampling	42
3.6 Data collection	43
3.7 Data analysis	44
3.8 Reliability and Validity	45
3.9 Ethical considerations	47

CHAPTER 4: RESEARCH FINDINGS

4.1 Introduction of themes	49
4.2 Understanding depression	49
4.2.1 Embodies symptoms	49
4.2.2 Emotional and relational symptoms	50
4.3 Causes of depression	51
4.3.1 Lack of money	51
4.3.2 Domestic disputes	52
4.4 Impact of depression	53
4.4.1 Domestic impact	53
4.4.2 Social impact	54
4.4.3 Occupational impact	54
4.5 Barriers to seeking mental health services	55
4.5.1 Lack of knowledge about depression	55
4.5.2 Lack of knowledge about where to access help	55
4.5.3 Lack of transport money	56

4.6 Knowledge about available MHS	56
4.6.1 Knowledge about currently available MHS	56
4.6.2 Knowledge about MHS rendered by the DoH	57
4.6.3 Utilization of MHS	57
4.6.4 Ensuring accessibility	58
4.7 Acceptable forms of interventions	61
4.8 Adherence to ART medication	63
4.9 Expectations from nurses and CHWs	64
CHAPTER 5: DISCUSSION OF RESULTS	
5.1 Introductory remarks	65
5.2 Understanding depression	67
5.3 Causes of depression	69
5.4 Impact of depression	72
5.5 Barriers to seeking mental health services	73
5.7 Knowledge about available MHS	75
5.8 Acceptable forms of interventions	77
5.9 Adherence to ART medication	80
5.10 Expectations from nurses and CHWs	81
6. CHAPTER 6: CONCLUSION AND RECOMMENDATIONS	
6.1 Conclusions	85
6.2 Limitations of the study	88
6.3 Recommendations for future research	89

7. REFERENCES	90
----------------------	-----------

8. APPENDICES

Appendix 1 -Interview schedule	105
Appendix 2 - Informed consent form	113
Appendix 3 -Ethical clearance for the main study	116
Appendix 4 - Ethical clearance for current study	117

CHAPTER ONE: INTRODUCTION

This introductory chapter primarily outlines the background of the study and puts forth the problem statement which rationalizes why this study has been conducted. This section also delineates the purpose of conducting this study and its significance, as well as presenting a brief overview of the subsequent chapters. Lastly, this chapter defines acronyms and terms that will be used throughout this thesis.

1.1 Background of the study

Sareceno, van Ommeren and Batniji (2007) indicates that international public health concerns for mental health have been accelerated by the 1993 World Development report as well as the Global Burden of disease report. Prince, Harwood and Blizard (2007) noted that the report revealed that neuropsychiatric conditions which include mental disorders such as affective disorders (e.g. bipolar and depression), substance use disorders, schizophrenia and neurological disorders such as epilepsy, migraine and Parkinson's disease (Lund, Tomlinson and Silva, 2012) account for about a third of disability adjusted life years. Indeed a number of authors are in agreement that mental disorders are one of the important factors that lead to disability and dependency which not only impairs the functioning of the individual but that of the economy as well (Prince, Harwood and Blizard, 2007; Harlé, Allen, and Sanfey, 2010 and Draper, Lund, and Kleintjes, 2009). Draper and colleagues (2009) also mention that mental health is an increasingly important concern in South Africa. They argue that neuropsychiatric conditions rank third in their contribution to disability in this country. Prince and colleagues (2007) write that the most disabling conditions include affective disorders (e.g. bipolar and depression), substance-use, psychotic disorders (e.g. schizophrenia) and dementia.

Previously, much focus was placed on neuropsychiatric disorders such as schizophrenia (and other psychoses), while Common Mental Disorders (CMDs) went largely undiagnosed and untreated (Petersen, Lund and Stein, 2011a). However recently, more attention has been given to (CMDs) such as depression, which is increasingly becoming a debilitating condition affecting both the wellbeing of the individual and the country's economy (Bayford and Bower, 2002 and Chartier and Provenchor, 2013). Wampold, Budge and Laska (2011) indicates that depression is a major health problem that entails serious clinical and social consequences and that it is expected to be a leading cause of disability in the year 2030. To complicate matters, in many developing countries, CMDs, primarily depression, have been observed to co-occur frequently with HIV/AIDS (Jin, 2006; Lawler, Mosepele and Seloilwe,

2011; Leserman, 2008 and Ramien, Exner and Kertzner, 2006). Among People Living With HIV (PLWHA), depression has been said to contribute to hastened HIV disease progression as well as to poor adherence with the HIV treatment regimen which ultimately lead to heightened mortality rates (Lawler, Mosepele and Seloilwe, 2011; Gonzalez, Batchelder and Psaros, 2011; Wagner, Ghosh-Dastidar and Garnett, 2012; Benton, 2006; Leserman, 2008; Gore-Felton, Koopman and Spiegel, 2006 and Antelman, Kaaya and Wei, 2007).

Despite the realization of the widespread impacts of neuropsychiatric disorders, especially CMDs on individual as well as the nation's wellbeing, a number of authors have written that in most low and medium income countries, the provision of mental health services remain a low priority. In many, if not all of these countries, mental health care is grossly under resourced (Sareceno and Saxen, 2002; Saxen, Thornicroft and Knapp, 2007 and Lund, Alison Breen and Alan, 2010). Knapp, Funk and Curran (2006) noted that mental health services in many countries, especially in low or middle income countries are chronically underdeveloped. They continue to argue that in these countries, there are very little or no available resources which are allocated to meet the mental health needs of the population. Despite depression co-morbid with HIV/AIDS being a public health concern in most South African Primary Health Level (PHL) clinics, it still goes unidentified mostly because of poor resources and inadequate training of clinical personnel to identify, diagnose and deal with such conditions (Petersen, Bhana and Campbell-Hall, 2009). In response to these challenges, a number of authors have called for mental health care to be integrated with mainstream primary health care as a strategy to increase accessibility of these services (Lund, Petersen, and Kleintjies, 2012 and Freeman, Patel and Collins, 2012). Task shifting has also been mooted as one of the best possible pathways to wide health service delivery (Petersen et al, 2011).

1.2 Problem statement

Although there is an abundance of literature around depression and mental health services, particularly in developing countries and about the impact of mental disorders in these countries, the review of literature suggests that there are few studies that have focused on exploring the perceptions of depression and mental health services of PLWHA with co-morbid depression within the South African context. Most of the studies done in this area have not tapped into the different but interrelated phenomena that impact on the lives of PLWHA with co-morbid depression, which this study will attempt to do. There is also

compelling evidence from a number of studies (see Nakimuli-Mpungu, Bass and Alexandre, 2012; Lawler et al., 2011; Gonzalez et al., 2011; Wagner et al., 2012 and Olisah, Baiyewu and Sheikh, 2010) that depression negatively impacts on ART treatment adherence, however, there are few local studies that have investigated this relationship. Thus, the current study will also look at whether depression has an impact on ART treatment adherence among the participants. This is particularly important given the prevalence of HIV/AIDS and depression co-morbidity in most African countries including South Africa (Brandt, 2009 and Petersen, Hancock and Bhana, 2013).

1.3 Aim of the study

The current study aims to explore how PLWHA, particularly women, with co-morbid depression perceive depression and mental health services. The secondary aim of the study is to learn about their perceptions of acceptable interventions, which may inform the development of appropriate and community accepted interventions. This study will use key informants who have first-hand knowledge about the structure of health services within their own community.

1.4 Significance of the study

Results from the proposed study are likely to yield rich and in-depth findings that cannot be otherwise obtained from primarily quantitative studies. The findings may also inform the development of interventions that might help PLWHA cope with and effectively manage depression or in the presence of such services, the findings might contribute in improving such services so that the care rendered to people is optimized and well received by PLWHA with co-morbid depression. The literature reviewed in this paper illustrates that depression co-morbid with HIV/AIDS carries with it grave implications for the health of the individual in question in that it potentially leads to hastened disease progression and poor adherence to HIV treatment, which likely leads to premature mortality. Literature however also reveals that mental health care can buffer these adverse consequences.

1.5 Outline of chapters

Chapter 1 serves as an introduction to the present study and outlines contextual the background against which the study was conducted. It offers a brief outline of the problem statement, aim, significance of the study. In essence it gives the reader a sense of what is the

study about, why it was conducted and its potential contribution either practically or academically.

Chapter 2 presents the literature review that is pertinent and relevant to the study. It contextualizes the study and largely draws on a vast body literature that has been done in the same field. This chapter discusses a range of topics that are relevant to this study, namely a general overview of depression followed by a discussion of depression and quality of life and depression and gender. HIV/AIDS stigma and mental health is also briefly discussed followed by a discussion on HIV/AIDS and depression. This chapter further looks at depression and HIV disease progression and depression and poor treatment adherence. A diagrammatic illustration of HIV/AIDS and depression co-morbidity and health related outcomes is also presented. The focus then shifts to mental health services in Africa generally and in South Africa specifically. The proposed pathways for the effective roll out of mental health services are also briefly highlighted.

Chapter 3 delineates the research methodology and outlines topics such as the aims and objectives of the study, research questions, research site, sampling methods, data collection, data analysis and ethical consideration. In essence, this chapter focuses on the methods of the study.

Chapter 4 presents the findings of the study.

Chapter 5 offers a discussion of the findings of the study in relation to the literature.

Chapter 6 is the conclusion and recommendations for future research. It also outlines the limitation of the study.

1.6 Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychological Association
DSM	Diagnostic Statistical Manual
ART	Anti- Retro-Viral Therapy
CHWs	Community Health workers
CMHWs	Community Mental Health Workers

HAART	Highly Active antiretroviral therapy
HIV	Human Immune Virus
LMICs	Low and Middle Income Countries
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
UNAIDS	United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
CMD	Common Mental Disorders
SASH	South African Stress and Health
DALYs	Disability Adjusted Life Years
QOL	Quality Of Life
MDD	Major Depressive Disorder
HRQL	Health Related Quality of Life
NIMH	National Institute of Mental Health
NCS	National Co-morbidity Study
WIHS	Women Interagency HIV Study
CBT	Cognitive Behavioral Therapy
IPT	Interpersonal Therapy
SRQ	Self Report Questionnaire
SCID	Structured Clinical Interview Diagnosis
MHS	Mental Health Services
DoH	Department of Health

1.7 Definition of terms

The provision of the following definitions is to ensure consistency of the use and understanding of these terms throughout this dissertation paper. .

Depression: Is defined as a “lowered mood or loss of interest or pleasure in all or almost all activities for a period of almost two weeks. There is presence of at least five of the following: diminished mood; diminished interest in activities; weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue; feelings of worthlessness; inappropriate guilt; diminished ability to think or concentrate and recurrent thoughts of death” (APA, 2013, p.160-161).

HIV/AIDS: AIDS stands for (**Acquired Immune Deficiency Syndrome**) which is a disease that is caused by a virus called HIV (**Human Immune Virus**).

Co-morbidity: It occurs when two or more disorders occur simultaneously.

Task shifting: McInnis and Merajver (2011) define task shifting as a “rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health care workers with shorter training and fewer qualifications in order to make efficient use of available human resources for health” (p.168).

Mental illness: Mental illnesses present themselves through clusters of symptoms, or illness experiences. When these symptoms, or experiences, are associated with significant distress and impairment in one or more domains of human functioning (such as learning, working or family relationships), they are defined as clinically significant mental disorders (Lund et al. (2009).

Mental Health: Is the ability to effectively carry out mental functions which results in productive activities, satisfying relationships with others, and the ability to successfully adapt to change and to cope with adverse situations. Throughout the course of development, mental health is the foundation of communication skills, learning, emotional growth and resilience (US Department of health and human service, 2000).

CHAPTER 2: LITERATURE REVIEW

2.1 Depression

The role played by neuropsychiatric disorders in increasing the burden of disease has recently come under the spotlight. Numerous authors have documented the impact that disorders such as affective disorders (e.g. depression), substance use, schizophrenia and many others have on the general functioning and wellbeing of the individuals concerned (Lund et al., 2012; Gupta, Dandu and Packel, 2010; Kessler, 2003; Brown, Brody and Stoneman, (2002). Burns (2011) comments that globally, mental disorders coupled with other neurological conditions are responsible for approximately 14 per cent of the global burden of disease. Burns continues to argue that currently, neuropsychiatric disorders surpass cardiovascular diseases and cancer as the leading cause of disability resulting from non-communicable diseases. According to Steiner and Gureje (2004), the World Mental Health Consortium, in one of the most sophisticated cross national surveys of psychiatric disorders, confirmed that worldwide, mental illness is highly prevalent, and is associated with impairment and remains largely untreated. Burns (2011) indicates also, that mental disorders are largely responsible for increased rates of mortality as a result of suicide as well as reduced life expectancy; for individual and collective suffering; for momentous loss of social and occupational functioning; for far-reaching disability; and for a significant burden on caregivers and families. Also the impact of mental disability is most felt in Low and Middle Income Countries (LAMIC). Similarly, Gureje, Kola and Afolabi (2007) also indicate that depression is associated with functional impairments, decreased quality of life and increased risk of mortality. They further state that it is now recognized as a public concern and will likely be the second highest leading cause of disability in the years to come.

The South African Stress and Health (SASH) study, which was the first nationally representative study of Common Mental Disorders (CMDs) in South Africa, revealed that anxiety, substance abuse and mood disorders are common among all the different race groups and across all provinces. It also uncovered that these disorders are the most prevalent with anxiety disorders at 8.1 per cent, substance disorders at 5.8 per cent and major depressive disorder at 4.9 per cent. The provinces affected most by anxiety and mood disorders are the Free State, Mpumalanga, KwaZulu Natal and Gauteng (Herman, Stein and Seedat, 2009 and Stein, Seedat and Herman, 2007).

Depression, in particular, has captured the well-deserved attention of the larger mental health community. Gupta et al. (2010) write that depression has been deemed a significant contributor to disease and disability especially in developing countries. They further mention that in 2004, the World Health Organization (WHO) ranked depression as the third leading contributor to the burden of disease internationally and among women, and the projections are that it will become the primary contributor to the burden of disease in the year 2030, especially in developing countries. Lawler et al. (2011) also reiterates that the WHO has listed depression as one of the utmost burdensome of diseases. Wampold et al. (2011) also attest to the fact that depression is a major health problem that entails serious clinical and social consequences.

2.1.1 Depression and Quality of Life (QOL)

Chan, Chiu and Wai-tong (2006) state that Quality of Life (QOL), as defined by the World Health Organization (WHO) denotes the individuals' perception of their position in life within the context of the culture and the value systems in which they live and relative to their goals and expectations. Angermeyer, Holzinger and Matschinger (2002) inform that there is a close link between depression and some components of quality of life. They indicate that a number of studies have demonstrated that depression is associated with impairment and disability in role functioning and that these role and social impairments cause negative impacts on the individual's living conditions, both social and material. In fact, the authors mention that several researchers have succeeded in showing that there is a reduction in QOL in patients suffering from depression as compared to the general public. Nuevo, Leighton and Dunn (2010) also attest to the latter and state that depressive disorders are an important public health concern due to their high prevalence as well as their impact on the individual's QOL. Further, Papakostas, Petersen and Mahal (2004) indicates that Major Depressive Disorder has been shown to account for an overwhelming 23 fold increase in social disability, as well as 5 fold surge in short term work incapacity. They state that patients with MDD obtained a low score on physical functioning and emotional functioning compared to those with other medical conditions. Depression patients were also found to have a lasting decrease in psychosocial functioning that was greater or equal to those of patients with chronic illnesses such as diabetes or osteoarthritis. Unfortunately, studies have shown that even a less severe depressive disorder (e.g. sub-syndromal depression) has been shown to have an adverse impact on psychosocial functioning (Papakostas et al. 2004).

In addition to QOL, some authors have specifically written about Health Related Quality of Life (HRQL). Saarijarvi, Salminen and Toikka (2002) have written that the concept of HRQL reflects an individual's idiosyncratic perceptions and life experiences. Impaired quality of life signifies functional limitations and apparent difficulties in everyday life as a result of disease or illness. They argue that depression has a negative impact on HRQL and studies have shown that HRQL declines drastically in patients with depression. Like Papakostas and colleagues (2004), Saarijarvi and colleagues mentions that the impact of untreated depression is at least equal to that of other somatic conditions such as articular diseases, diabetes and cardiac disease. They add that a two year follow-up study comparing disability resulting from depression to that of other somatic conditions revealed that the functional limitations caused by depression were similar to those caused by hypertension, myocardial infarction and/or congestive cardiac diseases. Furthermore, Papakostas and colleagues comment that studies have found that women with MDD have more impairment in family, marital and occupational roles compared to women who do not suffer from depression. They also mention that the results from the National Institute of Mental Health (NIMH) epidemiological catchment area programme revealed that individuals with MDD or sub-syndromal depression experienced high levels of household related stress, financial stress, general irritability, limitations in professional functioning as well as ill health. Powells, Abreu and de Oliveira (2008) write that depression takes a toll on the life of the individual as well as their families and significantly limit their social and occupational functioning and prompt other functional impairments. They further write that as a result of its high prevalence worldwide and it being a potential leading cause of disability, depression has been classified as one of the most debilitating condition and greatest cause of disability adjusted for years of life. Gupta (2010) and colleagues briefly highlight the adverse health related outcomes associated with depression. They name poor quality of life, increased risk of heart cardiovascular disease and increased rate of mortality among the many.

2.1.2 Depression and Gender

A number of studies, both international and local have proposed a link between depression and gender, females being disproportionately affected in contrast to males. Gore-Felton et al. (2006) have written that early prevalence data depicts that depression is 50 to 100 per cent greater in females compared to males. These findings were subsequently confirmed by the National Co-morbidity Study (NCS) which uncovered that women were roughly two thirds more likely than men to be depressed. Kessler et al. (1994) in Remien et al. (2006) stated that

in the general population, clinical depression is more common in women compared to men, Kessler (2003) adds that according to the Global Burden of Disease study, major depressive disorder appears to be a leading cause of disease related disability among women. The SASH study in South Africa also found mood disorders to be more prevalent in women. It also revealed that being female was associated with a heightened severity of mental disorders (namely anxiety, mood, impulse control and substance disorders) (Herman et al., 2009). Brown, Brody and Stonemen (2002) also write that the effort to determine the etiology of depression symptoms have centered around the epidemiological findings that, on average, females suffer more with depression than men. Noel-Hoeksema and Keita (2003) have also argued that most findings in psychology reveal that women are two times more likely to be diagnosed with depressive disorders. They further mention that this gender difference is not a new phenomenon; gender difference in depression has been found for decades in different cultures. Ngcobo and Pillay (2008) also write that women from different cultures across the world have an elevated chance of suffering from depression as compared to men. They go on to say that research on gender difference in depression that has progressed in the last 20 years suggest that women and men have similar causes of depression such as biological, personality, social and developmental factors. However, the authors mention that women have been found to have a particular vulnerability to other factors that might precipitate and flare depression such as neuroticism, substance use and adverse life experiences.

In addition, Jagannath, Unnikrishnan and Hegde (2011) in their study among 105 HIV positive individuals found that there was statistical significance between depression and sex, where females showed more depressive symptoms than men. They argued that this difference can be due to the fact that when males are depressed they get more support from their spouses and family whereas when females face depression they do not get adequate support from neither family nor their spouses, thus exposing them to escalating depressive symptoms which likely develops into full blown depression. The result of Jagannath and colleague's study (as cited above) which sought to understand depression in African women attending a state hospital, revealed that indeed more women present with depression than men. They also found that, although there was no pronounced difference between the mean ages of both the genders, the age of onset for depression in women was nevertheless earlier compared to men. Further, the authors maintained that the findings from their study revealed that a considerable number of patients presented with Major Depressive Disorders (MDD). They argue that such results should be an alert and an indication of the higher prevalence of psychopathology

which, in retrospect, may not be too much of a surprise given the poor socioeconomic conditions, violence directed to women, domestic abuse and other pathogenic conditions that many South African families are exposed to and live under (Jagannath et al, 2011).

In trying to understand why females were more predisposed to depression as compared to males, Rosenfield (1980) wrote an intriguing paper that reviewed some of the earlier theories that sought to explain why women were/are disproportionately predisposed to mental illness as compared to men. She wrote that that generally, much of the earlier argument focused on whether the female sex role is more stressful than the male sex role, thus making females more prone to mental illnesses. Although her argument might be deemed outdated in light of the more recent research which has been done on the etiology of depression particularly among women, it nonetheless lays a foundation for understanding the predisposing factors of depression among women. Rosenfield suggests that women have a greater predisposition to depression because of the way they have been socialized – they are expected to conform and must endure and accept the power and status differences between males and females. She mentions that sex role theorists assert that the way females are expected to express aggression predisposes women rather than men to depressive reactions. She states that expression of anger and hostility is perceived as inappropriate for women, thus they are likely to turn inwards the anger in the form of self-critical attitudes which she states is a process that characterizes depressive reactions, rather than externalize feelings of anger and conflict.

In South Africa, particularly, with the emergence of the democratic dispensation, there has been an incremental move towards equality between males and females, which in theory might disprove most of the early sex roles theories; however, the pervasive question is whether or not such equality has been reached in reality. It is, however, an undeniable fact that the vast majority of women are still subject to traditional sex roles, not just in South Africa but in almost all developing countries which makes such theories applicable still at this modern age. Brown (2000) and colleagues have also cited other factors such as economic constraints, lack of resource and marital problems as salient in the development of depression among women. Noel-Hoeksema and Kieta (2003) also mention that there is overwhelming evidence that women's position in society which is characterized by reduced power and status compared to men contributes to their heightened risk of developing depression.

2.2 HIV/AIDS, Stigma and Mental Health

Benton (2008) indicates that HIV continues to be public health problem. Doyle, Kahn and Hosang (2010) also indicate that the estimated number of people who were living with HIV worldwide during the year 2007 was 33.2 million with more than 2.5 million new infections and 2.1 million deaths per annum. Cook (2006) writes that Sub-Saharan Africa has been disproportionately affected by HIV/AIDS compared to other parts of the world. The 2011 Global Report by the WHO, UNAIDS and UNICEF also put forth that Sub-Saharan Africa continues to bears the heavy burden of HIV. It points out that although the number of new infections has decreased, the number of people living with HIV still remains extremely high. The report highlighted that in the year 2009 the number of people living with HIV in Sub-Saharan Africa reached a staggering 22.5 million. Antelman et al. (2007) lament about the fact that more than 60 per cent of the world's population infected with HIV resides in Sub-Saharan Africa. They further mention that more than 70 per cent of all deaths in this region are attributable to HIV/AIDS. Better still, statistics obtained from the 2011 global report indicated that Southern Africa remains the most unduly affected by the epidemic with a total of 11.3 million people living with HIV in 2009. The 2011 Global Report further points out that the HIV epidemic in South Africa remains the highest globally with figures being estimated at 5.6 million (WHO,UNAIDS and UNICEF, 2011).More recently, the midyear population statics from statistics South Africa for 2014 and 2015 indicate that the total number of PLWHA in South Africa increased from an estimated 4 million in 2002 to 5.51 million in 2014 and 6.19 in 2015.This illustrates that although the mortality rates have decreased as a result of access to ART which has increased the survival time of PLWHA (see Shisana, Rehle, Simbayi, Zuma and Jooste, 2012), prevalence rates are still on the rise. Antelman (2007) and colleagues further write that women are disproportionately affected by the HIV disease, representing an astounding 59 per cent of the total of people living with HIV in the Sub-Saharan region. Glynn, Carael and Auvert (2001) add that it has been observed that in numerous areas in this region, the prevalence of HIV in women tends to be particularly high, especially during the first few years of sexual activity, compared to men.

The picture becomes quite complicated when depression is co-morbid with HIV/AIDS. A number of authors have written about the factors that predispose HIV positive individuals to depression, namely stigma and discrimination and poor social support. The association between HIV/AIDS and stigma and discrimination is well known hence the acknowledgement that most people living with HIV/AIDS will undoubtedly experience some

form of discrimination upon disclosing their health status. (Cloete, Simbayi and Kalichman, 2008; Monjok, Smesny and Essien, 2009; Green, 1995; Steward, Herek and Ramakrishna, 2008).

HIV/AIDS related stigma has been defined prominently as a social process where people living with HIV/AIDS are degraded because of their medical characteristics or on the basis of the undesirable attributes which they are said to possess. (Derlega, Winstead and Brockington, 2010; Parkera and Aggleton, 2002 and Steward et al, 2008). Goffman (1963) in Parkera and Aggleton (2002), perceived stigma as a social processes that discredits, devalue and/or or belittle an individual. In their study, Simbayi, Kalichman and Strebel (2007) found that experiences of discrimination as well as internalized stigma were common among PLWHA in Cape Town. HIV/AIDS related stigma and discrimination has further been linked to compromised mental health. Brandt (2009) writes that both stigma and discrimination have been strongly associated with poor mental health. She continues to argue that stigma has been allied with elevated depressive symptoms as well as poor quality of life. Freeman et al. (2007) has also demonstrated that individuals who have experienced discrimination and isolation as a result of their HIV status were more likely to develop mental disorders, especially depression. Briongos-Figuero, Bachiller-Luque and Palacios-Martín, (2011) further writes that most problems associated with HIV/AIDS are frequently due to possible rejection by family members as well as stigma and discrimination. Thus, as a result, a significant number of these individuals usually demonstrate greater psychopathological disturbances compared to the general population.

With regard to social support, Schuster (2012) and colleagues, drawing on the work of Joiner (1999) write that there exists a reciprocal relationship between depression and HIV in that depression likely leads to poor social relations and poor social support in person with HIV; conversely, poor social support in persons with HIV is likely to lead to depression. With regard to the latter, one also has to consider the impact of negative thoughts that people with HIV might harbor about their illness and what it means to be HIV positive. Beck's cognitive triad speaks about the negative thoughts about the self, the world/environment and of the future (Beck, 2011). People with HIV may develop 'purely' internal negative thoughts about themselves; some of those negative thoughts may be influenced by what is said by others around them. Negative thoughts appear as one of the criteria for depression in the DSM-5 (APA, 2013); however, it may also be argued that constant and rigid negatives thoughts about the self may also predispose one to developing depression. Cognitive processes do not

preclude coping strategies employed by PLWHA in dealing with their condition. Gore-Felton et al. (2006), in addition to focusing on the physical outcomes associated with depression also looked at the quality of life of the affected individuals. They were able to illustrate through their research that depression adversely impacts on the quality of life of people living with HIV. More specifically their research focused on the coping strategies used by PLWHA. They found that depression was influenced by coping strategies and that HIV positive individuals exhibited a greater use of maladaptive coping strategies. They mention that according to the cognitive behavioral theories, maladaptive cognitive strategies makes one susceptible to depression, thus, maladaptive coping mechanisms such as avoidance makes one more prone to depression, which subsequently compromises quality of life. The authors thus suggest that it is of importance to screen HIV-positive patients for depression and to devise psychological interventions that focus on decreasing the patient's maladaptive coping strategies.

2.3 HIV/AIDS and Depression

Occurring on its own, depression entails a significant challenge to the general health system of any given country; matters become exacerbated when it co-occurs with other chronic conditions such as HIV/AIDS. Indeed, the relationship between HIV and depression has been well documented. Cruess, Petitto and Leserman (2003) mention that over the past 20 years there has been mounting evidence that depression and other mood disorders are commonly observed in people living with HIV/AIDS. Olisah, Baiyewu and Sheikh (2010) argue that HIV infection can lead to neuropsychiatric syndromes and thus, health professionals need to be cognizant of this possibility when assessing new patients and when monitoring changes in patients whom they treat. They further argue that depression is the most commonly observed disorder among people living with HIV/AIDS and that the prevalence rate of depression in this group ranges from 22 to 32 per cent which is approximately 3 to 5 times higher than that in the non-clinical population (Olishah, Baiyewu and Sheikh, 2010). Jin (2006) and Lawler et al. (2011) also add that PLWHA are at most risk for neuropsychiatric co-morbidity especially with depression. Jagannath et al. (2011) further report that psychiatric illnesses are more common in PLWHA compared to the general public. Cruess et al. (2003) state that in a study of 222 HIV positive patients presenting to an inner-city medical clinic in United State of America (USA), 52% scored above an established screening threshold for psychiatric distress, including elevated depression scores. Another study by Bing and colleagues cited by Cruess et. al. (2003) examined a sample of 2,864 adults receiving treatment for HIV in the

United States in 1996. They reported that almost 50 per cent of the participants screened positive for a psychiatric disorder, and that more than a quarter screened positive for major depression during the previous year. Moreover, in a review of research on HIV and mental health in Africa, Brandt (2009) indicates that there are disproportionately high levels of mental illness in people living with HIV. She further mentions that a number of psychiatric disorders have been associated with HIV, but among those, depression appears to be most common. Petersen, Hancock and Bhana (2013) also indicate that CMDs are the most frequently observed disorders in PLWHA, with depression having the highest prevalence. Further, Petersen and colleagues state that concern over the rising co-morbidity of mental disorders with other non-communicable and communicable diseases; particularly in people living with HIV/AIDS has served to raise the public health priority of mental disorders in South Africa. They further argue that co-morbidity of CMD with HIV/AIDS is of pressing concern to the South African Department of Health as it threatens to undermine the success of the country's anti- retroviral therapy (ART) programme.

Furthermore a number of writers have written about the high prevalence of mental disorders among females living with HIV/AIDS. Briongos-Figueroet et al. (2011) note that the depression prevalence among HIV positive people varies between 4 per cent and 30 per cent and affect women more frequently. Benton (2008) further reports that the high prevalence rates of depression among women suggest that women may be particularly vulnerable to the onset of depression during a physical illness compared to men. They further mention that depression is the most frequently occurring mental condition in HIV positive persons. Gore-Felton et al. (2006) documents that among HIV positive women, the prevalence of depression is two folds higher compared to their male counterparts. Leserman (2008) reported that the findings from the Women Interagency HIV Study (WIHS) that was conducted in the United States, California revealed that those with depressive symptoms were more likely to die from HIV in comparison to those who exhibited little or no depressive symptoms. The author then asserted that the mental health consequences of women diagnosed with HIV are of particular importance because the elevated psychological distress may take a toll on the individual, compromising their quality of life. Ramien (2006) and colleagues also provides an account of the impact of depression on the general wellbeing of women living with HIV. They suggest that depression has a momentous effect on the morbidity and mortality rates of women living with HIV/AIDS. They write that chronic depressive symptoms closely tie with disease progression, lowered CD 4 cell count and higher baseline viral load. With the latter in mind,

they mention that HIV positive women, who also happen to suffer from chronic depression, have mortality rates that are two times higher compared those with little or no depressive symptoms.

For the purpose of this dissertation, the two negative health related outcomes resulting from depression among HIV positive individuals that have been well documented and which will be discussed are disease progression and poor adherence to treatment.

2.4 Disease progression

According to Benton (2006), depression has been largely associated with negative outcomes for PLWHA including rapid disease progression which escalates the mortality rates among this group. Jagannath (2011) and colleagues state that depression impairs the immune functioning which in turn influences the individual's behavior and subsequently alter the course of the HIV infection. Gore-Felton et al. (2006) argue that mounting evidence points to the strong association between depression and HIV progression. They cite a number of studies which yield evidence that HIV positive individuals who suffer from chronic depression are more likely to progress quickly to AIDS and die early compared to those without depressive symptomatology.

Antleman and colleagues (2007) carried out a study to assess whether depression symptoms increase the risk of HIV disease progression and mortality among women. They found that depressive symptoms among women living with HIV were significantly associated with a heightened risk of disease progression. Their conclusion was that depression the single most significant predictor of HIV disease progression and mortality. Viewing the relationship between HIV and depression from a biomedical lens, Leserman (2003) suggests that HIV affects biological systems that overlap with those affected by depression and stress.

Biologically, systems affected by HIV and depression overlap, thus it is to be expected that chronic depression will influence the progression of the HIV disease. There is a growing body of literature pointing to the harmful impacts of stress and depression on cellular immunity particularly those aspects of the immune system that are most vulnerable thus worsening the course of HIV disease progression and other chronic life threatening diseases such as cancer (Leserman, 2003).

2.5 Depression and poor treatment adherence

According to Nakimuli-Mpungu et al. (2012) some Sub-Saharan countries, through the aid of donors and international organizations, have been able to establish ART programmes with the aim of reducing HIV/AIDS related mortality. The authors mention that the success of such programmes hinges on optimal adherence to treatment. Although a number of factors, such as socio-demographic, socioeconomic and gender among others (Nakimuli-Mpungu et al., 2012) have been found to play a role in treatment non-adherence, clinical depression by far remains one of the primary factors that play the most crucial and fatal role (Lawler et al., 2011; Gonzalez et al. 2011; Wagner et al. 2012). Olisah, Baiyewu and Sheikh (2010) mention that research suggests that depression in people living with HIV/AIDS may be associated with reduced adherence to ART medication. Amebir et al. (2008) in Olisah, Baiyewu and Sheikh (2010) reports that a study in Ethiopia found that patients who were not depressed were two times more likely to adhere to their ART treatment as opposed to those who were suffering from depression. Schuster, Manna and Bornovalova (2012) also reiterate that depression potentially lowers compliance with HIV treatment which compromises the optimal effect of the treatment. The authors continue to write that poor adherence results in health complications and medication resistant strains which lead to early death. The authors cite a study by Perry and Karasic which revealed that poor compliance with the HAART treatment results in a 2.5 fold increase in risk of death. Other authors (Sherr, Clucas and Harding, 2011; Wagner et al. 2012; Antelman et al. 2007; Remien et al. 2006; Benton, 2006; Lawler et al. 2011) also hold that depression plays a critical role in treatment non adherence among PLWHA.

Nakimuli-Mpungu (2012) and colleagues further indicate that in Sub-Saharan Africa, poor adherence entails not just poor outcomes but also virus resistance to first line treatment regimens. In their study, the authors uncovered that there is an association between depression symptoms and ART adherence. They further argued that HIV positive individuals who screened positive for significant depressive symptoms were significantly less likely to be adherent to their ART treatment compared to those individuals who did not screen positive to depressive symptomatology. Petersen et al. (2013) also indicate that CMDs increase risk for poor anti-retroviral treatment (ART) adherence. They mention that a review of 23 studies in Sub-Saharan Africa has revealed that good adherence is 55 per cent less likely in HIV-positive patients with depressive symptoms than those without. Such findings then reinforce the fact that HIV-positive individuals with co-morbid depression face the likelihood of poor

HIV treatment outcomes in the absence of mental health services to help them manage better the depression (Nkimuli-Mpaungu et al., 2012).

Gonzalez et al. (2011) indicates that good adherence to ART continues to be a pressing challenge. They mention that poor adherence is associated with an elevated risk of treatment failure and viral resistance. It is fair then, to assert that poor compliance with treatment compromises the health related outcomes of the individual which inevitably leads to disease progression and elevated rates of mortality. Thus, Gonzalez and colleague's advise that it is crucial that modifiable factors that are associated with poor treatment adherence be identified and interventions to address them be developed accordingly. These authors further suggest that depressive symptoms such as loss of interest, feelings of worthlessness and suicide ideation upset the self-management activities of the individual which are essential for the optimal effectiveness of HIV treatment. In simple terms, feelings of helplessness and loss of meaning in life experienced by depressed persons makes it difficult for them to initiate or be compliant with taking their treatment since they perceive no value in their existence. When patients are non-compliant, there is the possibility that they may develop viral resistance. From what has been said, it seems fitting to assert that depression seems to be defeating the effectiveness of ART treatment. In reference to the latter, Schuster and colleagues (2012) and Leserman (2008) maintain that although the ART era has been characterized by a decrease in the prevalence of opportunistic infections, immunological progression of HIV/AIDS still exists, with depression seemingly playing a crucial role.

2.6 Mental Health Services in Africa and South Africa

Sareceno and Saxena (2002) commented that an estimated 450 million people suffer from mental health related problems and that mental disorders account for a substantial proportion of the disease disability burden, yet mental health resources, particularly in low to middle-income countries (LMICs) remain scant. Burns (2011) puts forth that despite the alarming prevalence of mental disorders, services for people with mental illness and disability are almost universally inadequate and this situation is even worse in LMIC. Furthermore, he states that while progress in general health promotion and prevention is evident, the same cannot be said for mental health. Indeed, Petersen et al. (2013) points out that there is a large treatment gap for mental disorders (up to 90 per cent) in low and middle income countries (LMIC) and that in South Africa, an upper middle-income country, the treatment gap is 75 per cent for common mental disorders. Knapp et al. (2006) mentions that mental health

problems entail adverse consequences for quality of life and contributes to economic burden as well as sub-optimal functioning at the individual and national level thus maintaining the pattern of poverty especially in LMIC. Petersen (2010) also indicates that poor mental health hinders the development of people as well as the development of entire societies, thus keeping people locked in the cycle of poverty. Like Saerceno and Saxena (2002), Knapp and colleagues (2006) mention that despite the burden posed by mental problems, mental health resources in many countries remain scarce. Similarly, Prince et al. (2007) in their document entitled '*No health without mental health*', highlights that despite the new insights about the challenges posed by neuropsychiatric conditions on the quality of life, mental health continues to remain a low priority in most LMIC. They argue that most developing countries tend to place priority on the control of infectious diseases, reproductive health, as well as maternal and child health. In fact Saxena et al. (2007) mentioned that in Africa and Southern Asia, most countries spend less than 1 per cent of their health budget on mental health services. Burns (2011) adds that globally, mental health receives a ridiculously small proportion of health budgets and mental health services are mostly funded from general health budgets where they are awarded low priority, this being typically the case in LMIC countries who are also confronted by the challenge of dealing other major health problems such as HIV/AIDS. Alem (2000) also indicates that mental health services are profoundly inadequate in Africa. He laments about the problems inherent in centralized mental health care, mainly the fact that these services are largely inaccessible to the vast population that resides mostly in rural areas. At the root of the latter is inadequate funding for the decentralization of mental health services.

Knapp et al. (2006) in their paper titled '*Economic barriers to better mental health practice and policy*' provide rich information pertaining to the many barriers to mental health care, especially in LMIC. They argue that in these countries, there are not enough available resources at the right time and place allocated to meet the needs of the population. By way of example, they indicate that Ethiopia, a country badly hit by HIV/AIDS, has only one mental health hospital with only 390 beds and a small number of psychiatric nurses who are expected to provide mental health services to a population of over 55 million. Fox, Blank, and Rovnyak (2001) adds that poor roads and long distances to mental health facilities are two commonly cited barriers to seeking health for rural populations. Generally the problem does not reside in the individual's failure to seek health care services, rather the problem is

embedded in the large structural processes that make it difficult for people in rural areas to seek and efficiently receive health and mental health services.

South Africa's Mental Health Care Act No. 17 of 2002 is comprehensive and aims, *inter alia* "To provide for the care, treatment and rehabilitation of persons who are mentally ill; to set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and administration of the property of mentally ill persons; and to provide for matters connected therewith" (Government Gazette, 2002, p.2). The first section of the act is central to the tailoring and delivery of mental health services for the wider population. Article 6 1 (a) further states that health establishments need to provide any person in need of mental health care, treatment and rehabilitation with such services within the professional scope of such practice; and (b) that such health establishments need to refer such persons to appropriate mental health care levels for the latter services should the need arise (Government Gazette, 2002). Although very impressive on paper, the implementation of this act within the current South African context remains questionable, especially whether health establishments such as primary health clinics or districts hospitals effectively render such services and whether such services are rendered to the entire population remains a critical issue.

Burn (2011) states that despite South Africa's progressive mental health legislation, a number of barriers to accessing mental health care continue to exist, which result in: (i) psychiatric hospitals falling apart and thus unfit for human use; (ii) chronic shortages of mental health personnel; and (iii) an inability to develop important tertiary level psychiatric services. He argues that it is unfortunate that the state of affairs remains somewhat the same in spite of the constituted commitments to the restructuring of mental health care. It is a reality in South Africa and in many other African countries that the provision of mental health services remains a challenge. This is not to say that there are no advances in roll out of mental health services in South Africa. Although not widespread and widely felt; there are nevertheless some advances.

According to Lund (2010) and colleagues, within the South African context, there has been a growing recognition that mental health is a pressing public concern in need of attention. However, they mention that like in other LMICs, mental health services in South Africa remain grossly inadequate. Petersen, Bhana and Campbell-Hall (2009) published a

compelling paper that tied in the progressive history of mental health care in South Africa. They argued that during the reign of apartheid, mental health services were largely characterized by institutional care and psychopharmacological treatment. However with the advent of the new democratic dispensation in 1994, massive restructuring of the dispensation of health care took place which included deinstitutionalization, even though the focus was still on psychopharmacological management of patients with chronic mental disorders at Primary Health Care (PHC) levels. The latter inevitably excluded access to care for Common Mental Disorders (CMD) such as anxiety and depression. Swartz (1998) cited in Ngcobo and Pillay (2008) also noted that hospital services seem to be utilized primarily for more serious psychiatric problems, especially in black communities, while CMDs, although equally debilitating, especially when they occur with other somatic diseases (e.g. depression and HIV/AIDS), remain largely undetected and untreated. Petersen et al. (2009) revealed that decentralization and integrated PHC remains focused on emergency management and referral to secondary/tertiary care of patients presenting with severe mental disorders. They highlight that at the PHC clinic level, nurses sampled indicated that they do not have the time to identify and manage patients with CMDs, and even if they were able to identify such patients, they would encounter difficulties finding someone to refer them to. According to Ngcobo and Pillay (2008), the high prevalence of MDD among their participants indicate the actual high levels of psychopathology in society which highlights the severe lack of psychological services for the community, especially at primary care level.

Lund et al. (2010) flagged that evidence points to the fact that a significantly small proportion of individuals with CMDs receive mental health care. Their research revealed shocking statistics pertaining to the available mental health professionals per 100 000 population in all provinces in South Africa. The findings revealed that in the Eastern Cape there were only 0.1 psychiatrist, 0.2 psychologist and 0.3 social workers available for a 100 000 population. In Limpopo there were 0.1 psychiatrists, 0.1 psychologists and 0.1 social workers available to service a 100 000 population. Other provinces that were understaffed with mental health professionals included the North West, Northern Cape, Mpumalanga and KwaZulu Natal.

Burns (2011) indicates that in South Africa, not enough precedence is awarded to mental health by provincial health departments. He argues that previously there was no national mental health plan, and at a provincial level, only one of the nine provinces had a specified mental health plan. He further indicates that there were no funds set aside for mental health services either at national or provincial level hence the funding of mental health services from

general health budgets where they inevitably ended up at the bottom of a pile of pressing needs when money was being allocated. Burns cites research done in the province of KwaZulu Natal which uncovered a gross disproportion in the allocation of funds to psychiatric facilities. The research revealed that the budget increase for psychiatric hospitals was significantly lower than that of general hospitals, clearly illustrating a pattern of unfair treatment between psychiatric and general hospitals. Furthermore, the findings illustrated that four of the six psychiatric hospitals that were surveyed experienced a definite year-to-year decrease in budget allocations during a 5-year period; while during the same period none of the general hospitals experienced a decrease in the funds allocated to them. In a very compelling paper published in the Equal Rights Review Journal, Burns (2011, p. 106) passionately states that:

The gap that exists between the burden of mental illness and disability and the relative lack of mental health resources in South Africa is a human rights issue. The state has an obligation to provide services for the health needs of its people; and it is clear that services for those with mental illness and disability are woefully inadequate and, for many people, inaccessible in that nation. South Africa is by no means the only country characterized by a mental health gap – indeed most countries fall short of meeting the mental health needs of their citizens. However, South Africa is a nation that has publically declared its commitment to upholding the rights of the mentally ill and disabled in enacting one of the most progressive pieces of mental health legislation in the world. In making these commitments, the government of South Africa has affirmed its belief that all members of the society have a fundamental constitutional right to care.

Although Burns' sentiments still capture the plight of many South Africans, considerable advances have been made with regard to the implementation of sound mental health policy in South Africa. Stein (2014) indicates that in May 2013 a crucial step was taken when the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013 - 2020, that committed all United Nations member states to take specified actions to help reach the targets that were stipulated collaboratively by all the stakeholders. He further states, that a further important step forwards was taken in July 2013 when the National Health Council adopted the Mental Health Policy Framework (MHPF) and Strategic Plan 2013 - 2020 for South Africa. A document released by the South African Department of Health (2013) includes the mission, vision and objectives of The National Mental Health Policy Framework

and Strategic Plan 2013-2020. Essentially this policy framework aims to improve the mental health of all South Africans by the year 2020. Some of the important objectives include scaling up decentralized integrated primary mental health services; raising public awareness about mental health and to fight stigma and discrimination associated with mental illness; to promoting the mental health of the South African population, through collaboration between the Department of Health and other sectors; empowering local communities, especially mental health service users to participate in the promotion of mental wellness and recovery within their community and ensuring that the planning and provision of mental health services is evidence-based. Stein (2014) indicates that this initiative calls for celebration and congratulation as it marks the culmination of a great deal of work by many committed individuals, it addresses a significant gap in public health, and it offers hope for the many South Africans suffering from mental illness. Although it is still early days, there is optimism that this new Mental Health Policy Framework will better the lives of mental health service users, and will contribute in the effective rollout of mental health services in South Africa.

2.7 Proposed pathways for the effective provision of mental health services

In response to the many deficiencies evident in the delivery of mental health care in many developing countries, Lund et al. (2012) advocated for an integration of mental health into primary health care as means of narrowing the treatment gap in LMICs (which is now one of the objectives of the newly adopted Mental Health Policy Framework in South Africa). The authors argued that such integration would potentially and most likely set a platform for more holistic health care, increase accessibility to mental health services, provide opportunities of reducing stigma associated with receiving separate health care and reduce costs of accessing mental health care. Further, in response to the co-morbidity of depression and HIV/AIDS, Freeman (2012) and colleagues published a paper that called for an integrated mental health care for HIV/AIDS in South Africa. In their paper they highlight some of the factors that necessitate such integration. Firstly they identify the mental health consequences of HIV infection. These include cognitive impairments, and dementia due viral infection of the brain, anxiety and depression due to the impact of HIV/AIDS on the person's life, drug and alcohol use as well social difficulties faced by PLWHA as a result of stigma and discrimination. The second issue they look at is whether the provision of mental health services and interventions (as a result of the integrated mental health care initiative) will improve treatment outcomes for PLWHA. The authors argue that the provision of mental health care will likely result in

positive treatment outcomes such as slow disease progression and compliance with treatment regimens as a result of the effective management of depression which has been implicated in disease progression and poor treatment adherence. They also add that in addition to the treatment of specific mental disorders such as depression; several behavioral interventions may also contribute to good adherence such as motivational interviewing, Cognitive Behavioral Therapy (CBT) and group supportive therapy.

Task shifting has also been advocated for by a number of researchers as a possible viable and efficacious option to increase access to the delivery of mental health (Petersen, Lund and Stein, 2011; Rahman et al, 2008; Chibanda, Mesu and Kajawu, 2011). It entails the participation of non-specialists in the provision of psychopharmacological and psychosocial treatments under the supervision of trained mental health specialists (Saraceno et al, 2007 in Petersen, Bhana and Baillie, 2012). McInnis and Merajver (2011) also define task shifting as a “rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health care workers with shorter training and fewer qualifications in order to make efficient use of available human resources for health” (p.168). A report on skills mix in low income countries states that “in many developing countries, the skills of limited yet expensive professionals are not well matched to the local profile of health needs” (Fulton, Scheffler and Sparke, 2011, p.1). This report continues to state that when professional skills are not matched to the country’s local health care needs, the health care services become less accessible. The latter is all too familiar in many African countries. South Africa is no exception - where the vast majority of the population is unable to access mental health services. Petersen et al. (2012), citing Saraceno et al. (2007) indicate that in poorly resourced contexts, where there is a gross shortage of mental health specialists, a stepped care approach that incorporates task shifting has been suggested as the most feasible option for the scaling up of mental health services for common mental disorders.

Petersen et al. (2011a) discussed some important points regarding task shifting: they argue that there is ample evidence from LMICs that community-based workers can be trained to successfully render specific interventions in order to reduce the identified gaps in the provision of mental health services particularly for CMDs such as depression. A feasibility study by Petersen, Bhana and Baillie (2011c) that engaged trained Community Mental Health Workers (CMHWs) in rural South Africa in the provision of group IPT (Interpersonal Therapy) for PHC clinic patients with moderate to severe depressive symptoms yielded

promising results. More evidence to corroborate the effectiveness of task shifting comes from Petersen et al. (2011a) who highlighted some of the success stories of task shifting. They cite the Ugandan study that trained community based workers to effectively deliver group interpersonal therapy to people with depression which was later adapted to the South African context which currently bears promising results. Chatterjee et al. (2009) in Petersen et al. (2011b) used trained community based facilitators in India to successfully run a community based rehabilitation programme. A pilot study by Chibanda and colleagues (2011) revealed the potential effectiveness of task shifting. In their study they trained health care workers to deliver a problem solving approach based intervention through the 'Friendship Bench' which is placed in the clinic grounds. The intervention package included supervision and stepped care. They also mentioned that the intervention appeared to be acceptable to the community, but most importantly, the preliminary findings of their study showed that the intervention was efficacious in reducing psychological morbidity. Rahman et al. (2008) in Petersen et al. (2011b) developed an intervention based on principles of CBT, which could be delivered by ordinary village-based primary health workers to help depressed mothers in Pakistan. The results of their study indicated that the intervention was effective in relieving depression symptoms and in bettering the QOL of the participants. Petersen et al. (2011c) further write that the review of evidence based interventions for the six pressing conditions namely alcohol use disorders, attention-deficit hyperactivity disorder (ADHD), dementia, depression, epilepsy and schizophrenia in low to middle income countries suggests that brief screening tools administered by non-specialists for depression and substance use disorders have a good diagnostic validity and clinical utility. This attests to the effectiveness of delegating some tasks to less qualified health care workers in order to provide more services to the population, although training and continuous supervision is needed.

2.8 HIV/AIDS and depression co-morbidity and health related outcomes

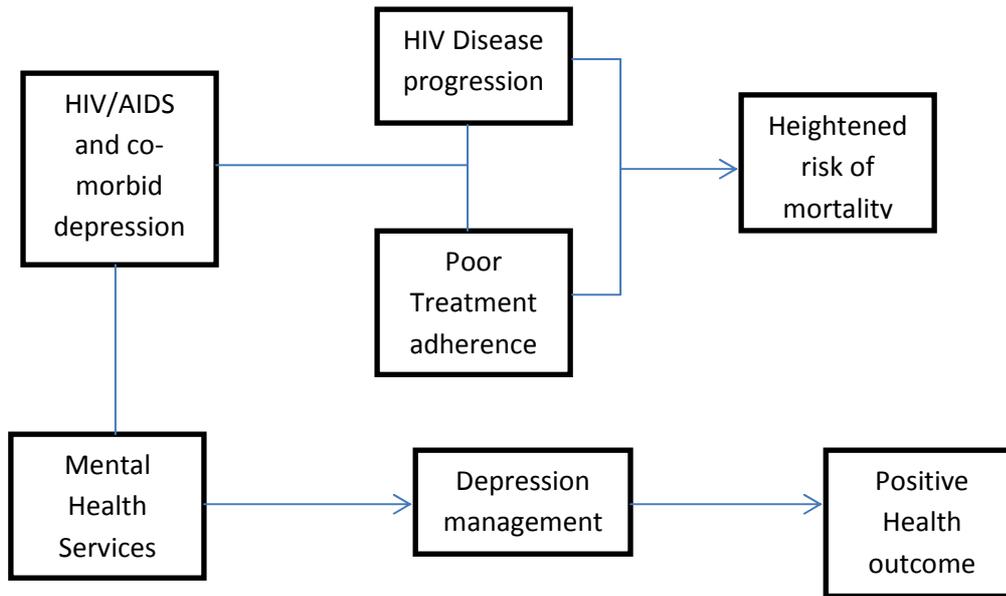


Figure 1

Depression co-morbid with HIV/AIDS contributes to poor treatment adherence and or HIV progression which either way leads to an elevated risk of early death. However if mental health services are introduced, they have the potential to act as a buffer between these two conditions and heightened risk of mortality by helping the individual effectively manage the depressive symptoms which could lead to improved compliance with the treatment regimens and to positive health outcomes and extended life years.

2.9 Theoretical framework: Kleinman’s Explanatory Model of Illness

The field of medicine and psychiatry in particular has seen a somewhat promising shift from the purely biomedical model of understanding disease and illness towards models that are culture sensitive and that incorporate patient’s perspectives and beliefs about their own illness. The latter is supported by an increase in studies that seek to explore patient’s subjective beliefs and interpretations of their illness (for an example see Sorsdahl, Flisher and Wilson, 2010; Lynch and Medin, 2010 and Buus, Johannessen and Stage, 2012). These models have come to be known as explanatory models and Lynch and Medin (2010) define explanatory models or framework as “sets of assumptions about what type of causes and causal principles are relevant for a particular phenomenon” (p. 2). These sets of assumptions

are normally held by patients and shared by their families, friends and the community that they are part of. They tap into the causes, manifestation and treatment of a particular illness as understood in that culture. Lynch and Medin differentiate between those models that attribute illness to physical causes and those that attribute it to psycho-social causes. They write that physical explanatory models attribute illness to a disruption in bodily or physiological process while the psycho-social models attribute illness to thoughts and emotions that usually stem from social or socioeconomic factors. As examples, they draw on the ethnographic work of Murdock (1980) and Evans-Prichard (1937) conducted in 139 non industrialized countries. These authors agree that most people attributed the etiology of their illnesses to psycho-social factors. For an example, the Zandes of Central Africa believed illness to be caused by jealousy or angry neighbors through the use of witchcraft, in Latin American societies; the Susto is a common cause of illness in which shocking emotional situations causes one's soul to leave one's body.

Further, Kleinman (1980) defines explanatory models as “notions about an episode of illness and its treatment that are employed by all those engaged in the clinical process” (p.105). According to Kleinman, explanatory models are conceptual frameworks that guide the understanding of how illness manifests, is interpreted and subsequently treated. Kleinman further notes that explanatory models assist in providing explanations for different dimensions of sickness, namely the etiology or cause of the sickness, timing and the nature of the manifestation of symptoms, pathophysiology and course of the sickness as well as treatment issues. Essentially, the explanatory model approach recognizes the importance of meaning attached to a particular illness within a specific cultural or perhaps religious context. Succinctly put, explanatory models give meaning to the person's experience of illness (Buss, Johannessen and Stage, 2012).

An important but often overlooked distinction that Kleinman, Eisenberg and Good (1978) highlight which is pertinent for treatment is between the terms ‘disease’ and ‘illness’. Kleinman and his colleagues write that “disease in the Western medical paradigm is a malfunctioning or maladaptation of the biological and psychophysiological processes in the individual whereas illness represents personal, interpersonal and cultural reactions to diseases or discomfort” (p. 252). They further argue that illness is in most part shaped by culture in a sense that how people perceive, experience and cope with disease is contingent on their explanation of sickness and the meaning making systems they employ. The way people communicate their sickness to others, the narratives that they use, the manner and nature in

which their symptoms manifest, their help or health seeking behaviors and their ability to adhere to their treatment regimens are thus all influenced by culture.

The explanatory model perspective is fitting for the current study as the study aims to explore service user's perceptions of depression and mental health services, that is, their idiosyncratic or culturally shared perceptions of depression and its treatment. Such exploration is warranted as it will share light on the probability of the utilization of psychological services in the treatment of depression. As mentioned earlier, Kleinman defines explanatory models as notions about illness and treatment as shared by all those engaged in the clinical process. This means that the use of explanatory models is not the sole forte of the patients or health services users, but health or mental health service providers also hold their own explanatory models to help them understand the clinical presentation of the patient. More often than not, patient's explanatory models about their illness are usually dismissed in favor of the biomedical model; however this risks alienating the patient and rendering their beliefs and culture less important. Moreover, Sorsdahl et al. (2010) note that previous research involving South African psychiatric patients has viewed the 'black experience' as being homogenous throughout the continent irrespective of differences in culture, religion, language etc. They further argue that previously it was believed that Africans have an innate desire to consult traditional healers instead of Western medical services. However the important factor that was grossly overlooked they argue, is that Western medical services have been largely unavailable to most African populations and to the vast South Africans in different parts of the country. The latter is pertinent to the health sector in South Africa which is marked by a shortage in the delivery of health care services, particularly mental health care.

However currently there is strong advocacy for the integration of cultural practices and beliefs about illness to the public health system (Sorsdahl et al. 2010). The latter stems from the realization that the provision of appropriate and effective health and mental health services require the participation of both service providers and service users. Such participation entails a dialogue about service user's cultural beliefs pertaining to different sicknesses and a negotiation about different choices of treatment.

The majority of the local studies done under the rubric of the explanatory model of illness perspective have been mostly attracted to focusing on people's perceptions about causes of either psychotic or bizarre illnesses, however less studies have focused on people's perceptions about common mental disorders such as depression. Sorsdahl et al. (2010)

conducted a study in Mpumalanga, South Africa that explored traditional healer's explanatory models about mental disorders and their treatment practices. In addition to focusing on psychotic disorders, their study also looked at CMDs (depression and anxiety). Their findings revealed that the majority of healers in their studies attributed depression to psychological reasons such as stress or thinking too much and a fairly substantial number felt that individuals suffering from depression required treatment from a Western doctor. However for individuals suffering from psychotic disorders such as schizophrenia, the majority of the healers attributed causes either to bewitchment or ancestral calling and strongly recommended treatment from a traditional healer (Sorsdahl et al. (2010). These findings have an important implication especially with the treatment of CMDs such as depression, in that, if traditional healers believe that medical treatment is effective for depression, they are more likely to refer their patients whom they believe to suffer from depression to hospitals. However the latter hinges on the traditional healer's knowledge about depression and it is in this case that involvement of traditional healers in the promotion of mental health is most essential.

Following the discussion in the preceding sections, it is clear that more still needs to be done with regard to the rolling out of mental health services in LMICs including South Africa. The success of the latter partly rests on the involvement of mental health services users at the grass root level and a consideration of their experiences and understanding of mental illness. Thus this study aims to explore how PLWHA with co-morbid depression perceive depression and mental health services.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Aim and objectives of the study

The principal aim of the current study is to explore how PLWHA with co-morbid depression perceive depression and mental health services. The secondary aim of the study is to learn about their perceptions of acceptable interventions which may inform the development of appropriate interventions. As noted above, there is a dearth of literature in this area, thus this study is designed to:

- ✚ Collect and accumulate useful information or data
- ✚ Increase knowledge and understanding of the issue being investigated
- ✚ And potentially contribute to the development and implementation of needed interventions

The objectives and research questions

- ✚ To understand PLWHA's knowledge about depression, its causes and its consequences
- ✚ To understand PLWHA's perceptions of the barriers that prevent them from seeking mental health services
- ✚ To understand PLWHA's knowledge about available mental health services
- ✚ To explore PLWHA's perceptions about acceptable interventions for depression
- ✚ To understand perceptions of the impact of depression on PLWHA's adherence to ART medication and;
- ✚ To explore PLWHA's perceptions of the role that should be played by nurses and Community Health Workers (CHWs) in the provision of mental health services for people living with depression.

3.2 Research design

A significant number of people who live in LMICs are yet to benefit from adequate mental health services. The involvement of different stakeholders' particularly mental health service users at a grass root level is an integral part of the development and implementation of mental health services. However, more often than not, the implementation or provision of services intended for community use take a top down approach that entails less or no consultation with stakeholders at grass root level. Although the current study is not for policy purposes, it may nonetheless influence the development of mental health services and the nature in which they are rolled out. To encourage optimal community engagement, the current study was built on the qualitative paradigm (Family Health International, 2002). The motivation behind the use of this approach is that qualitative research seeks to understand a problem or issue being researched from the perspective of the participants. In this case the research aims to look at the perceptions of PLWHA. Qualitative research provides the 'human' side of the issue, that is, it takes into account people's subjective experiences, their values, their opinions and their emotions about a particular issue. This yields in-depth and rich information (Family Health International, 2005).

Kleinman's explanatory model of illness framed the interview questions (Kleinman, 1980). The use of this framework allowed the research participants to share their understanding of mental disorders such as depression. Moreover it allowed participants to voice out their choice of treatment.

3.3 Study site

The study site was a primary health care facility in the North West (NW) Province of South Africa serving peri-urban population. North West province is home to 8.2% of South Africa's population and it is marked by high unemployment and poverty rates as well as disproportionate distribution of income between the various population groups. Further, the NW has an ante-natal HIV prevalence of 29.6% (Petersen et al, 2013). The PHC facility in which the study was done in provides HIV/AIDS and TB related treatment; it also provides HIV Counseling and Testing (HCT) as well as ART services for PLWHA.

3.4 Sample demographics

A total of 15 participants were interviewed in this study. All the participants were health service users living with HIV who also met the criteria for depression. All the participants

were female and their ages ranged from 25 – 53 years. The participant's educational level ranged between grade 2 and grade 11. Six out of the 15 participants reported having some form of employment during the time of the interview, and 11 of the participants reported that they receive some form of government grant. All the participants were black African females, fourteen were seTswana speakers and one was a Xhosa speaker. The participants came from a context characterized by poverty and high unemployment rates. Most of the participants who lived with their partners were not married but cohabited with them. An additional inclusion criteria that was used is detailed below:

- Women who are not pregnant and/or had not delivered a baby in the last 6 months
- PLWHA (on treatment or not)
- 18 years or older
- Do not need urgent medical attention
- Screen positive for depression with a cut off of 8 or more on the SRQ- 20
- Competent to participate in the interview, i.e., do not have difficulty with hearing, speaking, or cognition

3.5 Recruitment description and Sampling strategy

The sampling strategy that informed the recruitment of the participants was volunteer purposive sampling. The purposive technique selects cases with a specific purpose in mind. The recruitment of participants for this study was influenced by the purpose of the study: service users who are both HIV positive and depressed were selected because they were going to provide relevant and rich information that would ultimately serve the aim and objectives of the study. Potential participants were recruited from the waiting room over four randomly chosen days. The field workers then explained the purpose of the study to the potential participants while they were attending the HIV clinic before formally inviting them to participate in the study. Following informed consent procedures, the potential participants were interviewed in a private space at the clinic. A first stage screening instrument for common mental disorders, the Self Reporting Questionnaire – 20 (SRQ-20), previously validated in South Africa was administered to the potential participants (Bhagwanjee et al, 1998 and Rumble et al, 1996 in Petersen et al, 2013), using a cut- off point of 8 or above. The

second stage diagnostic screen used was the depression module of the Structured Clinical Interview for DSMIV Diagnosis (SCID I) for major depressive disorder (MDD). This instrument has also previously been used in South Africa and was administered by seTswana speaking psychologists who had received training and supervision in the use of this assessment tool (Petersen et al, 2013).

3.6 Data Collection

It needs to be declared here that the author of this dissertation was not involved in the data collection phase. The in-depth semi-structured individual interviews were conducted with the service users by field workers who are clinical psychologists. The interviews were conducted in private and comfortable rooms at the clinic in order to protect the identity of the participants and ensure confidentiality. Generally, the interviews enquired about the participant's knowledge about depression; the signs and symptoms they associated with depression; causes of their depression; how long have they been depressed; how the depression affect their lives; whether the depression affected their ART regimen or not; their health seeking behaviors; their knowledge and experiences of mental health services; their perceptions of how mental health services may be made accessible and the form of interventions they would be comfortable with. Because this study was a sub-study of a bigger study, the interviews also tapped into a broad range of issues which are beyond the scope of this dissertation.

Following informed consent procedures, the individual interviews were recorded in seTswana using a digital audio recorder with the permission of participants. The interviews were later transcribed and translated to English with back-translation checks done by a bilingual English-seTswana speaker. In-depth interviewing is a type of interview which is normally used by qualitative researchers to obtain rich data in order to achieve a full understanding of the participants' point of view or situation. This type of interview involves asking informants open-ended questions, and probing where necessary in order to elicit useful data (Berry, 1999). There is much value in the use of in-depth interviews such as facilitating the establishment rapport. In a one-on-one setting, the interviewer can dedicate full attention to each research participant, listen actively and probe as needed. In this kind of interview, each participant has enough time and opportunity to share their feelings, perspectives, and attitudes with the researcher. In addition to eliciting elaborate and exhaustive knowledge about the

individual's lived experiences, in-depth interviewing can also produce very precise and specific responses (Berry, 1999).

3.7 Data analysis: The Framework Approach

The framework approach was used in the analysis of the obtained data. Smith and Firth (2011) write that the framework approach was developed in the 1980s by social policy researchers as a method to aid in the management and analysis of qualitative data in applied policy research. It later then gained popularity as a method for analyzing qualitative data derived from healthcare research. Ritchie and Lewis (2003), in Smith and Firth (2011, p.53), mention that "the framework approach allows the researcher to explore data in depth while at the same time maintaining a transparent audit trail, which enhances the rigor of the analytical processes and the credibility of the findings". Smith and Firth mention that the framework approach shares some similarities with thematic analysis; however the framework approach emphasizes transparency in data analysis and the links between the stages of the analysis. The central focus of the analytical process of this approach is a series of related stages that allows the researcher to move back and forth across the data until a logical and meaningful account emerges (Ritchie and Lewis, 2003 in Smith and Firth, 2011).

Stages of the analysis process

The stages reviewed here were originally developed by Ritchie and Spencer (1994) and then cited by Srivastava and Thomson (2009). The data analysis process followed these steps.

1. Familiarization

Familiarization refers to the process whereby the researcher becomes acquainted with the transcripts of the collected data. The researcher becomes immersed in the data by listening to audiotapes or reading the transcripts. Because the data for this study was already transcribed and translated, the researcher familiarized himself with the data by reading the full interview transcript; this provided the researcher with the depth of information regarding the interview process and the line of questioning and responding. This process enabled the researcher to become aware of key ideas and recurrent themes.

2. Identifying a thematic framework

This is a stage where the researcher recognizes emerging themes or issues in the data set. At this stage the researcher allowed the data to dictate the themes and issues. Although some a-priori themes can be used in analysis of the data using a framework approach, the researcher focused more on the themes that emerge from the data.

3. Indexing

Indexing is a process of identifying portions or sections of the data that match-up to a particular theme. This process is applied to all the collected textual data such as transcripts of interviews. At this stage the researcher started drawing out the emerging themes and for convenience purposes used the tabular indexing system to sort out the themes and the corresponding data.

4. Charting

In this stage, the specific data pieces that were organized (indexed) in the previous stage were then arranged in charts of themes. This process entailed the extraction of data from the original transcript and placing it in charts that consist of the headings and sub-headings that were drawn during the thematic framework. Ritchie and Spencer in Smith and Firth (2011) write that what is important to remember here is that although the pieces of data are extracted from their original context, the data can still be easily traced to the case it came from.

5. Mapping and interpretation

This stage involves the analysis of the key characteristics as laid out in the charts. Essentially, in this step the researcher started making sense of the data as organized through the previous steps by making associations between the data. The complete interpretation of the data emerged from this step.

3.8 Reliability and Validity

Jopper (2000) in Golafshani (2003) defines reliability as the “extent to which results are consistent over time and are an accurate representation of the total population under study” (p.598). He further indicates that “validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are” (p.599). With regard to qualitative research, Golafshani indicates that there has been a lot of contention

among qualitative researchers about the applicability of validity and reliability in qualitative research. However, there has also been a realization of the need for qualifying checks for qualitative research hence the development of concepts of validity in qualitative research such as quality, rigor and trustworthiness (Golafshani, 2003).

Shenton (2004) wrote about the four criteria proposed by Guba namely credibility, transferability, dependability and confirmability. With regard to credibility, the current research met some of the provisions that aim to promote the confidence that the study has accurately captured the phenomenon under scrutiny. The researcher in the current study employed well established research methods such as a line of questioning (semi-structured one on one interviews), method of data analysis (the framework approach) and the use of validated instruments for the recruitment of participants (SRQ-20 and SCID-I). Tactics of encouraging honesty from participants such as the informed consent, informing participants about the voluntary nature of their participation and ensuring them that their refusal to participate will not bear any negative consequences for them.

Independence status of the researchers was emphasized and anonymity was ensured. Iterative questioning was also used by the interviews such as the use of probes in order to elicit detailed data. The background, qualifications and experiences of the investigators and field workers (psychologists and seasoned researchers) also ensured the credibility of the study.

During the writing up of this dissertation, past research findings in the same area were also examined to ascertain the degree of congruence between the current and past findings. On transferability, Shenton (2004) indicates that researchers have often had contrasting views with regard to the transferability of qualitative research findings. He points out that some naturalistic inquires believe that even conventional generalizability is never completely possible as all the observations are defined by the specific contexts in which they occur. Still others believe that although every case is unique, it is still an example within a broader group and thus transferability should not be quickly rejected although it should be approached with great caution. Although there was no intention of transferring the results from the current study to other contexts, some provisions were made to assist the reader in making a transfer. Sufficient contextual information about the fieldwork site was provided in the methodology section such as a brief background information about the research location as well as demographic information about the participants. Sufficient description of the phenomenon

under study was also provided to allow for proper understanding and comparison with similar phenomenon in other situations.

On dependability, Stenton (2004) argues that there is a close tie between credibility and dependability and that in practice, the demonstration of the former goes some distance in ensuring the latter. He argues that in order to address the issue of dependability, the processes in the study should be reported in sufficient details so as to enable future researchers to repeat the research. He further argues that with regard to dependability, the research design itself (this being a qualitative investigation) serves as a prototype model. On confirmability, Stanton indicates that it is the qualitative researchers' equivalent of objectivity. He indicates that care should be taken to ensure that the results reflect the experiences and ideas of the informants rather than the preferences of the researcher. He indicates that the methods employed in the research as well as the reasons for using them be mentioned in the report (in this report, methods such as sampling, data collection, data analysis were outlined and reasons for their choice delineated). Limitations of the study qualitative approach as well as limitations of the research findings were reported.

3.9 Ethical considerations

Since this study included individuals who are HIV positive and who suffer from depression, great care was taken especially in the questions asked and in the manner they were asked. Pertaining to questioning, there was a risk that even innocent questions could have disturbed the individuals, thus the interviewers applied great caution with regard to the questions asked. Because of the nature of the research focus, anonymity and confidentiality of the participants and the information obtained was ensured and pseudonyms were used to protect the identity of the participants. The participants were acknowledged of their right to withdraw from the research at any stage should they feel uncomfortable to continue and they were fully informed that their withdrawal from the study would in no way compromise the health care they received from the clinic. The researchers obtained the participants' informed consent in writing. The researchers also ensured that the participants did not just consent to participate, but that their consent was truly informed and this was done by communicating information about the study including risks and benefits and voluntary nature of participation in the language and manner that the individual participant fully comprehended. The participant's permission was also obtained before audio recording the interviews.

Considering the focus of this study, psychological support services were made available by the researchers in case the participants needed them at any stage of the research. The researchers ensured that benefits for all the participants were maximized while risks were minimized or at best eliminated.

Ethical approval for the study was sought and obtained from the Ethics Committee from the University of KwaZulu Natal while the permission to carry out the study was obtained from the relevant gatekeepers from the Primary Health Clinic where the study was conducted in.

CHAPTER 4: FINDINGS

4.1 Introduction of themes

Eight themes emerged from the study. The first theme was the participants' understanding of depression, that is, their knowledge about depression. Further a subtheme was developed from this theme, that of the signs and symptoms that indicated to the participants that they are depressed. The second theme was the causes of depression, that is, what the participants attributed the genesis of their depression to. The third theme was about the participant's subjective experiences of depression, primarily how depression has affected their personal as well as social lives. Theme 4 was the Barriers to seeking mental health services – the factors or circumstances that prevented them from seeking help for the depression. Theme 5 was the knowledge about available mental health services. This theme was further divided into four subthemes: (i) available services – that is, what kind of services are already in place (if there are any), (ii) knowledge about services provided by the department of health, (iii) utilization of mental health services – that is, should they be readily available to the community, would they be utilized by the community, and (iv) ensuring accessibility – the things that can be done to ensure that the community members have access to the mental health services. Theme 6 constituted of the type of interventions or forms of intervening that were perceived by the participants as acceptable. Theme seven alludes to the impact that depression has on the participant's ART medication regimen – whether it affects their adherence to ART medication or not. The last theme, theme 8 looks at the expectations that participants have about the nurses and Community Health Workers (CHW) – that is, the role that nurses and CHW are expected to play in the rolling out of mental health services.

4.2 Understanding depression

4.2.1 *Stress and embodies symptoms*

Most of the participants understood depression as stress that is caused by too much thinking or as painful nerves and somatic complaints. Many participants did not readily label or describe their suffering as emotional in nature but reported numerous somatic complaints.

Participant 1: *When someone has depression...It is stress...I can say it stress when it has grown...for me, I experienced nerves first*

Somatic complaints were further emphasized.

Participant 2: *I feel that my body is tired...I am tired in the nerves here; I feel that it is painful here at the back not knowing what it is. My mind...I...I...I think my mind...I feel tired in the mind.*

One individual did not seem to even link her condition to stress; she said

Participant 3: *I think it is nerves. I have heard for the first time that I have stress- I do not know what stress is.*

4.2.2 Emotional and relational symptoms

The participants reported a variety of symptoms which they felt indicated that they are depressed. The most common sign was that of crying or having an urge to cry most of the time:

Participant 4: *I have this urge to cry...I cry most of the time, for short and long periods ...I then realize that by talking to someone I get relief from the sadness it goes away.*

Another participant also shared a somehow similar experience indicating that:

Participant 5: *There is a time when I want to be alone. There is a time when I cry, not knowing why I am crying- I do cry... yes. Sometimes I ask myself why this thing happening to me.*

Another sign or behavior that stood out for a few participants is that of being angry and short tempered most of the time. However none of the participants reported that at any point did their anger oscillated to violence.

Participant 6: *I am short tempered, and I am not patient. I am not patient; I felt like walking away from people, getting away from the people that I live with.*

At times when the participants were hostile, atleast verbally, the hostility was usually directed at the children.

Participant 7: *I was short-tempered all the time fighting with children at home. That is when I realized that I had depression.*

One participant spoke about feeling suicidal and how she even had devised the plan to commit the suicide, to her that was the marker of depression.

Participant 8: *I noticed that I have depression because (coughing) I used to think about killing myself by ingesting poison and I did not want to listen to anybody's advice.*

4.3 Causes of depression

Two common themes emerged as the participants spoke about what they perceived to be the cause of their depression, namely their current socioeconomic situations (mainly the lack of employment which results in a lack of money for sustenance) and domestic problems with their partners.

4.3.1 Lack of money

The majority of the participants felt that their depression was primarily caused by and further perpetuated by lack of money to support themselves and their families, primarily their children. One of the participants spoke about how the lack of money is hindering her from bettering her house,

Participant 9: *I have been telling this sister that I think a lot about money because I want to make a stoep, I want to repair my back shack but I don't have money. I want to plaster my house inside and paint it- I can't, I don't have money and I get stressed. While I am still thinking of all this we run out of food and I would not know where to get money.*

Furthermore, for participant 11, it was not just only financing repairs for her house, but it was also about sustenance; ensuring that there is food on the table. Without money, she was not able to provide that nourishment for herself and her family.

Participant 11 also spoke bitterly about not being able to provide sustenance for her child and how that makes her feel.

Participant 11: *Hunger is making my life difficult and my child does not have what's required at school. The money issue causes me stress. When I think about that child, when he/she comes back from school he/she must eat and there is no food; that is when I feel more pain.*

For these women, the lack of money is a troubling issue. Most of them are single parents and are faced with the duty of single handedly raising sometimes more than one child while being unemployed. For almost all of them their partners are not in the picture and do not render any financial support. All of them are HIV positive and are on ART medication and they are required to have food in their stomachs before taking their medication.

Thus most of these women rely on the child grant for their children which is not nearly enough to sustain them. One of the participants commented that:

Participant 12: *I earn a grant of R160-00 for the young child. There is no food and sometimes I am depressed because they attend school...when they get to school sometimes they leave without eating. Sometime they cry telling me they are hungry and I don't have anything to give them and there is no one helping me that is why I got depressed.*

4.3.2 Domestic disputes

Another theme that frequently appeared was that of domestic dispute with partners. Most of the participants discussed that they attributed their depression to the fathers of their children for having affairs or not caring for or supporting them.

Participant 4: *My depression was actually caused by the father of my children (partner), by having an affair.*

On the other hand, another participant's experience did not only end with the affair, she also experienced physical assaults from her partner. She says

Participant 1: *I knew he had too many girlfriends but he would not admit that. If I start to talk about this thing he would like to beat me up and say a man is allowed to have affairs. So I stopped the marriage by the time I saw he was abusing me. However before I knew it, I was HIV positive.*

Other participants spoke about not getting any support from their partners

Participant 13: *He left me with the kids and he does not work and he doesn't support us, he doesn't care.*

For participant 8 even turning to her family after being abandoned by her partner did not do her any good.

Participant 8: *He does not care. He is no longer interested in me and yet he is the one who got me in this situation. When he does not care for me, I try to talk to my family and they 'throw their hands at me' (a sign of not willing to help), and I have to figure things out on my own.*

For these participants, it is not only being unable able to put bread on the table for themselves and their children that is troubling emotionally. Their unfaithful and sometimes unsupportive partners do not lessen the burden but in fact add to it or better yet, impose another burden all together.

4.4 Impact of depression

Numerous researchers have written extensively about the impact of depression on the functioning of the individual. The impact of depression permeates the different levels of the individual, from personal to social and to occupational. The participants in this study spoke about the impact of depression in the domestic, social and occupational spheres of their lives.

4.4.1 Domestic impact

A number of participants felt that they are no longer able to complete or sometimes even initiate their domestic chores. Participant 9 indicated that she could no longer do her chores as well as she used to:

Participant 9: *I realized I no longer clean like I used to before and I no longer have energy. If I wanted to wash the windows both inside and outside, I would only get to clean the inside and I would clean the outside the following day.*

Participant 7 spoke about how she has lost interest on the things that she previously enjoyed doing.

Participant 7: *I no longer liked cooking. I grew up as a person who liked to cook, liked doing chores, doing laundry, cleaning, but now I no longer like doing it.*

4.4.2 Social impact

For some participants, their relationships with their neighbors and others around them became strained due to the changes in their mood.

Participant 14: *My neighbors and my depression- sometimes when they talked to me I would not speak to them in a kind manner and now most of them are reluctant to speak to me.*

Participant 9 indicated that due to her lack of energy and frequent feelings of fatigue, she no longer visited people close to her and they started saying that she thinks she is better than other people. One participant even indicated that she had lost her friends because of the depression,

Participant 12 *I used to have friends before, but now I do not have friends.*

For almost all the participants, their struggle with depression has resulted in the loss of possible support networks – the neighbors and even friends. One would argue that in the event of a thinning web of social support and absence of mental health services, depression will thrive and it seems it is certainly thriving among these women.

4.4.3 Occupational impact

Further, other participants felt that their depressive state restricted their occupational opportunities. For participant 4, she felt that she would not be able to work because she was sickly,

Participant 4: *I cannot go and work or look for work, because I am just sitting and I am sick all the time.*

Participant 15 felt that no employer would take her in because of her constant fatigue

Participant 15: *I am always tired. Which employer will I work for when I am always so tired?*

For these women, this seems to be a vicious cycle. Most of them attributed their depression to financial constraints, in turn the depression makes them too sickly or too tired or not even motivated to look for a job. This means the financial constraints will persist and so will the depression if it remains untreated, which is the case with these participants.

4.5 Barriers to seeking mental health services

The participants reported on a number of factors that served as barriers to seeking mental health services namely a lack of knowledge about their condition, lack of knowledge about where to go, and in the event where they knew to go, a lack of transportation money.

4.5.1 Lack of knowledge about depression

A number of participants indicated that they did not seek help for their condition because they did not know what they were suffering from.

Participant 6: *The problem with many of us is that we do not know what depression is and I have just heard that I have depression. I do not know if you could advertise. Maybe you could advertise through posters in shops, clinics, halls and offices.*

Another participant added that sometimes people do not access mental health services (even if they are available) not because they choose not to use them, but because they are unaware that they need them and that they can benefit from them. She says:

Participant 9: *People do not use mental health services because they do not understand depression. This is the first time I have heard of it.*

4.5.2 Lack of knowledge about where to access help

Further to that, some participants indicated that in the event where they knew that they were depressed, they did not know where to go for help, or in which door to knock on to be assisted.

Participant 5: *There was nowhere I could go. I did not know where to go - I cannot (access service) because I do not have the knowledge. You need to have knowledge of a thing to be able to receive that thing.*

4.5.3 Lack of transport money

The other scenario that surfaced was when some participants knew that they were depressed and they believed that they can benefit from mental health services and had an idea with regard to where they might access these services. This scenario seems nearly perfect, but the barrier to accessing these services was the lack of money for transport.

Participant 5: *Some people stay very far from the clinic and getting transport means money.*

Another participant commented that it is difficult to save up money for transport because most people rely on the government grant money:

Participant 1: *Our problem in township is that too many people live on grant...the money for grants only last for two days...and next week there is no money.*

Most of the women who participated in this study in fact cited money for transport as a major barrier for them.

4.6 Knowledge about available mental health services

This theme closely ties to one of the previous themes that looked at the knowledge or perhaps the lack of knowledge about available services. However this theme is much broader and has been divided into four subthemes. Perhaps it is warranted here to briefly delineate the four subthemes. This principal theme (knowledge about available mental health services) is comprised of (i) whether there are services available now, as per the knowledge of the participants, (ii) knowledge about the mental health services rendered by the department of health, (iii) the utilization of those services should they be made readily available – that is according to the participants, will the community members of health service users utilize mental health service should they have access to them and finally, (iv) and how can these services (if available) be made accessible to all those who need them.

4.6.1 Knowledge about currently available services

Almost all of the participants in this study indicated that they had no knowledge about currently available mental health services. A frequent theme among the participants was

about counseling and that they have never received any counseling for their depression. Participant 4 said *'I never come across someone offering counseling'*. Participant 9 even asked *'What is counseling'*. Further to that, one participant indicated that in addition to not having received counseling, the health professionals did not convey to her that she had depression, either because they were unable to diagnose or did not know how to communicate such information, she says

Participant 12: *I have not received counseling. They noticed that I was depressed when I tested for HIV. So I am sure that they did know...you know sometimes they do not...they do not tell you they only give you pills you will only see your file written depression. They won't tell you upfront.*

4.6.2 Knowledge about the mental health services rendered by the department of health

Already one is starting to get a picture that health service users, especially those who rely heavily on PHC (Primary Health Clinics) do not have much knowledge about mental health services that are tailored for their use and benefit. This subtheme further looked at the knowledge about mental health services rendered by the DoH (Department of Health) in general; these services may not necessarily be located at PHC, they may be in district or tertiary hospitals. Again in this theme, what surfaced was the gross lack of knowledge about any mental health services offered by DoH. The frequent responses that came up were "no I do not know". Participant 13 said *'No, I did not know anything about available services'*, participant 5 expressed dismay as she said *'Are they available? Which ones?'* Again, knowledge is the key here –most people like these participants are in the dark, because not enough knowledge is disseminated to the communities, to the rural health service users. One participant rightly said:

Participant 12: *How a can a person come to you when they do not know anything? So you must give her/ him knowledge so that she/he may come to you.*

4.6.3 Utilization of mental health services

One might argue that the availability of mental health services is not as important as their utilization by the intended recipients. Any health services will have neither impact nor value if people do not make use of them; in fact, it will be a waste of state resources to put into

place undesired services. However all the participants in this study felt that if mental health services were made accessible to them and their community, they would without doubt be utilized since people are in need of them.

Participant 10: *A of lot people will use them- they will welcome them. There are many of us with problems. People will come in large numbers.*

Better still, another participant felt that it would be even better if these services are brought to the places where people can easily access them; she felt that that might increase their utilization as people will not have barriers such as distance and travelling costs. She says

Participant 1: *If they can be brought here at the clinic, too many people can be able to live a good life, or at the churches or at the schools because there are school learners who have depression.*

Other participants also felt that these services would be widely used, one participant mentioned that her painful experience with depression would encourage her to make use of these services, she said

Participant 3: *Yes, they will use them. I would use them because I know how painful this disease is.*

Better still; one participant mentioned that these services can indeed save lives!

Participant 14: *It can save lives because some depressed people can make decisions such as wanting to kill themselves, another can injure people in many ways. I believe that had I suppressed it I could have done something dangerous.*

4.6.4 Ensuring accessibility

Having mental health services put into place and readily available for a segment of a population is a start, but not the end goal. For these services to be fully effective and their benefits to be enjoyed by many, they have to be accessible to the greater public. Participants in this study shared their views on how mental health services can be made easily accessible in their communities. Participants mentioned different ideas but the three that came up frequently were starting up a movement (committee or organization) that will advocate for

the treatment of depression, proper advertisement of mental health services and having a specialized space and/or time for depression patients.

Some of the participants felt that launching a committee or an organization where relevant stakeholders (those suffering from depression) can come together and talk about their problems and know each other and the number of individuals requiring treatment for depression might set the process of ensuring the accessibility of mental health services in motion.

Participant 13: *I think a committee should be formed and just like you came here, we should sit down together at the table and let the community talk about this issue share what we have and learn from one another.*

What is perhaps key in the above quote is having a round table to talk about the issue of depression and importantly sharing with each other what people have and what they know, perhaps sharing information about where to access help.

Other participants advocated for a ‘word of mouth’ advertisement as medium for disseminating information about available mental health services.

Participant 12: *We can bring ourselves together as people, who have received these services, when you have been helped you are able to tell another person where you were helped. There can be a group of people who have been helped that spreads the word and people will come.*

In addition to the word of mouth advertisement, one participant felt that old fashioned press advertisement can also do the trick. She felt that the clinics should also play a proactive role in advertising the services that the department of health offers.

Participant 1: *At the clinic maybe there should be a poster...telling people about depression that it is something like this...where you get the medication for it - that you will get it here at the clinic.*

Whichever way, what is important here for the participants is the sharing and dissemination of information. What is also advocated for is a forming of a ‘work group’ where this information will be shared and where people will be able to learn from each other.

Other participants felt that there should be a specialized day where all the depressed individuals can come in and be attended to separately.

Participant 3: *There should be a place- I have never heard of a place where people can take their problems. I think that just like people who come to the clinic here there must be a day that is given to us to come to the clinic to be able to explain our problems to be able to get help.*

These participants felt that that they might be better attended and perhaps listened to if they come in on a day that has been set aside just for people with depression.

Still other participants felt that a specialized space or venue altogether might be what is needed. However participants had different reasons for suggesting a designated location where people with depression can be attended to rather than a clinic. For an example, one participant felt that people do not want to go to the clinics because they are afraid of them.

Participant 7: *You know the way people are afraid of the clinic. When you talk about the clinic...people are afraid...they will sit you there the whole day. If there can be an open space or halls, put the tents, like I saw yesterday the tents...tents are being placed for people who want to test.*

For participant 7, it is 'slow' service delivery, the waiting that make people dislike going to the clinic or perhaps being afraid of going to the clinic.

One participant shared her sad experience that has made her develop an aversion for the clinics, she said

Participant 12: *I was blind at that time and a certain sister did not treat me well. I don't know if she was aware that I could not see or not. When another one came in she told her that I was doing such and such and they humiliated me and I had to humble myself even when I did not want to.*

As much as these experiences cause certain aversions to primary health facilities, they also act as a barrier to health seeking because people fear the humiliation. On the other hand, the other participants' reason for suggesting other locations was because of infrastructural

problems at the clinics. One participant felt that mobile clinics might effectively render services, she said

Participant 6: *Construction takes a long time and people are sick, people have problems so mobiles will be better to deliver services quickly.*

This view better resonates with the view of another participant who felt that mental health services should be delivered to the door steps of those who cannot manage to go to the clinics or hospitals.

Participant 15: *They should be visited in their homes, those who are in need and those who do not have money, the grandmothers, grandfathers and those who do not have people who can take them to the clinic.*

4.7 Acceptable forms of interventions

One of the objectives of this study was to enquire about participant's perceptions of acceptable interventions. A group focused intervention that took the spotlight in almost all of the interviews. For an example, Participant 3 felt that group therapy might be meaningful because it might help women or people with depression realize that they are not alone in their struggle.

Participant 3: *It will be meaningful because you will find that... you would think you are the only one only to find out you are not alone. You would be able to accept who you are quickly.*

Better still, another participant felt that it would be beneficial if people suffering from depression could have that safe space where they can come together and discuss their struggles with others who can better understand the hardship of being depressed, she remarked that:

Participant 14: *I think that people with depression can sit down together and talk about their problems because when you talk to somebody else you get healed; you can tell her/him things you are not able to tell other people - I think that we can be helped in a group.*

For these participants, the key is having people who will listen, perhaps people who potentially share the same experience and people who can perhaps better relate. For participant 6, support groups would mean more than just psychotherapy, they would also play an essential role in psychoeducation of those who know little or none at all about their condition. She commented that

Participant 6: *Support groups are useful in helping people and gathering those who do not know, who do not understand. I would be encouraged to join a support group by the fact that I can share my problems with them and we could also help others as a group.*

Participant 13 also remarked that:

Participant 13: *I would like to be helped with other people and not as an individual.*

Still, one participant felt that more traditional means of intervening would also suffice and would be equally acceptable:

Participant 4: *Some people will accept counseling and medication.*

Another participant felt that she would be more comfortable with a truly multidisciplinary team; she remarked that:

Participant 9: *It should have traditional doctors and medical doctors (team). I would like for it to be like that.*

Two participants also expressed still their unwavering confidence and trust on the nurses and felt that some people would be most comfortable in the hands of the nurses. For an example, one of the participants said:

Participant 3: *They can accept to be helped by nurses because nurses are knowledgeable about a lot things and a nurse can help you when you have a big dreadful problem but another person won't be able to do that.*

Even though participant 7 also advocated for support groups, she also felt that the presence of nurses in those support groups might add extra comfort for the group members; she remarked that:

Participant 7: *There must be nurses to listen when we build each other in a support group.*

4.8 Adherence to ART medication

Almost all the participants reported that the depression did not affect their adherence to ART medication; almost all of them reported adhering religiously to their medication, for an example, one participant stated that:

Participant 7: *I take the medication well at the stipulated time as I was instructed.*

All the other participants simply responded with a no when they were asked if the depression affected the way they take their ART medication. This finding is in stark contrast with some of the cited studies which have implicated depression as one of the major culprits in medication non adherence.

However a few other participants reported that they did not strictly adhere to their ART medication regimen and different reasons, other than the depression were cited. Two participants spoke about not having food to eat and thus being unable to take their medication because if you take them on an empty stomach it can cause problem, for an example, one of the participants said:

Participant 12: *I sometimes do not take them because you need to eat food. I have no food and they can be nasty when you take them on an empty stomach. You can even collapse.*

Still another participant reported that she failed to adhere to her medication regimen because of the side effects of the medication. She indicated that the medication used to drug her and make her feel sleepy and hence she was not able to carry out her house chores.

Participant 6: *To tell truth it is has been long since I have taken the medication. I was taking them properly... I took them for six months so but they used to drug me. I was always sleeping. The children were not going to school. They drugged me- I was always sleeping. I didn't bath, I could not cook, I could not clean ...I had to stop them.*

4.9 Expectations of nurses and CHW

The participants also expressed their expectations of the roles that nurses and Community Health Workers (CHW) should play as health service providers. What frequently came out was the expectation of both nurses and CHWs to provide counseling for those who need it. The provision of medication was also not left out; in fact, counseling and medication seemed to go hand in hand. For an example, one participant felt that:

Participant 15: *They can help by giving counseling and medication - And yes, with counseling but the nurses are for medication so; counseling is for community care workers.*

Participant 15 felt that the tasks can be distributed between the nurses and the CHWs; the nurses specializing in giving medication while the CHWs taking charge of counseling. Participant 9 also echoed the same sentiments and commented that CHW should be able to sit them down and listen to their problems, encouraging them and also providing them with psychoeducation while nurses should be there to examine them medically and give them medication. Further, one of the participants commented that nurses are expected to examine the patient thoroughly in order to properly ascertain their problem rather than just giving them pills and sending them off. She commented that:

Participant 1: *If you come with the problem, say that you have a headache, they must assess your problem properly, and they must not just give you pills and say get out and go.*

Still, one participant felt that health care providers, however, needed to be properly trained if they are to effectively carry out such tasks.

Participant 12: *Nurses will give counseling if they have been trained properly and they will not be able to give counseling if they have not been trained properly.*

Perhaps this teaches us that sometimes the best solution is not necessarily the most sophisticated nor specialized, but maybe the most simple and accessible.

CHAPTER 5: DISCUSSION OF RESULTS

5.1 Introductory remarks

In keeping with the evidence that there is a paucity of mental health services for people with CMDs as discussed in the literature review, almost all of the participants in the current study had never received psychotherapy to help them deal with depression, let alone pharmacotherapy although it is well documented that psychotherapy in conjunction with antidepressant medication is an effective treatment for Major Depressive Disorder (MDD) (Dua, Barbui and Clark, 2011). This can only mean that in most Primary Health Clinics (PHCs), where most people frequent, mental health services are largely unavailable. All of the participants in this study were unaware of any mental health services that are rendered by the Department of Health, whether in clinics or hospitals, clearly then enough has not been done to ensure the accessibility of whatever services are currently available. Burns (2010) clearly states that worldwide, mental health services receive an unreasonably small proportion of health budgets. Furthermore, Lund et al. (2010) flagged that current evidence points to the fact that a significantly small proportion of individuals with CMDs receive mental health care. Their research revealed shocking statistics where very few mental health specialists were available per 100 000 population in all provinces in South Africa. Unfortunately remote rural communities who are largely served by PHC facilities are the least well serviced.

The threat of CMDs to the health and wellbeing of people in the context marked by a shortage of mental health services to address this problem is further propagated by the HIV/AIDS pandemic. Numerous studies cited in the literature review of this dissertation show an undeniable interlink between depression and HIV (e.g. Petersen et al, 2013). Sub-Saharan Africa bears the excessive burden of HIV/AIDS (Cook, 2006 and WHO, UNAIDS and UNICEF, 2011). Together with chronically under-resourced mental health services, the future does not bode well. The current study was conducted within this context with the aim of understanding the perceptions of depression and mental health services by People Living With HIV/AIDS (PLWHA) with co-morbid depression. The secondary aim of the study was to understand their perceptions of acceptable interventions which may potentially inform the development of appropriate interventions.

The objectives of this study were:

- ✚ To understand PLWHA's knowledge about depression, its causes and its consequences
- ✚ To understand PLWHA's perceptions of the barriers that prevent them from seeking mental health services
- ✚ To understand PLWHA's knowledge about available mental health services
- ✚ To explore PLWHA's perceptions about acceptable interventions for depression
- ✚ To understand perceptions of the impact of depression on PLWHA's adherence to ART medication and;
- ✚ To explore PLWHA's perceptions of the role that should be played by nurses and Community Health Workers (CHWs) in the provision of mental health services for people living with depression.

The themes outlined below were derived from the above stated objectives of this study:

1. **Knowledge about depression** – this theme looked at the participant's understanding of what depression is and at the signs and symptoms they presented with.
2. **Causes of depression** – this theme focused on the experiences that the participants felt were a source or cause or even a perpetuating factor of their depression.
3. **Impact of depression** – this theme looked at how depression has affected the participant's daily lives.
4. **Barriers to seeking mental health services** – this theme examined the barriers or factors that have prevented the participants from seeking health services to manage their depression.
5. **Knowledge about available MHS** – this was perhaps a broad theme and looked at different things such as currently available services, MHS provided by the DoH, how to ensure accessibility to MHS and whether MHS will be utilized by community members should they be made available.
6. **Acceptable interventions** – this theme focused on the types of psychosocial interventions that the participants perceived to be appropriate and that would potentially be embraced by the community.

7. **Adherence to ART medication** – this theme looked at whether suffering from depression made the participants not to adhere to their ART medication or not.
8. **Expectations about nurses and CHWs** – this theme looked the roles that services users expected the nurses and CHWs to play in the rolling out of MHS.

5.2 Knowledge about depression

Most of the participants in the study understood depression to be stress. They believed that they were depressed because they were thinking too much. Although there is no single term or word for stress in many African languages, there are however phrases that convey the idea such as thinking too much or a troubled soul. This perception of depression as stress is in line with the explanatory model of the traditional healers in Sorsdahl et al. (2010) who attributed causes of depression to psychological factors such as stress. With depression, which is a medicalized and Western term, words and terms that refer to it are not easily available in many African languages. Mosotho, Louw and Calitz (2008) rightly point out that our emotions and feelings are usually shaped and expressed by our choice of words and the sentence that we construct. They further state that certain emotions or affective states are expressed more easily in some languages than in others. For example, the word “depressed” does not necessarily exist in the languages of some cultures, nonetheless, Mosotho and colleagues argue that the absence of this word in certain cultures, like many African cultures does not rule out the presence of this disorder in those cultures.

Moreover, the participants also spoke about depression as ‘painful nerves’. Ahmed and Bhugra (2007) and Mosotho et al. (2008) speak about ‘distress idioms’ or as Ahmed and Bhugra call it – ‘culturally patterned idioms of distress’. Ahmed and Bhugra (2007) define idioms of distress as linguistic and bodily styles of expressing and experiencing illness or simply as cultural ways of talking about distress. Different cultures speak and understand illnesses in different ways and they create a vocabulary to refer to those illnesses that is understood within that culture or across related cultures. The participants in this study used a mutually understood term (in their own culture), that of ‘painful nerves’ to refer to depression or stress. To an outsider, this term may be incomprehensible; however to the individuals who share this cultural understanding, it conveys a certain message. Ahmed and Bhugra also give examples some of these distress idioms that are used by different cultures to refer to depression, for an example, in Nigeria they use distress idioms such as ‘*Heat in the head*’ or

'Biting sensation all over the body', the Mexican-Americans use idioms such as *'Nervios'* which in English translates into *Nerves*; they also use *'brain ache'* to refer to depression. Ahmed and Bhugra also correctly point out that knowledge of these cultural idioms can facilitate the diagnosis of depression (while minimising the risk of misdiagnosis) and also help with establishing rapport.

Another important observation that is related to the preceding discussion of distress idioms is the prominent presentation of depression by the participants. Most of the participants reported first and foremost somatic complaints such as fatigue, body aches, back pain etc. Mosotho et al.(2007) argue that depression has different presentations in different cultures, especially in non-Western cultures. They write that there is general consensus among researchers that non-Western patients suffering from depression do not complain of a depressed mood and feelings of guilt to the same extent as patients in Western countries. Instead, they tend to complain of mostly somatic symptoms and seldom manifest suicidalbehaviour (although the current picture in South Africa is checked by suicidal ideation and attempts). In fact, previously, suicide was thought to be a foreign and rare practice among the black community, however recently, discoveries have been made about its extensiveness and perhaps commonness amongst the black populace. The commonness of suicide within the black community is not necessarily a recent phenomenon; it can be argued that it is a long standing practice which, over the years has been grossly underreported and covered due to cultural reasons. However with the changing time, more and more suicide attempts and even completed suicide has been observed among the black population (Niehaus, 2012).

The participant's understanding and perception of depression highlight the explanatory model that they use to make sense of their illness. Lynch and Medin (2006) argued that illness may either be attributed to physical or psycho-social causes and they write that psycho-social causes involve emotions and social factors while physical causes pertain to the disruption of bodily functions. Most participants attributed the causes of depression to psycho-social factors such as thinking too much and stress which essentially has a social and emotional component. Buss, Johanessen and Stage (2012) also report that participants in their study on explanatory models of depression and treatment adherence attributed their depression to psycho-social factors instead of biological factors. They argue that psychosocial explanations might dominate because they afford people the autonomy to take action in the management of their illness while biological causes many render them helpless. Further, the presentation or

manifestation of depressive symptoms among the participants in this study illustrated the idiosyncratic or culturally shared ways of experiencing certain sicknesses. Most of the participants presented with somatic complaints which may be appropriate or acceptable ways of 'being sick' in their culture. The latter is entrenched on the participant's explanatory model or in their meaning making system they use. Kleinman et al. (1978) argued that culture shapes the way people perceive, and experience illness, the manner in which they present symptoms and how they communicate their illness to others.

For some mental health practitioners, the somatic presentation of depression may make it difficult to accurately diagnose depression, especially in the black community where this kind of presentation is most common. This then may lead to individuals going undiagnosed thus not given appropriate medical attention and going on to suffer in silence. It is in such situations that mental health professionals are compelled to equip themselves with at least basic knowledge about the different explanatory models of illness relevant in the South African context. However, Mosotho et al. (2008) indicate that across different cultural and social settings, core symptoms of depression can certainly be found such as sadness, lack of joy, anxiety and tension, diminished energy and loss of interest. The participants of this current study also reported symptoms that are common to all cultures and settings such as irritability, being teary most of the time, sleep disturbances, loss of interest on things previously enjoyed and feeling sad. The DSM 5(Diagnostic Statistical Manual) lists symptoms of depression as "depressed mood, diminished interest or pleasure in activities, significant weight loss, and disturbance in sleep (insomnia or hyper-insomnia), agitation, fatigue and recurrent thoughts of death" among the others (APA, 2013, p.160-161). This illustrates that even though there might be variations in the presentation of depression across different cultures, most of the core and common symptoms are also almost always present, they just require some more digging before they can surface to view.

5.3 Causes of depression

The participants in this study cited poverty as a primary cause of their depression followed by domestic disputes with their partners. These women spoke about being confronted with the tasks of ensuring that there is food on the table for themselves and for their children and that their children have all the necessary school equipment. Most of the participants were single parents, caring for one or more children, unemployed and having no source of income except the child grant from the government. These participants reported being solely responsible for

their households; they have a duty to cook, clean, wash and care for their children, they are unemployed and thus cannot afford domestic help, thus it all sits on their shoulders. Even for those who live with their partners, as women, they are still expected to assume the roles that are set aside for women, primarily that of homemaking. Although life will not necessarily grind to a halt when these duties or chores are not carried out, it will certainly become very messy, thus against their fatigue, low energy and lack of interest or motivation, these women have to soldier on and do what they must. Thapa, Martinez and Clausen (2014) in their study that looked at depression among older adults in South Africa and Uganda found that unemployment appeared to be a significant determining/predisposing factor of depression in women both in Uganda and South Africa. Also a study conducted by Ngcobo and Pillay (2008) on African women presenting for psychological services in general hospital revealed that most of the depressed patients were unemployed and struggled to secure income to sustain their families. Ngcobo and Pillay further write that previous research conducted in the rural areas of South Africa revealed that socioeconomic statuses marked by unemployment and low income were associated with a heightened prevalence of depression.

This seems to resonate with the findings of this study where the participants came from a rural community where employment, especially for women is very scarce and where depression is evident. Moultrie and Kleintjes (2006) in their chapter entitled *Women's Mental Health in South Africa* write about this very pressing matter. They state that common life stressors and events that are commonly experienced by women extend beyond childbearing and reproductive events but also include unemployment and poverty as well as single parenthood, as evident from the findings of the current research. Moultrie and Kleintjes (2006) further indicate that women and especially black African women who live in rural areas (which is the home to the poorest South Africans) are disproportionately affected by poverty. They also mention that over representation of depressive and anxiety disorders in women is linked to the multiple social roles that women have to assume such as being breadwinners and homemakers within a context characterized by poverty.

In addition to their economic standing as a cause of depression, other participants spoke about their domestic problems, mainly with their partners. Some women were abandoned by their partners and received no financial or emotional support from them and thus were left to raise their children on their own. Some were troubled by their partners having affairs with other women and for one participant, it did not just stop at him having affairs, it also

escalated to physical abuse. For example, one of the participant's experiences of physical abuse illustrates an all too familiar narrative for most women in South Africa. Most women are subjected to abusive relationships with limited escape routes, most endure the beating and affairs and some of them end up contracting HIV because of their partner's infidelities. Most of these women remain locked in these dysfunctional relationships because of financial dependency as most are unemployed, some because of the pressures from society, from beliefs that a women need to endure all, even if it is to her detriment. Moultrie and Kleintjes (2006) comment on this issue and write that in a study done by Dewes et al. (2004) (in Moultrie and Kleinjie, 2006), they discovered that in a South African population-based sample, significant determinants of partner violence were poverty (low income), being black African or Coloured, low levels of education and cohabitation (as opposed to marriage). In the current study all these determinants are evident – poverty or low income, race (Black African) and cohabitation. With regard to the latter, most of the participants who lived with their partners were not married but cohabited with them.

It can be argued here that although depression as a disease has neurological bases, it is also very plausible and perhaps evident from these findings and other studies that have been cited that it also has very strong social roots. Patel et al. (2010) in their chapter entitled *Mental disorders: equity and social determinants* wrote about a myriad of social factors that play a critical role in the aetiology, perpetuation and maintenance of depression. They indicated that a review of the literature yielded compelling evidence regarding the role of socioeconomic position, and roles of gender inequality and education as determinants of depression. They further report that these findings indicate high levels of the unequal distribution of depression across individuals in different socioeconomic strata, with considerably elevated rates of depression among those with low socioeconomic statuses and in countries characterized by high income inequality. They also argue that differential exposure to risk factors for depression is frequently inversely related to social position with risk of exposure being greater among people in lower socioeconomic positions. Also Lund et al. (2010) in their systematic review study on poverty and common mental disorders in LMICs reported that the literature shows that there is a consistent association between CMDs and a range of poverty dimensions particularly in LMICs. What is clear here is that above and beyond other factors, socioeconomic related factors are strong determinants. The information from this current study also clearly suggests that social factors such as poverty together with partner

relational problems play an irrefutably critical role in the aetiology, perpetuation and maintenance of depression.

5.4 Impact of depression

For the participants in this study, the impact of depression was three-fold – domestic, social and occupational. Some participants reported not being able to carry out their domestic chores such as cleaning and cooking and for them, that inability to maintain their household caused even more frustration. It can be recalled that most of the women in the study are single parents and the burden of ensuring that their homes are well kept rests on their shoulders; even for those who cohabit with their male partners, because of the social roles assigned to males and females, they are still expected to be good housekeepers regardless of their somewhat deteriorating health condition. Others spoke about a diminished prospect of employment largely due to some of the symptoms of depression such as fatigue and lack of motivation.

Further the participants reported a deteriorating relationship between themselves and their neighbours and in some instance even friends. This they attributed to the symptoms of depression such as irritability, being withdrawn and wanting to spend time alone and not feeling like talking to other people and low mood. A thinning or diminished social support, can serve as a perpetuating factor for depression. Paranzella, Alloy and Whitehouse (2006) have argued that social support has been said to be both a risk factor for and the consequence of depression. This illustrates that poor or diminished social support can be a potential cause of depression; however in other instances it can be a consequence of depression as evident in the current study where participants reported a weakening of social relationships as a consequence or result of their depression. In a study by Prince, Patel and Saxena (1997) that looked at a relationship between depression and demographic variables, social support, and life events, the results revealed that risk factors for depression were loneliness and the number of social support deficits (SSDs). The more the number of social support deficits, the higher the risk of depression. Although their study only looked at SSD as a risk factor, it can be inferred that SSD as a consequence of depression also plays an important role in the perpetuation and even maintenance of depression provided that there are no interventions introduced.

It cannot be denied that depression; especially unmanaged depression has far-reaching and momentous impacts on the quality of life of those affected. Fried and Nesse (2014) report that about 60 per cent of individuals who meet criteria for Major Depressive Disorder (MDD) report severe impairment in functioning. They further mention that some impairments associated with depression are commonly greater than impairment caused by other common, chronic medical conditions such as diabetes, hypertension or heart attack. Additionally, they indicate that depression impairs functioning in various domains such as domestic, occupational and leisure. Papakostas et al. (2004) also indicates that MDD has been shown to account for a staggering 23 fold increase in social disability as well as 5 fold increase in short term work disability. They state that patients with MDD were found to score lower on physical and emotional functioning compared to those with other medical conditions. For the participants in this study, depression continues to cause significant impairments in their domestic, social and occupational functioning. Amidst of all that they have to face, from trying to make ends meet for their families and some having relationship problems, these impairments only serve to make the desperate situation dire. The participants spoke about strained and even severed relationships with neighbors and friends. Still others spoke about reduced occupational opportunities given not only the fact that employment is in itself rare, but also because they are either too sickly, too fatigued or lack the necessary drive to seek out any available employments.

5.5 Barriers to seeking mental health services

Factors such as gender, race, geographical location, attitudes, knowledge and socioeconomic status among the many have been said to play an important role in preventing people from seeking mental health services (Jackson et al, 2007, Bruwer, Sorsdahl and Harrison, 2011, Fox et al, 2001 and Gulliver, Griffiths and Christensen, 2010). Participants in the current study pointed out three critical factors that acted as barriers that prevented them from seeking mental health services, namely (i) lack of knowledge about depression, (ii) lack of knowledge about where to seek help and finally (iii) lack of money for transportation. With the first factor, participants felt that their lack of understanding of depression, not knowing what depression is and what it means to be depressed prevented them from seeking help; after all how can one seek help for something he/she does not understand. Bruwer et al. (2011) highlight that some people may not seek these services because of the lack of perceived need for treatment; in this case the lack of a perceived need might be only associated with not

knowing that their condition can be treated. Suffice to say, if people do not know what they are suffering from, then they cannot know what can ease their suffering and thus naturally will not seek appropriate help. What is important is not only the availability of mental health services, but also the knowledge not only about their existence but also about the different common mental disorders. As evident from the responses of some of the participants, even if there are mental health services put into place, if the community members do not know about them, they will not seek them, same, if they do not know their relevance in their lives, they will have no motivation nor need to access them. Thus people need to know whether they are depressed or not, and they can only know that if they know what depression is, which in this case most the participants were not aware that they themselves were depressed. Indeed Bruwer et al. (2011) rightfully point out that one of the factors that prevent people from seeking mental health services is low levels of mental health literacy. Jackson, Judd and Komita (2007) asked a rather important question of “so if an individual has little capacity to recognize symptoms, or has a negative view of the mental health problem, then are they unlikely to refer themselves to a mental health service if they develop a mental healthproblem”? (p. 147).

Furthermore, in the event where people do know what they are suffering from, they face a challenge of not knowing where to go to seek help for their problems as some of the participants in this study pointed out. Gulliver, Griffiths and Christensen (2010) indicate that one of the barriers is not having information regarding where to go in order to access help. Lack of money for transport is common, especially in rural communities, and this comes as no shock given that rural areas in South Africa are known for their high rates of unemployment (Moultrie and Kleinjies, 2006). Bruwer et al. (2011); Fox et al. (2001) and Gulliver, Griffiths and Christensen (2010) indicate that additional barriers to receiving adequate mental health care include structural factors such as lack of funding, the conviction that the disorder will get better on its own, the view that mental illness is a result of personal weakness, and the desire to deal with the problem via non-medical routes. Poverty, race and living in rural areas have all been associated with individuals failing to seek appropriate services help for mental health problems. Furthermore, poor roads and long distance as well as cost of care have also been identified as significant barriersto help-seeking for mental health care. As a case in point; for most rural communities, the nearest and perhaps accessible health facility is a clinic and more often than not, many specialized mental health services such as psychology and psychiatry are based in districts and tertiary hospitals which often are

remotely located from other rural communities. Thus in order to access these services, community members need to travel long distances and in most instances many are not able to afford the travelling costs. Taking into consideration the context in which the participants in this study are in, it is not hard to imagine that travelling expenses could be the least of their worries given that they have to put food on the table and clothe their children. In those circumstances, the motivation of saving even a little money for travelling becomes diminished, seeking mental health services from afar does not become a top priority. For these women and many others in similar situations, their best hopes are nearby primary health clinics to which they can travel to by foot.

5.6 Knowledge about available MHS

As indicated in the discussion on the previous theme, knowledge is key to the uptake of mental health services. What determines the value of a service that is designed to be used by people is its consumption by the populace; in other words, any service can be deemed useful if people are actually using it. What stands between services, or in this case, mental health services and their utilization by the greater public, among many other things (some discussed in previous passages), is knowledge about these services. Do people know what they are used for and do they know where they can be accessed? This theme (knowledge about MHS) focuses on that. It is also worth mentioning that it was perhaps a broad theme with a number of subthemes underneath it. The first subtheme looked at the knowledge about currently available services combined with knowledge about services provided by the department of health, either at the local clinics of the nearest hospital (considering that the participants were from a rural community). All the participants reported that they had no knowledge of any mental health services that were available; in fact most of the participants did not even know what counseling was or what it entailed.

Moreover, other factors worth considering are the lack of knowledge about where to access mental health services, low levels of mental health literacy and so forth. Other factors may point to misdiagnosis, where depression is mistaken and thus not correctly treated or in fact not diagnosed at all because the depression is not picked up and thus no referrals made. A study by Petersen and colleagues (2009) unearthed that at the PHC clinic level, most if not all nurses simply did not have a time to identify and manage patients with CMDs and even if they are able to identify such patients, they frequently encounter difficulties finding someone to refer them to. This paints a picture of a nearly dysfunctional structure, where nurses,

presumably because of the high work load combined with short staffing, and also perhaps with low levels of mental health literacy, were not able to identify signs of depression from some of their patients. Furthermore, in a case where some nurses were able to give a proper diagnosis, they simply did not know where to refer to, and how. As a case in point, most of the participants in this study had never received any form of psychological or psychiatric intervention for their depression either because their depression was not detected or diagnosed in the first place, or in the event that it was detected, there were no clear channels of referral. It is also disturbing that in the event where a diagnosis was made, that information was not communicated to the patient at all; this goes back to one of the previous themes, that people may not seek help because they do not have any information about their condition. This then, boils down to the training of primary health level nurses on mental disorders and their diagnosis, since they are the first line of contact with many health service users who are not able to travel to hospital due to some already mentioned barriers. This also hinges on the dissemination of information, particularly about the referral procedure and channels among all the health care providers, specifically between primary health clinics and hospitals who normally render mental health services. At the end of the day, it is the patients who have to bear the consequences of their illness. The only way that patients can be empowered with knowledge is if healthcare workers such as nurses and themselves are firstly empowered with knowledge about mental illness themselves, starting with knowledge about the CMDs.

The second subtheme, the utilization of mental health services, is particularly important with regard to planning, that is when thinking about whether or not to implement MHS where there aren't any presently. This theme looked at the probable utilization of mental health services if they were made available. The participants felt that people (those who require mental health services) will undoubtedly use these services should they be made available and accessible. This clearly illustrates that there is a need for these services in this community. If there is anything that can be taken from this, is that people are in need and perhaps even desperate for mental health services; and people will use these service if they are made available. The participants expressed a need for mental health services hence the upfront willingness to use them should they be made available. In this case, the provision of these services will not be a waste of state resources; on the contrary, it will be filling a need. Again, the importance of knowledge cannot be stressed enough, people need to know about what is offered and made available to them. The last and equally important subtheme was about making these services accessible to the greater community (those that are already in

place). The participants raised very important and worthwhile suggestions about how mental health services can be made accessible to community members. They suggested ideas such as having posters put up at the clinic that inform about depression – the signs and symptoms that would help people know if they are depressed, the formation of committees or groups of people who have depression so that they could have a platform to discuss this issue and share important information about where and how to access help. One participant spoke about word of mouth advertisement where all those who have been successful in getting help can pass on the message to others who are also in need of mental health services. Yet others advocated for a specialized day for depressed people so that the nurses could have enough time they need to make an appropriate diagnosis and management. This would make sense given that most clinics are more often than not short staffed while servicing hundreds of patients on a daily bases. In most of these instances, top priority is given to those who need typical medical attention and not psychological attention. Indeed sometimes CMDs are not detected, not because of the lack of knowledge on the side of the health professionals, but rather, because of the lack of time for psychological screening. Lastly, others suggested specialized days and venues where they can meet as a group and offer support to one another.

Whether it would be resource intensive or even stretching it too far, these are some of the ways that the participants felt would make mental health services better accessible to their larger community. What is also motivating is that some of these ideas can be brought to life by the participants without relying on the resources of the state, such as word of mouth advertisement, psychoeducation and the formation of committees and or coalitions to tackle this problem. Almost all of these ideas illustrate the service user's willingness to get down and dirty and to be involved in ensuring accessibility of mental health services to their community.

5.7 Acceptable interventions

A worthwhile and perhaps crucial factor to consider in the planning and delivery of mental health services for communities is what will be acceptable in the community, what kind of interventions will be appealing and embraced by the service users. While participants reported that mental health services would undoubtedly be utilized by community members should they be made available, it is also important to understand which forms of interventions will be most appropriate. Mental health service users in South Africa are not a homogenous group and thus interventions need to be tailored to cater for the diverse belief systems that we

have in this country. The participants' prime selection was support groups above and beyond other forms of therapy. This does not come as a surprise considering that most traditional societies favor collectivism as opposed to individualism. Most societies or cultural groupings in South Africa are collectivist in nature and individualism is not necessarily held in high esteem like in most Western cultures. In these collective cultures or communities, people are encouraged to discuss their problems and family or community elders are invited to intervene because of the wisdom they possess. It is no wonder then that most of the participants opted for a group approach, where they will not deal with their problem as an individual, but where they will tackle their problems as a collective. Durkheim (in Dillon, 2010) argues that traditional communities tend to have a collective conscious and this collective conscious exerts a strong authority over the community members and regulates expectations and behaviors of individuals. He further suggests that in traditional communities, there is little individualism, little personal freedom or autonomy, rather the individual is absorbed into the collective (Dillon, 2010). Although societies and communities have evolved over time and the collective conscious does no longer bear as much control over individuals in now semi-traditional communities, the sense of collectivism and communality still surpasses individualism.

Kleinman et al. (1978) noted that cultural beliefs bear much influence with regard to who people go to for treatment. For the participants in this study, depression has a social meaning, it is caused by the amalgamation of adverse socioeconomic factors that are not just experienced by the individual alone but which are felt by the larger community. The choice of group support by the participants reflects their perceptions about the etiology of their depression, ultimately their explanatory model of depression. This form of intervention compared to individualistic interventions is more fitting for the participant's context as it will allow them to deal with issues collectively. The participant's choice of support groups serves to highlight their beliefs in solving problems as a collective rather than as an individual. For these participants, it is not about 'me', but it is about 'us'. It is vital then that the planning of mental health services take such issues into account since these services are made for the people, for the use by the people.

In light of some of the available evidence, group psychotherapy does not appear to be a bad route to take. For an example, Torkaman, Langrudi and Abdolmohammadi (2014) study of the effectiveness of group psychotherapy for depression, anxiety and stress among women

with breast cancer, found that supportive psychotherapy for depression, anxiety and stress is effective in women with breast cancer, compared to the control group. Although these results cannot necessarily be generalised to HIV patients, they give one hope about the effectiveness of group psychotherapy for depression in general. McDermut, Miller and Brown (2001) also conducted a study that sought to assess the effectiveness of group psychotherapy for depression. They reported that 45 of the 48 studies they used revealed that group psychotherapy successfully reduced depressive symptoms in participants. Another benefit of group psychotherapy is that it allows for a number of people with similar or related problems to be helped all at once which is both resource and time effective as compared to individual therapy where the specialist spends more time and resource attending to only one patient at a time. Additionally, Pfeiffer, Heisler and Pietter (2011) conducted a meta-analysis study to assess the efficacy of peer support for reducing the symptoms of depression. They write that peer support services involve an engagement of non-professional individuals who have similar stressors or health problems for the purpose of reciprocal support. They further indicate that while cost and availability are significant barriers to the delivery of professional mental health services, peer support services can easily be delivered at a relatively low cost. Thus the cost effectiveness of this intervention may allow it to extend into community settings (Pfeiffer et al, 2011). This speaks directly to the section on barriers to health seeking and may potentially be part of a solution to the problem of accessibility of mental health services. From their analysis, Pfeiffer et al. (2011) concluded that the results from randomized controlled trials indicated that peer support interventions improve depression symptoms more than standard care alone. Although peer support is not necessarily a form of traditional group therapy, the fact that it calls people with similar ailments or problems together (forming a group), and has a facilitator (someone who has gone through those problems, not necessarily a professional); qualifies this as a support group. Further, group psychotherapy seems like a good idea especially in contexts where very few mental health specialists such as psychologists have to attend to a larger number of service users. In South Africa, Petersen, Hancock and Bhana (2014) conducted a pilot randomized controlled trial (RCT) that sought to assess the effectiveness of a group-based intervention for depression co-morbid with HIV/AIDS that was delivered by community health workers. The outcomes of the study showed that there was a decrease of depressive symptoms in PLWHA compared to those who received standard care. The results also suggested that using lay HIV councilors to deliver manualised group based counseling for PLWHA with co-morbid depression is potentially effective and acceptable strategy ensuring the delivery of mental

health services particularly in resource-constrained contexts such as South Africa and other LMICs.

The preceding discussion ultimately boils down to one important consideration, that is, are the mental health interventions appropriate or acceptable? As mentioned previously, these services are made to be utilized by people, and evidently, in South Africa people are not a homogenous group with homogenous beliefs, culture and traditions, rather South Africa is marked by diversity that needs to be embraced by being diverse and culturally sensitive.

5.8 Adherence to ART medication

A lot of literature cited in the literature review section has suggested a converse relationship between the severity of depression and adherence to ART medication for PLWHA who also suffer from depression. Depression is known for causing decreased motivation for doing a lot of things, in some cases a decreased motivation to live, causes fatigue and in some instance results into forgetfulness. Decreased motivation to live may lead one into purposefully forgetting to take his/her medication, in some instances the motivation may altogether be unconscious and the forgetting might not be necessarily consciously purposeful but might be the playing out of unconscious processes.

However, participants in this study reported that their depression did not affect their adherence to their ART medication regimen. While some participants did report poor adherence, factors other than depression were implicated, primarily, the lack of appropriate nutrition. For some of these participants, the only reason for 'skipping' or selectively taking their ART medication was that they cannot take them on an empty stomach. Kagee, Nothling and Coetzee (2012) obtained similar responses from some of the participants in their study; they reported that one of the primary barriers to medication adherence identified by patients was not having enough food. Several of the participants in their study reported that they often hesitant to take medication on an empty stomach due to side effects that they would experience afterwards such as vomiting and dizziness. Kagee and colleagues argue that overwhelming data on HIV incidence and prevalence in Sub-Saharan Africa indicates that HIV/AIDS is more common among those living in poverty while in turn, poverty makes adherence to ART medication even more difficult, making this a vicious cycle. A low socioeconomic status was one of the major challenges reported by the participants in this study and for some it served as also a barrier to adherence to their ART medication regimen.

Other factors, besides food insecurity that are implicated in poor treatment adherence include side effects associated with treatment, low health literacy, poor social support, excessive use of substances as well as stigma and discrimination (Kagee, Nothling and Coetzee, 2012). Kagee and colleagues also correctly point out that poor adherence to ART is highly predictive of viral load and drug resistance. Therefore poor adherence undoubtedly impacts on the recovery time, quality of life and mortality among HIV-infected persons. Moreover, poor adherence might lead to the development of drug-resistant strains of HIV, resulting in resistance to treatment and the need for more expensive second line drugs. Olisah, Baiyewu and Sheikh (2010) also add that adherence to ART medication is critical since even minor deviations from the prescribed regimen can result in viral resistance. This clearly shows that poor adherence does not only potentially cost the patients their wellbeing and even perhaps their lives, it is also financially costly to the state when more expensive second line drugs have to be used in order to try and tame the now resistant strains. Kagee (2004) adds that the issue of treatment adherence is likely to have important health, economic and social implications and that non-adherence is both costly and deleterious to health. It is worth mentioning that the South African government has made considerable improvements with regard the ART roll out and in ensuring that all eligible citizens, regardless of their socioeconomic status receive ART medication.

Kagee (2004) indicates that post-apartheid South Africa has witnessed the brisk changes in the delivery of health services as well as an uptake of these services. However it is without doubt that there is still a lot of work that needs to be done in addressing some of the issues that contribute to poor adherence that are already mentioned. Although the central factor of this study (depression) did not directly emerge as a contributory factor in poor treatment adherence, many of the triggers of depression such as poverty seem to contribute considerably.

5.9 Expectations about nurses and CHWs

Although a few participants expressed low levels of confidence and faith in the PHC system because of the poor treatment they had received from the nurses, others nevertheless maintained that they still had confidence and trust in the nurses and believed that they [nurses] can play an important role in addressing the issue of CMDs such as depression. CHWs were also not left out and the participants strongly believed that they too can play vital role in helping community members cope with depression. Participants in the current study

expressed that they expect both nurses and CHWs to help with the provision of counseling and medication to people struggling with depression. The participants further suggested that nurses would be better suited to issuing medication while CHWs would be better at providing counseling. For these participants and perhaps the community that they come from, nurses and CHWs are the first point of contact when seeking health care services; they are the people that the community relies on and in some instances look up to.

Kleinman et al. (1978) writes that culture contributes to determining whom people go to for help for their illness. As discussed earlier on, the participant's explanatory model of depression centers on psycho-social causes that carry an emotional component. Although the participant's explanatory model of depression did not centre on the physical causes which would warrant a purely biomedical intervention, they did not however, disregard the role of health professionals. In fact most of the participants felt that medical and psychological interventions such as counseling, group support and medication were of importance for the treatment of depression. Participants also emphasized the role that health care professionals such as nurses and CHWs can play in the treatment of depression. A small number of participants felt that they might feel more comfortable if traditional healers also formed part of the mental health team. These findings suggest that there is not always a linear relationship between people's explanatory models and their choice of treatment, thus people may attribute the causes of their sicknesses to psycho-social factors but might seek medical or psychological interventions. This is in line with Sorsdahl's et al. (2010) argument that previously, psychiatric patients in South African were thought to hold homogeneous explanatory models and an innate desire to consult traditional healers while in actual fact some resorted to traditional healers because they did not have access to health care services.

In view of the preceding discussion, one can postulate that forging of a partnership between mental health care professionals and traditional healers might be to the best interest of service users. Additionally, collaborative care between mental health specialists, nurses and CHWs may be the best way to make use of available resources, with specialists who are less available, reserved for more severe or treatment resistant cases within a task shifting approach. In essence, a task shifting approach was indirectly advocated for by the participants as a viable and conducive approach to the delivery of mental health services.

There has been widespread advocacy and support for the implementation of task shifting especially in LMICs where mental health resources are scarce. Buttorff, Hock and Weiss

(2012) indicates that the effective management of non-communicable diseases such as CMDs typically requires a joint effort from the different health care professionals as well as continuing care for sometimes prolonged periods. Thus, in resource-scarce areas, a task-shifting strategy can be advantageous, in which community or lay health workers (with supervision from primary-health-care specialists) provide basic screening and management, instead of physicians and professional nurses. Buttorff and colleagues also point out that there is growing evidence of the effectiveness of task-shifting in the management of some chronic conditions such as HIV/AIDS and some mental disorders. With regard to mental disorders, particularly CMDs, Buttorff et al. (2012) argue that collaborative stepped care led by lay health workers has been found to be effective in the primary treatment of depression and anxiety in LMICs. Furthermore, in their study on the integration of mental health care to primary health care in South Africa and Uganda, Petersen et al. (2011b) found that task shifting was received well in both sites by district/sub-district management. They further mention that in South Africa, shifting psychosocial care for people with CMDs to CHWs was also viewed positively by both PHC staff and CHWs. Moreover, they indicate that having dedicated CHWs providing a specific psychological treatment programme for women with depression was also well received as it provided a referral pathway for people presenting with depression at community PHC facilities. Petersen and colleagues' findings resonate with those of the current study where participants viewed task shifting, or the delegation of services, to CHWs and sometimes to nurses positively. Further, Petersen et al. (2014) in their study on the effectiveness of group-based counseling intervention within a task shifting approach commented that the delivery of the intervention by lay HIV counselors was well received by the participants. They also indicated that given that lay HIV counselors exist in the majority of PHC facilities in South Africa, in the context of under-resourced psychological services, they may potentially serve as vehicles for the scaling up of counseling services especially for common mental disorders.

At a slightly different but related angle, Swartz, Kilian and Twesigye (2014) advocates for task shifting for a somehow different but equally important reason, that of minimizing or perhaps eradicating linguistic and cultural barriers. They write that it is generally accepted that good mental health care is largely dependent on language and communication. They further indicate that it is through the use of language that symptoms are communicated, and language forms the medium through which varied aspects of treatment are delivered. They further point out that there is mounting evidence pointing to the effectiveness of many forms

of psychotherapeutic interventions for a range of disorders; however, they correctly point out that these interventions depend centrally on there being some kind of understanding between the clinicians and service users. The importance of language in a therapeutic relationship is well-known and has been debated by numerous clinicians and researchers, however it sometimes gets overlooked or taken for granted, and here, Swartz and colleagues reminds us just how important linguistic factors are. While it is recognized that the primary argument for advocating task shifting is that of resources, Swartz and colleagues also embrace the argument that that lay counselors or community workers who deliver mental health care in poorly resourced context may provide far better care than do highly trained mental health specialists. They attribute the latter to the fact that community members trained to provide mental health services are more likely to share cultural, linguistic, and social backgrounds with the service users as opposed to mental health specialists. This is particularly applicable and important in South Africa, a society characterized by diversity and multiculturalism, and also a gross incompatibility between clinicians and service users with regard to culture, religion and beliefs. On the same note, Swartz et al. (2014) also remark that cultural competence in mental health care provision is of essence, and thus an aspect of the cultural strengths of community health workers may be their cultural and linguistic competence to understand the cultural and linguistic background of the service users.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

This chapter presents the conclusions to this study. It also identifies the limitations of the study findings and offers recommendations for the implementation of mental health interventions as well as recommendations for future research.

6.1 Conclusions

Post-apartheid South Africa bears witness to a number of promising changes especially in the provision of health care (Kagee, 2004). Although the delivery of mental health services has always lagged behind other health services, good progress has nonetheless been evident. However, even greater progress is still needed before mental health services are made available to all. The current study was conducted within the context characterised by the unrelenting HIV/AIDS pandemic and the growing prevalence of CMDs, especially depression, and furthermore the pressing concern of the increasing co-morbidity between these two conditions (see Petersen et al, 2013). This study was aimed at exploring how PLWHA with co-morbid depression perceive depression and mental health services. Acknowledging the fact that South Africa is characterized by diversity with reference to culture, religion and traditions, and that there can be no 'one fit all' forms of interventions; this study then further sought to learn about the participant's perceptions of acceptable interventions which may potentially inform the development of appropriate and accepted interventions.

The theoretical perspective that was used to frame this study was Kleinman's explanatory model of illness. This use of this perspective allowed the exploration of the participant's perceptions about the etiology and manifestation of depression symptoms. The use of this framework also created a respectful and non-judgmental environment for participants to share their preferred choices of treatment for depression. One might argue that the use of this kind of approach allows an interchange of knowledge and information between mental health service providers and the users of those services. It creates a platform for an open and mutually respectful negotiation about the forms of acceptable interventions. This has a fundamental impact on the development and implementation of appropriate and acceptable mental health services.

Most of the participants understood depression as stress or as painful nerves. With regard to the latter, Ahmed and Bhugra (2007) and Mosotho et al. (2008) speak about distress idioms or more thoroughly, culturally patterned idioms of distress which essentially pertain to how people understand and express their distress in culturally defined ways. As recommended by Ahmed and Bhugra, it is important that mental health professionals attempt to familiarise themselves with some of the indigenous knowledge about mental disorders of the population that they work with. This will not only aid in avoiding misdiagnosis or failure to make a diagnosis when it should be made, but as Ahmed and Bhugra indicated, it will also aid in the establishment of a good working relationship between the clinicians and their clients.

Two factors surfaced as strong determinants of depression, namely poverty and partner relational problems which is an all too familiar scenario in South Africa. Numerous strategies have been put in place to reduce the rate of unemployment in South Africa; however, there has been little progress in that area. Strategies that have also sought to empower women have also benefited a few, leaving the majority out in the cold. Issues of domestic abuse and intimate partner violence mainly towards women are also soaring in this country. A number of authors and researchers (Patel et al, 2010; Lund et al, 2014 and Moultrie and Kleintjes, 2006) have written about the social determinant of depression citing socioeconomic factors as well as intimate partner violence as contributing factors. Although it may sound redundant to still call for government intervention in the empowerment of and protection of women from abuse and in targeting unemployment, the threat of depression which, has as determinants, some of these social issues, warrants it. The roll out of mental health services is undoubtedly an effective way of addressing mental illness, however also striving to minimise or better yet eliminate all together factors that predispose people to developing certain mental illnesses such as depression, should be an ideal.

Further, the findings indicate that some people living with HIV with co-morbid depression possess no knowledge about available mental health services nor do they believe that mental health services are accessible for them. The participants indicated that in their local clinic, no mental health services were rendered; this may either be an actual fact or if they are available, the participants had never heard of them. A strong factor that emerged from this study is the gross lack of knowledge about mental health services in general and low levels of mental illness literacy. Within the context of this study, the lack of knowledge acted as a barrier, not just to accessing of mental health services, but also to the realisation of the need of mental

health interventions. Some participants in the study reported that they did not know what they were suffering from, they possessed no knowledge of depression, and this lack of knowledge about their condition acted as a barrier to seeking appropriate help, perhaps even from seeking help at all. What is clearly needed is mental health education that will not only target active health service users but that will be tailored for the entire community.

It may very well be possible that numerous other people in the community who are not health service users also suffer from depression but because of low mental illness literacy they continue to suffer in silence. In this regard, PHCs, which are essentially closest to the people, should play an active role by delivering psychoeducation through a variety of means such as outreach programmes or print media. CHWs can also play an important role in providing door to door psychoeducation and screening for those who are unable to travel to the clinic especially the elderly as suggested by one of the participants. Participants further suggested that people could be made aware of MHS through word of mouth by those who have been able access services, print adverts (e.g. posters) in clinics providing information about depression and where to access help; as well as community support groups where people suffering from depression could meet and share information with regard to accessing help. The findings also suggested the possibility of a high utilisation rate of mental health services, should they be made available and accessible. Additionally, it emerged that most of the participants indicated that they favoured being helped in a group with other people over receiving help as individuals and it was understood from the perspective that collectivism is still dominant in rural and traditional communities (Dillon, 2010).

This highlights the importance of taking into consideration the communal value systems of a group of people during the planning and implementation of mental health services. In light of the fact that South Africa is characterized by diversity in terms of culture, beliefs, religion and traditions, it is important that interventions are designed to accommodate service users' values and belief systems. The goal should not be to develop universal mental health interventions (although this might be appealing considering its cost effectiveness) that will provide different groups of people with the same intervention; rather the goal should be to create interventions that are appropriate for the different groups of people.

It further emerged from other research studies that depression possibly contributes to poor adherence to the ART medication regimen for people living with HIV (Olisah, Baiyewu and Sheikh, 2010; Schuster, Manna and Bornovalova, 2012; Sherr et al. 2011; Wagner et al.

2012; Antelman et al. 2007; Remien et al. 2006; Benton, 2008 and Lawler et al. 2011), however, in this study, participants indicated that depression did not necessarily interfere with their adherence to their ART medication regimens. Most of the participants reported that they adhered to their medication regimens as prescribed by the health professionals. For those who did not strictly adhere to their ART medication regimens, reasons for skipping their medication included poverty, or specifically lack of food as a reason for not taking their medication as prescribed. Although HIV is not necessarily a disease of the poor, there is no refuting that the incidence rate is disproportionately higher among those living in poverty (Kagee, Nothling and Coetzee, 2012) for a variety of reasons. Poor adherence to ART medication carries a heavy price to pay both for the patients (development of drug resistant strains, disease progression and sometimes death) and for the country's economy (funding for more second line drugs to tame the drug resistant strains). What is needed is strong advocacy to address these factors which seem to threaten the ART campaign.

Task shifting also came out as an important factor in this study. Participants suggested that both nurses and CHWs carry out mental health duties such as counseling and the prescription of medication. This makes sense for the participants, and perhaps for most rural communities that are serviced by PHCs, as the first line of, and perhaps frequent contact is with the nurses and CHWs. Numerous studies have advocated for task shifting and some have attested to its effectiveness and affordability. Petersen's et al. (2011) study also demonstrated services users and providers willingness to embrace task shifting in their respective districts. In the context of under resourced mental health services and a shortage of mental health specialists, the option of task shifting as a mechanism for delivering mental health services in a cost effective manner should be strongly considered. Many studies have demonstrated that it is a doable and perhaps effective strategy and is supported not only by service providers, but also service users as well.

6.2 Limitations of the study

Although this study yielded rich data that is contextually relevant, however like any other research it has certain limitations which are delineated below:

1. Although the purpose and nature of the study design was not to generalize the finding to the larger population, it is perhaps worthwhile to mention that the participants in this study represent only a small section of the populace as well as a specified locale

or context. Thus, these findings do not necessarily indicate a generalized unavailability or inaccessibility of mental health services in South Africa; infact it is possible that other settings may have entirely different experiences.

2. This study is part of a bigger study and the author of this paper was not involved in the data collection process. Thus some aspect of fieldwork experience that might have enhanced the discussion of the findings could not be reported on.
3. Another limitation is that of the number of participants. Although qualitative research does not necessarily sample for the aim of generalizing, nevertheless, the number of participants play a crucial role with regard to the amount and variability of the data collected; the more the participants, the more diverse the data.
4. Language also presented a challenge. Firstly the translation of interview questions from English to seTswana entailed some loss of the intended meaning of the questions. The back translations of the interview after they were transcribed from seTswana back to English possibly resulted in a loss of some information.

6.2 Recommendations for future research

1. With regard to depression and ART medication adherence, it would be worthwhile to explore in a larger study, using methods other than self-report, whether depression is a factor in poor adherence to ART medication.
2. The current study focused only on females with living with HIV and also suffering from depression, it would be worthwhile in the future to obtain male service user's perspectives.
3. Although it is being advocated that task shifting be the next step to be taken in the delivery of mental health services, there is still a limited number of studies attesting to its effectiveness within the South African context. It would then be useful to have more studies examining the effectiveness of task shifting especially for HIV and CMDs.

REFERENCES

- Alem, A. (2000). Human rights and psychiatric care in Africa with particular reference to the Ethiopian situation. *Acta Psychiatry Scand*, 101, 93-96.
- Angermeyer, M. C., Holzinger, A., Matschinger, H., & Stengler-Wenzke, K. (2002). Depression and quality of life: Results of a follow-up study. *The International Journal of Social Psychiatry*, 48(3), 189-199. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=12413247&site=ehost-live>
- Ahmed, K. and Bhugra, D. (2007). Depression across ethnic minorities cultures: Diagnostic issues. *World Association of Cultural Psychiatry*, 47-56.
- Antelman, G., Kaaya, S., Wei, R., Mbwambo, J., Msamanga, G. I., Fawzi, W. W., & Fawzi, M. C. S. (2007). Depressive symptoms increase risk of HIV disease progression and mortality among women in Tanzania. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 44(4), 470-477. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17179766&site=ehost-live>
- American Psychiatric Association (2013). Diagnostic and Statistical Manual of mental disorders (5th ed). Washington DC.
- Bailey, R. (2008). Prisons and HIV/AIDS. In Ndinga-Muvumba, A. & Pharoah, R. (Eds), HIV/AIDS and society in South Africa, (pp. 167-181). Pietermaritzburg: University of KwaZulu Natal Press.
- Beck, J.S. (2011). Cognitive Behavioral Therapy: Basics and beyond (2nd ed). New York, Guilford Press.
- Benton, T.D. (2006). Depression and HIV/AIDS. *Current Psychiatry Reports*, 10, 280–285.
- Berry, S.Y. (1999). Collecting data by in-depth interviewing. Paper presented at the British Educational Research Association Annual Conference, University of Sussex at Brighton, September 2 - 5 1999.

- Burns, J.K. (2011). The Mental Health Gap in South Africa – A Human Rights Issue. *The Equal Rights Review*, 6, 99-113.
- Burns, J.K. (2010). Mental health services funding and development in KwaZulu-Natal: A tale of inequity and neglect. *South African Medical Journal*, 100 (10), 662-666.
- Buus, N., Johanessen, H. and Stage, K.B. (2012). Explanatory models of depression and treatment adherence to antidepressant medication: A qualitative interview study. *International journal of nursing studies* (49), 1220-1229.
- Buttorf, C., Hock, R.S., Weiss, H.A., Naik, S., Araya, R.....Patel, V. (2012). Economic evaluation of a task-shifting intervention for common mental disorders in India. *Bulletin of the World Health Organization*, 90, 813-821. doi:10.2471/BLT.12.104133
- Brandt, R. (2009). The mental health of people living with HIV/AIDS in Africa: A systematic review. *African Journal of AIDS Research (AJAR)*, 8(2), 123-133.
doi:10.2989/AJAR.2009.8.2.1.853
- Briongos-Figuero, L., Bachiller-Luque, P., Palacios-Martín, T., De Luis-Román, D., & Eiros-Bouza, J. (2011). Depression and health related quality of life among HIV-infected people. *European Review for Medical and Pharmacological Sciences*, 15(8), 855-862.
Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=21845794&site=ehot-live>
- Brown, A. C., Brody, G. H., & Stoneman, Z. (2000). Rural black women and depression: A contextual analysis. *Journal of Marriage & Family*, 62(1), 187. Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=2819080&site=ehost-live>
- Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D. J., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African stress and health study. *Psychiatric Services (Washington, D.C.)*, 62(7), 774-781.
doi:10.1176/appi.ps.62.7.774

- Byford, S., & Bower, P. (2002). Cost-effectiveness of cognitive-behavioral therapy for depression: Current evidence and future research priorities. *Expert Review of Pharmacoeconomics & Outcomes Research*, 2(5), 457-465. doi:10.1586/14737167.2.5.457
- Chan, S. W. C., Chiu, H. F. K., Wai-tong, C, Thompson, D. R., & Lam, L. (2006). Quality of life in Chinese elderly people with depression. *International Journal of Geriatric Psychiatry*, 21(4), 312-318. doi:10.1002/gps.1461
- Chartier, I.S., & Provencher, M. D. (2013). Behavioral activation for depression: Efficacy, effectiveness and dissemination. *Journal of Affective Disorders*, 145(3), 292-299. doi:10.1016/j.jad.2012.07.023
- Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: Piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Public Health*, 11, 828-828. doi:10.1186/1471-2458-11-828
- Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., & Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20(9), 1105-1110. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010055810&site=ehost-live>
- Cook, N. (2006). AIDS in Africa. Retrieved from <http://fpc.state.gov/documents/organisation/6756.pdf>
- Cruess, D.G., Petitto, J.M., Leserman, J., Douglas, S.D., Gettes, D.R., Ten Have, T.R. & Evans, D.R. (2003). Depression and HIV Infection: Impact on Immune Function and Disease Progression. *CNS Spectrums*, 8, 52-58.
- Derlega, V. J., Winstead, B. A., & Brockington, J. E., Jr. (2008). AIDS stigma among inmates and staff in a USA state prison. *International Journal of STD & AIDS*, 19(4), 259-263. doi:10.1258/ijsa.2007.007141

- Department of Health (2013). National Mental Health Policy Framework and Strategic Plan 2013-2020. Retrieved from <http://www.health-e.org.za/wp-content/uploads/2014/10/national-mental-health-policy-framework-and-strategic-plan-2013-2020.pdf>
- Dillon, M. (2010). *Introduction to Sociological Theory: Theorists, Concepts, and their Applicability to the Twenty First Century*. United Kingdom, Wiley-Blackwell.
- Doyle, S.M., Kahn, J.G., Hosang, N. & Carroll, P.R. (2010). The Impact of Male Circumcision on HIV Transmission. *The Journal of Urology*, 183, 21-26.
- Draper, C. E., Lund, C., Kleintjes, S., Funk, M., Omar, M., & Flisher, A. J. (2009). Mental health policy in South Africa: Development process and content. *Health Policy and Planning*, 24(5), 342-356. doi:10.1093/heapol/czp027
- Dua, T., Barbui, C., Clark, N., Fleischmann, A., Poznyak, V., van Ommeren, M., ... Saxena, S. (2011). Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: Summary of WHO recommendations. *Plos Medicine*, 8(11).doi:10.1371/journal.pmed.1001122
- Family Health International (2002). *Qualitative Methods: A field guide for Applied Research in Sexual and Reproductive Health*. USA, Library of Congress.
- Family Health International (2005). *Qualitative Research Methods: A Data Collector's Field Guide*. USA, Library of Congress
- Fox, J. C., Blank, M., Rovnyak, V. G., & Barnett, R. Y. (2001). Barriers to help seeking for mental disorders in a rural impoverished population. *Community Mental Health Journal*, 37(5), 421-436. doi:10.1023/A:1017580013197
- Freeman, M., Patel, V., Collins, P. Y., & Bertolote, J. (2012). Integrating mental health in global initiatives for HIV/AIDS. *The British Journal of Psychiatry: The Journal of Mental Science*, 187, 1-3. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=15994563&site=ehost-live>

- Fried, E.F. and Nesse, R.M. (2014).The Impact of Individual Depressive Symptoms on Impairment of Psychosocial Functioning. *PLoS ONE*,9(2). doi:10.1371/journal.pone.0090311.
- Fulton, B. D., Scheffler, R. M., Sparkes, S. P., Auh, E. Y., Vujicic, M., &Soucat, A. (2011). Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health*, 9(1), 1-11. doi:10.1186/1478-4491-9-1
- Glynn, J.R., Carael, M., Auvert, B., Kahindo, M., Chenge, J., Musonda, R,...Buve, A. (2001). Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia. *AIDS*, 15, 51-60.
- Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Quality Report*, 8 (4), 597-607.
- Gonzalez, J. S., Batchelder, A. W., Psaros, C., & Safren, S. A. (2011). Depression and HIV/AIDS treatment non-adherence: A review and meta-analysis. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 58(2), 181-187. doi:10.1097/QAI.0b013e31822d490a
- Gore-Felton, C., Koopman, C., Spiegel, D., Vosvick, M., Brondino, M., &Winningham, A. (2006).Effects of quality of life and coping with depression among adults living with HIV/AIDS. *Journal of Health Psychology*, 11(5), 711-729. doi:10.1177/1359105306066626
- Goyer, K. C., & Gow, J. (2001).Confronting HIV/AIDS in South African prisons. *Politikon: South African Journal of Political Studies*, 28(2), 195-206.doi:10.1080/02589340120091655
- Government Gazette (2002). Mental Health Care Act No. 17 of 2002. Retrieved from http://www.justice.gov.za/legislation/acts/2002-017_mentalhealthcare.pdf&sa
- Green, G. (1995). Attitudes towards people with HIV: Are they as stigmatizing as people with HIV perceive them to be? *Social Science & Medicine*, 41(4), 557-568. doi:10.1016/0277-9536(94)00376-5

- Gulliver, A., Griffiths, K.M. & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *Biomed Central Psychiatry, 10*, 113.
- Gupta, R., Dandu, M., Packel, L., Rutherford, G., Leiter, K., Phaladze, N., . . . Weiser, S. D. (2010). Depression and HIV in Botswana: A population-based study on gender-specific socioeconomic and behavioral correlates. *Plos One, 5*(12), doi:10.1371/journal.pone.0014252
- Gureje, O., Kola, L., & Afolabi, E. (2007). Epidemiology of major depressive disorder in elderly Nigerians in the Ibadan study of ageing: A community-based survey. *Lancet, 370*(9591), 957-964. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17869636&site=ehost-live>
- Harlé, K. M., Allen, J. J. B., & Sanfey, A. G. (2010). The impact of depression on social economic decision making. *Journal of Abnormal Psychology, 119*(2), 440-446. doi:10.1037/a0018612
- Herman, A. A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African stress and health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal = Suid-Afrikaanse Tydskrif Vir Geneeskunde, 99*(5), 339-344. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=19588796&site=ehost-live>
- Holden, C. (2000). Global survey examines impact of depression. *Science, 288*(5463), 39. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=3053636&site=ehost-live>
- Jackson, H., Judd, F., Komita, A., Fraser, C., Murray, G., . . . Wearing, A. (2007). Mental health problems in rural contexts: What are the barriers to seeking help from professional providers? *Australian Psychologist, 42* (2), 147-160. DOI: 10.1080/00050060701299532

- Jagannath, V., Unnikrishnan, B., Hegde, S., Ramapuram, J.T., Rao, S., Achappa, B.,...Kotian, M.S. (2011). Association of depression with social support and self-esteem among HIV positives. *Asian Journal of Psychiatry*, 4, 288–292.
doi:10.1016/j.ajp.2011.10.006
- Jin, H., Hampton Atkinson, J., Yu, X., Heaton, R. K., Shi, C., Marcotte, T. P., . . . Grant, I. (2006). Depression and suicidality in HIV/AIDS in china. *Journal of Affective Disorders*, 94(1-3), 269-275. Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=16764941&site=ehost-live>
- Kagee, A., Nothling, J. & Coetzee, B. (2012).The perspectives of users of antiretroviral therapy on structural barriers to adherence in South Africa. *South African Family Practice*, 54 (6), 540-544.
- Kagee, A. (2004). Treatment adherence in South African primary health care. *South African Family Practice*,46(46), 26-30.
- Kessler, R. C. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, 74(1), 5-13. doi:10.1016/S0165-0327(02)00426-3
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., . . . Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *JAMA: The Journal of the American Medical Association*, 289(23), 3095-3105. Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=12813115&site=ehost-live>
- Kleinman, A. (1980). Patient and healers in the context of culture. Berkeley: University of California Press.
- Kleinman, A., Eisenberg, L. and Good, B. (1978). Culture, Health and Illness: Clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine* (88), 251-258.

- Knapp, M., Funk, M., Curran, C., Prince, M., Grigg, M., & McDaid, D. (2006). Economic barriers to better mental health practice and policy. *Health Policy and Planning, 21*(3), 157-170. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=16522714&site=ehost-live>
- Lawler, K., Mosepele, M., Seloilwe, E., Ratcliffe, S., Steele, K., Nthobatsang, R., & Steenhoff, A. (2011). Depression among HIV-positive individuals in Botswana: A behavioral surveillance. *AIDS and Behavior, 15*(1), 204-208. doi:10.1007/s10461-009-9622-2
- Leserman, J. (2003). HIV disease progression: Depression, stress, and possible mechanisms. *Biological Psychiatry, 54*, 295–306.
- Leserman, J. (2008). Role of depression, stress, and trauma in HIV disease progression. *Psychosomatic Medicine, 70*(5), 539-545. doi:10.1097/PSY.0b013e3181777a5f
- Lund, C., Kleintjes, S., Kakuma, R., & Flisher, A. J. (2010). Public sector mental health systems in South Africa: Inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology, 45*(3), 393-404. doi:10.1007/s00127-009-0078-5
- Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., . . . Fairall, L. (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low- and middle-income countries. *PLoS Medicine, 9*(12), 1-6. doi:10.1371/journal.pmed.1001359
- Lund, C., Petersen, I., Kleintjes, S. and Bhana, A. (2012). Mental Health Services in South Africa: Taking stock. *African Journal of Psychiatry, 15*, 402-405
- Lund, C., Alison Breen, A., Alan, J., Flisher, A.J., Ritsuko Kakuma, R., Corrigall, J. . . Joska, J.A. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science and Medicine, 71*, 517-528. doi:10.1016/j.socscimed.2010.04.027

- Lynch, E. and Medin, D. (2006). Explanatory models of illness: A study of within-culture variation. *Journal of cognitive psychology* (2), 1-25.
- McInnis, M. G., & Merajver, S. D. (2011). Global mental health: Global strengths and strategies: Task-shifting in a shifting health economy. *Asian Journal of Psychiatry*, 4(3), 165-171. doi:10.1016/j.ajp.2011.06.002
- McDermut W., Miller, I.W. & Brown, R.A. (2001).The efficacy of group psychotherapy for depression: A meta-analysis and review of the empirical research. *Clinical Psychology: Science and Practice*,8, 98–116.doi: 10.1136/ebmh.4.3.82
- Monjok, E., Smesny, A.& Essien, E.J. (2009). HIV/AIDS - related stigma and discrimination in Nigeria: Review of research studies and future directions for prevention strategies. *African Journal of Reproductive Health*, 13(3), 21-25.
- Moultrie, A. & Kleinjies, S. (2006). Women’s mental health issues in South Africa. In Ijumba, P. and Pedarath, A. (Eds).South African Health Review (2006). Durban, Health System’s Trust.
- Mosotho, N.L., Louw, D.A., Calitz, F.W.J. & Esterhuyse1, K.G.F. (2008). Depression among Sesotho speakers in Mangaung, South Africa. *African Journal of Psychiatry*, 11, 35-43.
- Nakimuli-Mpungu, E., Bass, J.K., Alexandre, P., Mills, E.J., Musisi, S., Ram, M.,...Nachega, J.B. (2012). Depression, Alcohol Use and Adherence to Antiretroviral Therapy in Sub-Saharan Africa: A Systematic Review. *AIDS Behav*, 16, 2101–2118. DOI 10.1007/s10461-011-0087-8
- Ngcobo, M., & Pillay, B. J. (2008).Depression in African women presenting for psychological services at a general hospital. *African Journal of Psychiatry*, 11(2), 133-137. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=19582332&site=ehost-live>
- Niehaus, I (2012).Gendered Endings: Narratives of Male and Female Suicides in the South African Low veld. *Cult Med Psychiatry*, 36, 327-347. DOI 10.1007/s11013-012-9258-y

- Noel-Hoeksema, S. & Keita, G.P. (2003). Women and depression: an introduction. *Psychology of Women Quarterly*, 27, 89-90.
- Nuevo, R., Leighton, C., Dunn, G., Dowrick, C., Lehtinen, V., Dalgard,Ayuso-Mateos, J.L. (2010). Impact of severity and type of depression on quality of life in cases identified in the community. *Psychological Medicine*, 40, 2069-2077.
doi:10.1017/S0033291710000164
- Olisah1, V.O., Baiyewu, O. & Sheikh, T.L. (2010).Adherence to highly active antiretroviral therapy in depressed patients with HIV/AIDS attending a Nigerian university teaching hospital clinic. *African Journal of Psychiatry*, 13, 275-279.
- Papakostas, G. I., Petersen, T., Mahal, Y., Mischoulon, D., Nierenberg, A. A., & Fava, M. (2004). Quality of life assessments in major depressive disorder: A review of the literature. *General Hospital Psychiatry*, 26(1), 13-17. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=14757297&site=ehost-live>
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, 57(1), 13-24. doi:10.1016/S0277-9536(02)00304-0
- Panzarella, C., Alloy, L.B. & Whitehouse, W.G. (2006).Expanded Hopelessness Theory of Depression:On the Mechanisms by which Social Support Protects Against Depression. *Cognitive Therapy Research*, 30, 307-333. DOI 10.1007/s10608-006-9048-3
- Patel, V., Lund, C., Hatherill, S., Plagerson, S., Corrigan, J., and Funk, M. Social determinants of mental disorders. In: Blas E, Sivasankara-Kurup A, (Eds). Priority public health conditions: From learning to action on social determinants of health. Geneva: WHO; 2009.
- Petersen, I. (2010). Moving science to service in I. Petersen, A. Bhana, A. Flisher, L. Swartz and L. Richter (Eds). At the heart of development: Mental health promotion in low resourced settings. Pretoria, HSRC Press.

- Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S., . . . Flisher, A. J. (2009). Planning for district mental health services in South Africa: A situational analysis of a rural district site. *Health Policy and Planning, 24*(2), 140-150.
doi:10.1093/heapol/czn049
- Petersen, I., Hancock, J.H., Bhana, A. & Govender, K. (2013). Closing The Treatment Gap For Depression Co-Morbid With HIV In South Africa: Voices Of Afflicted Women. *Health, 5*, 557-566.
- Petersen, I., Lund, C., & Stein, D. J. (2011a). Optimizing mental health services in low-income and middle-income countries. *Current Opinion in Psychiatry, 24*(4), 318-323.
Retrieved from
<http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-11421-010&site=ehost-live>
- Petersen, I., Ssebunnya, J., Bhana, A. & Baillie, K. (2011b). Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. *International Journal of Mental Health Systems, 5*, (8).
- Petersen, I., Bhana, A., & Baillie, K. (2011c). The feasibility of adapted group-based interpersonal therapy (IPT) for the treatment of depression by community health workers within the context of task shifting in South Africa. *Community Mental Health Journal, 48*(3), 336-341. doi:10.1007/s10597-011-9429-2
- Petersen, I., Hancock, J.H., Bhana, A. and Govender, K. (2014). A group-based counseling intervention for depression co-morbid with HIV/AIDS using a task shifting approach in South Africa: A randomized controlled pilot study. *Journal of Affective Disorders, 158*, 78-84. doi.org/10.1016/j.jad.2014.02.013
- Pfeiffer, P.N., Heisler, M., Pietter, D., Rogers, M.A.M. & Valenstein, M. (2011). Efficacy of peer support interventions for depression: a meta-analysis. *General Hospital Psychiatry, 33*, 29-36. doi:10.1016/j.genhosppsy.2010.10.002.
- Powell, V. B., Abreu, N., de Oliveira, I. R., & Sudak, D. (2008). Cognitive-behavioral therapy for depression. *Revista Brasileira De Psiquiatria, 30*, S73-S80. doi:10.1590/S1516-44462008000600004

- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *Lancet*, 370(9590), 859-877. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17804063&site=ehost-live>
- Prince, M.J., Harwood, R.H., Blizard, R.A, Thomas, A. and Mann, A. (1997). Social support deficits, loneliness and life events as risk factors for depression in old age. The Gospel Oak Project VI. *Psychological Medicine*, 27, 323-332.
- Rahman, A., Malik, A., Sikander, S., Roberts, C., & Creed, F. (2008). Cognitive behavior therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: A cluster-randomized controlled trial. *Lancet*, 372(9642), 902-909. doi:10.1016/S0140-6736(08)61400-2
- Remien, R. H., Exner, T., Kertzner, R. M., Ehrhardt, A. A., Rotheram-Borus, M., Johnson, M. O., . . . Kelly, J. A. (2006). Depressive symptomatology among HIV-positive women in the era of HAART: A stress and coping model. *American Journal of Community Psychology*, 38(3-4), 275-285. doi:10.1007/s10464-006-9083-y
- Rosenfield, S. (1980). Sex differences in depression: Do women always have higher rates? *Journal of Health and Social Behavior*, 21(1), 33-42. doi:10.2307/2136692
- Saarijärvi, S., Salminen, J. K., Toikka, T., & Raitasalo, R. (2002). Health-related quality of life among patients with major depression. *Nordic Journal of Psychiatry*, 56(4), 261-264. doi:10.1080/08039480260242741
- Saraceno, B., & Saxena, S. (2002). Mental health resources in the world: Results from project atlas of the WHO. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 1(1), 40-44. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=16946821&site=ehost-live>
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., . . . Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet*, 370(9593), 1164-1174. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17804061&site=ehost-live>

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *Lancet*, 370(9590), 878-889. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17804062&site=ehost-live>

Scale up services for mental disorders: A call for action. (2007). *Lancet*, 370(9594), 1241-1252. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=26966323&site=ehost-live>

Schuster, R., Bornovalova, M., & Hunt, E. (2012). The influence of depression on the progression of HIV: Direct and indirect effects. *Behavior Modification*, 36(2), 123-145. doi:10.1177/0145445511425231

Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.

Sherr, L., Clucas, C., Harding, R., Sibley, E., & Catalan, J. (2011). HIV and depression - a systematic review of interventions. *Psychology, Health & Medicine*, 16(5), 493-527. doi:10.1080/13548506.2011.579990

Shisana, O., Rehle, T., Simbayi L.C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D. et al. (2014) *South African National HIV Prevalence, Incidence and Behavior Survey, 2012*. Cape Town, HSRC Press.

Simbayi, L. C., Kalichman, S., Strebel, A., Cloete, A., Henda, N., & Mqeketo, A. (2007). Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science & Medicine*, 64(9), 1823-1831. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=17337318&site=ehost-live>

- Smith, J., & Firth, J. (2011). Qualitative data analysis: The framework approach. *Nurse Researcher*, 18(2), 52-62. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=58053945&site=ehost-live>
- Sorsdahl, K.R, Flisher, A.S, Wilson, Z., and Stein, D.J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry* (13), 284-290
- Srivastava, A. & Thomson, S.B. (2009). Framework Analysis: A Qualitative Methodology for Applied Policy Research. *Research Note JOAAG*, 4 (2), 72-79.
- Statistics South Africa (2014). Mid-year population estimates. Retrieved from: <http://www.statssa.gov.za/.../p03022014.pdf>
- Statistics South Africa (2015). Mid-year population estimates. Retrieved from: <http://www.statssa.gov.za/.../p03022015.pdf>
- Stein, D.J., Seedat, S., Herman, A.A., Heeringa, S.G., Moomal, H., Myer, L....Williams, D. (2007). Findings from the first South African Stress and Health Study. South African Medical Research Counsel.
- Stein, D.J. (2014). Editorial: A new mental health policy for South Africa. *South African Medical Journal*, 104 (2), 115-116. DOI:10.7196/SAMJ.7938.
- Steward, W. T., Herek, G. M., Ramakrishna, J., Bharat, S., Chandy, S., Wrubel, J., & Ekstrand, M. L. (2008). HIV-related stigma: Adapting a theoretical framework for use in India. *Social Science & Medicine*, 67(8), 1225-1235.
doi:10.1016/j.socscimed.2008.05.032
- Swartz, L., Kilian, S., Twesigye, J., Attah, D. & Chiliza, B. (2014). Language, culture, and task shifting - an emerging challenge for global mental health. *Global Health Action*, 7, 23433.doi.org/10.3402/gha.v7.23433
- Thapa, S.B., Martinez, P. and Claussen, T. (2014). Depression and Its Correlates in South Africa and Ghana among People Aged 50 and Above: Findings from the WHO Study on

Global Ageing and Adult Health. *Journal of Psychiatry*, 17 (6), 14-89.

doi:10.4172/1994-8220.1000167

Torkaman, M., Langrudi, R.R., Abdolmohammadi, K., Mogadas, A., Malekirad, A.A...
Mohammadian, K. (2014). The effectiveness of supportive group psychotherapy for
depression, anxiety and stress in women with breast cancer. *Indian Journal of
Fundamental and Applied Life Sciences*, 4 (3), 615-655.

US Department of Health and Human Services. Mental health: a report of the surgeon
general. (2000). Rockville, MD, U.S. Department of Health and Human Services,
Substance Abuse and Mental Health Services Administration, Center for Mental Health
Services, National Institutes of Health, National Institute of Mental Health.

Wagner, G.J., Ghosh-Dastidar, B., Garnett, J., Kityo, C., and Mugenyi, P. (2012). Impact of
HIV Antiretroviral Therapy on Depression and Mental Health Among Clients With HIV
in Uganda. *Psychosomatic Medicine*, 74, 883-890.

Wampold, B. E., Budge, S. L., Laska, K. M., Del Re, A. C., Baardseth, T. P., Fluckiger, C., . .
. Gunn, W. (2011). Evidence-based treatments for depression and anxiety versus
treatment-as-usual: A meta-analysis of direct comparisons. *Clinical Psychology Review*,
31(8), 1304-1312. doi:10.1016/j.cpr.2011.07.012

WHO, UNAIDS, UNICEF (2011). Global HIV/AIDS Response: Epidemic updates and
health sector progress towards universal access. Retrieved from [http://
www.unaids.org/.../unaids/.../unaidspublication/2011/20111130_UA](http://www.unaids.org/.../unaids/.../unaidspublication/2011/20111130_UA)

APPENDICES

Appendix 1: interview schedule that was used for the research

Interview guide for interviews with service users (HIV-depression)

Objective of Questionnaire

To establish among potential users, their subjective understanding of depression, what they think are the potential influences of depression in HIV-positive people and how they think they can be helped with this mental health problem.

Research Questions

- 1) How do HIV positive people understand depression, particularly in terms of its manifestations and course?
- 2) What influences do people living with HIV identify as a source of their depression
- 3) What interventions do they perceive as helpful?
- 4) How would these interventions meet the needs of HIV positive people with depression?
- 5) What are existing pathways to care and how can these be improved to promote greater identification, access and demand for treatment of depression?
- 6) What are existing pathways through care for depression and how can these be improved to promote recovery? What are attitudes to task shifting?
- 7) How to increase accountability of treatment services?
- 8) How to reduce stigma and discrimination?

Guidelines

Welcome and introduction

Greeting

Thank participants for agreeing to participate

Explaining the project (including what is meant by common mental health problems and depression)

Explaining the rationale for the interview

INTRODUCTION

At present in South Africa, many people who suffer from mental disorders such as depression can't get treatment because there aren't enough specialists to deliver the care. In this study we are working with South Africa's Ministry of Health to try to improve this situation. In order to ensure that the service developed is appropriate for your context and fits with local understandings of depression and healing, we are interested to hear about your opinions on how people with depression can best be helped.

Thank you for agreeing to participate and giving your time.

Interview questions

Cultural / General understanding/ Causes and course of HIV-related depression

1. How would you know if a person is depressed? (Probe for understanding of depression e.g., is it understood as stress, nerves etc.)
2. Do you see yourself as having this problem (being depressed)? Explain why or why not including if others have told him/her that s/he is depressed (If yes, please explain how this (depression) feels for you?). Probe for signs and symptoms.
3. How does depression affect your life?

Probe for the problems they have caused for the participant.

4. Do you think the depression will go away or do you think it will always be there? (be a problem)

5. What do you think caused the depression?

Prompt:

- Incidences and situations (e.g. lack of support following disclosure, no-one to disclose to, abandonment by partner, partner infidelity, stigma and discrimination, lack of money for basics, death of someone close to you, interpersonal conflict, etc.)
- Cultural interpretations e.g. witchcraft

6. Can you describe days when you feel worse?

Prompt:

- What makes it worse?
- Are there particular situations you can think of that make it worse?
- Is there something you did yourself to make it worse?
- Is there something someone else did to make it worse? What did they do?

7. Does feeling like this (being depressed) affect your ability to take your ARV medicines regularly? If Yes,

Prompt:

- What makes it difficult to take your ARV medication?
- Can you remember situations when you didn't take your medication?
- If no, what helps you to take your ARV medication when you are feeling depressed?

Pathways to Care (including identification, access and demand)

8. Have you or someone you know who is troubled by depression ever sought help for this problem?

- If yes, what made you seek help?
 - Did you identify yourself as having a problem with depression?
 - Did someone else identify your problem of depression and suggest you seek help?
- If yes, who was this person and who did they suggest you seek help from?

- Who did you seek help from?
 - How did you know where to seek help from?
 - What was the nature of the help you received?
 - What was your experience of the help you received?
 - How long did it take to get help once identified as having depression?
 - Would you seek help from this source again for your depression?
 - If yes – Why?
 - If no – Why not?
- Do you / did you feel less depressed after this help?
9. Are you aware of any services specifically offered by the Department of Health to help you with your depression?
- If no, do you think that if such services were available people like yourself would want to use them?
 - What could be done to improve identification of people like yourself with depression in the community?
 - What can be done to make mental health services easier to access for women in the community?
 - What can be done to make mental health services easier to access for the poorest people in the community?
 - What would help to make people want to use these services?
 - Would increasing awareness that you can be helped with depression and mental health problems improve demand?
 - Would bringing the service closer to where people live help improve demand?
 - Would ensuring that the service fits with local understandings of depression and treatment help improve demand?
 - If yes, what services are these?
 - Were you able to access these services with ease?
 - If you were not able to access them with ease,

- Is distance or transport an issue?
- Is cost of services an issue?
- Is finding someone to go with you an issue?
- Is there a problem with a lack of understanding of local views of depression and mental health issues?
- Is there a concern about quality of care in PHC / availability of medicines and/or counselling?
- Can you think of anything else that could be done to make it easier to access these services?
-

What interventions are perceived as helpful (treatment and pathways through care and how can these be improved)

10. Can you describe days when you feel better.

Prompt:

- What makes you feel better?
- Was there anything you did yourself?
- Was there someone who assisted you to feel better? If so, whom? What did they do?

11. Are you on any medication for your depression?

If yes, who prescribed the medication?

What helps you to take your medication regularly?

Who reviews your medication?

How often is it reviewed?

12. Have you ever received counselling for your depression?

If yes,

- Who did you receive counselling from?
- What was the nature of the counselling you received?
- What was your experience of the counselling you received?
- Would you go for counselling from this source again for your depression?
 - If yes – Why?
 - If no – Why not?

13. Have you or anyone that you know who suffers from depression ever joined a support group? If yes

- Was this helpful?
- If No, Why not?
- What would motivate you to join or remain in a support group?

14. If you could imagine the perfect way to help people like yourself who are troubled by depression in this community, what would it be like?

Prompt

- What do you think can be done?
- Would it be best done alone or with other people (what are the reasons for your choice?)
 - Where would it take place?
 - Who would provide this help?
 - What could the community do to help?
 - What could be done by PHC nurses?
 - What could be done by Community Health Workers?
- What do you think some of the benefits of this help might be? (refer to participant's answers to above questions)

What do you think some of the difficulties / obstacles to getting this help might be?
(Refer to participant's answers to above questions)

Attitudes to Task-Shifting

15. If general health workers, such as nurses and community health workers were trained to provide treatment such as medication or counselling for depression - would this be acceptable to people such as yourself and others in the community?

- Would treatment services provided by nurses be acceptable?
- If yes, what kind of services would be acceptable for them to provide?
- If no, probe for why not.
- Would treatment services provided by CHWs be acceptable?

- If yes, what kind of services would be acceptable for them to provide?
- If no, probe for why not.

Accountability

16. Is there some way in which people can indicate whether they are satisfied with mental health care services including services for depression?

- If yes, what methods currently exist?
- If no, what method can you think of that could be put in place that would help with this?

Stigma and Discrimination

17. As someone with depression, have you experienced negative attitudes from service providers such as being disrespected, ignored or discriminated against?

If yes, can you describe this experience – what happened?

- What could be done to change this?

18. As someone with depression, have you experienced negative attitudes from your family, community members or people you work with such as being disrespected, ignored or discriminated against?

- If yes, can you describe this experience – what happened?
- What could be done to change this?
- Do you think awareness-raising of depression in relation to its causes, symptoms and how people can help will be helpful for reducing stigma and discrimination?

19. Do you feel that your family members understand your depression?

Are there times when you feel you are not a valued member of your family? What makes this worse?

What makes this better?

What makes you feel a valued member of your family?

FUNCTIONING & RECOVERY

20. Do you feel that you have lost confidence in yourself since you have suffered from depression?

- What would it take for you to regain your self- confidence?
- What would make you feel like you are more in control of your life?
- What would give your life more meaning and purpose?

21. What social activities or groups do you miss out on since you have had this depression?

- What would you like to be involved in?
- What could be done to help you be more involved socially?

22. If you are working, how does feeling depressed affect your relationship with people that you work with?

23. Does feeling depressed affect your ability to work / generate an income?

24. Do you believe that it is possible to recover from depression?

- What would recovery mean for you?

25. Do you think there may be any issues that we may have not adequately covered in this interview?

Appendix 2: Consent form

Appendix C : Understanding mental disorders in the Dr Kenneth Kuanda district

Study Information Sheet

The Research Study

We are asking you to participate in a research study aimed at understanding mental disorders in the Dr Kenneth Kuanda district. The study will be conducted by researchers from the **PR**ogramme for **I**mproving **M**ental Health **CarE** in South Africa (PRIME-SA) which is a collaboration between the universities of KwaZulu-Natal, Cape Town and the Department of Health.

What are we trying to learn?

In this research we want to understand how service users understand mental disorders and what are appropriate psychosocial interventions.

Why is it important?

This study is important so that it can inform the development of culturally and contextually appropriate services for this problem.

Who will be involved and how long will it last?

Service users attending Clinics in Dr Kenneth Kuanda district will participate in the study. The interviews will run over a period of four months from September to December 2011.

What will it mean if you participate in the study?

If you agree to participate in this study you will be asked to answer a number of questions about your mental health. If you are thought to suffer from a mental health problem you will sit for an hour long tape recorded interview during which a research assistant will ask questions on what you think influences the development of your problem as well your experiences of what is helpful. This information will be used to

inform the development of appropriate psychosocial interventions for people with mental health problems.

Is there any disadvantage from participating in this study?

There is the possibility that you may have a mental health problem yourself or that participation in the study may remind you of a time that you had such a problem. If you get distressed by this, we will refer you for psychological help.

What if I change my mind later?

You are free to withdraw at any stage from participating in the study and your decision will not disadvantage you in any way.

Who will see the information that we collected?

All records will be kept completely confidential. Your identity will be anonymous and following analysis of the data, the tapes and transcripts will be destroyed. The data will only be seen by the researchers and investigators.

Who to contact if you want to know more, or if you have a problem at any time?

If you want more information on the study before deciding whether or not to participate, or if you participate and later need help or have questions, please contact:

Prof I. Petersen
School of Psychology
University of KwaZulu-Natal
Tel: 031 260 7970

If you wish to know more about your rights as a participant in this study you can contact:

Ms Phumelele Ximba, Research Office, University of KwaZulu-Natal.
Tel: 2603587

Consent to Enroll

I, _____ agree to participate in the research study on understanding mental disorders in the Dr Kenneth Kuanda district to understand culturally and contextually appropriate ways for treating these disorders. I have received and understood the study information sheet. I have discussed the advantages and disadvantages of participating in the study and I agree to participate in the interviews as stated in the information sheet.

I know I can leave the research study at any time without prejudice and be referred for psychological help if need be.

Signature: _____

Name: _____

Date: _____

Witness 1

Signature: _____

Name: _____

Date: _____

Witness 2

Signature: _____

Name: _____

Date: _____

You may keep the information sheet. The signed consent form will remain in our study files.

Appendix 3: Ethical clearance for the main study



Research Office, Govan Mbeki Centre
Westville Campus
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximbap@ukzn.ac.za

25 March 2011

Prof. I Petersen (3106)
School of Psychology

Dear Prof. Petersen

PROTOCOL REFERENCE NUMBER: HSS/0135/011

PROJECT TITLE: The development and evaluation of the feasibility of a model for the psychological treatment for depression in HIV positive-women in South Africa using a task shifting approach

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. 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 Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Dr. J Harness Hancock
cc. Dr. K Govender
cc. Prof. A Bhana

Postal Address:

Telephone:

Facsimile:

Email:

Website: www.ukzn.ac.za

Founding Campuses:

■ Edgewood

■ Howard College

■ Medical School

■ Pietermaritzburg

■ Westville

Appendix 4: Ethical clearance of current study



13 December 2013

Mr Nkanyiso L Madlala (209501912)
School of Applied Human Sciences – Psychology
Howard College Campus

Dear Mr Madlala,

Protocol Reference Number: HSS/1489/013M (Approved under HSS/0135/011)
Project Title: The study will assess service user and service provider perceptions of the availability of mental health services for People Living with HIV/AIDS (PLWHA) who suffer from depression

Approval – No Risk

In response to your application dated 27 November 2013, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

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

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

Yours faithfully

.....
Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

cc Supervisor: Professor Inge Petersen
cc Academic Leader Research: Professor D McCracken
cc School Administrator: Ms Ausie Luthuli

Humanities & Social Sciences Research Ethics Committee

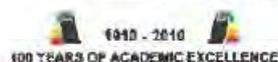
Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snvmanm@ukzn.ac.za / mohump@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville