UNIVERSITY OF KWAZULU-NATAL

EXPLORING THE KNOWLEDGE, ATTITUDES, SKILLS AND PREPAREDNESS OF NURSES ON THE INTEGRATION OF MENTAL HEALTH CARE INTO HIV/AIDS SERVICES IN THE ETHEKWINI DISTRICT, KWAZULU-NATAL

WINNIE BAPHUMELELE CELE

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EXPLORING THE KNOWLEDGE, ATTITUDES, SKILLS AND PREPAREDNESS OF NURSES ON THE INTEGRATION OF MENTAL HEALTH CARE INTO HIV/AIDS SERVICES IN THE ETHEKWINI DISTRICT, KWAZULU-NATAL

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BY

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DECLARATION

I, Winnie Baphumelele Cele, hereby, declare that “Exploring the knowledge, attitudes, skills and preparedness of nurses on the integration of mental health care into HIV/AIDS services in the eThekwini District, KwaZulu-Natal”, is my own work and that the relevant literature and views and opinions of authors expressed in this study are acknowledged in the references.

Student: Ms. Winnie Baphumelele Cele

Supervisor: Dr. Joanne R Naidoo

DEDICATION

This dissertation is dedicated to my late father, Mr. Ernest Lakhe Ngcongo, and my late sister, Gugulethu Perfect Ngcongo, for believing in me and all your love and care, rest in peace.

It is also dedicated to my family, the Ngcongo and Cele families.

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ABSTRACT

Aim: This study aim was to explore and describe the level of knowledge, attitudes, skills and preparedness of nurses regarding integration of mental health care into HIV/AIDS services.

Background: HIV/AIDS continues to be a major public health problem worldwide and in the sub-Saharan region in particular. Literature has shown a relationship between mental health problems and HIV/AIDS. People living with HIV/AIDS (PLWHA) and mental health problems (MHP) are not cared for appropriately by nurses competent to deal with mental health disorders when attending HIV/AIDS services.

Methodology: The research study was based on a positivist paradigm and a quantitative descriptive study and explorative design were adopted in this study. As a result, data was collected through a structured questionnaire. One hundred and twenty four nurses were randomly sampled from different HIV/AIDS services and Primary Health Care centres.

Findings: The study found that nurses have different perceptions about their provision of mental health care to PLWHA. Most nurses reported positive perceptions about caring for PLWHA who have MHP in general settings although some had negative perceptions. It was found that some nurses would be willing to learn on how to care for PLWHA who have MHP if they get in-service education and support from mental health care specialists. Lack of knowledge, skills and preparedness was identified due to lack of support from the mental health care specialists and lack of basic education and training. This reduced nurses' ability and willingness to care for these people.

Conclusion: Basic education and training, continuous in-service education and support from mental health care specialists will result in more willing, knowledgeable and skilled nurses when caring for PLWHA and MHP.

Key Words: Mental Health, HIV/AIDS, Primary Health Care

LIST OF ABBREVIATIONS/ACRONYMS

AIDS:	Acquired immunodeficiency syndrome
ART:	Antiretroviral Therapy
BMJ:	British Medical Journal
CINAHL:	Cumulative Index to Nursing and Allied Health Literature
HIV:	Human immunodeficiency virus
MAPP:	Maudsley Alcohol Pilot Project
MHP:	Mental Health Problems
MHPPQ:	Mental Health Problems Perception Questionnaire
PHC:	Primary Health Care
PLWHA:	People Living With HIV/AIDS
RM:	Registered Midwife
RN:	Registered Nurse
RPN:	Registered Psychiatric Nurse
UKZN:	University of KwaZulu-Natal
WHO:	World Health Organization

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Outlined in an exploratory study on the state of mental health, Williams, Narciso, Browne, Roberts, Weir and Gafril (2005) noted that in most countries, mental health issues are not prioritized in terms of the national and provincial planning. The same author further argued that compounding the lack of attention given to mental health issues globally, many countries have out-dated legislation and health related policies, with mental health related issues being neither prioritised nor being earmarked in financial planning (Williams et al., 2005). The majority of health care professionals who care for people living with HIV/AIDS in South Africa are nurses working at outpatient and inpatient settings, where they are expected to deal with the mental health problems of these clients (Williams et al., 2005). The provision of mental health care to people living with HIV/AIDS (PLWHA) is vital because, apart from the physical illness associated with the virus, these clients are often also affected by mental health problems (Myer, Smit, Le Roux, Parker, Stein and Seedat, 2008; WHO, 2008; Freeman, Nkomo, Karaar and Kelly, 2007; Wright, Lubben and Mkandawire, 2007; Collins, 2006; Mwale, 2006; Kaharuza, Bunnel, Moss, Purcell, Bikaako-Kajura and Wamai, 2006; Mellins, Kang, Leu, Havens and Chesney, 2003).

Freeman, Nkomo, Kaffar and Kelly (2008) reported on a joint meeting of a variety of stakeholders from academia, public and non-governmental organizations in South Africa at which HIV/AIDS was highlighted as an impending threat in managing mental health that requires urgent attention. Mental health problems (MHPs) are disturbing human emotional and psychological experiences (Angus, Lauder and Reynold, 2001) and, as such, it is very important that nurses provide holistic care by dealing with the mental health problems of people living with HIV/AIDS. This is in line with the recommendations of the World Health Organization (WHO), which promotes the

integration of mental health services with general health services, where non–mental health specialists are involved in providing mental health care (WHO, 1999). Supporting this, Freeman et al. (2008) noted that the relationship between HIV/AIDS and mental health goes unnoticed in many countries, such as South Africa, where, according to KZN statistics on HIV/AIDS, the incidence is 39.5% in KwaZulu-Natal (DoH, 2011).

Two national prevalence studies have estimated how many people are living with HIV/AIDS in South Africa and two reports have been presented on AIDS deaths (Roy, 2003).

1.2 BACKGROUND TO THE STUDY

1.2.1 The State of HIV and AIDS in the South African context

Based on its sample of 32.225 women attending 1,424 antenatal clinics across all nine provinces, the South African Department of Health's study estimates that in 2010, 30.2% of pregnant women aged between 15 and 49 were living with HIV/AIDS. Although South Africa had one of the fastest expanding epidemics in the world up until 1998, the HIV/AIDS prevalence among pregnant women has remained relatively stable since 2006 (Vitiello, Burnam, Bing, Beckman and Shapiro, 2006).

Sub-Saharan Africa is one of the regions most affected by HIV and AIDS. This region comprises of nearly fifty sovereign countries, which are grouped into five sub-regions, namely Eastern Africa, Southern Africa, West Africa, Central Africa and the islands of the eastern coast of the continent (Beaglehole, Epping-Jordan, Patel, Chopra, Ebrahim and Kidd, 2008). The World Bank defines the majority of the countries within the region as middle to low-income countries. The region has a population of approximately 809,115,000, 2.7% (22 million) of whom are living with HIV/AIDS (WHO, 2005). According to the UNAIDS report, 2011, 67% of all the people living with HIV/AIDS worldwide live in this region. Prevalence for adults in this region varies substantially from sub-region to sub-region and from country to country, ranging from 23-32% in Botswana and Swaziland, 12-28% in South Africa and to between 2% to 5% in many East African countries (UNAIDS, 2010). There has been a decrease in the adult HIV

and AIDS prevalence in a number of East African countries, most notably in Rwanda from 5.2% in 2004 to 3% in 2008 (UNAIDS, 2008b). The prevalence of HIV and AIDS varies in Rwanda from 7.3% in urban areas to 2.2% in rural areas (UNAIDS, 2008b). This same report indicates that in 2007, 17 million people were newly infected with HIV and that 75% of all AIDS related deaths world-wide occurred in this region (UNAIDS, 2008b).

Although the medical care of people with AIDS largely remains the responsibility of the primary care services, the mental health services are increasingly feeling the brunt of the epidemic (Collins, 2006). This could be attributed to the high prevalence of HIV infection among people admitted to psychiatric wards (Komiti, Judd, Grech, Mijch, Hoy, Williams et al., 2003).

Both HIV infection among people with psychiatric disorders and psychiatric illness among people with HIV infection underscore the critical role that mental health providers will play in integrating HIV prevention and care activities into mental health care settings (Collins, 2006).

It is clear that people living with HIV/AIDS worldwide are affected by mental health problems (Hoadley, 2010; Collins, 2006). Mental health problems are disturbing human emotional and psychological experiences and it is very important that nurses must provide holistic care when dealing with mental health problems of people living with HIV/AIDS (Angus et al., 2001).The secretary General of the World Federation for Mental Health (WFMH), Garrison said that it is clear from the grassroots partners and member that there is a demonstrated need for strengthened mental health services addressing stress management, social support and self-esteem among people living with stress affected by HIV/AIDS (UNAIDS, 2008a). Caregivers in particular experience high levels of stress and their role can take a substantial mental health and physical toll as they care for the physical, emotional and economic needs of their family members (UNAIDS, 2008a).

1.2.3 HIV/AIDS and Mental Illness

Reviews have found sero-prevalence rates among individuals with severe mental illness range from 4% to 22.9%, with an average of 7.8%, and sero-prevalence rates among adults in psychiatric settings to average 6.9%. These rates are much higher than the 0.43% of the United States population estimated to be infected with HIV. In one of the few studies that directly compared HIV prevalence in individuals with and without a severe mental illness; Parle (2012) used hospital discharge data and found that individuals with a mental illness were 1.44 times more likely to be HIV positive than those without a mental illness. Individuals who are dually diagnosed with both severe mental illness and a substance use disorder appear to be at even greater risk. A recent review of studies among dually diagnosed individuals (i.e. individuals with severe mental illness and a substance use disorder) found HIV prevalence rates that ranged from 6% to 23%. The findings showed that those who have a co-occurring substance use disorder are 2.93 times more likely to be infected with HIV than those without a co-occurring substance use disorder. However, the effects of being infected with HIV on mental health are less clear (Reed and Fitzgerald, 2005).

1.2.4 Mid-year population estimates of HIV/AIDS

The Statistics South Africa Report (2011), estimated the national mid-year population as 50,59 million, 52% of which (approximately 26 million) are female as reflected in Table 1.1. The province of Gauteng comprised the largest share of the South African population, with approximately 11.3 million people (22.4%) living in this province. KwaZulu-Natal is the province with the second largest population of 10.8 million people (21.4%). With a population of approximately 1.10 million people (2.2%), the Northern Cape remains the province with the smallest share of the South African population. Nearly one-third (31.3%) of the population is aged younger than 15 years and approximately 7.7% (3.9 million) is 60 years or older. Of those younger than 15 years, approximately 23% (3. 66 million) live in KwaZulu-Natal and 19.4% (3.07 million) live in Gauteng.

Table 1.1: Mid-year population estimates by province, 2011

	Population estimate	% of total population
Eastern Cape	6 829 958	13.5
Free State	2 759 644	5.5
Gauteng	11 328 203	22.4
KwaZulu-Natal	10 819 130	21.4
Limpopo	5 554 657	11.0
Mpumalanga	3 657 181	7.2
Northern Cape	1 096 731	2.2
North West	3 253 390	6.4
Western Cape	5 287 863	10.4
Total	50 586 757	100.00

1.2.5 Mental health care providers' attitudes and HIV related services

The attitudes of mental health care providers to sexual relations and HIV among people with serious mental illness continue to influence the extent to which these issues are

addressed in HIV/AIDS services and Primary Health Care settings (Kimironko Health Centre, 2008; Collins, 2006; Komiti, Judd, Grech, Mijch, Hoy, Lloyd et al., 2001).

1.2.6 Concepts of mental health and HIV/AIDS

The HIV/AIDS pandemic impacts on all aspects of those societies in which the prevalence rates are high and there is limited access to drugs and services that treat or attend to people who are suffering from both HIV/AIDS and mental health problems due to lack of integration of these services (Freeman et al., 2008).

Freeman et al. (2008) describe the complexity of the pandemic, arguing that the dramatic increase in severe illness and death in the communities that are most affected will inevitably result in a dramatic rise in mental health problems. While not universally true, and perhaps not yet evident in some situations where the epidemic is in its early stages, whole societies will increasingly experience the mental health impact of the virus. Starting with the infected person him/herself, the effects will ripple in widening circles to the direct family and caregivers of the infected person, to other family or friends and finally to the entire community. The communities will be confronted with multiple deaths and large numbers of children will be orphaned. The strong relationship between HIV/AIDS and mental health explains the need for mental health problems to be attended to in Primary Health Care and HIV/AIDS settings and the importance of mental health training for all the health professionals so as to be able to deliver successfully (WHO, 2010).

According to Freeman et al. (2008), mental health problems peak at the time of hearing the diagnosis, when the person becomes symptomatic and in the last stages of AIDS. People close to the infected person also experience depression and anxiety when their loved ones die (Freeman et al., 2008).

While HIV/AIDS dominates the overall burden of fatal diseases, neuropsychiatric conditions, particularly depression and psychosis, are responsible for the greatest proportion of non-fatal disabling conditions globally (Lopez, Mathers, Ezzati, D and Murray 2006). Together, depression and psychosis are the seventh leading cause of

HIV/AIDS in high income countries (Beaglehole et al., 2008; Lopez et al., 2006). These authors further estimate that neuropsychiatric disorders, most notably uni-polar depression, account for 14% of the global burden of disease and demonstrate that this figure is increasing, particularly in lower-middle income countries. Reflected in Table 1.2 the HIV prevalence is highest among females aged between 25 and 29 years old, while among males, the highest prevalence of HIV are among the group aged 30-34 years.

Table 1.2: Estimated HIV prevalence among South Africans, by age and sex, 2008

Age	**Male prevalence%**	**Female prevalence %**
2-14	3.0	2.0
15-19	2.5	6.7
20-24	5.1	21.1
25-29	15.7	32.7
30-34	25.8	29.1
35-39	18.5	24.8
40-44	19.2	16.3
45-49	6.4	14.1
50-54	10.4	10.2
55-59	6.2	7.7
60+	3.5	1.8
Total	**7.9**	**13.6**

HIV/AIDS continues to be a major public health problem worldwide. The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2013)estimated that in 2012, 35.3 (32.2 - 38.8) million people were living with HIV/AIDS. This reflects an increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 (1.9 - 2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1 - 3.7) million in 2001. At the same time, the number of AIDS deaths is also declining with 1.6 (1.4 - 1.9) million AIDS related deaths in 2012, down from 2.3 (2.1 - 2.6) million in 2005. However, 2.7 million people were newly infected with the virus and 2 million people died due to AIDS related illness in 2013.

1.2.7 Preparedness of nurses in relation to HIV/AIDS and mental health

It has been documented that nurses working in general hospital settings do not provide adequate mental health care due to their lack of knowledge and skills in dealing with mental health problems (Mavundla, 2000). This not only compromises the care of people living with HIV/AIDS, but also poses a challenge to the success of HIV and AIDS intervention programmes. According to Freeman, Patel, Collins and Bertolote (2005), HIV/AIDS intervention programmes must include mental health care if they are going to be successful.

The World Health Organization's (WHO) report on HIV/AIDS and mental health outlines a number of studies which have demonstrated a high prevalence of psychiatric disorders in people infected by HIV/AIDS (WHO, 2008). According to Faber, Mirsalimi, Williams and McDaniel (2003), the prevalence rates of psychiatric disorders among people living with HIV are high, but vary from country to country and from study to study. Bing, Burnam and Longshore (2001) conducted a study to estimate the prevalence of psychiatric disorders and substance abuse among American adults infected by HIV/AIDS and found that nearly half of their sample (n=2864) reported a psychiatric disorder. Similarly, Israelski, Prentiss, Lubega, Balmas, Garcai, Muhammad et al. (2007) estimated the prevalence of psychiatric co-morbidity among a group of people in Northern California receiving primary care for HIV/AIDS. This study revealed that in a sample of 118 people, 56% screened positive for at least one psychiatric disorder.

1.2.8 Challenges and attitudes among nurses towards mental health and HIV/AIDS related care

Nurses develop negative attitude when nursing or managing clients who present with both problems, that is HIV/AIDS and mental health problems, because of lack of knowledge in handling such clients (Baingana, Thomas and Comblain, 2005). The attitudes of mental health care providers (MHCPs) to sexual relations and HIV /AIDS among people with mental illness continue to influence the extent to which these issues are addressed in care settings (Kimironko Health Centre, 2008; Collins, 2006; Komiti et

al., 2001). North American studies suggest that lack of knowledge, stigmatizing ideas and institutional barriers have limited providers readiness to respond to HIV/AIDS prevention needs in mental health settings (Kimironko Health Centre, 2008; WHO, 2008; Komiti et al., 2003). The providers' age, sex, sexual orientation and clinical experience working with HIV/AIDS have been linked to their comfort in addressing HIV/AIDS in some mental health care settings (Komiti et al., 2001).

Literature suggests that the attitudes and self-perceptions of nurses have an influence on their mental health care interventions (Angus et al., 2001; Mavundla, 2000). This may mean that the quality of mental health care received by people living with HIV/AIDS depends on the nurses' self-perceptions and attitudes at any particular moment. This is consistent with viewpoints of Lauder, Reynolds, Smith and Sharkey (2002); and Angus et al. (2001), who assert that there is a direct link between the self-perceptions of nurses and the effectiveness or success of their mental health nursing interventions. These authors categorised nurses' self-perceptions and attitudes about their provision of mental health care as role competency, role support and therapeutic commitment. They further described role competency as nurses' attitude and self-perceptions of having the necessary knowledge and skills to provide mental health care, and role support as their perceived level of access to mental health specialists. They argued that role competency and role support influence therapeutic commitment, which they described as the nurses' self-perceptions about their willingness to deal with MHP.

Hence, it is necessary for nurses to have adequate knowledge, skills and support for them to have positive attitudes or perceptions about dealing with MHP (Stuckler, King, Robinson and Mckee, 2008). This is corroborated by Mavundla (2000), who claimed that nurses who feel that they are not adequately prepared to care for or to handle people with mental health problems have negative attitude about dealing with mental health problems.

1.2.9 Lack of policies on the management of people

HIV/AIDS continues to be a major public health problem worldwide. The Joint United Nations Programme on HIV/AIDS (2013) estimated that in 2012, 35.3 (32.2-38.8) million

people were living with HIV/AIDS. This is an increase from previous years as more people are receiving the lifesaving antiretroviral therapy. There were 2.3 (1.9-2-7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1-3.7) million in 2002. At the same time the number of AIDS related deaths is also declining with 1.6 (1.4-1.9) million Aids related deaths in 2012, down from 2.3 (2.1-2.6) million in 2005, 2.7 million people were newly infected with the virus and 2 million people died due to AIDS related illness.

1.2.10 Risk of mental Health in KwaZulu-Natal

Of the nine provinces in South Africa, KwaZulu-Natal (KZN) has various factors that make it one of the highest risk regions for mental disorders in the country. This province has the highest proportion of people living beneath the poverty line, the highest poverty gap, the second highest level of income inequality, the third highest unemployment rate, the highest prevalence rate of HIV/AIDS and the second highest murder rate (World Bank 2009; Freeman et al., 2008; Williams et al., 2005), all of which are recognised risk factors for mental illness. While prevalence rates of mental disorders are not available for the various provinces, a comparison of suicide rates in six major cities of South Africa showed that eThekwini (Durban) in KZN had the second highest epidemiology network on Drug Use (SACENDU) and that KZN has the fourth highest prevalence of treated substance abuse (Freeman et al., 2008).

Goldberg (2008) stated that studies of mental health must take cognisance of the disordered behaviours arising as a result of psychological or psychiatric conditions. Studies have consistently shown higher rates of mental health disorders in individuals living with HIV/AIDS compared to normal clinical samples. There are two important facets which form the basis of explanations of this finding. Firstly mental health disorders, including those that related to or arising as a result of substance abuse, have been shown to be related to HIV/AIDS infection, as well as to have a considerable potential impact on treatment success (Stuckler et al., 2008). Conversely, it is important to note that some mental health conditions arise as a direct result of HIV/AIDS infection.

Thus there is an elevated risk that psychiatric conditions may be exacerbated by the virus or, in fact, present as a precursor to infection (Stuckler et al., 2008).

1.3 PROBLEM STATEMENT

Research indicates that people with mental illness are at risk becoming infected with HIV/AIDS as they may be vulnerable to substance abuse and may engage in risky sexual behaviour (Freeman et al., 2005). People living with HIV/AIDS are also more likely to develop some form of mental illness like depression (WHO, 2008). Depression has been found to be the most common psychiatric disorder affecting people with HIV/AIDS. According to Valente (2003), depression constitutes one of the most common reasons for psychological evaluation and treatment for people living with the HIV/AIDS infection. It is estimated that the prevalence of depression among people living with HIV/AIDS in industrialized countries ranges from 9 to 60% (Kaharuza et al., 2006). Two studies, HIV Costs and Service Utilization (HCUS) and Coping with HIV/AIDS in the South East (Wright and Shuff, 1995) found that depression was the most prevalent psychiatric disorder among people living with HIV/AIDS in the United States, with similar prevalence rates of 36% and 35% respectively. Basu, Chwastiak and Bruce (2002) report that the prevalence of psychiatric disorders among HIV/AIDS infected people in India is approximately 50%, with major depressive disorder being the most common co-morbid disorder, with a prevalence ranging from 4% to 45%. In Uganda, Kaharuza et al. (2006) found that among 1017 HIV infected participants assessed for depression, 47% screened positive for depressive symptoms.

Although psychiatric disorders, particularly depression, appear to be high in people living with HIV/AIDS, they frequently go undetected and therefore untreated in HIV/AIDS care settings (Israelski et al., 2007; Petrushkin, Boardman and Ovuga, 2005).

The degree of psychological distress is frequently related to various factors, including the severity of the symptoms of the HIV/AIDS infection, a shortened life expectancy, complicated therapeutic regimens, stigmatization and loss of social support. Studies on the treatment of depression in people living with HIV/AIDS have showed promising results. In a critical review on the treatment of depression in people living with

HIV/AIDS, antidepressant medications were shown to be as effective in ameliorating major depression in HIV positive patients as in physically healthy patients (Mavundla, 2000). Furthermore, psychological interventions combining cognitive-behavioural therapy, individual psychotherapy, counselling and education on self-management techniques have been shown to effectively treat depression in people living with HIV/AIDS (Valente, 2003).

Significant numbers of infected people have developed mental health problems, and this often adversely impacts in HIV/AIDS treatment and adherence, depression and psychosis (Freeman et al., 2005).

Although the risks of integrating exposure to medications used to prevent vertical transmission remain unknown, early prevention of HIV offers the best opportunity to avoid life-long morbidity. Prevention opportunities (e.g. PMTCT) that are available within the context of HIV treatment and general medical care include HIV testing and initiation of ART during pregnancy, elective caesarean or minimally invasive assisted deliveries and exclusive or deferred breastfeeding when it is affordable and safe. These interventions have reduced the rates of vertical HIV transmission in both high and low resourced settings (Kaaya, Eustache, Lapidos-Salaiz, Musisi, Psaros and Wissow, 2013).

Efforts to engage women in PMTCT may be undermined, however by co-occurring mental health problems. Excessive alcohol consumption may interfere with the use of preventive health care and decision to test for HIV during pregnancy. Post-delivery depression can reduce mother's participation in early infant HIV diagnosis and infant's adherence to short course antiretroviral prophylactic medication. This interference further makes the case for integration of mental health services within HIV prevention and care (Chorwe Sungani, 2010).

Unfortunately, PMTCT services are often established as vertical programs, lacking sufficient integration even with maternal, neonatal and child health programs, which share similar goals and provide a basic platform and infrastructure for effective and sustainable delivery of HIV services. In some low- resourced settings, however it has

been feasible to include expanded PMTCT as an integral component of antenatal care by establishing on site ART services as well as training maternal and child health nurses to implement simplified integrated protocols. Ancillary services such as caregiver social support have the potential to influence adherence to ART as an integral and treatment plans for mothers and children. They could also support children to cope with and adjust to HIV and Aids, with potential positive effects on behavioural and emotional support symptoms, some of which are associated with neurocognitive harms (Kaaya et al., 2013).

1.4 AIM OR PURPOSE OF THE STUDY

The aim of this study was to explore and describe the level of knowledge, skills, attitudes and preparedness of nurses regarding integration of mental health into HIV/AIDS services.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to explore and describe the:

- Level of knowledge regarding mental health management among nurses in HIV/AIDS services
- Attitudes of nurses regarding managing people who present with both mental health problems and HIV/AIDS
- Skills or behaviour of nurses regarding management of people with mental problems and HIV/AIDS
- Factors that are barriers to integration of mental health into HIV/AIDS services
- Management of mental health problems among people living with HIV/AIDS.

1.6 RESEARCH QUESTIONS

The research questions of the study were:

- What is the level of knowledge regarding mental health management among nurses working with people living with HIV/AIDS in Primary Health Care setting?
- What are the attitudes of nurses regarding mental health management among people living with HIV/AIDS in Primary Health Care?

- What are the skills practice of nurses regarding mental health management and HIV/AIDS?
- What are the barriers of integrating mental health into HIV/AIDS services as experienced by the nurses in Primary Health Care?
- What is the management of mental health problems among people living with HIV/AIDS?

1.7 SIGNIFICANCE OF THE STUDY

Exploring the knowledge, attitudes, skills and preparedness of nurses with regard to the integration of mental health into HIV/AIDS aims to have a significant contribution to nursing in the following manner:

Nursing practice: Government needs to improve the way on how to handle people who present with both mental health problems and HIV/AIDS by developing guidelines and policies that will address the attitudes of nurses who work with people who are infected as well as ensuring that nurses are well equipped with relevant knowledge, skills and practices for the nurses to be able to deal with such cases. Basic in-service education, such as seminars, need to be taken into consideration (Williams et al., 2005). There must be enough staff to carry out educational programmes in hospitals and clinics. The demands of patient care has overwhelmed and stretched their resources, leading providers to question whether HIV/AIDS should really be a priority (Collins, 2006). Nurses should therefore be educated on HIV/AIDS and mental health, with special emphasis on the relationship between the diseases (Freeman et al., 2005). Staff shortages need to be addressed and providers also complained of a general neglect of psychiatric services by some hospital administrations, which left them feeling vulnerable and fearing for their safety. This was supported by (Collins, 2006), who noted that staff working with psychotic patients were at risk of contracting HIV/AIDS.

Exploring the knowledge, attitudes, skills and preparedness of nurses will illuminate the gaps in terms of nurse preparedness, especially those at a Primary Health Care level. The findings of this study may lead to creating interventions such as in-service training as noted by Collins (2006).

Nursing research: A number of studies that have been conducted have noted the link between mental health disorders and HIV/AIDS infection and they all agreed that the common health disorders of people living with HIV/AIDS include depression, anxiety, substance abuse, alcohol abuse and psychosis (Freeman et al., 2007; Baingana et al., 2005). This gives a clear understanding and insight that there is a need for integrating mental health into HIV/AIDS services for the benefit of those clients that present with both mental health disorders and HIV/AIDS (Williams et al., 2005). This study will contribute to research in understanding the current practices of nurses at service delivery.

Community: Given the complexity of HIV/AIDS in the community it is critical to understand the patterns of disclosure and acceptance among PLWHA. Literature has demonstrated that there is still evidence of HIV related stigma, which affects the mental health of PLWHA, giving rise to high incidence of depression and other related mental illness (Beagelehole, 2008). This study is thus important to address integration of mental health into HIV/AIDS services among health care workers who deal with community.

Nursing Education: This study will highlight the gaps in the curriculum on assessing mental health care and will hopefully lead to the inclusion of core competencies in the mental health curriculum. This study could also lead to the introduction of staff development programmes (Stuckler et al., 2008).

1.8 OPERATIONAL DEFINITION OF TERMS

The following definitions apply for the study

Mental health is a state of being in which a person is simultaneously successful at working, loving and resolving conflict by coping and adjusting to the recurrent stresses of everyday living. This does not mean that a mentally healthy person has no problems. He or she might at certain times experience severe distress, but is generally able to cope with the distress (Uys and Middleton, 2004). In the context of this study, mental health refers to a physical, psychological, social, emotional and spiritual state of well-

being, in which a person is simultaneously successful at working, loving and resolving conflict by coping and adjusting to the recurrent stresses of everyday living.

Primary Health Care refers to providing essential health care that is universally accessible to individuals and families in the community and is provided as close as possible to where people live or work. It refers to care that is based on the needs of the population. It is decentralized and requires the active participation of the community and family. In this study, Primary Health Care refers to the services that are accessible to the individual in the community and care which is based on the needs of the population.

Integration is a method of service delivery that provides people with seamless services from multiple programmes or areas within programmes without repeated registration procedures, waiting periods or other administrative barriers. It differs from system co-ordination, in which services from multiple agencies are provided, but for which people may have to visit different locations and register separately for each of the agency's programmes to obtain these services (WHO, 2010).

HIV refers to the Human Immunodeficiency Virus. It is a virus that attacks the immune system, thus making it much harder for those infected to recover from minor infections and illness. HIV is transmitted from person to person (Kirschner, Strijbos and Martens, 2004).

AIDS stands for acquired immunodeficiency syndrome and is the point at which the body can no longer fight off infections and illnesses. AIDS is not transmitted, but is the result of HIV destroying the blood cells that fight infections (Roy, 2003).

HIV/AIDS services are those services that manage and treat all the related HIV/AIDS diseases and offer antiretroviral treatment to those who need it, according to the level of their CD 4 count and viral load. The main purpose of the service is to reduce the level of HIV developing to the stage of AIDS and to prevent opportunistic infections (UNAIDS, 2008).

1.9 THEORETICAL FRAMEWORK

A theoretical framework provides the context for the study. The researcher used the Theory of Therapeutic Commitment, which was developed by (Lauder et al., 2002) to guide this study.

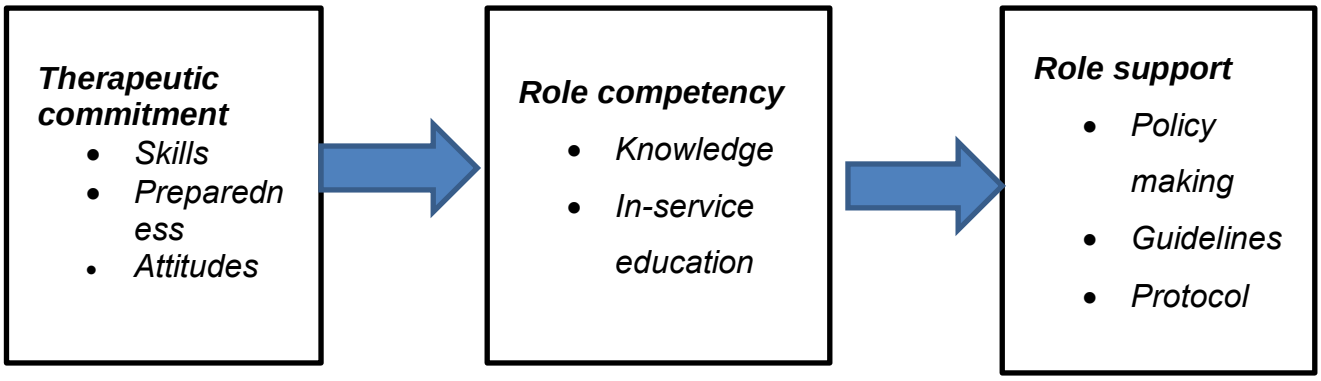

Figure 1.1: Theory of Therapeutic Commitment, Role Competency and Role Support (Lauder et al., 2002).

Therapeutic relationships are the cornerstone of nursing practice with people who are experiencing threats to their health and this includes people suffering from a mental illness (Lauder et al., 2002).

The theory of Therapeutic Commitment is a revised version of the Maudsley Alcohol Pilot Project (MAPP) model, which was originally developed by Shaw, Spartley, Cartwright and Harwin (1978) to explain the factors which influence the therapeutic commitment of unspecialised health professionals in dealing with alcohol and alcohol related problems.

The model linked the perceived levels of knowledge and skills of health professionals with their ability to establish effective therapeutic relationships. The core concepts of the original MAPP model included role legitimacy, therapeutic commitment and role adequacy. Shaw et al. (1978) described role adequacy as the health professionals' confidence in their capacity to respond effectively to clients problems, role legitimacy as the extent to which health professionals perceive that they have the right to intervene in

clients problems and therapeutic commitment as behaviours and attitudes that qualify health professionals. The MAPP model proposed that health professionals feel insecure in their roles if they do not have adequate knowledge and skills to deal with the mental health problems (MHP) of their clients. This is consistent with the revised model, the Theory of Therapeutic Commitment (Lauder et al., 2002).

1.10 APPLICATION OF THE THEORETICAL FRAMEWORK IN THIS STUDY

The Theory of Therapeutic Commitment purported that role competency and role support have a direct influence on the therapeutic commitment of nurses (Lauder et al., 2002; Angus et al., 2001). It is also apparent that perceived low levels of role support or role competency may have a negative influence on the nurses' levels of therapeutic commitment to dealing with mental health problems of people living with HIV/AIDS (Lauder et al., 2002). The theory predicts that interventions by nurses who are not specialized become more effective if their levels of therapeutic commitment are high (Cartwright 1980). As such, it can be argued that the same variables may influence the success of nursing interventions for people living with HIV and AIDS who are also experiencing mental health problems.

Nurses who display high levels of therapeutic commitment are able to reduce feelings of insecurity in their clients and achieve successful outcomes (Lauder et al., 2000). This is supported by Cartwright (2004), who stated that health professionals who are not therapeutically committed to their clients affectively withdraw and do not provide the necessary environment for creating a therapeutic relationship and hence fail to achieve successful outcomes. On the other hand, the creation of a therapeutic nurse-client relationship facilitates the nurse's understanding of the client's needs and, consequently, the planning of appropriate interventions. For these reasons, it can be said that successful outcomes are closely associated with the attitudes of the health professionals. In this study, the three components of the model apply as follows:

Role competency relates to the knowledge that the nurse possesses with regard to management of clients or people living with HIV/AIDS who also have mental health problems. Role competency is a self-perception that working with mental health

problems is a legitimate part of one's role and that one has the skills and knowledge to discharge this responsibility well (Lauder et al., 2002).

Role support means the self-perception that one has a source of specialist support from which advice can be easily obtained. It also relates to nurses' attitudes and how well prepared they are in attending to mentally ill clients without stigmatizing them or treating them differently because of the nature of their illness (Lauder et al., 2002).

Therapeutic commitment refers to the support that the nurse renders to people living with HIV/AIDS and is conceptualized as a predisposition to working therapeutically with people. It also refers to therapeutic relationships, which are those interpersonal engagements between professionals and patients that are directed at improving and supporting wellbeing and it is necessary to understand how these develop throughout a nurse's career (Forchuk and Reynolds, 2001).

1.11 CONCLUSION

The aim of this chapter was to highlight mental health and its relationship with people living with HIV/AIDS, drawing both from international and African literature. This chapter presented the introduction and background to the study. It also presented the problem statement, the aim and objectives of the study, the research questions, the significance of the study, the operational definitions and the theoretical framework of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the current literature with respect to the phenomenon of mental health and HIV/AIDS in Primary Health Care settings and the knowledge, attitudes, skills and preparedness of nurses working in these services. The following search terms "mental health and HIV/AIDS, mental health in Primary Health Care, and integrating of mental health into HIV/AIDS services in Primary Health Care", were used to search for literature in the on–line databases of CINAHL, MEDLINE – EBSCOHelath, MEDLINE-PUBMED, Bio-Med Central and Science Direct.

This literature review is presented in three sections. The first section provides an overview on issues around mental health and HIV/AIDS globally, within sub-Saharan Africa as well as in KwaZulu-Natal. It also discusses the available literature on integrating mental health into HIV/AIDS services in Primary Health Care settings in KwaZulu-Natal. The second section reviews common mental health disorders affecting people living with HIV/AIDS, while the third section explores the knowledge, attitudes, skills and preparedness of nurses working with people who have mental problems or disorders and are also living with HIV/AIDS, and its impact on the treatment outcomes of HIV/AIDS. This review also addresses the role of a nurse in the management of mental health problems associated with HIV/AIDS.

Mental neurological and substance use (MNS) disorders occur frequently in patients with HIV and are associated with negative outcomes including reduced adherence to antiretroviral medications (ART), and diminished quality of life. A review of of the selected databases from 2001 to 2012 revealed a dearth of evaluated mental health services in HIV primary care particularly in low and middle income countries. Available findings suggest, however that opportunities do exist in HIV primary care to integrate interventions for recognition and treatment of depression and alcohol use disorders and prevention of HIV neurocognitive disorder (i.e. HAND) (Kaaya et al., 2013).

Among patients receiving treatment for HIV/AIDS, MNS disorders may occur at rates that exceed those of physical co-morbidities. Depression is twice as common in people living with HIV (especially when symptomatic) that is uninfected individuals. In addition, alcohol use is frequent in persons receiving treatment for HIV and AIDS in one Saharan African study, with adverse effects and hazardous alcohol use were reported as 27% and 3.0% respectively, with adverse effects on ART adherence. HAND prevalence ranges from 20% to 56% worldwide, and is especially high in older patients and those with advanced immune suppression. In low income countries, HAND is compounded by poverty opportunistic central nervous infections, and assessment challenges (Kaaya et al., 2013).

A variety of mechanisms links MNS disorders to HIV disease. Firstly, the social conditions under which most patients with HIV live (e.g. limited employment, housing and food insecurity, exposure to stigma, and fear of sero-status disclosure) contribute to the development and exacerbation of MNS disorders (Kaaya et al., 2013). MNS disorders, in turn, are associated with greater suffering, including poorer psychological adjustment to a chronic progressive and life threatening illness; lower quality of life; HIV/AIDS treatment adherence and outcomes and an increased risk of HIV transmission. Secondly, HIV/AIDS co-morbid substance use disorders can influence HIV transmission by increasing vulnerability to sexual exploitation and impairing the judgement required to engage in sage sexual practices. Thirdly, HIV/AIDS directly affects the central nervous system (CNS) with increasing evidence of long term cognitive effects that may, despite achievement of non-detectable viral load, not be reversible with currently available ART. HIV/AIDS also puts individuals at risk for acquiring other infectious and non-infectious conditions that affects the CNS including malaria, tuberculosis, and lymphomas and further impair CNS function (Kaaya et al., 2013).

The need to redesign health system to integrate care for MNS disorders with other chronic disease care was identified as one of the Grand Challenges in Global Mental Health (GCGMH). Although robust evidence for occurrence of HIV and MNS disorder co-morbidities exists less evidence regarding implementation of programs that integrate

their care within HIV treatment is available, particularly in settings with generalized epidemics. At a minimum package of care for selected MNS disorders should be included when scaling up HIV primary care prevention and treatment services. This paper is the fourth in a five-part series providing a global perspective on integrating mental health (Kaaya et al., 2013).

There is a need to train health care workers to collaborate in reducing mental health and HIV/AIDS related stigma (The World Federation for Mental Health, 2014), noted the lack of integration needs and voices of people experiencing mental health problems and stated that increased empowerment of these people is needed. The National Director of the Zimbabwe AIDS Network, Chaza-Jangira, indicated that increased community level support is needed for those who receive positive diagnosis, and that better understanding is needed around how mental health problems increase the vulnerability of individuals to HIV/AIDS infection (Challco, Gerosa, Bittencourt and Isotani, 2014).

2.2 MENTAL HEALTH AND HIV/AIDS GLOBALLY

HIV/AIDS is a significant cause of death and disability in low and middle income countries (Baingana et al., 2005). Reflected in Figure 2.1, globally an estimated 35.3 million people were living with HIV/AIDS in 2012 (UNAIDS, 2013), an increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4) million in 2001. At the same time the number of deaths is also declining with 1.6 million AIDS deaths in 2012, down line from 2.3 million in 2005 (UNAIDS, 2013).

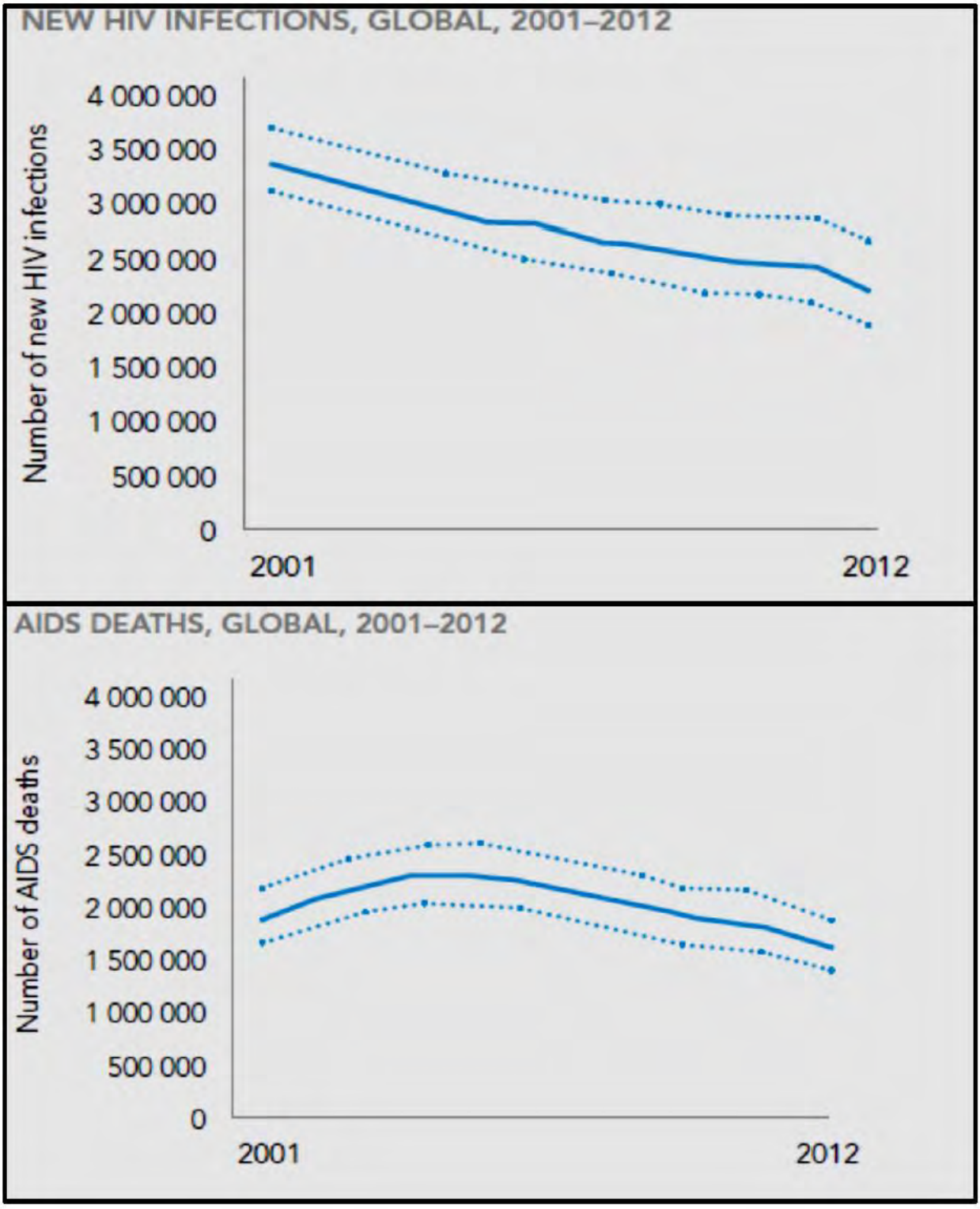

Figure 2.1: Global new HIV infections and AIDS related death 2001- 2012 (UNAIDS, 2013).

2.3 MENTAL HEALTH AND HIV/AIDS

Mental health and HIV/AIDS are closely interlinked, mental health problems, including substance use disorders, are associated with increased risk of HIV infection and AIDS and interfere with their treatment, and conversely some mental disorders occur as a direct result of HIV infections (WHO, 2010).

Incidence studies have demonstrated a high sero-prevalence of HIV infection in people with serious mental illness. Prevalence rates in mental illness in both in and outpatients have been reported to be between 5% and 23%, compared with a range of 0.3% to 0.4% in the general population in the United States of America over comparable time periods. Some studies have reported behavioural risk factors among people with severe mental illness, estimating transmission of HIV/AIDS infection among these to be between 30% and 60% of (WHO, 2008). World-wide reports from the World Bank indicate that mental health disorders, and especially depression, are among the most prevalent health problems, resulting in enormous losses in terms of human resources and economic potential. Unfortunately few studies have attempted to systematically assess mental health care needs in South Africa at community level and little information is available regarding the risk factors associated with these problems (Phielix, Prins and Kirschner, 2010).

Even fewer studies have assessed the prevalence of common mental health problems in primary care settings or at traditional healers. An epidemiological study conducted by Bhagwanjee, Parekh, Paruk, Petersen and Subedar (1998) among rural African adults in KwaZulu-Natal revealed an unexpectedly high prevalence of anxiety and depressive disorders amongst adults (Collinson, 2008). Macleod, Masilela and Malomane (1998) indicate that mental health problems are wide spread, constituting a considerable burden to the community. Both authors conclude that Primary Health Care services need to be improved to ensure that these disorders are adequately recognized and treated in this setting. They further suggested the integration of mental health care services into HIV/AIDS services or Primary Health Care services to ensure that people

who are suffering from both mental health problems and HIV/AIDS can be treated in one area, which could reduce costs and promote good service delivery to people.

The World Health Organisation (2008) stated that HIV/AIDS imposes a significant psychological burden. People with HIV/AIDS often suffer from depression and anxiety as they adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for instance shortened life expectancy, complicated therapeutic regimens, stigmatization and loss of social support, family or friends. HIV infection can be associated with high risk of suicide or attempted suicide. The psychological predictors of suicidal ideation in HIV/AIDS infected individuals include concurrent substance use disorders, past history of depression and presence of hopelessness. Apart from the psychological impact, HIV/AIDS infection has direct effects on the central nervous system and causes neuropsychiatric complications, including HIV encephalopathy, depression, mania, cognitive disorder and frank dementia, often in combination. Infants and children with HIV/AIDS infection are more likely to experience deficits in motor and cognitive development compared with HIV/AIDS negative children (WHO, 2008). Cognitive impairment in HIV/AIDS has been associated with greatly increased mortality and independency of other factors, such as baseline clinical stage, CD4+ cell count, serum haemoglobin concentration antiretroviral treatment, and social and demographic characteristics (Adewuya, Afolabi, Ola, Ogundele, Ajibare and Oladipo, 2007).

Like any other chronic and fatal disease, HIV/AIDS affects every aspect of a person's life, including their mental health. Many research studies suggest that mental illnesses are common in people living with HIV/AIDS (WHO, 2008; Bing et al., 2001)conducted a study to estimate the prevalence of psychiatric disorders and substance abuse among American adults infected by HIV/AIDS and found that nearly half of their sample (n=2864) reported some form of psychiatric disorder, such as major depression and psychosis, as well as anxiety disorders, such as general anxiety disorder and panic attacks, and 40% reported having used an illicit drug. Similarly, Israelski et al. (2007) estimated the prevalence of psychiatric co-morbidity of three stress related disorders among Northern Californians receiving primary care for HIV/AIDS. Their study revealed

that in a sample of 118 people, 56% screened positive for at least one psychiatric disorder. Vitiello (2006) found that 29.1% of all patients studied suffered from psychiatric disorders, namely major depression, dysthymia, generalized anxiety disorder, panic disorder and post-traumatic stress disorder (PTSD).

Sub-Saharan Africa is one of the world regions most affected by HIV/AIDS. The region comprises nearly fifty sovereign countries grouped into five sub-regions, namely Eastern Africa, Southern Africa, West Africa, Central Africa and the islands of the eastern coast of the continent (Beaglehole et al., 2008). The World Bank defines the majority of the countries within the region as middle-income countries. The region has a population of approximately 809115.000, 2.7% (22 million) of whom are living with HIV/AIDS (Population Reference Bureau, 2008). According to the UNAIDS report, 67% of all the people living with HIV/AIDS world-wide live in this region. The same report indicates that for 2007, 17 million people were newly infected with HIV/AIDS and that 75% of all AIDS related deaths world-wide occurred in this region (UNAIDS, 2008).

The HIV/AIDS prevalence for adults in this region varies substantially from sub-region to sub-region and from country to country, ranging from 23-32% in Botswana and Swaziland, 12-28% in South Africa and to between 2% to 5% in many East African countries (UNAIDS, 2008). The HIV/AIDS prevalence in adults has decreased in a number of East African countries and most notably in Rwanda from 5.2% in 2004 to 3% in 2008 (UNAIDS, 2008). The prevalence of HIV/AIDS varies in Rwanda from7.3% in urban areas to 2.2% in rural areas (UNAIDS, 2008). Although the HIV/AIDS overall prevalence rate is decreasing in parts of the sub-Saharan region, it is the leading cause of death in the region and fourth in the list of the ten leading diseases for global disease burden (Stuckler et al., 2008). Furthermore, HIV/AIDS is increasingly being regarded as a chronic disease which in turn, contributes to the burden of chronic diseases which is increasing in low-middle income countries (Beaglehole et al., 2008).

The World Health Organization's (WHO) report on HIV/AIDS and mental health outlines a number of studies which have demonstrated a high prevalence of psychiatric disorders in people living or infected by HIV/AIDS (WHO, 2008). A number of studies

conducted in different countries in Africa have documented a high prevalence of psychiatric disorders among people with HIV/AIDS (Myer et al., 2008; Adewuya et al., 2007; Sebit, Tombe, Siziya, Balus, Nkomo and Maramba, 2003). These rates range from 19% in South Africa, 59% in Nigeria, 71% in Zimbabwe to 81% in Uganda. This variation in rate may be related to either clinical aspects, such as the stage of the HIV/AIDS disease or the methodology used to determine this prevalence. For example, Myer (2008) studied the common mental disorders among people living with HIV/AIDS in South Africa. This study found the overall prevalence of mental illness in HIV/AIDS infected individuals to be high, with 19% of participants having depression, post-traumatic stress disorder, or alcohol abuse or dependence. In Nigeria, Adewuya et al. (2007) found that 59% of HIV/AIDS positive people who participated in their study had a co-morbid psychiatric disorder, and this rate was significantly higher than in non-infected people. In Zimbabwe, psychiatric disorders were also found to be high among people living with HIV/AIDS. The findings showed that 71.3% of HIV infected individuals had a co-morbid psychiatric disorder, compared to 44.3% of the HIV/AIDS negative control group (Sebit et al., 2003). In Uganda, Petrushkin, Boardman and Ovuga (2005) found that the total prevalence of psychiatric disorders were 82.6% of which depressive and anxiety disorders were the most common ones.

A number of reasons are given for the presence of psychiatric disorders among people living with HIV/AIDS. Freeman et al. (2005) state that premorbid mental history, effects of the HIV virus on the central nervous system, the psychological impact of living with HIV/AIDS, side effects of medication and results of social stigma and discrimination constitute some of the reasons for the high level of mental disorders affecting people living with HIV/AIDS. However, according to Freeman et al. (2007), not everyone living with HIV/AIDS has a mental disorder.

Research suggests there are some socio-demographic factors and HIV medical related factors that increase the risk of depression among people living with HIV/AIDS. Clinical factors, such as number of HIV related symptoms, time since diagnosis of HIV status, illicit drug use and heavy alcohol use were significantly associated with psychiatric disorders among people living with HIV/AIDS (Myer et al., 2008; Bing et al., 2001). On

the other hand, socio demographic factors, such as unemployment, marital status, living alone and poor social support were found to be significantly associated with the high prevalence of psychiatric disorders among people living with HIV/AIDS (Adewuya et al., 2007; Bing et al., 2001).

It is argued that there can be no health without mental health and that systematically addressing neuropsychiatric disorders in Primary Health Care is one of the ways in which the burden of co-morbid diseases, especially mental disorders and HIV/AIDS, can be reduced over time (Prince, Saxena, Maj , Maselko and Phillips, 2007). Depression has been found to be associated with lower overall health and poorer quality of life among people living with HIV/AIDS than with HIV negative control groups(Williams et al., 2005).

The World Health Organization (2008) recommended that a successful HIV/AIDS intervention programme should include appropriate strategies for the assessment and management of mental disorders as part of the routine service. Sraelski et al. (2007); Freeman, Nkomo, Kaffar and Kelly (2008); and Freeman et al. (2005) argue that people receiving Primary Health Care for HIV/AIDS should be routinely screened and treated for symptoms of mental disorders as this has been shown to significantly improve the HIV/AIDS disease outcome. These authors suggest that estimating the prevalence of depression among HIV/AIDS affected people is important to developing and/or improving services for the treatment of mental illness at HIV treatment sites and thus, to improving HIV disease outcome and quality of life.

Rwanda has made a number of efforts to improve the medical care of those affected by HIV/AIDS and it is more than likely that these efforts have contributed to the decreasing adult prevalence rate (UNAIDS, 2008). For example, services for the prevention of HIV transmission from mothers to children have expanded and are accessible in more than half of the country's health facilities. Furthermore, the rate of male partners participating in mother to child transmission prevention services has increased from 9% in 2003 to 74% in 2006 (UNAIDS, 2008). The sites providing ARVs increased from 76 in 2005 to 165 in 2007 and the ARVs coverage rate grew from 71% to 84% (UNAIDS 2008).

Although psychiatric disorders, particularly depression, appear to be high in people living with HIV/AIDS, they frequently go undetected and therefore untreated in HIV/AIDS services or care settings (Israelski et al., 2007; Petrushkin et al., 2005). For example, Israelski et al. (2007) found that 56% of participants met the symptom criteria of depression, post-traumatic stress disorder and acute disorders and, of these, only 43% reported current treatment for any mental health condition. Only 24% of participants reported that they were currently receiving psychotherapy services and only 35% reported current use of psychiatric medications. Similarly, Petrushkin et al. (2005) found that none among a small sample were receiving any treatment for their psychiatric disorders. Untreated depression among HIV infected people has been found to be associated with poor outcome of HIV/AIDS treatment and is likely to cause immunosuppression (Olatunji, Mimiaga, O'Cleirigh and Safren, 2006). Berger-Greenstein, Carlos, Cuevas, Brady, Trezza and Mark (2007) found that some of the psychiatric symptoms of depression, such as difficulty in concentrating, fatigue and suicidal thoughts, interfere with medication adherence among people living with HIV/AIDS.

The prevalence of mental disorders in people living with HIV/AIDS in South Africa ranges from 19% to 43%. For example, Freeman et al. (2007) estimated the prevalence of mental disorders in this population using a large sample (n= 900). This study found that 43.7% of the total sample screened positive to at least one mental disorder. The most common disorders in this study were depression, psychosis, alcohol abuse and post-traumatic stress disorders. Myer (2008) studied three common mental disorders (depression, post-traumatic stress disorder and alcohol abuse) among individuals living with HIV/AIDS and found that 19% of their sample (n= 88) met the criteria for at least one psychiatric disorder. Four of the most commonly occurring psychiatric problems in people living with HIV/AIDS are mood disorders, suicide, anxiety disorders and substance abuse and two of these are reviewed below.

2.3.1 Suicide among people living with HIV/AIDS

Suicide and suicidal attempts have been found to be high in people infected by HIV/AIDS. Komiti et (2001) conducted a review of existing literature on suicidal behaviour in people living with HIV/AIDS and found an increase in both suicidal ideation, and completed suicide. Roy (2003) researched the prevalence of suicide among people living with HIV/AIDS and examined the risk characteristics of these patients. In a sample of 149 HIV/AIDS infected patients, it was found that 66 patients (44.3%) had attempted suicide. Gender was related to the increase in suicide attempts, with women being at higher risk ($p = 0.01$) than men. Other characteristics associated with suicide attempts among people living with HIV/AIDS in Roy's study was the history of depressive disorders (Roy, 2003). In France, suicide attempts have been found high among people living with HIV/AIDS. Preau (2008) conducted a study with 2932 French people living with HIV/AIDS. The findings indicated that 22% had attempted suicide, a figure which is much higher than the prevalence of suicide attempts in the French general adult population of 8%.

The literature suggest that there are at least three periods in the illness cycle during which time people are more at risk for suicide. Meel (2006) argues that the period following the person's awareness of HIV/AIDS status is one of the most important risk periods for suicide. The author suggests that this may be exacerbated by an unexpected positive result or a result disclosure for which the person was not adequately prepared beforehand.

2.3.2 Anxiety disorders and HIV/AIDS

Findings from a South African study by Martin (2008) revealed that 34 participants (40%) from a sample of 85 patients recently diagnosed with HIV/AIDS screened positive to post-traumatic stress disorder (PTSD) related to HIV/AIDS, of whom 82.4% were clinically distressed. High rates of anxiety disorders were also reported in Nigeria, where Adewuya et al. (2007) found that 12.5% screened positive for PTSD, 9.1% had social anxiety disorder, 8% had generalized anxiety disorder, 6.8% panic disorder, 4.5% had specific phobia and 3.4% had obsessive disorders. Anxiety is a common symptom in

HIV-infected patients, particularly when the symptoms are severe or persistent. These disorders include panic disorder, generalized anxiety disorder, obsessive-compulsive disorder and PTSD. Among HIV infected patients receiving medical care, 20.3% were found to have an anxiety disorder, with 12.3% meeting the criteria for panic disorder, such as adjustment disorder and 2.8% having generalized anxiety disorder. Patients with other psychiatric disorders, such as adjustment disorders, major depression, psychosis or substance use disorders can also present with significant anxiety. To help patients receive optimal care, clinicians need to be aware of the differences among these disorders. Furthermore, patients with histories of anxiety or mood disorders were found to be susceptible to recurrence of anxiety symptoms during the course of HIV illness (Vitiello et al., 2006).

The American State Department of Health AIDS Institute (2006) recommend that clinicians should consider the diagnosis of an anxiety disorder when a patient presents with common somatic symptoms, such as chest pain, diaphoresis, dizziness, gastrointestinal disturbances and/or headaches, for which no underlying medical etiologic can be established. Anxiety symptoms, such as worry, nervousness, fear and tension are commonly experienced by people with HIV during periods of their illness, and may be a response to a stressful situation. An anxiety disorder occurs when symptoms interfere with a patient's daily function, for example if the patient is unable to work, leave home, attend to medical care or if it interferes with personal relationships and causes marked subjective distress (Vitiello et al., 2006; Bing et al., 2001).

2.4 INTEGRATING MENTAL HEALTH AND HIV/AIDS SERVICES

Integrating mental health into HIV/AIDS services initiative programmes presents an opportunity to improve the health of people with HIV/AIDS. The WHO (2009) has produced a series of modules and some training material for integrating mental health interventions into antiretroviral therapy programmes. HIV/AIDS programmes need to include assessing mental and substance use disorders and their appropriate management (WHO, 2008). Primary Health Care providers, including HIV/AIDS counsellors, can be trained to recognize and treat common mental and substance use

disorders and refer patients to specialized services, when warranted (WHO, 2008).Such providers need to be properly trained and supported by adequate supervision, and a process of referral to mental health services needs to be an integral part of the health infrastructure (WHO, 2008; Clark, Parker and Gould, 2005; Lauder et al., 2002). The services for mental health and substance disorders need to collaborate closely with HIV/AIDS services at all levels in order to facilitate co-ordinated action involving other relevant community based resources (WHO, 2008).

Despite the fact that developing countries carry more than 90% of the burden of HIV/AIDS, little information about the interaction between HIV/AIDS and mental health is available in low–middle income countries. Research and support are needed in those countries to facilitate this interaction, including the relationships between mental health and substance use disorders and HIV/AIDS. Furthermore, research should investigate service delivery and cost effective models of service provision, and the impact of interventions for mental disorders and substance use on the outcomes of HIV/AIDS disease (WHO, 2008; Reed and Fitzgerald, 2005).

2.5 MENTAL HEALTH AND HIV/AIDS IN THE AFRICAN CONTINENT

2.5.1 Mental health and HIV/AIDS in Rwanda

Rwanda is a small, landlocked country (approximately 228200 square kilometres) located in East Africa, bordered by the Demographic Republic of Congo in the east, Burundi in the south, Tanzania in the west and Uganda in the north. It is considered the most densely populated country in Africa, with an estimated population of 9 200000 and a population density of 351 persons per square km (Goodyear, 2005). Rwanda is designated as a low-income category country according to the World Bank classification of countries (http:web.worldbank.org). The first case of HIV/AIDS in Rwanda was reported in 1983 in the Centre Hospitalier Universitaire de Kigali, followed by the first study of HIV/AIDS prevalence among the general population in 1986. This study established a prevalence of 17.8% in urban settings and 1.3% in rural areas (University of Cape Town [UCT], 2014). At the end of 2001, it was estimated that 11.1% of the adult

population in Rwanda were living with HIV/AIDS (Stahl, Koschmann and Suthers, 2006).

This rate declined to 7% in 2004 and to 3% among the general population in 2005 (University of Cape Town [UCT], 2014; WHO, 2008). This decline in prevalence is possibly associated with the coordinated efforts of the Ministry of Health, the TRAC Plus and the District Aids Control Committees, which have been established in each of the 30 districts (Goodyear, 2005). Mental health in Rwanda is coordinated by the National Mental Health Programme within the Ministry of Health, and mental health care services have been integrated into the Primary Health Care system. Although there is little information available in the literature regarding the prevalence of depression in the general population in Rwanda, a few studies assessing depression have found it to be in HIV infected people and among the genocide affected group. Cohen, Fabri, Cai, Shi and Binagwaho (2006) conducted a study to assess the improvement in the post-traumatic stress disorder and depressive symptoms in HIV infected Rwandan women on antiretroviral therapy, and found that at baseline, 59% of HIV positive women (n=779) had post-traumatic stress disorder, while 81% had clinical significant depression.

2.5.2 Mental health and Primary Health Care in Kenya

Kenya is one of the poorest countries in the world, ranked 144 out of 177 countries in the United Nations Human Development Report for 2007. The gross national income per capita was US $520 in 2005 and US $770 in 2008. The population is estimated to be 38million and life expectancy is 54 years. More than one in ten children die before the age of five, and four women out of every 1 000 die in childbirth. The prevalence of HIV/AIDS is 7.7% in women and 4% in men (Villasclaras-Fernández, Hernández-Leo, Asensio-Pérez and Dimitriadis, 2013). Kenya had been assumed to have more political stability than other African states, but in the context of unemployment, economic disparities and widespread concerns about access to ancestral lands, there was widespread violence immediately after the 2007 general election, leading to ethnic division, the displacement of approximately 500 000 people and more than 1 300

deaths (Villasclaras-Fernández et al., 2013). The government of Kenya spends approximately US $10 per capita per year on health. Investment in health largely focuses on communicable diseases, especially HIV/AIDS and malaria. Population access to health care remains very restricted, with only 1-2 nurses and clinical officers for each 10 - 20.000 population, and there are no doctors at primary care level in the public health system (Villasclaras-Fernández et al., 2013).

2.5.3 Mental health and HIV/AIDS in Malawi

Malawi's Mental Health Treatment Act makes provision for mental health care and control of mental hospitals in Malawi (Haris, 1968). The provision of mental health care is further explicated by the country's National Mental Health Policy. This policy, amongst other things, stipulates that mental health services must be incorporated into the general care system, as provided by the Ministry of Health and Population (Ministry of Health and Population, 2001). However, as there is a scarcity of mental health specialists, they are rarely found in general care settings. There are 2.5 mental health care nurses per 100 000 population (WHO, 2005), and only one psychiatrist is employed by the Ministry of Health to cater for a population of fourteen million people (Onrubia and Engel, 2009).

In Malawi, the majority of all the health care professionals are nurses and they provide the bulk of health care services. They also provide most of the mental health care services to clients in the country (Skuse, 2008). In addition, the majority of health care professionals caring for PLWHA in Malawi are nurses, both at outpatient and inpatient settings, and they are expected to deal with the mental health problems (MHP) of these people. The provision of mental health care to PLWHA is important because, apart from the physical illnesses associated with the virus, they are also affected by mental health problems (World Health Organisation, 2008; Freeman et al., 2008; Freeman et al., 2007; Wright et al., 2007; Mwale, 2006; Freeman et al., 2005; Mellins et al., 2003).

Considering the established relationship between mental health problems and HIV/AIDS, it is likely that some of the PLWHA in the country are affected by MHPs. It is apparent that HIV/AIDS is associated with the ethology of mental health problems in

PLWHA and also that the mental attitude of PLWHA would influence their prevention or treatment of the virus (Freeman et al., 2007; Wright et al., 2007). Providing mental health care to PLWHA in HIV/AIDS settings may be helpful in preventing further spread of the infection and improving the quality of life of those who are affected. However, in many developing countries like Malawi, mental health care issues are not usually considered as important aspects of HIV/AIDS intervention programmes (Lazarus and Freeman, 2009).

2.5.4 Mental health and HIV/AIDS in South Africa

It is clear that people living with HIV/AIDS worldwide are affected by mental health problems (Hoadley, 2010; Collins, 2006). Mental health problems are disturbing human emotional and psychological experiences and it is very important that nurses must provide holistic care when dealing with mental health problems of people living with HIV/AIDS (Angus et al., 2001). The Secretary General of the World Federation for Mental Health (WFMH), Garrison, said:

> "*it is clear from the grassroots partners and member that there is a demonstrated need for strengthened mental health services addressing stress management, social support and self-esteem among people living with stress affected by HIV/AIDS (Challco et al., 2014). Caregivers in particular experiences high levels of stress and their role can take a substantial mental health and physical toll as they care for the physical, emotional and economic needs of their family members".*

Professor Robertson, WFMH Board Member and Lead Volunteer on the Africa initiative, went on to describe the AIDS epidemic as a humanitarian catastrophe, and challenged participants to consider whether current AIDS interventions were being undermined by a lack of accessible and effective mental health interventions. This was echoed by Dr Njenga, President of the African Association of Psychiatrists and Allied Professions, who offered an overview of the status of mental health in Africa, and concluded that a scale-up of comprehensive mental health services working in collaboration with national and local AIDS programmes was urgently needed (Challco et al., 2014). The three

researchers have a similar overview of the lack of integration of mental health care services into HIV/AIDS services. This gives us then a clear insight that our country (South Africa) needs to review its policies and the budget that is allocated for mental health services (Challco et al., 2014).

Considerable discussion took place on the interaction between mental health and HIV/AIDS at the forum of the World Federation for Mental Health (WFMH) Africa Initiative, identifying concerns, cautions and challenges for the initiative in going forward. A group of expert consultants in mental health and HIV/AIDS policy Freeman, Nkomo, Kaffar and Kelly (2008) suggested that a wide range of people are 'mentally affected' by HIV/AIDS, and that society as a whole is also affected. They argued that it not only those who are infected with the virus and their carers who encounter mental health problems, but that those who are unsure about their status and ruminating about whether or not they are positive might also be affected. They further presented research from various African based studies which had concluded that there is evidence of a link between mental health and AIDS in Africa. These studies found that mental disorders are higher in people living with HIV/AIDS as compared to the general population and that the relationship between mental disorders and HIV/AIDS is bi-directional. Mental disorders were shown to be both a risk factor and a consequence of HIV/AIDS (Challco et al., 2014).

Dr Anderson, a senior director of the office on AIDS at the American Psychological Association, also referred to increasing American based data on the complex interactions driving the epidemic, particularly with regard to issues of substance use and trauma. He suggested that it be recognized that in order to treat a physical disorder such as HIV/AIDS, attention must be paid to the individual's mental health given that mental health issues often develop during times of major physical illness, regardless of the presence of effective treatment (Challco et al., 2014). However, according to (Ghebrehiwet and Barrett, 2007), no studies have been conducted to assess the kind of training required by these general practitioners or on how the general practitioners feel when attending these patients.

Studies have suggested that fewer funds are being allocated for mental health than for other disciplines, but little is being done to bring this to the attention of the government or the Department of Health (DoH, 2013). Furthermore, there is a paucity of research concerning the aspect of the relationship between mental health and HIV/AIDS (Freeman et al., 2008; Williams et al., 2005). For integration of services to be successful, it must occur at all levels, national, provincial and regional. The programme should include specialists who are trained in mental health, including mental health doctors and nurses, to give proper guidance on how to handle patients who are mentally ill and affected by HIV/AIDS infection (van Leeuwen, Janssen, Erkens and Brekelmans, 2013; Williams et al., 2005).

2.6 EXPLORING GAPS IN MENTAL HEALTH AND HIV/AIDS

There is a need to train health care workers to collaborate in reducing mental health and HIV/AIDS related stigma (Albery, Heuston, Ward, Groves, Durand and Gossop, 2003). The World Federation for Mental Health (2014) noted the lack of integration of the needs and voices of people experiencing mental health problems and stated that increased empowerment of these people is needed. The National Director of the Zimbabwe AIDS Network, Chaza-Jangira, indicated that increased community level support is needed for those who receive a positive diagnosis, and that better understanding is needed around how mental health problems increase the vulnerability of individuals to HIV/AIDS infection (Challco et al., 2014).

2.7 MENTAL HEALTH MATTERS RELATING TO HIV/AIDS

There are relevant concerns regarding the mental health of people with HIV/AIDS as mental health issues are closely associated with the experience of living with HIV/AIDS and with the course and management of the disease. Thus there are distinct mental health related issues that would be relevant to HIV/AIDS programmes, such as cognitive impairment and dementia due to viral infection of the brain, depression and anxiety due to impact of the behaviours, the psychiatric side effects of some antiretroviral therapy, and the social difficulties faced as a result of stigma and discrimination (Olatunji et al., 2006).

Providing mental health interventions in settings that are already desperately short of mental health resources may not be feasible. However, there are opportunities that are evident, such as the roll out of the 3 by 5 initiative, which involves intensive and widespread training in the WHO Integrated Management of Adolescent and Adult Illnesses (IMAI). By including mental health in the IMAI guidelines and ensuring adequate training in basic medical and psychological management of disorders, a holistic and integrated primary mental health care approach can be promoted (WHO, 2010) .

Mental disorders, including substance use disorders, are risk factors for contracting HIV/AIDS, and the presence of HIV/AIDS increases the risk of development of mental disorders. The resulting co morbidity complicates help seeking, diagnosis, quality of care provided, treatment and outcomes (WHO, 2008). There are several barriers to diagnosing mental health problems in HIV/AIDS infected individuals. Patients often do not reveal their psychological state to health care professionals for fear of being stigmatized further. Also, health care professionals are often not skilled in detecting psychological symptoms and, even when they do, they often fail to take the necessary action for further assessments, management and referral (WHO, 2008).

Effective and readily available treatment and preventive measures for injecting drug users can prevent the spread of HIV/AIDS among such groups if sufficient proportions the target population can be reached. Appropriate policies and programmes should ensure that the prevention treatment service meets the needs of the clients and includes a combination of interventions. Treatment of substance use disorders should be integrated with HIV/AIDS prevention and treatment interventions (WHO, 2008; Collins, 2006).

2.8 THE MENTAL HEALTH ANDPOVERTY PROJECT (MHAPP)

There is growing recognition that mental health is a crucial public health and development issue in South Africa (SA). According to the University of Cape Town (2014), neuropsychiatric conditions rank third in their contribution to the burden of

disease in SA, and 16.5% of South Africans reported having suffered from mental disorders in their last year.

However, mental health is not given the priority it deserves in SA and a national mental health policy has not been formally adopted and implemented. The aim of the Mental Health and Poverty Project (MHaPP) is to examine the mental health policy and systems in SA, with a view to identifying the key barriers to mental health policy development and implementation, and steps that can be taken to strengthen the mental health system in the country. The current mental health policy in SA was analysed using the WHO-AIMS instrument, the WHO Checklist for Mental Health Policy and Plan and interviews with mental health policy stakeholders in SA (University of Cape Town [UCT], 2014).

2.9 CURRENT STATUS OF THE MENTAL HEALTH POLICY IN SOUTH AFRICA

South Africa's first post-apartheid mental health policy guideline, the National Health Policy Guidelines for Improved Mental Health in SA, was approved in 1997. A chapter on mental health was also included in the Department of Health's White Paper for the Transformation of the Health System in South Africa in 1997. The policy guidelines were drafted as an overview document, with the intention of drafting more detailed policies for specialised policy issues. No official plan accompanied the policy, but national targets with indicators were set to guide the realisation of selected priorities (University of Cape Town [UCT], 2014). The policy guidelines were approved for implementation at the highest level, but due to capacity constraints within the national office, they were neither formally published nor widely circulated throughout the country. Nor were all the specific policy guidelines completed or followed by the development of implementation guidelines. Furthermore, current officials in the National Directorate for Mental Health and Substance Abuse maintain that these guidelines did not conform to policy development protocols established since 1999, and do not constitute official policy. Therefore, this Directorate is in the process of drafting a new mental health policy for SA. The most recent draft of this policy is dated April 2006 (University of Cape Town [UCT], 2014).

2.10 CONCLUSION

This chapter highlighted the literature on mental health disorders among people living with HIV/AIDS and the relationship between them. It also highlighted the link between mental health problems and people living with HIV/AIDS, as compared to mental disorders in the general population. The current attitudes, preparedness, skills and knowledge of the general practitioners were also noted and a gap was identified in that there is little or nothing that has yet been done with regards to this. This chapter emphasized the importance of integrating mental health into HIV/AIDS services, as many people living with HIV/AIDS present with mood disorders, anxiety, psychosis and depression.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research approach, setting and design. It includes a discussion of the sampling procedure and tools that were used to collect data, how data was managed and analysed, the ethical issues that arose during the course of the study and the precautions that were taken to manage these.

3.2 RESEARCH PARADIGM AND APPROACH

This research study was based on a positivist paradigm which leads the quantitative researcher to perceive the world as external and science as value free. According to this approach, the social and physical world, including experience, can be known and studied (Terre Blanche, Durrheim and Painter, 2006). This paradigm argues that observers are independent, and their values can be suspended in order to understand what is being studied. Reality is seen as a whole and it can be understood by dividing it and studying its parts (Unutzer, Chan, Hafer, Knaster, Shields et al, 2012). This paradigm also argues that it is possible to understand and describe the reality of specific phenomena through direct observation and measurement of its discrete aspects (O'Leary, 2004).

A quantitative approach is seen as objective as it relates to phenomena or conditions independent of individual thought. It is perceptible to all observers and relies heavily on statistics and figures (Unutzer et al., 2012). Data derived from observation and measurement is therefore numerically represented, is beyond chance and has applicability beyond the sample to a wider population (Terre Blanche et al., 2006; Burns and Grove, 2005).

This study therefore aimed to explore and describe the knowledge, attitudes, skills and preparedness of nurses who work in HIV/AIDS services towards people who present with mental problems, as well as the significance of the relationship between mental

health and HIV/AIDS. The quantitative approach is therefore suitable for this study as it represents these observations and the relationship among them in explicit, numerical terms (Babbie, 2007). A quantitative approach was also suitable for this study as it only explored the knowledge, attitudes, skills and preparedness. Quantitative researchers use deductive reasoning to generate hunches that are tested in the real world (Polit and Beck, 2004). Quantitative research is conducted to describe new situations or concepts in the world (Burns and Grove, 2008).

3.3 RESEARCH DESIGN

A non-experimental descriptive exploratory survey was used in this study. According Polit and Beck (2006), the purpose of an exploratory descriptive study is to describe and document aspects of a situation as it naturally occurs. It is designed to get more information about characteristics within a particular field of study (Burns and Grove, 2005). Babbie (2007) describes exploratory research as a precise measurement of the characteristics of the population. Its methods, therefore, allow for the exploration of knowledge, attitudes, skills and preparedness of nurses, which was to be explored in this study. Rather than simply observing and describing, exploratory descriptive research investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related (Polit and Beck, 2006).

This design often uses surveys in the form of questionnaires to elicit the information on the selected phenomenon.

3.4 RESEARCH SETTING

This research was conducted in three Primary Health Care facilities, one HIV/AIDS health care facility and various community health care clinics within the eThekwini health district. The three Primary Health Care facilities were attached to district level hospitals located in suburbs of the eThekwini health district in KwaZulu-Natal. The three facilities offer comprehensive HIV/AIDS care, and initiate and monitor antiretroviral therapy. A total number of 299 nurses worked at these primary healthcare facilities at the time of the study, and consisted of 142 Registered nurses, 77 Enrolled nurses and

80 Enrolled nursing auxiliaries. Fifty-eight (n=58, 44.2%) nurses from the Primary Health Care facilities were purposefully sampled to participate in the study. The HIV/AIDS health care facility was a stand-alone facility within the premises of a district level hospital. This facility offers comprehensive HIV/AIDS care and 41 (31.2%) nurses were purposefully sampled from this facility. The community health care clinics, which are serviced by a district level hospital, can be found in various locations in the eThekwini health district. They provide limited Primary Health Care services and refer cases that cannot be managed to the district level hospital. Patients who use these facilities present with opportunistic infections, such as pulmonary tuberculosis, pneumonia, sexually transmitted diseases, as well as mental health problems, such as depression, anxiety, psychosis and delusions. It is estimated that on average, approximately 3 115 patients per month use these facilities. Twenty-five (19%) of nurses were purposefully sampled to participate in the study.

3.5 STUDY POPULATION

A population is defined by Polit and Beck (2008) as all the individuals with common, defining characteristics. The population included nurses working in the eThekwini district who deal with clients who are suffering from both HIV/AIDS and mental health problems on daily basis. The target population included all those nurses who attend to clients in the Primary Health Care services, HIV/AIDS services and clinics on daily basis and who have been working there for not less than two years. Only registered nurses who had a qualification in general nursing and in mental health nursing were included, as it is they who attend to patients who present with both mental health problems and HIV/AIDS and who offer antiretroviral therapy. They are expected to be informative and knowledgeable because they have been working in these settings for at least two years.

3.6 INCLUSION AND EXCLUSION CRITERIA

3.6.1 Inclusion Criteria

To be eligible for inclusion in the study participants had to be:

- Registered nurses who had a qualification in general or mental health nursing;

- attending to clients in either Primary Health Care services, HIV/AIDS services and clinics on a daily basis; and
- have been working in these settings for a minimum of two years

3.6.2 Exclusion Criteria

Participants who had been recently employed in these areas or who had been working there for less than two years were excluded from the study and were not asked to share their views and experiences

3.7 SAMPLING PROCEDURES

3.7.1 Sampling method

Burns and Grove (2005) define a sample as a subset of the population that is selected for a particular study and sampling as the process through which a group of people and or events are selected for study. A purposive sampling technique was used to select or recruit the participants for this study. According to Polit and Beck (2008), purposive sampling entails using the most conveniently available people as study participants. The sample therefore cannot claim to be representative of the population, thus limiting the generalizability of the research results. The researcher has minimized the biases of non-probability sampling by ensuring that all respondents were consistent with the characteristics of the target population, thereby maximizing representation.

3.7.2 Calculating the sample size

The sample size was estimated based on the resources and time available. The researcher purposively sampled 124 participants that were available from the three settings.

3.7.3 Procedure for selecting the participants

Participants were purposively selected from the target population. Participants were those who had been practising in this area for not less than two years and with experience of the clients that were receiving services from these areas. The actual

sample size was 124 professional nurses or registered nurses that were selected based on the criteria for inclusion and this was the half of the targeted population that was randomly sampled first.

3.8 DATA COLLECTION INSTRUMENT

The study used a self-developed structured questionnaire that was based on general practitioners' knowledge, attitudes, skills and preparedness. The instrument consisted of two sections. Section A was made up of 6 items, which focused on exploring and describing the demographic characteristics of the participants. Items included age, gender, professional qualification, work experience, workplace and whether mental health lectures had been received during training. Items were made up of numerical and categorical variables. Section B was made up of 30 items on a five point Likert scale ranging from Strongly Agree to Strongly Disagree which explored and described the knowledge, attitudes, skills and preparedness about therapeutic commitment and the role competency and role support of the participants. The Likert scale consisted of several declarative items on which respondents were asked to indicate the degree to which they agree or disagree with the opinion expressed by the statement (Polit and Beck, 2004). A Likert scale must have at least five exclusive possible responses from which the participant will only choose one (Pallant, 2007). The instrument was in English because all participants were able to read, speak and understand English. Refer to Appendix 1.

3.9 VALIDITY AND RELIABILITY OF THE INSTRUMENT

3.9.1 Validity

Validity refers to the degree to which an instrument measures what it is supposed to measure (Polit and Hungler, 1999). Content validity was used in this study to validate that the items in the instrument actually measured what they aimed to measure in terms of the research objectives.

Table 3.1: Content Validity

Theoretical framework	Research objective	Questionnaire item
Theoretical commitment	To explore and describe the level of knowledge regarding managing people who presents with problems and HIV/AIDS.	1-12
Role competence (knowledge, preparedness)	To explore and describe the skills or behaviour of nurses regarding management of people with mental problems and HIV/AIDS.	13-19
Role support (attitudes, skills)	To explore and describe the attitudes of nurses regarding managing people who present with both mental health problems and HIV/AIDS.	20-30

3.9.2 Reliability

According to Polit and Beck (2004), reliability refers to the accuracy and consistency of information obtained in a study. Reliability was obtained by constructing questions simply to prevent misinterpretation and to construct different sections of the questionnaire in the same manner. The test-retest method was used in this study to assess the instrument's stability over time (Patel, Jenkins and Lund, 2012). The reliability of the instrument was tested by administering the questionnaire to five (5) registered nurses of the population, and then administering the same questionnaire to the same participants two weeks later. The two rounds of the questionnaire from these respondents were then checked to see if the results were consistent, which would indicate the reliability of the questionnaire to elicit the necessary information. The internal consistency of the questionnaire was measured using Cronbach's alpha coefficient and alpha was found to be.0.800, which was considered satisfactory. Polit and Beck (2004) maintained that in practice, coefficients normally range from a low of

0.00 to a high of 1.00. Cronbach's alpha is a statistic commonly used as a measure of the internal consistency reliability of a psychometric instrument (Polit and Beck, 2004).

3.10 DATA COLLECTION PROCESS

Data was collected using the lists of registered nurses who had been practising as general practitioners for more than two years and this was accessed through the information from the nurse managers of the Primary Health Care centres or HIV/AIDS service centres. Appointments were set to meet with the operational manager of each Primary Health Care service or HIV/AIDS service centre or clinic. The researcher met the person in charge per appointment and explained the purpose of the study, as well as its significance. The researcher then met with the participants to explain the purpose of the study and to make them aware of their rights to participate or not. The researcher then distributed the questionnaire by hand during tea and lunch breaks or at a time convenient to them. She then waited for the participants to complete the questionnaire, which took approximately 30 minutes, and collected them immediately after completion to fast track and enhance the response rate.

Participants who failed to complete the questionnaire within the given time were provided with a special box, which was kept in the duty room, to place their questionnaires once they had finished. Those questionnaires were collected by the researcher two days after completion. A letter that clarified the purpose and significance of the study was attached to each instrument. It was estimated that data collection would take two weeks and the second week was for the administration of the questionnaire.

3.11 DATA ANALYSIS

Data was analysed using the Predictive Analysis Software (previously known as Statistical Package for the Social Sciences) Version 21 for Windows. Each item of the questionnaire was coded. Frequencies were computed to determine the percentage for each item contained in the questionnaire. Cross tabulations for Chi-Square analysis were performed to test differences in the ratings of the general practitioners' knowledge,

attitudes, skills and preparedness. The level of significance for all the data analysis was set at .05. Descriptive statistics such as the average mean and standard deviation were calculated using Spearman rho, independent – Samples Kruskal-Wallis Test and was compared using the Pearson Chi-Square and correlation.

3.12 ETHICAL CONSIDERATIONS

Polit and Beck (2004) maintain that when humans are used as study participants, care must be exercised to ensure that their rights are protected. Ethical consideration related to the protection of the rights of human subjects underpinned this study. Ethics is defined as a system of moral values that is considered the degree to which research procedures adhere to professional, legal and social obligations with respect to the study participants (Polit and Beck, 2008). In accordance with these obligations, the research proposal was sent for approval and ethical clearance to the Research and Ethics Committee of the University of KwaZulu-Natal. Permission to conduct the research and to request participants to complete the questionnaire was obtained from the health care clinics where the samples were drawn. A letter and informed consent (Appendix 3) explaining the purpose and the significance as well as nature of the study were given to each participant. They were also informed that they had the right to withdraw at any stage of data collection. All participants were assured that no information would be given out or shared with any other stakeholders without their consent or authorization.

Gillis and Jackson (2010) highlight the importance of conducting a research study in an ethical manner by adhering to the guiding principles of ethics. The three main principles that guided this study were respect for persons, beneficence, justice and autonomy.

Respect for persons: This principle forms the foundation of the participants' rights to informed consent, privacy and confidentiality (Balabanova et al., 2010). Information regarding this research study was offered both verbally and in the form of a document to the participants of the study and the consent of participants was obtained upon their review of the information packet.

Confidentiality and anonymity of the target population was ensured by not having any identification on the data collection tool. Relevant indicators were used instead of

participants' names so that information could not be traced back to individuals. The data collection tools will be stored in a safe and locked place at the School of Nursing at the University of KwaZulu-Natal for a period of 5 years and only the researcher and research supervisor will have access to the data collected and copies of the relevant review documents.

Beneficence: The data collected in the study will not be used to exploit or inflict harm on the participants, but rather help in making recommendations based on the research findings that may aid in improving services for PLWHA who have mental illnesses in the province of KwaZulu-Natal.

Justice: All participants in the research study were treated equally and fairly. The population sample selection was conducted randomly so as to avoid bias. The researcher explained the nature and benefits of the study to the nurses (Appendix 2). There were no monetary benefits for completing the questionnaire. Participants were also made aware that refusal to participate would have no effect on their employment or study status.

Autonomy: Participants were made aware of their willingness to participate on the research that they were allowed to withdraw at any given point or to decline to answer questions without giving reasons whenever they feel uncomfortable to do so.

3.13 DATA MANAGEMENT

All data collected was used for the purpose of the study only. During data analysis crude data was kept under lock and key to ensure confidentiality. Data was stored on a computer which has a code of access (password) known only by the researcher. In accordance with the university's policy, 5 years after the report has been completed, written data will be burnt or the paper shredded and data stored on the computer will be erased from both the programme and the recycle bin.

3.14 CONCLUSION

This chapter outlined the research methodology that was used during this study and highlighted how data was collected, stored, analysed and managed. It also outlined the ethical considerations that were followed in order to ensure that neither the participants nor the researcher were harmed in any way.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 INTRODUCTION

The findings of the study are presented in this chapter. The main aim of the study was to explore and describe the level of knowledge, skills, attitudes and preparedness of nurses regarding integration of mental health into HIV/AIDS services.

The research objectives for this study were to: (a) explore and describe the level of knowledge regarding mental health management among nurses in HIV/AIDS services, (b) explore and describe the attitudes of nurses regarding managing people who present with both mental health problems and HIV/AIDS, (c) explore and describe the skills or behaviour of nurses regarding management of people with mental problems and HIV/AIDS; (d) explore factors related to integration or barriers to integration of mental health into HIV/AIDS services; and (e) explore and describe management of mental health problems among people living with HIV/AIDS.

The quantitative data describing the demographic characteristics of the respondents is presented first. This is followed by descriptive statistics of the respondents about their provision of mental health care to people living with HIV/AIDS. All the data was collected using a self-administered questionnaire (Appendix 1), which had two sections: namely, Section A, which focused on the demographic characteristics of respondents; and Section B, which consisted of an adapted version of the Mental Health Problem Perception Questionnaire (MHPPQ). In Section B, a five point Likert Scale was used to measure the levels of therapeutic commitment, role competency and role support in nurses regarding their provision of mental health care to people living with HIV/AIDS.

Data were analyzed using the Predictive Analysis Software. The theoretical framework and the research questions guided the data analysis. The relationship between therapeutic commitment, role competency and role support and respondents demographics were tested using non-parametric tests, namely the Kruskal-Wallis test

and the chi square test. The study findings are presented in the form of tables and graphs.

4.2 SAMPLE REALIZATION

The study respondents comprised of 124 nurses working in 3 selected clinical settings located in the eThekwini health district in KwaZulu-Natal. The researcher achieved the sample size by personally distributing 131 self-administered questionnaires to nurses who had agreed to participate in the study. Of the 131 questionnaires that were handed out, 124 completed questionnaires were returned. The 7 that were not returned or fully completed were thus not included in the study. This was to minimize the risk of non-response error to the sample size. The actualized sample size of 124 respondents of the envisioned 131 respondents equated a 94, 6% response rate.

4.3 SOCIO-DEMOGRAPHIC CHARACTERISTICS

Socio-demographic variables that were assessed included the respondents' gender; age; professional category; work setting; and number of years of experience. These are reflected in table 4.1. The findings from this study showed that 75% (n=93) of the sample was female. Regarding the professional qualification of the respondents, the findings showed that the majority of the sample (n=54, 41.2%) were registered psychiatric, community and midwifery nurses (RPCM), followed by registered nurses (RN) n=39 (29.7%), followed by registered midwives n=15 (11.4%), followed by registered Primary Health Care nurses (RPHC) n=14 (10.6%) followed by registered psychiatric nurses (RP) (n=2, 1.5%). No enrolled nurses (ENs) or enrolled nursing auxiliaries (ENAs) participated in the study.

Table 4.1: Socio-demographic characteristics

	Variables	n value	Percentage
Age	30 years and below	6	4.8
	31-35 years	13	10.5%
	36-40 years	36	29.0%
	41-45 years	26	21.0%
	46-50years	22	17.7%
	51 years and more	21	16.9%
Gender	Male	31	25.0%
	Female	93	75.0%
Professional qualification	registered nurse	39	31.5%
	registered midwife	15	12.1%
	registered psychiatric, community, midwife	54	43.5%
	registered psychiatric	2	1.6%
	registered nurse PHC	14	11.3%
Work setting	PHC setting	58	46.8%
	HIV/AIDS services	41	33.1%
	Clinic	25	20.2%
Received mental health lectures as part of the training	Yes	73	58.9%
	No	51	41.1%
Years of experience	0 to 5 years	10	8.1%
	6 to 10 years	31	25.0%
	11 to 15 years	33	26.6%
	16 to 20 years	28	22.6%
	21 to 25 years	14	11.3%
	26 and above	8	6.5%

Regarding the work experience of the respondents, the study findings revealed that the group of the respondents (n=33, 26.6%) had been working for periods of 11 to 15 years. The results of the study indicates that the majority of respondents (46.8%, n=58) were working in the PHC setting, while 33.1% (n=41) were working in the HIV/AIDS service setting and 20.2% (n=25) were working in the clinics. The study findings showed that most of the respondents (55.7%, n=73) had received mental health lectures as part of their training.

4.3.1 Histogram of the age of the respondents

The age of the respondents ranged from 25 to 62 years old. The mean age was 42.5 years, with a standard deviation of 7.46. The median was 42 years and the mode was 39 years. See figure 4.1 for histogram of age.

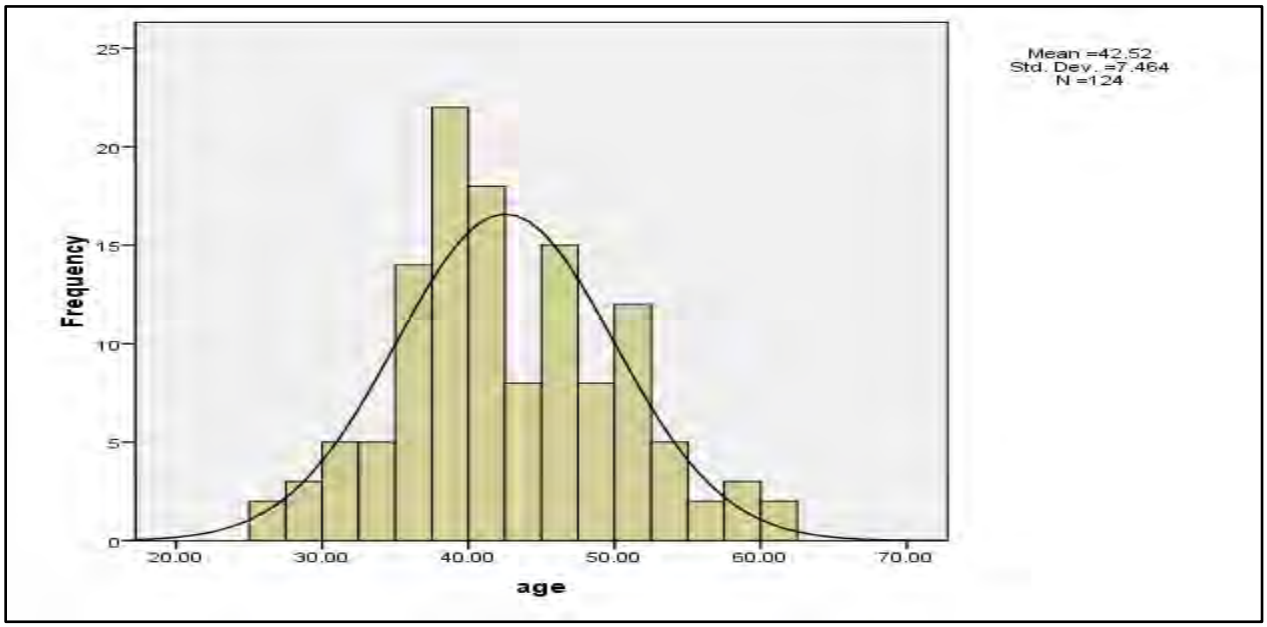

Figure 4.1: Age distribution of respondents

4.3.2 Age and gender cross tabulation

The findings from this study revealed that majority of the respondents were between the ages of 36 and 45 years old. A cross-tabulation revealed that of the 36 respondents who were between 36-40 years, 30.6% (n=11) were males and 69.4 % (n=25) were females: of the 26 respondents who were between 41-45 years old, 57.7% (n=15) were females and 42.3% (n=11) were males; and of the 22 respondents who were 51 years and older, 90.9% (n=20) were females and 9.1% (n=2) were males. Only 2 males and 4 females fell within the 30 years of age and below category. See figure 4.2 of cross tabulation of age and gender.

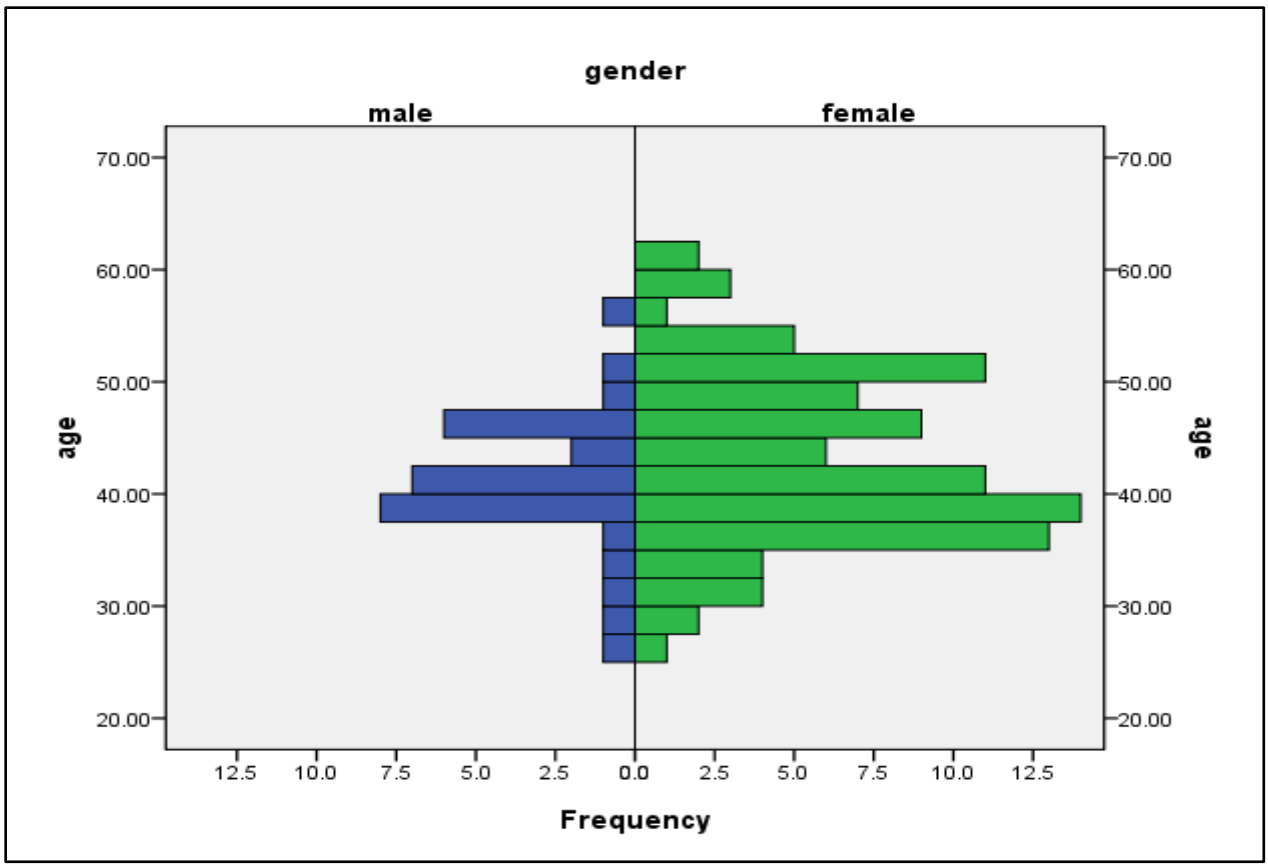

Figure 4.2: Age and gender of the respondents

4.3.3. Work setting and the gender

The findings from this study revealed that out of 93 females who participated in this study, 47.3% (n=44) were working in PHC, 34.4% (n=32) in HIV/AIDS services and 18.3% (n=17) were working in the clinics. With regard to the 31 males who participated in this study, 45.2% (n=14) were from PHC, 29% (n=9) were from HIV/AIDS services and 25.8 % (n=8) were from the clinics.

4.3.4 Cross tabulation of the qualification and age of participants

The findings from this study revealed that in the category of the registered nurses 33.3% (n=13) were aged between 36 and 40 years and 23.1% (n=9) were 51 years or older. Only 7.75 (n=3) were 30 years old and below. In the category of the midwives, it was found that 33.3% (n=5) were between 41 and 45 years and only 5.6% (n=3) were aged 30 years and below. For the registered PHC nurses, it was found that 42.9% (n=6) were 51 years and more, while 37.5% (n=5) were aged between 41 and 45 years. This is reflected in table 4.2.

Table 4.2: Cross tabulation of the qualification and the age of the respondents

			Qualification of the respondents					
			registered nurse	registered midwife	registered psychiatric, community, midwife	registered psychiatric	registered nurse PHC	Total
Age	30 years and below	n	3	0	3	0	0	6
		%	7.7%	0.0%	5.6%	0.0%	0.0%	4.8%
	31-35 years	n	5	0	8	0	0	13
		%	12.8%	0.0%	14.8%	0.0%	0.0%	10.5%
	36-40 years	n	13	4	15	1	3	36
		%	33.3%	26.7%	27.8%	50.0%	21.4%	29.0%
	41-45 years	n	3	5	13	0	5	26
		%	7.7%	33.3%	24.1%	0.0%	35.7%	21.0%
	46-50 years	n	6	4	11	1	0	22
		%	15.4%	26.7%	20.4%	50.0%	0.0%	17.7%
	51 years and more	n	9	2	4	0	6	21
		%	23.1%	13.3%	7.4%	0.0%	42.9%	16.9%
Total		n	39	15	54	2	14	124
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

4.3.5 Qualification of the respondents and work setting

The results of the study revealed that out of 124 nurses who responded to the questionnaire, n=58 (46.8%) worked in Primary Health Care setting, n=41 (33.1%) worked in HIV/AIDS services and n=25 (20.1%) worked in the community health care clinics. Of those working in PHC services, n=21 (36.2%) were registered nurses, n=9

(15.5%) were registered midwives, n=18 (31%) were registered psychiatric, community and midwifery nurses, n=1 (1.7%) was a registered psychiatric nurse and n=9 (15.5%) were registered PHC nurses. Respondents who worked in HIV/AIDS services included n=10 (24.4%) registered nurses, n=3 (7.3%) registered midwives, n=24 (58.5%) registered psychiatric, community and midwifery nurses, and n=4 (9.8%) registered PHC nurses. There were no registered psychiatric nurses. Of those who worked in clinics, n=8 (32.0%) were registered nurses, n=3 (12.0%) were registered midwives, n=12 (48.0%) were registered psychiatric, community, and midwifery nurses, n=1 (4.0%) was a registered psychiatric nurses and n=1 (4.0%) was a registered PHC nurse. In summary, the PHC services and HIV/AIDS clinics, was made up of n=39 (31.5%) registered nurses, n=15 (12.1%) registered midwives, n=54 (43.5%) registered psychiatric, community and midwifery nurses, n=2 (1.6%) registered psychiatric nurses and n=14 (11.3%) registered PHC nurses. See table 4.3.

Table 4.3: Qualification of the respondents and the work setting

			Qualification of the respondents					
			registered nurse	registered midwife	registered psychiatric, community, midwife	registered psychiatric	registered PHC nurse	Total
The work setting	PHC services	N	21	9	18	1	9	58
		%	36.2%	15.5%	31.0%	1.7%	15.5%	100.0%
	HIV/aids services	N	10	3	24	0	4	41
		%	24.4%	7.3%	58.5%	.0%	9.8%	100.0%
	Community health care clinic	N	8	3	12	1	1	25
		%	32.0%	12.0%	48.0%	4.0%	4.0%	100.0%
Total		N	39	15	54	2	14	124
		%	31.5%	12.1%	43.5%	1.6%	11.3%	100.0%

4.3.6 The age and professional qualification of the respondents

Reflected in figure 4.3 majority of the respondents across all qualifications were between 36 and 45 years of age.

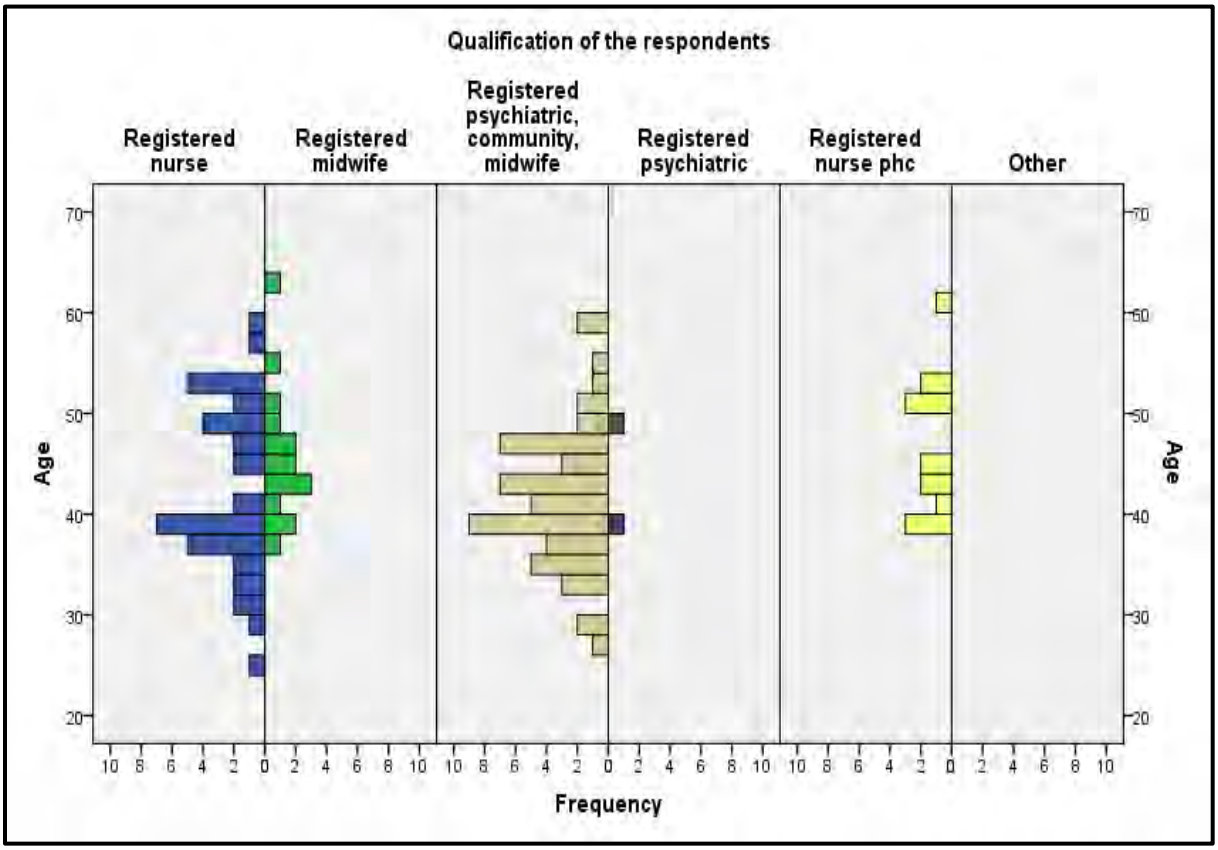

Figure 4.3: The age and professional qualification of the respondents

4.3.7 Received mental health lectures as part of training and nursing qualification

With regards to the variable on whether they had received mental health training or not, the 124 respondents gave the following responses: Of the total of 39 registered nurses, n=15 (38.5%) agreed that they had received mental health lecturers and n=24 (61.5%) disagreed; of the 15 registered midwives, n=9 (60.0%) agreed to having received mental health lecturers while n=6 (40%) disagreed; of the 54 registered psychiatric, community and midwifery nurses, n=44 (81.5%) agreed to having received mental health lectures while n=10 (18.5%) disagreed; of the 2 registered psychiatric nurses, n=1 (50%) agreed to have received mental health lecturers and n=1 (50%) disagreed; of

the 14 registered Primary Health Care nurses, n=4 (28.6%) agreed to have received mental health lectures and n=10 (71.4%) disagreed. In summary, of the total of 124 nurses who responded to the questionnaire, n=73 (58.9%) agreed to have received mental health lectures and n=51(41.1%) disagreed.

4.3.8 Years of experience

The findings revealed that the number of years of experience ranged from 2 to 34 years. The mean was 14.6, median was 14, the mode was 9 and the standard deviation was 7.10. Figure 4.4 displays the years of experience.

Figure 4.4: Years of experience

4.3.9 Work setting and years of experience

The findings demonstrated that out of the 58 respondents who worked in the PHC services, 27.6% (n=16) had between 6 to 10 years of experience, 22.4% (n=13) had between 11 and 15 years of experience and 6.9% (n=4) had 26 years and more years of experience. It was found that of the 41 respondents who worked in the HIV/ AIDS

services, 34% (n=14) had between 11 to 15 years of experience. Of the 25 respondents who worked in the community health care clinics, 36% (n=9) had between 6 to 10 years of experience. The study findings revealed that majority of the respondents (n=33, 26.6%) had been working for 11 to 15 years, see table 4.4.

Table 4.4: The work setting and years of experience of the respondents

			WORK SETTINGS			Total
			PHC	HIV/AIDS SERVICES	CLINIC	
years of experience category	0 to 5 years	n	7	1	2	10
		%	12.1%	2.4%	8.0%	8.1%
	6 to 10 years	n	16	6	9	31
		%	27.6%	14.6%	36.0%	25.0%
	11 to 15 years	n	13	14	6	33
		%	22.4%	34.1%	24.0%	26.6%
	16 to 20 years	n	12	10	6	28
		%	20.7%	24.4%	24.0%	22.6%
	21 to 25 years	n	6	6	2	14
		%	10.3%	14.6%	8.0%	11.3%
	26 and above	n	4	4	0	8
		%	6.9%	9.8%	0.0%	6.5%
Total		n	58	41	25	124
		%	100.0%	100.0%	100.0%	100.0%

4.3.10 Gender and the years of experience

Reflected in table 4.5, this study revealed that 25.8% (n=24) of the females had between 11 to 15 years of experience, 25.8% (n=24) had between 6 to 10 years of experience and 8.6% (n=8) had 26 years and more years of experience. Regarding the males, 29% (n=9) had between 11 to 15 years of experience, and 29% (n=9) had between 16 to 20 years of experience.

Table 4.5: Gender and years of experience

			Gender		Total
			Male	female	
Years of experience	0 to 5 years	N	4	6	10
		%	12.9%	6.5%	8.1%
	6 to 10 years	N	7	24	31
		%	22.6%	25.8%	25.0%
	11 to 15 years	N	9	24	33
		%	29.0%	25.8%	26.6%
	16 to 20 years	N	9	19	28
		%	29.0%	20.4%	22.6%
	21 to 25 years	N	2	12	14
		%	6.5%	12.9%	11.3%
	26 and above	N	0	8	8
		%	0.0%	8.6%	6.5%

4.3.11 Years of experience and the age of the respondents

The findings from this study revealed that of the six respondents who fell in the age group of 30 years and younger, the majority (n=4, 66.7%) had between 0 to 5 years of experience, followed by 33.3% (n=2), who had between 6 to 10 years of experience. Of the 49 who were aged between 31 to 40 years old, 44.9 % (n=22) had between 6 to 10 years of experience, followed by 36.7% (n=18) who had between 11 to 15 years of experience. In the age group of 41 to 50 years old (n=48), 41.7% (n=20) had between16 to 20 years of experience. It was also found that 38.1% (n=8) had 26 and more years of experience of in the age group of 51 years and older. See figure 4.5 of experience and age.

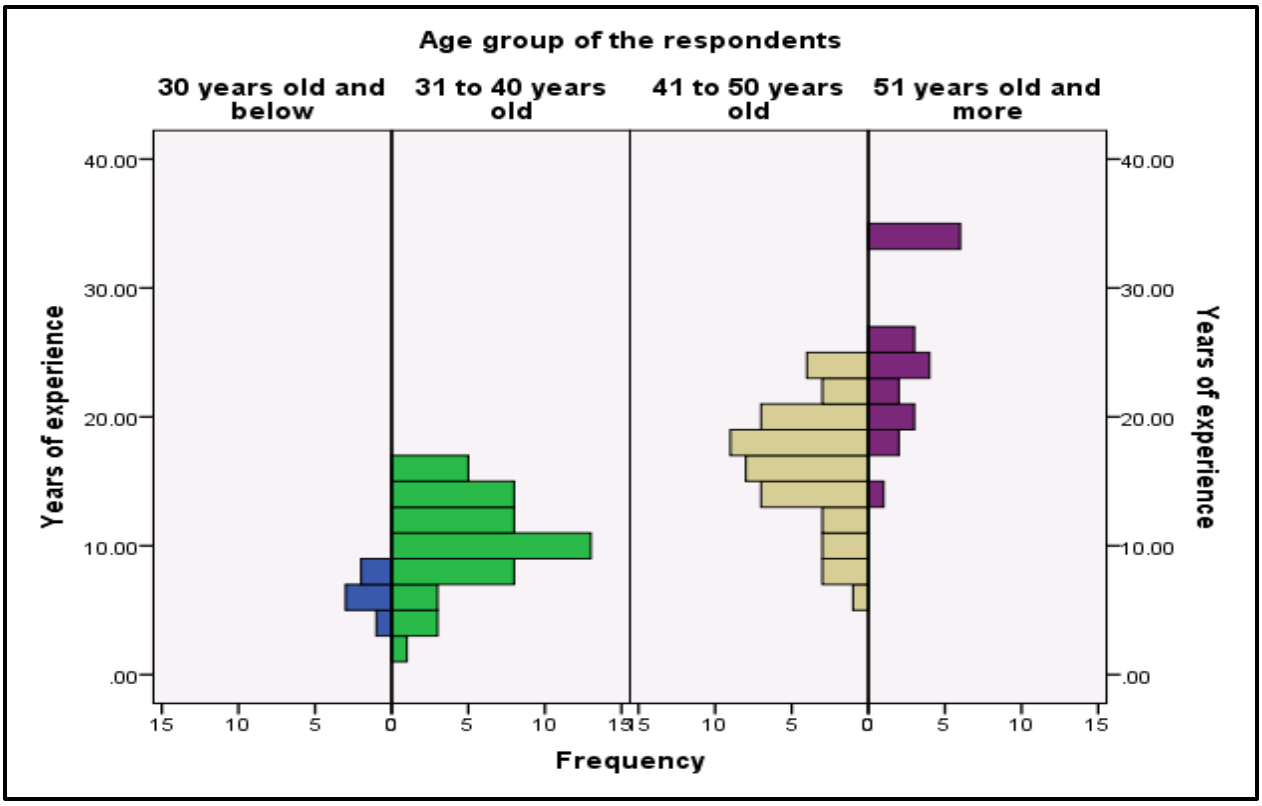

Figure 4.5: Years of experience and age

4.3.12 Years of experience and the qualification of the respondents

The findings from this study, as expressed in table 4.6 revealed that of the 39 registered nurses, 28.2 % (n=11) had between 6 to 10 years of experience. Of the 15 midwives, 26.7% (n=4) had between 6 to 10 years of experience and 26.7% (n=4) between 21 to 25 years of experience. Of the 54 comprehensive nurses (registered psychiatric, community, midwives), 31.5% (n=17) had between 11 to 15 years of experience, followed by 24.1% (n=13) who had 16 to 20 years of experience. All psychiatric respondents (n=2) had more than 5 years of experience. It was found that out of 14 registered PHC nurses, 35.7% (n=5) had between 11 to 15 years of experience.

Table 4.6: Years of experience and the qualification of the respondents

			Qualification of the respondents					Total
			registered nurse	registered midwife	registered psychiatric, community, midwife	registered psychiatric	registered nurse PHC	
Groups of years of experience	0 to 5 years	n	4	0	5	0	1	10
		%	10.3%	0.0%	9.3%	0.0%	7.1%	8.1%
	6 to 10 years	n	11	4	14	1	1	31
		%	28.2%	26.7%	25.9%	50.0%	7.1%	25.0 %
	11 to 15 years	n	8	3	17	0	5	33
		%	20.5%	20.0%	31.5%	0.0%	35.7%	26.6 %
	16 to 20 years	n	8	3	13	1	3	28
		%	20.5%	20.0%	24.1%	50.0%	21.4%	22.6 %
	21 to 25 years	n	5	4	3	0	2	14
		%	12.8%	26.7% and	5.6%	0.0%	14.3%	11.3 %
	26 and above	N	3	1	2	0	2	8
		%	7.7%	6.7%	3.7%	0.0%	14.3%	6.5%
Total		N	39	15	54	2	14	124
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %

4.4 PERCEIVED KNOWLEDGE, SKILLS AND ATTITUDES REGARDING MENTAL HEALTH MANAGEMENT AMONG NURSES IN HIV/AIDS SERVICES

4.4.1 Perceived knowledge regarding mental health management among nurses in HIV/AIDS services

Due to the poor response on the Likert scale attribute for strongly agree and strongly disagree, the responses were merged with agree and disagree. This was done to provide greater statistical meaning of the data. The findings of this study as reflected in

table 4.7. revealed that the respondents reported various degrees of knowledge about the relationship between mental health and HIV/AIDS, indicating that they had enough knowledge on how to deal with different types of mental health problems in PLWHA and about factors that put PLWHA at risk of mental health problems, as well as being educationally prepared to handle or to resolve mental health problems in PLWHA.

With respect to the perceived knowledge of the respondents regarding mental health management in HIV/AIDS services, 37.9% (n=47) disagreed that they have sufficient knowledge about the relationship between mental health and HIV/AIDS, whilst 25.0% (n=31) agreed with this statement. The study found that 46.85% (n=58) disagreed with the statement that they have enough knowledge on how to deal with different types of mental health problems in PLWHA and only 20.2% (n=25) agreed with this statement. The findings showed that 43.5% (n=54) disagreed with the statement that they were educationally prepared to handle or to resolve mental health problems in PLWHA, while 20.2% (n=25) agreed with this statement. The results also revealed that 37.9% (n=47) disagreed with the statement that they have enough knowledge about factors that put PLWHA at risk of mental health problems, however 24.2% (n=30) agreed with the statement. Findings of the study revealed that 33.9% (n=42) disagreed with the statement that they know how to treat and manage people who have long term mental health problems and suffer from HIV/AIDS, while,30.6% (n=38) agreed with this statement.

Table 4.7: Perceived knowledge on mental health management

Variable / item	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	1		2		3		4		5	
	n	%	n	%	n	%	n	%	N	%
I feel I have enough knowledge about the relationship between mental health and HIV/AIDS	24	19.4	47	37.9	11	8.9	31	25.0	11	8.9
I have enough knowledge to deal with different types of mental health problems in PLWHA	21	16.9	58	46.8	8	6.5	25	20.2	12	9.7

I am educationally prepared to handle or resolve mental health problems in PLWHA	21	16.9	54	43.5	8	6.5	25	20.2	16	12.9
I feel that I have enough knowledge about factors that put PLWHA at risk of mental health problems	32	25.8	47	37.9	5	4.0	30	24.2	10	8.1

The overall score of perceived knowledge of the respondents regarding mental health management in HIV/AIDS services was calculated, with 4 items being considered, and the responses ranging from 1 to 5 (i.e. strongly disagree to strongly agree). The maximum score was 25 and the minimum score was 5. The higher the score, the more knowledgeable the respondents perceived themselves regarding mental health management in HIV/AIDS services. The mean score was 13.07; the mode was 10, the median 12 and standard deviation 5.42. An average of 50% of the respondents had a score of 12, and at least 75% had a score of 17, which indicates that the respondents perceived themselves as knowledgeable regarding mental health management in HIV/AIDS services.

4.4.2 Overall perceived knowledge regarding mental health management

The overall knowledge of the respondents on mental health management was further grouped into the following three categories: 20-25: good knowledge, 10-19: average knowledge, below 9: poor knowledge. Reflected in figure 4.6, this study revealed that, out of 124 respondents 56.5% (n=70) reported having average knowledge regarding mental health management in HIV/AIDS services, followed by 25.8% (n=32) who reported having poor knowledge. Only 17.7% (n=22) indicated that they had good knowledge regarding mental health management in HIV/AIDS services.

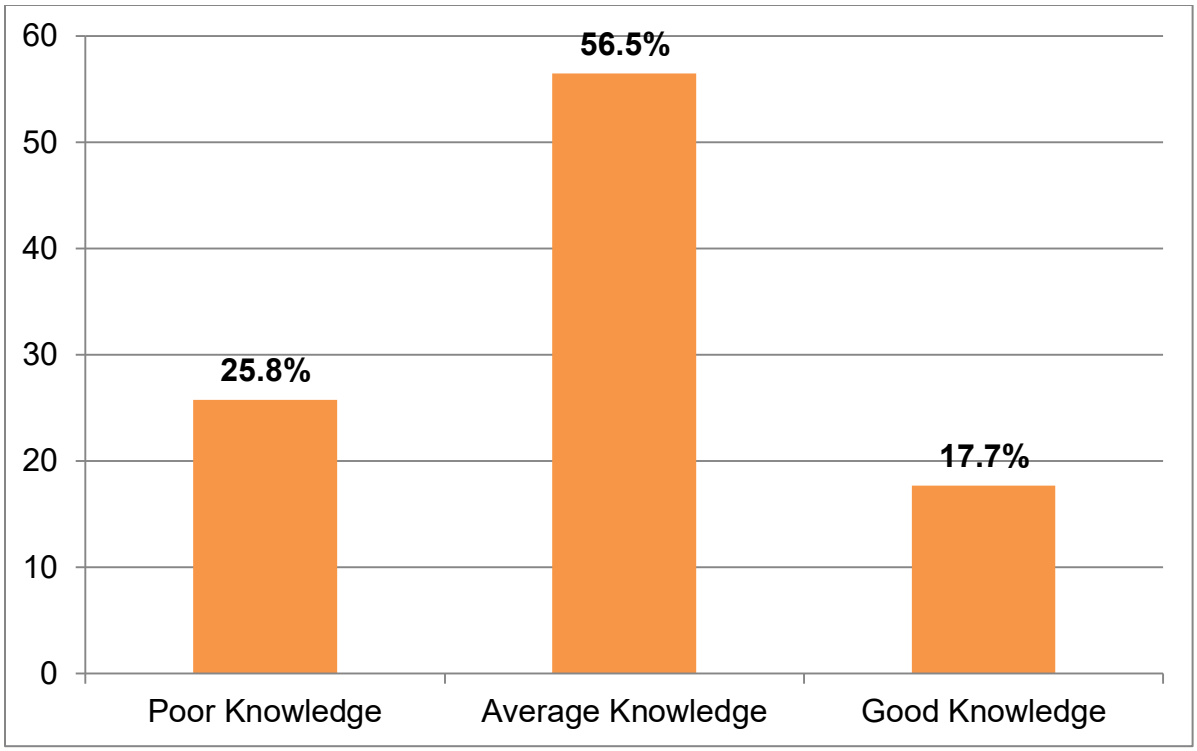

Figure 4.6: Perceived knowledge regarding mental health management

4.4.3 Cross tabulation of the overall perceived knowledge and the work setting

The study findings demonstrated that of the 70 respondents who reported having average knowledge, 44.3% (n=31) were working in PHC; 28.6% (n=20) were from the clinics and 27.1% (n=19) were from HIV/AIDS services. It was also found that 53.1% (n=17) from the clinic and 43.8% (n=14) from HIV/AIDS services reported having poor knowledge regarding mental health management in HIV/AIDS services.

Table 4.8: Cross tabulation of the overall perceived knowledge and work setting

Overall perceived knowledge regarding mental health management among nurses in HIV/AIDS services		work setting			
		PHC setting	HIV/AIDS SERVICES	CLINIC	TOTAL
Poor Knowledge	n	17	14	1	32
	%	53.1%	43.8%	3.1%	100.0%
Average Knowledge	n	31	19	20	70
	%	44.3%	27.1%	28.6%	100.0%

Good Knowledge	n	10	8	4	22
	%	45.5%	36.4%	18.2%	100.0%
Total	n	58	41	25	124
	%	46.8%	33.1%	20.2%	100.0%

A chi square test was performed to establish the relationship between the work setting and the overall perceived knowledge of the respondents and the findings were not regarded as significant (p.value=0.52, df=4, X^2=9.402).

4.4.4 Cross tabulation of knowledge and qualification

Reflected in table 4.9, of the 70 respondents who reported having average knowledge, 44.3% (n=31) were registered psychiatric, community, midwifery nurses and 32.9% (n=23) were registered nurses. Out of 22 respondents who reported having good knowledge, 59.1% (n=13) were registered psychiatric, community, midwives, while 22.7% (n=5) were registered nurses.

Table 4.9: Cross tabulation of knowledge and the qualification

		Qualification					Total
Overall Perceived knowledge regarding mental health management among nurses in HIV/AIDS services		registered nurse	registered midwife	registered psychiatric, community, midwife	registered psychiatric	registered nurse PHC	
Poor Knowledge	n	11	2	10	1	8	32
	%	34.4%	6.2%	31.2%	3.1%	25.0%	100.0%
Average Knowledge	n	23	10	31	0	6	70
	%	32.9%	14.3%	44.3%	.0%	8.6%	100.0%
Good Knowledge	n	5	3	13	1	0	22
	%	22.7%	13.6%	59.1%	4.5%	.0%	100.0%
Total	n	39	15	54	2	14	124
	%	31.5%	12.1%	43.5%	1.6%	11.3%	100.0%

A chi square test was performed to establish the relationship between the qualification and the overall perceived knowledge of the respondents and the result was not significant (p.value=0.54, df=8, X^2 =15.254).

4.4.5 Perceived skills regarding mental health management

The findings from this study as shown in table 4.10, revealed that 49.2% (n=61) disagreed with the statement that they have enough skills to handle mental health problems in PLWHA, such as psychosis or depression, while, 22.6% (n=28) agreed with this statement. The results discovered that although 29.8% (n=37) agreed with the statement they have skills to assess, identify and treat PLWHA who have mental health problems, 33.1% (n=41) disagreed with this statement. The findings revealed that 35.5% (n=44) disagreed with the statement that they have the skills to work with PLWHA who have mental health problems, while 28.2 % (n=35) agreed with the same statement. Furthermore, 36.3% (n=45) agreed with the statement they have good qualities for working with people who have mental health problems and HIV/AIDS, and 28.2% (n=35) disagreed with the same statement.

Table 4.10: Perceived skills regarding mental health management

	Strongly Disagree		**Disagree**		**Neutral**		**Agree**		**Strongly Agree**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I have enough skills to handle MHPs in PLWHA	21	16.9	61	49.2	7	5.6	28	22.6	7	5.6
I feel I have skills to assess, identify and treat PLWHA who have MHPs	32	25.8	41	33.1	6	4.8	37	29.8	8	6.5
I have the skills to work with PLWHA who have MHPs	33	26.6	44	35.5	3	2.4	35	28.2	9	7.3
I feel I have good qualities for working with people who have MHPs and HIV/AIDS	28	22.6	35	28.2	3	2.4	45	36.3	13	10.5

The overall score of perceived skills of the respondents regarding mental health management in HIV/AIDS services was calculated, with 4 items being considered and the responses ranging from 1 to 5 (i.e. strongly disagree to strongly agree). The maximum score was 20 and the minimum score was 4. The higher the score, the more skilful the respondents perceived themselves regarding mental health management in HIV/AIDS services. The mean score was 10.46; the mode was 16, the median 10 and standard deviation 4.45. An average of 50% of the respondents had a score of 10, and at least 75% had a score of 14, which indicated that there were high perceptions of skills regarding mental health management among nurses in HIV/AIDS services.

4.4.6 The overall skills of the respondents on mental health management

The overall skills of the respondents on mental health management were further grouped into the following three categories: 15-20 = good skills; 7-14 = average skills; and six and below = poor skills. The findings from this study revealed that 54.8% (n=68) of the respondents reported having average skills regarding mental health management in HIV/AIDS services while 23.4% (n=29) reported having good skills. It was found that only 21.8% (n=27) reported having poor skills, this is reflected in figure 4.7.

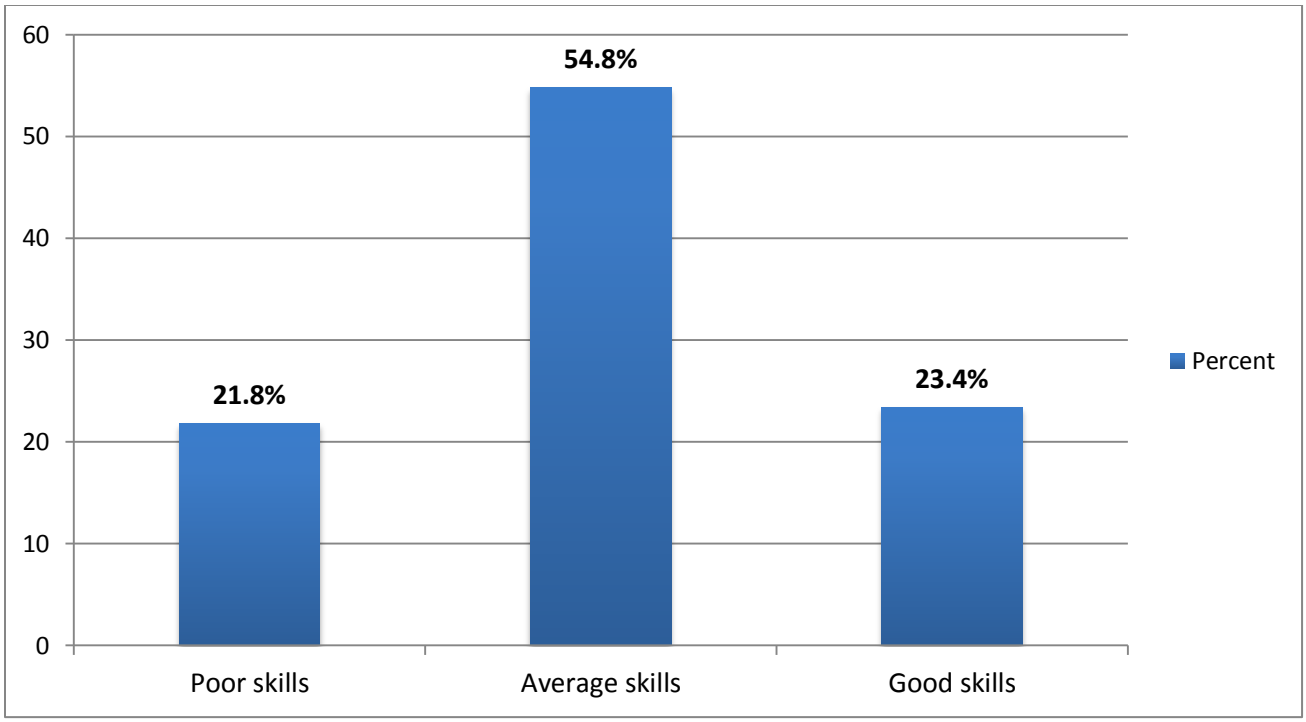

Figure 4.7: The overall skills of the respondents on mental health management

4.4.7 Cross tabulation of overall perceived skills and the work settings

The findings from this study as reflected in table 4.11, revealed that of the 68 respondents who reported having average skills regarding mental health management in HIV/AIDS services, 42.6% (n=29) were from the PHC facilities, 29.4% (n=20) were from the clinics and 27.9% (n=19) were from HIV/AIDS services. It was also found that of the 29 who reported having good skills, the majority (51.7%, n=15) were from PHC and 31% (n=9) were from HIV/AIDS services. Figure 4.7 displays the overall skills of the respondents on mental health management.

A chi square test was performed to establish the relationship between the qualification and the overall perceived knowledge of the respondents and the result was found to be significant (p.value = 0.022, df = 4, X^2 =11.435).

Table 4.11: Cross tabulation of overall perceived skills and work setting

			work setting			
			PHC	HIV/AIDS SERVICES	CLINIC	Total
Overall perceived skills regarding mental health management among nurses in HIV/AIDS services	Poor skills	n	14	13	0	27
		%	51.9%	48.1%	.0%	100.0%
	Average skills	n	29	19	20	68
		%	42.6%	27.9%	29.4%	100.0%
	Good skills	n	15	9	5	29
		%	51.7%	31.0%	17.2%	100.0%
Total		n	58	41	25	124
		%	46.8%	33.1%	20.2%	100.0%

4.4.8 Overall perceived skills and nursing qualification

The findings from this study as shown in table 4.12, revealed that of the 68 respondents who reported having average skills regarding mental health management in HIV/AIDS services, 42.6% (n=29) were registered psychiatric, community and midwifery nurses, while 30.9% (n=21) were registered nurses.

A chi square test was performed to establish the relationship between qualification and the overall perceived knowledge of the respondents and the result was not significant (p.value=0.068, df=8, X2=14.571).

Table 4.12: Overall perceived skills and nursing qualification

variables			qualification of the respondents					total
			registered nurse	registered midwife	registered psychiatric, community, midwife	registered psychiatric	registered nurse PHC	
Overall Perceived skills regarding mental health management among nurses in HIV/AIDS services	Poor skills	n	11	1	8	1	6	27
		%	40.7%	3.7%	29.6%	3.7%	22.2%	100.0 %
	Average skills	n	21	10	29	0	8	68
		%	30.9%	14.7%	42.6%	.0%	11.8%	100.0 %
	Good skills	n	7	4	17	1	0	29
		%	24.1%	13.8%	58.6%	3.4%	.0%	100.0 %
Total		n	39	15	54	2	14	124
		%	31.5%	12.1%	43.5%	1.6%	11.3%	100.0 %

4.4.9 Perceived attitudes regarding mental health management among nurses in HIV/AIDS services

The findings from this study revealed that of the 124 respondents, 33.1% (n=41) agreed and 15.3% (n=19) strongly agreed that they were prepared to attend to people who present with mental health problems in an HIV setting. However a significant percentage of the respondents (34.7%, n=43) disagreed and 14.5% (n=18) strongly disagreed that they were prepared to attend to people who present with mental health problems in an HIV setting.

It was found that n=47 (37.9%) of the respondents disagreed with the statement *"I to want to work with PLWHA who have mental health problems"* and only n=36 (29.0%) of the respondents agreed. The results also revealed that 61.3% (n=76) agreed to the statement of having no negative attitudes in working with people who are mentally ill and HIV infected, while 14.5% (n=18) disagreed with the statement. The study also revealed that 36.3% (n=45) of the respondents disagreed and 18.5% (n=23) strongly

disagreed with the statement that they felt that they had something to offer PLWHA who have mental health problems, although 29.8% (n=37) agreed with the statement. The results of the study reported that although 51.6% (n=64) agreed that they can understand PLWHA who have mental health problems, 20.2% (n=25) disagreed with the statement. The findings from the study revealed that 41.9% (n=52) agreed to the statement that they have the right to ask mentally ill clients about their HIV/AIDS status, but 24.2% (n=30) disagreed with the statement. This is shown in table 4.13.

Table 4.13: Perceived attitudes regarding mental health management

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
I am interested in the nature of mental health problems of people living with HIV/AIDS (PLWHA) and treating them	20	16.1	41	33.1	5	4.0	17	13.7	41	33.1
I am prepared to attend to people who present with mental health problems in an HIV setting	18	14.5	43	34.7	3	2.4	41	33.1	19	15.3
I want to work with PLWHA who have mental health problems	13	10.5	47	37.9	16	12.9	36	29.0	12	9.7
I have no negative attitudes in working with people who are mentally ill and HIV infected	4	3.2	18	14.5	10	8.1	76	61.3	16	12.9
I feel that I have something to offer in PLWHA who have mental health problems	23	18.5	45	36.3	5	4.0	37	29.8	14	11.3
In general, I feel that I can understand PLWHA who have mental health problems	13	10.5	25	20.2	11	8.9	64	51.6	11	8.9
I feel I have the right to ask clients who are mentally ill about their HIV/AIDS status	14	11.3	30	24.2	11	8.9	52	41.9	17	13.7

The findings from this study revealed that of the 124 respondents, 33.1% (n=41) agreed and 15.3% (n=19) strongly agreed that they were prepared to attend to people who present with mental health problems in an HIV setting. However a significant percentage of the respondents (34.7%, n=43) disagreed and 14.5% (n=18) strongly disagreed that they were prepared to attend to people who present with mental health problems in an HIV setting.

The overall score of perceived attitudes of the respondents regarding mental health management in HIV/AIDS services was calculated, with 7 items being considered and the responses ranging from 1 to 5 (i.e. strongly disagree to strongly agree). The maximum score was 28 and the minimum score was 9. The higher the score, the more the respondents perceived themselves having a good attitude regarding mental health management in HIV/AIDS services. The mean score was 18.7 the mode was 16, the median 19 and standard deviation 4.69. An average of 50% of the respondents had a score of 19, and at least 75% had a score of 23, which indicates that there was a high positive attitude among the respondents regarding mental health management in HIV/AIDS services.

4.4.10 Overall perceived attitudes regarding mental health management among nurses in HIV/AIDS services

The overall attitudes of the respondents on mental health management were further grouped into the following three categories; 22-28: good attitude; 14-21: average attitudes; below 13: poor perceived attitude. See figure 4.8 of perceived attitudes regarding mental health management.

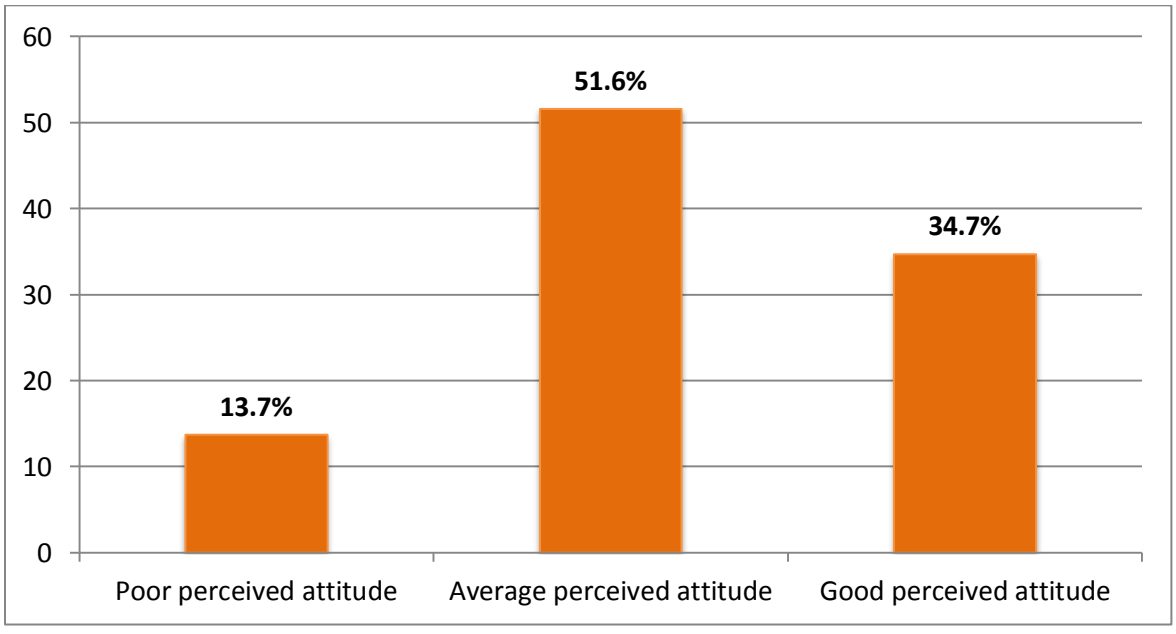

Figure 4.8: perceived attitudes regarding mental health management

4.4.11 Cross tabulation of the overall perceived attitudes and the work settings

The findings from this study demonstrated in table 4.14 showed that of the 64 respondents who reported having average attitudes regarding mental health management in HIV/AIDS services, 40.6% (n=26) were from the PHC setting and 31.2% (n=20) were from HIV/AIDS services. It was also found that of the 43 respondents who reported having good attitudes regarding mental health management in HIV/AIDS services, 55.8% (n=24) were from the PHC facilities and 30.2% (n=13) were from HIV/AIDS services. A chi square test was performed to establish the relationship between qualification and the overall perceived knowledge of the respondents and the result was not significant (p.value = 0.136; df = 4; $X^2 = 6.998$).

Table 4.14: Cross tabulation of the overall perceived attitudes and work setting

			Work setting			Total
			PHC	HIV/AIDS services	CLINIC	
Overall perceived attitudes regarding mental health management among nurses in HIV/AIDS services	Poor perceived attitude	n	8	8	1	17
		%	47.1%	47.1%	5.9%	100.0%
	Average perceived attitude	n	26	20	18	64
		%	40.6%	31.2%	28.1%	100.0%
	Good perceived attitude	n	24	13	6	43
		%	55.8%	30.2%	14.0%	100.0%
Total		n	58	41	25	124
		%	46.8%	33.1%	20.2%	100.0%

4.4.12 Cross tabulation of the overall perceived attitudes and the qualification

This findings from this study showed that of the 68 respondents who reported having average attitudes regarding mental health management in HIV/AIDS services: 45.3% (n=29) were registered psychiatric, community, midwifery nurses, while 28.1% (n=18) were registered nurses. It was also found that of the 43 respondents who reported having good attitudes regarding mental health management in HIV/AIDS services,

48.8% (n=21) were registered psychiatric, community, midwifery nurses and 32.6% (n=14) were registered nurses. A chi square test was performed to establish the relationship between qualification and the overall perceived attitudes of the respondents and the result was not significant (p.value = 0.344; df = 8; X^2 = 8.981).

Table 4.15: Cross tabulation of the overall perceived attitudes and the qualification

			Qualification of the respondents					
			registered nurse	registered midwife	registered psychiatric community midwife	registered psychiatric	registered PHC nurse	Total
Overall perceived attitudes regarding mental health manage-ment among nurses in HIV/AIDS services	Poor perceived attitude	n	7	1	4	1	4	17
		%	41.2%	5.9%	23.5%	5.9%	23.5%	100.0 %
	Average perceived attitude	n	18	9	29	1	7	64
		%	28.1%	14.1%	45.3%	1.6%	10.9%	100.0 %
	Good perceived attitude	n	14	5	21	0	3	43
		%	32.6%	11.6%	48.8%	0.0%	7.0%	100.0 %
Total		n	39	15	54	2	14	124
		%	31.5%	12.1%	43.5%	1.6%	11.3%	100.0 %

4.5 PERCEIVED BARRIERS/CHALLENGES RELATED TO THE INTEGRATION OF MENTAL HEALTH INTO HIV/AIDS SERVICES.

With respect to the perceived barriers or challenges related to the integration of mental health into HIV/AIDS, the study revealed that 33.9% (n=42) of the respondents agreed and 29.8 % (n=37) strongly agreed with the statement that they often have difficulty in assessing and identifying mental health problems in PLWHA, with only 29.0% (n=36) disagreeing with the above statement. The study reported that 36.3% (n=45) disagreed that they feel uncomfortable and insecure when working with people who have mental

health problems and HIV/AIDS and 33.1% (n=41) agreed with the statement. The findings discovered that 33.9% (n=42) disagreed with the statement that they find it difficult to work with people who have mental health problems and here the results revealed that there was an equal scoring since 33.9% (n=42) agreed with the same statement. The study showed that 45.2% (n=56) disagreed and 25.0% (n=31) agreed with the statement that there is absolutely nothing they can do to help PLWHA who have mental health problems.

Table 4.16: Perceived barriers/challenges related to the integration of mental health into HIV/AIDS services.

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
I often have difficulty in assessing and identifying mental health problems in PLWHA	5	4.0	36	29.0	4	3.2	42	33.9	37	29.8
I often have difficulty in knowing how to communicate with mentally ill people who live with HIV/AIDS	10	8.1	43	34.7	2	1.6	48	38.7	21	16.9
I feel uncomfortable and not secure when working with people who have mental health problems and HIV/AIDS	4	3.2	45	36.3	7	5.6	41	33.1	27	21.8
I find difficult in working with people who have mental health problems and HIV/AIDS	8	6.5	42	33.9	9	7.3	42	33.9	23	18.5
I feel that there is absolutely nothing that I can do to help PLWHA who have mental health problems	9	7.3	56	45.2	14	11.3	31	25.0	14	11.3

The score of overall perceived barriers/challenges of the respondents related to the integration of mental health into HIV/AIDS services was calculated, with 5 items being

considered and the responses ranging from 1 to 5 (i.e. strongly disagree to strongly agree). The maximum score was 25 and the minimum score was 6. The higher the score, the more the respondents perceived barriers/ challenges related to the integration of mental health into HIV/AIDS services. The mean score was 16.2 the mode was 16, the median 16 and standard deviation 4.24. An average of 50% had a score of 16, and at least 75% had a score of 19, which indicates that there was a high perception of barriers/challenges related to the integration of mental health into HIV/AIDS services.

The score of overall perceived barriers / challenges of the related to the integration of mental health into HIV/AIDS services was calculated, with 6 items being considered and the responses ranging from 1 to 5 (1= strongly disagree, 2 = disagree, 3 = neutral; 4 = agree; 5 = strongly agree). The maximum score was 29 and the minimum score was 8. The higher the score, the more the respondents perceived barriers/ challenges related to the integration of mental health into HIV/AIDS services. The mean score was 20.07, the mode was 20, the median 20 and standard deviation 3.47. An average of 50% had a score of 20, and at least 75% had a score of 22 which indicated that respondents perceived many barriers/ challenges related to the integration of mental health into HIV/AIDS services.

The chi-square test was performed in order to establish the relationship between the overall score of the perceived factors to promote the integration of mental health into HIV/AIDS services and was significant (p value was 0.012). However the same test was not significant in the work setting (p value was 0.490).

4.6 PERCEIVED FACTORS TO PROMOTE THE INTEGRATION OF MENTAL HEALTH INTO HIV/AIDS SERVICES

With respect to the perceived factors that will promote the integration of mental health into HIV/AIDS services, the following responses were revealed by the study: 51.6% (n=64) of the respondents agreed and 33.9% (n=42) strongly agreed that guidelines on how to deal with PLWHA who have mental health problems would assist in their treatment or management. The study findings also revealed that 43.5% (n=54) agreed that they need basic training on mental health problems for them to be able to help

PLWHA who have mental health problems, 56.5% (n=70) agreed, 22.6% (n=28) strongly agreed and 41.1% (n=51) disagreed with the statement that there is a need to talk about nurses' attitudes when dealing with PLWHA who have mental health problems. The findings revealed that 33.9 % (n=42) strongly disagreed that they receive adequate support from mental health services within their district and 36.3% (n=45) disagreed that they receive adequate support from mental health services outside their district when working with people who have mental health problems and PLWHA, while 33.1% (n=41) agreed with the statement. It was found that 56.5% (n=70) agreed and 25.8% (n=32) strongly agreed that the work settings need to equip them with the necessary skills to work with PLWHA and have mental health problems.

Table 4.17: Perceived factors to promote the integration of mental health into HIV/AIDS services

	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
I feel that guidelines on how to deal or handle PLWHA who have mental health problems can assist me in treating or managing them	6	4.8	8	6.5	4	3.2	64	51.6	42	33.9
I feel there is a need for basic training on mental health problems for me to be able to help PLWHA who have mental health problems	6	4.8	20	16.1	5	4.0	54	43.5	39	31.5
I feel there is a need to talk about the attitudes that nurses have when facing PLWHA who have mental health problems	2	1.6	16	12.9	8	6.5	70	56.5	28	22.6

When working with people who have mental health problems and PLWHA, I receive adequate support from mental health services within my district	42	33.9	51	41.1	6	4.8	17	13.7	8	6.5
When working with people who have mental health problems and PLWHA, I receive adequate support from mental health services outside my district	4	3.2	45	36.3	7	5.6	41	33.1	27	21.8
I feel the work setting needs to equip me with skills that are needed for me to be prepared to work with PLWHA and have mental health problems	4	3.2	15	12.1	3	2.4	70	56.5	32	25.8

4.7 REPORTED MANAGEMENT OF MENTAL HEALTH PROBLEMS AMONG PEOPLE LIVING WITH HIV/AIDS

With respect to the management of mental health problems among people living with HIV/AIDS, it was discovered that 54.0% (n=67) agreed and 16.9% (n=21) strongly agreedto the statement that it is good for mental health to be integrated into HIV/AIDS services in PHC setting. The study also revealed that 38.7% (n=48) disagreed with the statement that it is not good for mental health to be integrated into HIV/AIDS services in PHC setting, while 28.2% (n=35) agreed with this statement. The study found that 65.3% (n=81) agreed and 21.8% (n=27) strongly agreed that it is significant to get adequate information on the relationship between mental health and HIV/AIDS.

A chi square test was performed for the reported management of mental health problems among people living with HIV/AIDS, their qualifications, the work settings. The test showed that the management of HIV/AIDS was not significantly associated with the participants work setting or qualifications ($p = 0.518$, and 0.871) for the work settings.

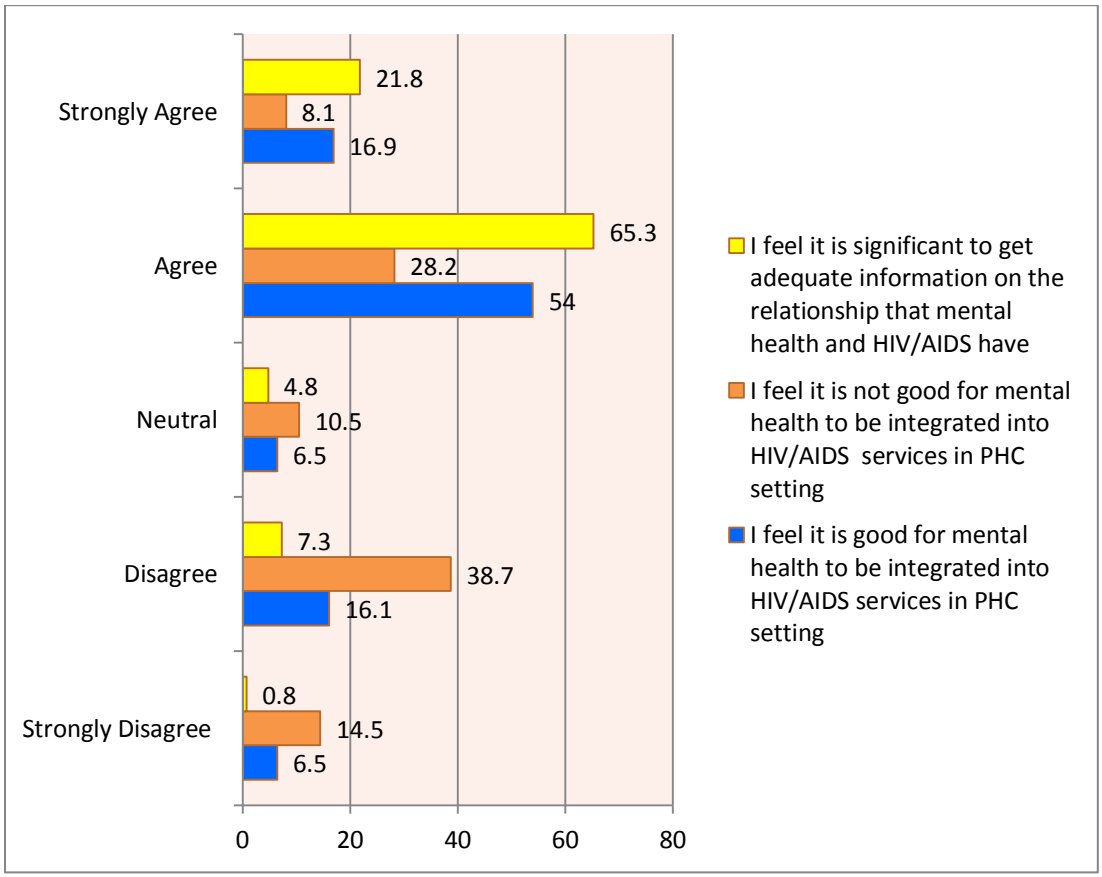

Figure 4.9: Reported management of mental health problems among people living with HIV/AIDS

4.7.1 Cross tabulation of the reported management of mental health problems among people living with HIV/AIDS and the qualification of the respondents

Respondents felt that it is good for mental health to be integrated into HIV/AIDS services in the PHC setting with 51.3% (n=20) of registered nurses agreeing, 63% (n=34) of the registered psychiatric, community, midwifery nurses agreeing, and 35.7% (n=5) of the registered PHC nurses also agreeing. Although some of the respondents in this study reported that they felt it was not good for mental health to be integrated into HIV/AIDS services in PHC setting, they were significantly fewer; 38.5% (n=15) registered nurses, 13.3% (n=2) registered midwives, 51.9% (n=28) registered

psychiatric, community, midwifery nurses) and 38.7% (n=48) registered PHC nurses disagreed.

Table 4.18: Cross tabulation of the reported management of mental health problems among people living with HIV/AIDS and the qualification of the respondents

Variables			Qualification of the respondents					Total
			registered nurse	registered midwife	registered psychiatric, community midwife	registered psychiatric	registered nurse PHC	
I feel it is good for mental health to be integrated into HIV/AIDS services in PHC	Strongly disagree	n	1	0	4	0	3	8
		%	2.6%	.0%	7.4%	.0%	21.4%	6.5%
	Disagree	n	9	4	3	1	3	20
		%	23.1%	26.7%	5.6%	50.0%	21.4%	16.1%
	Neutral	n	1	1	3	0	3	8
		%	2.6%	6.7%	5.6%	.0%	21.4%	6.5%
	Agree	n	20	7	34	1	5	67
		%	51.3%	46.7%	63.0%	50.0%	35.7%	54.0%
	Strongly agree		8	3	10	0	0	21
		%	20.5%	20.0%	18.5%	.0%	.0%	16.9%
I feel it is not good for mental health to be integrated into HIV/AIDS services in PHC	Strongly disagree	n	7	2	8	0	1	18
		%	17.9%	13.3%	14.8%	.0%	7.1%	14.5%
	Disagree	n	15	2	28	1	2	48
		%	38.5%	13.3%	51.9%	50.0%	14.3%	38.7%
	Neutral	n	3	1	5	1	3	13
		%	7.7%	6.7%	9.3%	50.0%	21.4%	10.5%
	Agree	n	13	7	10	0	5	35
		%	33.3%	46.7%	18.5%	.0%	35.7%	28.2%
	Strongly agree	n	1	3	3	0	3	10
		%	2.6%	20.0%	5.6%	.0%	21.4%	8.1%
I feel it is significant to get adequate information on the relationship between mental health and HIV/AIDS	Strongly disagree	n	0	0	1	0	0	1
		%	.0%	.0%	1.9%	.0%	.0%	.8%
	Disagree	n	4	1	2	0	2	9
		%	10.3%	6.7%	3.7%	.0%	14.3%	7.3%
	Neutral	n	3	1	2	0	0	6
		%	7.7%	6.7%	3.7%	.0%	.0%	4.8%
	Agree	n	24	10	36	1	10	81
		%	61.5%	66.7%	66.7%	50.0%	71.4%	65.3%
	Strongly agree	n	8	3	13	1	2	27
		%	20.5%	20.0%	24.1%	50.0%	14.3%	21.8%

4.8 CONCLUSION

This chapter covered the findings from the study, including the socio-demographic characteristics; perceived knowledge regarding mental health management among nurses in HIV/AIDS services; perceived skills regarding mental health management among nurses in HIV/AIDS services; perceived attitudes regarding mental health management among nurses in HIV/AIDS services; perceived barriers/challenges related to the integration of mental health into HIV/AIDS services; perceived factors promoting the integration of mental health into HIV/AIDS services; and reported management of mental health problems among people living with HIV/AIDS.

The findings revealed that the respondents reported that they had enough knowledge about the relationship between mental health and HIV/AIDS; enough knowledge on how to deal with different types of mental health problems in PLWHA; were educationally prepared to handle or to resolve mental health problems in PLWHA; and had enough knowledge about factors that put PLWHA at risk of mental health problems. The findings from this study revealed that of the 124 respondents, 56.5% (n=70) of the nurses reported having average knowledge regarding mental health management in HIV/AIDS services, followed by 25.8% (n=32), who reported having poor knowledge. Only 17.7% (n=22) of the respondents reported have good knowledge regarding mental health management in HIV/AIDS services.

The overall skills of the respondents on mental health management were further grouped into the following three categories: scores of 15-20 = good skills, 7-14 = average skills, and six and below = poor skills. The findings from this study revealed that 54.8% (n=68) of the respondents reported having average skills regarding mental health management in HIV/AIDS services while 23.4% (n=29) reported having good skills. It was found that only 21.8% (n=27) reported having poor skills. The overall attitudes of the respondents on mental health management were further grouped into three categories: scores of 22-28 represented good attitudes, 14-21 average attitudes, and 13 and below, poor attitudes. It was found that 51.6% of the respondents scored average attitudes, 34.7% good attitudes, and 13.7% poor attitudes.

Regarding the perceived barriers or challenges related to the integration of mental health into HIV/AIDS, the study reveals that 33.9% (n=42) agreed and 29.8% (n=37) strongly agreed with the statement that they often have difficulty in assessing and identifying mental health problems in PLWHA, while 29.0% (n=36) disagreed with the above statement. Findings showed that 36.3% (n=45) disagreed that they feel uncomfortable and insecure when working with people who have mental health problems and HIV/AIDS, while 33.1% (n=41) agreed with the statement, 33.9% (n=42) disagreed with the statement that they found it difficult to work with people who have mental health problems and an equal number of 33.9% (n=42) agreed with the statement. The study showed that 45.2% (n=56) disagreed with the statement that there is absolutely nothing they can do to help PLWHA who have mental health problems and 25.0% (n=31) agreed with this statement.

With respect to the management of mental health problems among people living with HIV/AIDS, it was discovered that 54.0% (n=67) agreed and 16.9% (n=21) strongly agreed with the statement that it is good for mental health to be integrated into HIV/AIDS services in PHC setting. The study also revealed that 38.7% (n=48) disagreed with the statement that it is not good for mental health to be integrated into HIV/AIDS services in PHC setting. However, 28.2% (n=35) agreed with this statement. The study found that 65.3% (n=81) agreed and 21.8% (n=27) strongly agreed that it is significant to get adequate information on the relationship between mental health and HIV/AIDS.

The following chapter will present a discussion of the findings, as well as the conclusion and recommendations.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a discussion of the most significant findings of this research study, which have been supported by relevant literature. It also discusses the limitations of this study and outlines a number of recommendations for health organisations and for nursing education, practice and research. The purpose of this study was to explore the knowledge, attitudes, skills and preparedness of nurses on the integration of mental health care into HIV/AIDS services in the eThekwini district, KwaZulu-Natal. The theory of therapeutic commitment, which guided the study, will also be interpreted.

A discussion of the demographic findings will be presented first, following by perceived knowledge regarding mental health management among nurses in HIV/AIDS services, followed by perceived attitudes regarding mental health management among nurses in HIV/AIDS services, followed by perceived skills regarding mental health management among nurses in HIV/AIDS services, then, perceived barriers/challenges related to the integration of mental health into HIV/AIDS services, perceived factors to promote the integration of mental health into HIV/AIDS services and reported management of mental health problems among people living with HIV/AIDS.

The demographics characteristics (age, gender, professional qualification, work experience, workplace) of the professional nurses and whether they had received mental health lectures during training will be discussed in relation to the dependent variables in the study, therapeutic commitment, role competency and role support.

5.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS

This study shows that three quarters of the respondents were females (75%, n=93), with only 25% (n=31) being males, indicating that females are still the majority in both

Primary Health Care and HIV/AIDS services caring for both people who are presenting with mental health problems and have HIV/AIDS. The findings of this study are supported by the current statistics of nurses in South Africa according to South African Nursing Council, where females are the majority (qualified females in the profession are 238 000 and female students are 6083) versus qualified male nurses in the profession which are 22 698, and male students are 664 (SANC, 2013)

These findings are also supported by the study conducted by Chorwe-Sungani (2010),in Blantyre, Malawi, exploring therapeutic commitment for general nurses in dealing with mental health problems of people living with HIV/AIDS, whose general nurse participants were 84.6% (n=115) female and 15.4% (n=21) male. The findings from this study also aligned with a study conducted in Nigeria by Umeh, Essien, Ezedinachi and Ross (2008) seeking to explore knowledge, beliefs and attitudes about HIV/AIDS related issues, and the sources of knowledge among health care professionals in Southern Nigeria, whose study found that the majority of the respondents were females (277, 65%) and only 135 (31.7%) were males. This is in line with another study that was conducted by Wahsheh and Hassan (2011), exploring the knowledge and attitudes of Jordanian nurses towards patients with HIV/AIDS, particularly in regards to their sources of information and education, where more than half of the respondents in the study were females (59%). This is an indication that the nursing profession is occupied in majority by females

With regards to the variable on whether respondents had received mental health training or not, of the 39 registered nurses, n= 15 (38.5%) indicated that they had received mental health lecturers, while n= 24 (61.5%) indicated that they had not; of the 15 registered midwives, n= 9 (60.0%) agreed that they had received mental health lecturers and 6 (40%) disagreed; of the 54 registered psychiatric, community and midwifery nurses, n=44 (81.5%) agreed to having received mental health lectures, while10 (18.5%) disagreed; of the 2 registered psychiatric nurses, n=1 (50%) agreed to having received mental health lecturers and n=1 (50%) disagreed; and of the 14 registered Primary Health Care nurses, 4 (28.6%) agreed to have received mental health lectures, while 10 (71.4%) disagreed. In summary, of the 124 nurses who

responded to the questionnaire, n= 73 (58.9%) indicated that they had received mental health lectures and n= 51 (41.1%) indicated that they had not.

The findings therefore, revealed that the majority of the respondents had received mental health lectures. However, with respect to the professional qualification of the respondents, it was found that although more registered psychiatric, community and midwifery nurses had received mental health lectures than all other categories of nurses, there was no significant relationship between professional qualification and therapeutic commitment and role competency. Furthermore, although the majority of respondents had received mental health lectures, when asked if they have interest in caring for the people who suffer from HIV/AIDS and mental health problems, many of the participants responded that they did not. This indicated that nurses had little interest in caring for people living with HIV/AIDS and presenting with mental health problems even although mental health nursing had been part of their qualification. This finding is contrary to the results of Chorwe-Sungani (2010), who, exploring nurses' perceptions about their provision of mental health care to people living with HIV/AIDS in Blantyre, Malawi, found that nurses who had not specialized in mental health nursing had lower levels of role competency.

With respect to the perceived knowledge of the respondents regarding mental health management in HIV/AIDS services, 37.9% (n=47) disagreed that they have enough knowledge about the relationship between mental health and HIV/AIDS, while 25.0% (n=31) agreed with this statement. The study found that 46.85 (n=58) disagreed with the statement that they have enough knowledge on how to deal with different types of mental health problems in PLWHA, and the minority, which was 20.2% (n=25), agreed with this statement. The findings showed that 43.5% (n=54) disagreed with the statement that they were educationally prepared to handle or to resolve mental health problems in PLWHA, while 20.2% (n=25) agreed with this statement; 37.9% (n=47) disagreed with the statement that they have enough knowledge about factors that put PLWHA at risk of mental health problems, while 24.2% (n=30) agreed with the statement; and 33.9% (n=42) disagreed with the statement that they know how to treat

and manage people who have long term mental health problems and suffer from HIV/AIDS as opposed to 30.6% (n=38) who agreed with this statement.

Studies conducted by Chorwe-Sungani (2010) and Clark et al. (2005) both found that nursing qualification had a significant effect on therapeutic commitment, role competency and role support. In the current study, however, findings revealed that most nurses perceived that they have low levels of role competency. Many nurses reported that they did not have adequate knowledge or skills to identify, assess and treat patients with mental illness, and a significant proportion of nurse respondents felt that they could not appropriately advise patients about mental health problems. Furthermore, this study found that many respondents felt that they were inadequately supported when caring for patients with mental illness, which is in line with the study of Clark et al. (2005), where the respondents had the same feelings with respect to role support. However, in his study there was a degree of neutrality in responses to some role support questions, possibly because some respondents considered they received adequate support from mental health services within their district during working hours, while after hours, the reverse held.

Regarding the work experience of the respondents, the findings revealed that respondents had been working for 11 to 15 years. The study findings indicate that there was no significant association between work experience and therapeutic commitment, role competency and role support since their responses indicated lack of interest in working with PLWHA who have mental health problems regardless of their work experience. While this is in line with the study by Chorwe-Sungani (2010),it is contrary to findings from the study on competence of general practice nurses caring for patients with mental health problems in the somatic department conducted by Svediene, Jankauskiene, Kusleikaite and Razbadauskas (2009). Their findings provided a statistically significant link between the duration of employment and competency, meaning that the more work experience nurses have, the more competent they become in dealing with mental health problems. However, this may not be true for those nurses

who do not receive ongoing in-service education on how to handle PLWHA and have mental health problems.

The results of this study are supported by the study conducted by Mall, Sorsdahl, Swartzand, Joska (2012),exploring the issues of knowledge and practice in mental health care as role of nurses in providing mental health care to PLWHA, thereby attempting to integrate mental health and HIV/AIDS care. Their study revealed that although the majority of participants were in favour of mental health screening for PLWHA, they lacked confidence to conduct the screening themselves. Most participants displayed poor knowledge of mental disorders and reported that they referred to colleagues or to an external mental health service if they suspected a possible mental disorder in a patient.

The age of the participants in the current study ranged from 25 to 62 years old. The mean age was 42.5 years, with a standard deviation of 7.46. The median was 42 years and the mode was 39 years. The findings indicated that there was no association between age and therapeutic commitment, role competency and role support. The majority of the respondents were aged between 36 and 45. A cross-tabulation revealed that of the 36 respondents who were aged between 36-40 years, 30.6% (n=11) were males and 69.4% (n=25) were females. Furthermore, of the 26 respondents aged between 41-45 years, 57.7% (n=15) were females and 42.3% (n=11) were males; of the 22 respondents who were 51 years and older, 90.5% (n=19) were females and 9.5% (n=2) were males. And only 2 males and 4 females were aged 30 years and younger. Similarly, the Malawian study by Chorwe–Sungani (2010)revealed no differences in the levels of therapeutic commitment, role competency and role support across the age groups. This author suggests that this may be partly attributed to the fact that nurses in Blantyre district, do not generally have access to the ongoing in-service education in mental health and support from mental health specialists, regardless of their age.

5.3 PERCEIVED KNOWLEDGE, SKILLS AND ATTITUDES OF NURSES REGARDING MENTAL HEALTH MANAGEMENT IN HIV/AIDS SERVICES

5.3.1 Perceived knowledge regarding mental health management in HIV/AIDS services

With respect to the perceived knowledge of the respondents regarding mental health management in HIV/AIDS services, 37.9% (n=47) disagreed that they have enough knowledge about the relationship between mental health and HIV/AIDS. However 25.0% (n=31) agreed with this statement. The study found that 46.85 (n=58) of the participants disagreed with the statement that they have enough knowledge on how to deal with different types of mental health problems in PLWHA, with only 20.2% (n=25) agreeing with this statement; and 43.5% (n=54) disagreed with the statement that they were educationally prepared to handle or resolve mental health problems in PLWHA, with only 20.2% (n=25) agreeing with this statement. The results also revealed that 37.9% (n=47) disagreed with the statement that they had enough knowledge about factors that put PLWHA at risk of mental health problems, while 24.2% (n=30) agreed, and 33.9% (n=42) disagreed with the statement that they know how to treat and manage people who have long term mental health problems and suffer from HIV/AIDS, while, 30.6% (n=38) agreed with this statement.

The overall score of perceived knowledge of the respondents regarding mental health management in HIV/AIDS services was calculated, with 4 items being considered and the responses ranging from 1 to 5 (i.e. strongly disagree to strongly agree). The maximum score was 25 and the minimum score was 5. The higher the score, the more knowledgeable the respondents perceived themselves regarding mental health management in HIV/AIDS services. The mean score was 13.07; the mode was 10, the median 12 and standard deviation 5.42. An average of 50% had a score of 12, and at least 75% had a score of 17, which indicated a higher perceived knowledge regarding mental health management among nurses in HIV/AIDS services.

Similar results were found in Australia, by Clark et al. (2005), where 62% of the respondents felt that they lacked adequate knowledge and skills for them to provide

mental health care. The main focus of their study was on rural generalist nurses perceptions of the effectiveness of their therapeutic interventions for patients with mental illness. Their findings revealed that 70% of the respondents indicated that limited knowledge of mental health problems was an issue preventing nursing staff in rural and remote settings from providing optimum care to patients with mental illness. Furthermore, 29% of the respondents indicated that they had never received or undertaken training or education in relation to the care, treatment or assessment of patients with mental illness. It further stated that rural nurses do not feel competent, nor adequately supported, to deal with patients with mental health problems. However, according to Clark et al. (2005), nurses play an integral role in the delivery of health care services to people suffering from mental illness in rural and remote areas of Australia.

Nurses have a higher frequency of contact with PLWHA than most other health care providers (Delobelle, Rawlinson, Ntuli, Malats, Decock and al, 2009). However, nurses are not usually competent enough to deal with mental health problems (Svediene et al., 2009; Atkin, Holmes and Martin, 2005). The findings of the current study suggested that PLWHA are not always attended by nurses who are competent enough to deal with mental health care problems.

This is consistent with the findings of Chorwe-Sungani's, (2010) Malawian study, where nurses provide the majority of health care in general settings. The findings showed that many nurses perceived that they lacked knowledge and skills to deal with mental health problems. The fact that PLWHA may not always access relevant mental health care in general settings defeats the very purpose of the National Mental Health Policy of Malawi (Ministry of Health and Population [MOHP], 2001) which advocates for the provision of mental health care in general settings.

This is supported by other studies that have indicated that nurses must have adequate knowledge and skills to deal with mental health problems of people living with HIV/AIDS (Collins , Holmand , Freeman and Patel 2006; Freeman et al., 2005) because they are usually the frontline health care providers in general settings (Atkin et al., 2005; Lauder et al., 2002). Rural generalist nurses require knowledge, skills and networks in mental

health that will enable them to provide effective mental health care, but a number of studies have suggested that undergraduate nursing students are not specifically prepared for work in the mental health field (Moxham, Dwyer, Happell, Reid-Searl, Kahl, Morris et al., 2010; Clark et al., 2005). Gorman, Buikstra, Hegney, Pearce, Rogers-Clark, Weir et al. (2007) found that nurses believed the amount and type of support services available impacted upon their scope of practice.

From the findings of this study, it is clear that nurses have varying perceptions about their levels of knowledge, skills and competency to care for people living with HIV/AIDS who have mental health problems. Clark et al. (2005); Lauder et al. (2002); and Lethoba, Netswera, and Rankhumise (2006), in their nursing literature, have stated that nurses' self-perceptions in this regard have an influence on their nursing interventions. This may probably mean the quality of mental health care that is received by PLWHA may vary according to the nurse's level of role competency. Other studies (Chorwe-Sungani, 2010 and Uebel,2013) have indicated that having adequate knowledge and skills evokes positive self-perceptions about mental health care in a nurse and this helps in rendering and ensuring the therapeutic interaction and understanding of the client needs (Mavundla, 2000).

With regards to the variable on whether respondents had received mental health training or not, respondents gave the following responses: of the 39 registered nurses, only 15 (38.5%) had received mental health lecturers, while 24 (61.5%) had not; of the 15 registered midwives, 9(60.0%) had received mental health lecturers, while 6 (40%) had not received the mental health care lecturers, of the 54 registered psychiatric, community and midwifery nurses, 44 (81.5%) had received mental health lectures, while 10 (18.5%) had not, of the 2 registered psychiatric nurses, 1 (50%) had received mental health lecturers and 1 (50%) had not; and of the 14 registered PHC nurses, 4 (28.6%) had received mental health lectures and 10 (71.4%) had not. In summary, of the 124 nurses who responded to the questionnaire, 73 (58.9%) had received mental health lectures and 51 (41.1%) had not.

It is significant that nurses are adequately equipped with enough knowledge and skills to care for people with mental health care problems and for the nurses to be able to understand the relationship between HIV/AIDS and mental health problems. In this study, the majority of the respondents reported that they had received mental health care lecturers during their training. It is however noted that many nurses have demonstrated low levels of role competency. This was found in the responses of the respondents who completed in the questionnaire. It is assumed, therefore, in this study that the low levels of role competency that were demonstrated by nurses were evoked by lack of in-service education of nurses on how to deal with mental health problems in PLWHA. This is in line with the study conducted by Munro et al. (2007) who proposed that effective and appropriate training helps nurses to improve their knowledge, skills and attitudes regarding mental health care. Training in mental health promotes confidence in nurses and in their dealing with mental health problems in general settings (Moxham et al., 2010). It is argued in some literature that nurses who did not receive any mental health care lectures have little interest in caring for PLWHA and people with mental health problems (Lauder et al., 2002). It was interesting to note that there are nurses from this study who are willing to care for PLWHAs who present with mental health problems provided they receive adequate mental health care lecturers and in-service education training and this was shown in their responses on the statement “I am interested in the nature of mental health problems of people living with HIV/AIDS and the treatment of them’’.

Findings of studies conducted in Singapore and Turkey by Ngan et al. (2000) and Bektas and Kulakac, (2007) respectively, revealed that nurses’ levels of anxiety in caring for people with HIV/AIDS were reduced by education. In South Africa, similar findings were highlighted in studies conducted by Madumo and Peu (2006); Lohrmann, V¨alim¨aki, Suominen, Muinonen, Dassen and Peate (2000); Petro-Nustas, Kulwicki and Zumout (2002). Rondahl, Innala and Carlsson (2003) concluded that there was a need for nursing education not only to have biomedical knowledge of HIV/AIDS, but also that education should include broader cultural and ethical issues surroundings in HIV/AIDS.

5.3.2 Perceived skills regarding mental health management in HIV/AIDS services

The findings from this study revealed that 49.2% (n=61) of the respondents disagreed with the statement they have enough skills to handle mental health problems in PLWHA such as psychosis, depression. However, 22.6% (n=28) agreed with this statement. The study results discovered that 29.8% (n=37) agreed with the statement that they have skills to assess, identify and treat PLWHA who have mental health problems, though 33.1% (n=41) disagreed with this statement.

The results showed that 35.5% (n=44) of the respondents disagreed with the statement that they had the skills to work with PLWHA who have mental health problems, while 28.2 % (n=35) agreed; 36.3 % (n=45) agreed with the statement “I have good qualities for working with people who have mental health problems and HIV/AIDS”, and 28.2 % (n=35) disagreed with the same statement.

This study is supported by Chorwe-Sungani (2010), who found that nurses’ self-perceptions of their knowledge and skills regarding their provision of mental health care to PLWHA who have MHP are diverse. This was demonstrated by the varied responses he got from the participants on the role competency scale. Some nurses perceived themselves as having necessary knowledge and skills to care for PLWHA who have MHP, while others perceived themselves as lacking such knowledge and skills.

The results from this study are in line with the literature where it has been documented that nurses working in general hospital settings do not provide adequate mental health care due to their lack of knowledge and skills in dealing with mental health problems (Mavundla, 2000). This not only compromises the care of PLWHA, but also poses a challenge to the success of HIV and AIDS intervention programmes. According to Uebel, Guise, Georgeu, Colvin and Lewin (2013) and Freeman et al. (2005), HIV/AIDS intervention programmes must include mental health care if they are going to be successful.

5.3.3 Perceived attitudes regarding mental health management in HIV/AIDS services

According to (Baingana et al., 2005), nurses develop negative attitudes when nursing or managing clients who presents with HIV/AIDS and mental health problems because of lack of knowledge in handling such clients. However, the World Health Organization (WHO) report on HIV/AIDS and mental health outlines a number of studies which have demonstrated a high prevalence of psychiatric disorders in people infected by HIV/AIDS (WHO, 2008). According to Faber, Mirsalimi, Williams and McDaniel (2003), the prevalence rates of psychiatric disorders among people living with HIV are high, but vary from country to country and from study to study. Bing (2001) conducted a study to estimate the prevalence of psychiatric disorders and substance abuse among American adults infected by HIV/AIDS and found that nearly half of their sample (n=2864) reported a psychiatric disorder. Similarly, Israelski et al. (2007) estimated the prevalence of psychiatric co-morbidity among a group of people in Northern California receiving primary care for HIV/AIDS. This study revealed that in a sample of 118 people, 56% screened positive for at least one psychiatric disorder. The study by Chorwe-Sungani (2010) found that nurses had positive attitudes in providing mental health care to PLWHA, although several of them expressed a lack of interest in caring for PLWHA who have MHP.

The literature suggests that the attitudes and self-perceptions of nurses have an influence on their mental health care interventions (Angus et al., 2001; Mavundla, 2000). This may mean that the quality of mental health care received by PLWHA depends on the nurse's self-perceptions, attitudes at any particular moment. This is consistent with Lauderet et al. (2002); and Anguset et al. (2001), who asserted that there is a direct link between the self-perceptions of nurses and the effectiveness or success of their mental health nursing interventions. These authors categorised nurse's self-perceptions and attitudes about their provision of mental health care as role competency, role support and therapeutic commitment. They further described role competency as nurses' attitudes and self-perceptions of having the necessary knowledge and skills to provide mental health care; and role support as their perceived

level of access to mental health specialists. They argued that role competency and role support influence therapeutic commitment, which they described as the nurses' self-perceptions about their willingness to deal with MHPs. Hence, it is necessary for nurses to have adequate knowledge, skills and support for them to have positive attitudes or perceptions about dealing with MHPs (Stuckler et al., 2008). This is corroborated by Mavundla (2000), who claimed that nurses who feel that they are not adequately prepared to care for or handle people with mental health problems have negative attitude about dealing with mental health problems.

The findings from this study revealed that out of 124 respondents, 33.1% (n=41) agreed and 15.3% (n=19) strongly agreed that they were prepared to attend to people who present with mental health problems in an HIV setting. However a significant percentage of the respondents, (34.7%, n=43) disagreed and 14.5% (n=18) strongly disagreed that they were prepared to attend to people who present with mental health problems in an HIV setting. Furthermore, n=47 (37.9%) of the respondents disagreed with the statement that they wanted to work with PLWHA who have mental health problems, with only n=36 (29.0%) of the respondents agreeing to the statement.

The majority of participants (61.3%, n=76) agreed to the statement of having no negative attitudes in working with people who are mentally ill and HIV infected, with a mere 14.5% (n=18) disagreeing with the statement. However, although 29.8% (n=37) agreed with the statement "I feel that I have something to offer PLWHA who have mental health problems", 36.3% (n=45) disagreedand18.5% (n=23) strongly disagreed with the statement. Just over half the participants (51.6%, n=64) agreed that they can understand PLWHA who have mental health problems, while 20.2% (n=25) disagreed with the statement and 41.9% (n=52) agreed that they have the right to ask mentally ill clients about their HIV/AIDS status and 24.2% (n=30) disagreed with the statement.

These findings are supported by Chambers, Guise, Välimäki, Botelho, Scott, Staniulienė and Zanotti (2010), who found that nurses generally had positive attitudes towards MHPs. The findings are also similar to Chorwe-Sungani (2010), who found that nurses had positive attitudes in providing mental health care to PLWHA, although several of

them expressed a lack of interest in caring for PLWHA who have MHP. A South African study conducted by Mavundla (2000), on the contrary, found that nurses' perceptions about dealing with MHP in general settings were mostly negative.

The findings from this study showed that of the 68 respondents who reported average attitudes regarding mental health management in HIV/AIDS services, 45.3% (n=29) were registered psychiatric, community, midwifery nurses and 28.1% (n=18) were registered nurses. It was also found that of the 43 respondents who reported good attitudes regarding mental health management in HIV/AIDS services, 48.8% (n=21) were registered psychiatric, community, midwifery nurses and 32.6% (n=14) were registered nurses.

The attitudes of mental health care providers to sexual relations and HIV among people with serious mental illness (SMI) continue to influence the extent to which these issues are addressed in HIV/AIDS services and Primary Health Care settings (Moxham et al., 2010; Kimironko Health Centre, 2008; Collins, 2006; Komiti et al., 2001).It has been documented that nurses working in general hospital settings do not provide adequate mental health care due to their lack of knowledge and skills in dealing with mental health problems(Mavundla, 2000). This not only compromises the care of PLWHA, but also poses a challenge to the success of HIV and AIDS intervention programmes. North American studies suggest that lack of knowledge, stigmatization and institutional barriers have limited providers readiness to respond to HIV/AIDS prevention needs in mental health settings(Kimironko Health Centre, 2008; Komiti et al., 2003). Provider's age, sex, sexual orientation and clinical experience working with HIV/AIDS have been linked to their comfort in addressing HIV/AIDS in some mental health care settings (Komiti et al., 2001).

In this study it was discovered that many of the nurses are not comfortable in dealing with mental health problems of the PLWHA due to lack of training and this is supported by the study conducted by Ssebunnya, Kigozi, Kizza, and Ndyanabangi (2010) that found that nurses tend to be uncomfortable dealing with mental disorders and may also question their role in managing mental disorders.

5.4 PERCEIVED BARRIERS/CHALLENGES RELATED TO THE INTEGRATION OF MENTAL HEALTH INTO HIV/AIDS SERVICES.

The literature shows that there is growing recognition that mental health is a crucial public health and development issue in South Africa (SA). Neuropsychiatric conditions rank third in their contribution to the burden of disease in SA and 16.5% of South Africans report having suffered from mental disorders in their last year (University of Cape Town [UCT], 2014). However, mental health is not given the priority it deserves in SA, and a national mental health policy has not been formally adopted and implemented. The aim of the MHaPP is to examine mental health policy and systems in SA, with a view to identifying the key barriers to mental health policy development and implementation, and steps that can be taken to strengthen the mental health system in the country. Current mental health policy in SA was analyzed using the WHO-AIMS instrument, the WHO Checklist for Mental Health Policy and Plan and interviews with mental health policy stakeholders in SA (University of Cape Town [UCT], 2014).

On the perceived barriers or challenges related to the integration of mental health into HIV/AIDS services, the study reveals that 33.9% (n=42) of the respondents agreed and 29.8% (n=37) strongly agreed to the statement that they often have difficulty in assessing and identifying mental health problems in PLWHA, with only 29.0% (n=36) disagreeing with the above statement. Furthermore, while 36.3% (n=45) disagreed that they feel uncomfortable and insecure when working with people who have mental health problems and HIV/AIDS, 33.1% (n=41) agreed with the statement. An equal number of respondents (33.9%, n=42) agreed and disagreed with the statement that they find it difficult to work with people who have mental health problems. Findings showed that 45.2% (n=56) disagreed with the statement that there is nothing they can do to help PLWHA who have mental health problems and 25.0% (n=31) agreed with this statement.

The findings of this study are in line with the study conducted by Uebel et al. (2013), who argued that the administrative work required of clinic staff tended to reinforce the existing organization of care and thus to hinder integration in a number of ways. For

example, some programmes had specific forms for each consultation to ensure that important clinical information was elicited and recorded within the patient's general file. In many clinics there were also separate medical files for HIV and other chronic diseases. In addition, many programmes had their own registers in which the number of patients seen had to be recorded. These specific records of the various programmes tended to hinder efforts to integrate HIV care into all consultations within the clinic. The shifting of clinical tasks to nurses requires adjustments in the roles of other supporting staff, such as pharmacists. Within the context of a stretch trial, a shortage of support staff tended to hinder the integration of HIV care into other services, which is the same as integrating mental health care into HIV/AIDS services (Uebel et al., 2013).

The literature reveals that the budget that is allocated for mental health is insufficient compared to other disciplines, but nothing has ever been done about bringing this to the attention of the government or the Department of Health. Furthermore, little research has been undertaken concerning the relationship between mental health and HIV/AIDS (Freeman et al., 2008). For this integration to be successful, it must start at a national level and then be cascaded to provincial and regional levels and there must be mental health specialists, such as mental health doctors and mental health nurses in all levels so to lead and give the proper guidance on how to handle patients who are mentally ill and affected by HIV/AIDS infection (Herztig, Muhlemann, Burnand, Favrat, Haftgoli, Verdon et al., 2012).

5.5 PERCEIVED FACTORS TO PROMOTE THE INTEGRATION OF MENTAL HEALTH INTO HIV/AIDS SERVICES

On the perceived factors to promote the integration of mental health into HIV/AIDS services the following responses were revealed by the study: 51.6% (n=64) of the participants agreed and 33.9% (n=42) strongly agreed that guidelines on how to deal with or handle PLWHA who have mental health problems would be of assistance to them, and 56.5% (n=70) agreed and 22.6% (n=28) strongly agreed to the statement saying there is a need to talk about nurses' attitudes regarding PLWHA who have mental health problems. Furthermore, 41.1% (n=51) disagreed and 33.9% (n=42)

strongly disagreed with the statement saying that they receive adequate support from mental health services within their district when working with people who have mental health problems and PLWHA. Although 36.3% (n=45) disagreed that they received adequate support from mental health services outside their district, 33.1% (n=41) agreed with the statement. The majority of respondents (56.5% (n=70) agreed and 25.8% (n=32) strongly agreed that they felt that the department should equip them with the skills that are needed to work with PLWHA who have mental health problems. Almost half of the respondents (43.5%, n=54) agreed that there is a need for basic training on mental health problems for them to be able to help PLWHA and have mental health problems.

These findings are in line with the study conducted by Satriano, Rothschild, Steiner and Oldham (1999),on training needs. Rating the importance of mental health services for people infected with HIV, 62.1% (197/137) of the respondents rated it as essential and 34.7% (110/317) as very important. Overall, 74% (226/304) of the clinics felt that their staff needed training in neuropsychiatric manifestations of HIV and 73% (221/303) in legal, ethical and policy issues. The number of known HIV positive patients influenced the frequency with which clinics stated that their staff needed training in HIV risk interviewing, and conducting HIV risk reduction groups.

The findings are also supported by Jenkins (2013), who investigated health system challenges to integration of mental health delivery in primary care in Kenya from the perspective of primary care health workers. Her study participants reported that it was not easy to apply the skills learned on the training course because there was a lack of support and supervision from the district medical team who were more focussed on other problems, such as malaria. It also became evident that the nurses, themselves, tended to concentrate on what they knew would be checked by the district officials and therefore gave less attention to mental issues.

The World Health Organization (2008) recommended that a successful HIV/AIDS intervention programme should include appropriate strategies for the assessment and management of mental disorders as part of the routine service. Jenkins (2013), Israelski

et al. (2007); Freeman, Nkomo, Kaffar and Kelly (2008); and Freeman et al. (2005) argue that people receiving Primary Health Care for HIV/AIDS should be routinely screened and treated for symptoms of mental disorders as this has been shown to significantly improve the HIV/AIDS disease outcomes. These authors suggest that estimating the prevalence of depression among HIV/AIDS affected people is important to developing and/or improving services for the treatment of mental illness at the HIV treatment site and thus, to improving HIV disease outcome and quality of life.

The WHO (2008) has produced a series of modules and training material for integration of mental health interventions into antiretroviral therapy programmes, which presents an opportunity to improve the mental health of people with HIV/AIDS. HIV/AIDS programmes need to include assessments of mental and substance use disorders and their appropriate management (WHO, 2008). Primary Health Care providers, including HIV/AIDS counsellors, can be trained to recognize and treat common mental and substance use disorders and refer patients to specialized services when warranted (WHO, 2008). Such providers need to be properly trained and supported by adequate supervision, and the process of referral to mental health services need to be an integral part of the health infrastructure (Chorwe Sungani, 2010; Chambers, 2010; WHO, 2008; Clark et al., 2005; Lauder et al., 2002). The services for mental health services and substance disorders need to collaborate closely with HIV/AIDS services at all levels in order to facilitate co-ordinated action involving other relevant community based resources (WHO, 2008).

Despite the fact that developing countries carry more than 90% of the burden of HIV/AIDS, little information about the relationship between HIV/AIDS and mental health is available in low-middle income countries. Support and research are needed in those countries on that relationship, as well as relationships between mental health and substance use disorders and HIV/AIDS. Furthermore research should investigate service delivery, cost effective models of service provision and the impact of interventions for mental disorders and substance use on the outcomes of HIV/AIDS disease (WHO, 2008; Reed and Fitzgerald, 2005). The services for mental health services and substance disorders need to collaborate closely with HIV/AIDS services at

all levels in order to facilitate co-ordinated action involving other relevant community based resources (WHO, 2008).

South Africa's first post-apartheid mental health policy guideline, the National Health Policy Guidelines for Improved Mental Health in SA, was approved in 1997 and in the same year, a chapter on mental health was included in the Department of Health's White Paper for the Transformation of the Health System in SA. The 1997 policy guidelines were drafted as an overview document, with the intention of drafting more detailed policies for specialised issues. No official plan accompanied the policy, but national targets with indicators were set to guide the realisation of selected priorities (University of Cape Town [UCT], 2014).

The 1997 policy guidelines were approved for implementation at the highest level. However, due to capacity constraints within the national office, they were neither formally published nor widely circulated throughout the country, nor were all the specific policy guidelines completed or followed by the development of implementation guidelines. Furthermore, current officials in the National Directorate of Mental Health and Substance Abuse maintain that these guidelines did not conform to policy development protocols established since 1999,and therefore do not constitute official policy. The Directorate is in the process of drafting a new mental health policy for SA, the most recent draft of which is dated April 2006 (University of Cape Town [UCT], 2014).

5.6 REPORTED MANAGEMENT OF MENTAL HEALTH PROBLEMS AMONG PEOPLE LIVING WITH HIV/AIDS

On reported management of mental health problems among people living with HIV/AIDS, it was discovered that 54.0% (n=67) agreedand 16.9% (n=21) strongly agreeto the statement that it is good for mental health to be integrated into HIV/AIDS services in a PHC setting. However, only 38.7% (n=48) disagreed with the statement that it is not good for mental health to be integrated into HIV/AIDS services in a PHC setting and 28.2% (n=35) agreed with this statement. The majority of respondents

(65.3%, n=81) agreed and 21.8% (n=27) strongly agreed that it is significant to get adequate information on the relationship between mental health and HIV/AIDS.

The findings of this current study are aligned with the study conducted by Jenkins (2013), where the health workers in the focus groups indicated that clear targets for mental health need to be established and monitored from the national to the community level. They suggested that there is no need to use protocols for managing common psychiatric disorders, but that continued support, supervision and training on mental health are crucial. Other factors that they felt need to be addressed are lack of resources in clinics, poverty of the clients and long distances to suitably equipped facilities. They also felt that management of violent mentally ill patients in HIV/AIDS services needs to be addressed since nurses felt threatened by such patients and cannot manage them on their own (Jenkins et al., 2013).

The findings of this current study are also supported by Uebel et al. (2013), who investigated integrating HIV care into nurse-led Primary Health Care services in South Africa. These authors reported that nurse managers had mixed attitudes towards the integration of mental health care to HIV care. They found that nurses and managers often had a passion for developing specialist expertise in one area of care and developing good nurse-patient relationships, both of which tend to favour the separation of services by health conditions (TB/HIV/AIDS), rather than integrated care (Uebel et al., 2013).

Freeman et al. (2008), who reported on a joint meeting of a variety of stakeholders from academia, public and non-governmental work in South Africa, highlighted that HIV/AIDS is an impending threat in the management of mental health which requires urgent attention. As mental health problems are disturbing human emotional and psychological experiences (Angus et al., 2001), it is very important that nurses provide holistic care by dealing with the MHP of PLWHA. This is in line with the recommendations of the World Health Organization, which promotes the integration of mental health services with general health services, where non-mental health specialists take part in the provision of mental health care (WHO, 1999). Supporting this, Freeman et al. (2008) noted that

the intersection between HIV/AIDS and mental health is under-developed in many countries, including South Africa, which is 39.5% in KwaZulu-Natal alone (KZN statistics on HIV/AIDS (DoH, 2011). Furthermore, there is a need to train health care workers in order to reduce mental health and HIV/AIDS related stigma (Albery et al., 2003). Kantontoka (2008) noted the lack of attention being paid to the needs and voices of people experiencing mental health problems, and stated that increased empowerment of these people is needed.

The results of the study have revealed that there is a relationship between role competency, role support and therapeutic commitment. The increase in role competency was associated with therapeutic commitment, as well as increase in role support, as proposed by Chorwe-Sungani (2010).

5.7 STRENGTHS AND LIMITATIONS OF THE STUDY

5.7.1 The strengths

The strengths of the study were based on the research methodology and research approach that were used, and are summarized as follows:

A quantitative study enables the researcher to be independent of the phenomenon of interest and hence not engage with the phenomenon or respondents being researched. According to Gillis and Jackson (2001), positivists believe in value free research so that personal values have no influence on the results of a study. They stated that positivists rely on numerical analysis of data. Thus, the researcher only collected numerical and ordinal data that was subjected to statistical analysis. This is the first study that has been conducted on the exploring the attitudes, skills, knowledge and preparedness of nurses on the integration of mental health care into HIV/AIDS services. The study may assist nurse educators when developing their curriculum to introduce mental health care into all the training programmes to prepare nurses to work with PLWHA who have MHP. It may assist health stakeholders to develop and incorporate educational programmes into their policies and curricula that emphasize the effectiveness of the integrated services.

5.7.2 The limitations

The study had several limitations. The data was collected from one district (eThekwini) and it was not easy to access a large number of nurses due to staff shortages and workload in a working environment. The other limitation of the study was that it used a self-reporting questionnaire to collect data and respondents might have been tempted to present themselves favorably.

5.8 RECOMMENDATIONS

A number of key recommendations emerged from the study and will be discussed as follows: clinical recommendations, education and professional recommendations, managerial and policy recommendations, and research recommendations.

5.8.1 Clinical recommendations

Integration of mental health into HIV/AIDS initiatives and programmes presents an opportunity to improve the health of people with HIV/AIDS. The WHO has produced a series of modules and training material for integration of mental health interventions into antiretroviral therapy programmes. HIV/AIDS programmes in countries need to include assessment of mental and substance use disorders and their appropriate management. Primary Health Care providers, including HIV counselors, can be trained to recognize and treat common mental and substance use disorders and refer patients to specialized services when warranted. Such providers need to be properly trained and supported by adequate supervision, and the process of referral to mental health services needs to be an integral part of the health infrastructure. The services for mental health and substance use disorders need to collaborate closely with HIV/AIDS services at all levels in order to facilitate coordinated action involving other relevant community based resources. Integration of HIV/AIDS into mental health services provides opportunities for identifying individuals at risk of HIV infection, introducing HIV prevention and detecting those who are infected and providing them with appropriate HIV treatment and care. Integration of HIV/AIDS services into mental health care provides opportunities for both improving early detection of MNS co-morbidities with HIV infection and implementing

effective interventions appropriate for existing health, family and community resources. The evidence for the need is clear, and the evidence base for interventions suggests that it is feasible in low-resourced settings. Ultimately, successful integration of HIV/AIDS services into mental health care will require shared commitment of providers and policymakers along with collaborative learning to address remaining challenges (Kaaya et al., 2013).

5.8.2 Educational and professional recommendations

In addition to imparting skills, training also needs to address the overall attitude of Primary Health Care workers to embrace persons with mental disorders. This calls for regular in-service training of all general health nurses. Adequate supervision of Primary Health Care, HIV/AIDS services staff is another key issue which has to be addressed if integration is to succeed. Mental health care professionals should be available regularly in the Primary Health Care settings to monitor and provide technical support and supervision at all levels for the staff. This was noted to be lacking, which further casts doubt on the effectiveness of the integration process. Thus, the need for further training of the Primary Health Care nurses in HIV/AIDS services in mental health is essential.

For upcoming students in the nursing profession, this study supports the fact that quality knowledge is obtained via the nursing schools, as reflected in the high knowledge scores of the respondents, who got their information through this source. Hence nursing colleges should constantly update and improve their curricula so that the students can benefit maximally.

There are significant implications for further interventions designed for health care professionals. Better structured education targeted to all nurses in the nursing profession working in both rural and urban hospital settings, in the form of health talks, seminars, in-service-training, continuing medical education and school curricula, would improve the HIV/AIDS knowledge for health care providers most efficiently and effectively. In addition, by fostering a more positive environment where universal precautions are in effect, and empathy for HIV/AIDS patients is encouraged, more positive views on the care of PLWHA who present with mental health problems would

be expected. It is essential that general nurses have access to support, ongoing training and in-service education on mental health issues, which may give them an opportunity of improving their knowledge and skills and consequently their therapeutic commitment in dealing with mental health problems of PLWHA (Chorwe Sungani, 2010). According to WHO (2010), it is significant that the nursing education mental GAP intervention guide must be included in the nursing curriculum of the nurses during their basic training. Nurse educators, together with the government, need to intensify the training of mental health specialists so that they can be readily available to support nurses who are caring for clients with mental health problems and suffer from HIV/AIDS (Ngo, Rubinstein, Ganju, Kanellis, Loza and al, 2013; Chorwe Sungani, 2010).

5.8.3 Managerial and policy recommendations

A successful HIV/AIDS intervention program must include the assessment of mental disorders and their appropriate management as part of their services.

The department of health needs to develop appropriate materials and models for the quality delivery of mental health care within the general health care services and Primary Health Care as well as HIV/AIDS services.

There is a need to support research on mental health care and HIV/AIDS. The role of mental health in HIV/AIDS services and treatment programmes needs to be clearly indicated and highlighted by the stakeholders in order to ensure the good implementation of integrating mental health into HIV/AIDS services. The government may consider the introduction of liaison mental health nurses or mental health nurse consultants in the general settings. Readily employed nurses in general settings can be utilized for this purpose (Collins, Tinsel, Chockalingam, Daar and Maddox, 2013; Sharrock and Happell, 2006).

5.8.4 Research recommendations

The researcher recommends that the following research would be of benefit to the nursing profession:

- To explore the gap between the government policies on mental health care and their implementation
- A comparative study to identify the fair allocation of funds between mental health care and other disciplines, such as orthopedics, urology etc.
- To explore quality of care given to PLWHA who present with MHP
- Conduct further implementation research to build the evidence base on integration and scaling up of care for mental disorders in PLWHA

5.9 CONCLUSION

The study has revealed that there is a great need for mental health to be integrated into HIV/AIDS services based on the results that were found from the respondents. Although a number of the respondents mentioned that that they find it difficult to work with people who are presenting both with mental health and HV/AIDS problems, those that had received mental health care lectures during their training were interested to work with these people. The findings showed, however, that some of the respondents felt that they were not getting any support within and outside their respective districts. The responses also revealed that respondents believe that they do not have adequate knowledge and skills to provide therapeutic help for patients with mental health problems and HIV/AIDS. According to Chorwe Sungani (2010), education and training concerning mental health problems is a factor that can influence their therapeutic commitment, role competency and role support.

In accordance with recommendations of (Patel et al., 2012), it is suggested that mental health be integrated into routine health care platforms, because this integration is the only feasible way to address the treatment gaps for mental health problems in PLWHA. It is furthermore suggested that the skills packages for various members of the general

nurses be refined since the nurses have indicated in this study that they do not have adequate skills to deal with PLWHA who also present with MHP

There are a number of generic health system weaknesses in South Africa which impact on efforts for horizontal integration of mental health care into HIV/AIDS care practice. A major lever for horizontal integration of mental health care into the health system would be the inclusion of mental health care in the national health sector reform strategy at community primary care and district levels rather than just at the higher provincial and national levels, so that supportive supervision from the district level to primary care would become routine practice rather than a very scarce activity. Enhanced general nurses' education about mental health care in liaison with the community leaders and health stakeholders is a crucial adjunct to addressing these health system weaknesses (Jenkins et al., 2013).

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APPENDICES

Appendix 1: Information Sheet

Date: 29/03/12

Name of Research student:	Winnie B. Cele
Address of student	33 Mons Road, Bellair, 4094
Student no.	209539990
Contact no:	072 094 292 3
Name of supervisor:	Dr J.R.Naidoo
Contact no. :	031- 260 2213
Name of Department:	School of Nursing
Name of Institution :	University of KwaZulu-Natal (Howard College)

Dear Participant

I am completing a research project as part of the requirements for the Master's Degree in Nursing (Mental Health)

Title of the research: Exploring knowledge, attitudes, skills and preparedness of nurses on the integration of mental health into HIV/AIDS services in eThekwini district, KwaZulu –Natal
Purpose of the research: Explore and describe the level of knowledge, skills, preparedness and attitudes of nurses regarding integration of mental health into HIV/AIDS services .Explore and describe the monitoring and evaluation of current mental health policies and plans or revisit the way how this integration can be successful done by having proper guidelines for treating people living with HIV/AIDS and mental illness.

Procedure : If you consent, you will be asked to complete a questionnaire about knowledge, skills, attitudes and preparedness about integration of mental health into HIV/AIDS services; it will be about 20 minutes to complete the questionnaire

Ethical Aspects: Please note that all the information given will be kept confidential and only used for research purpose. Your identity will not appear in any report of the research.

Please note that you are free to decline to answer questions without giving reasons whenever you feel uncomfortable to do so. However, it is important to know that the information given may contribute in making recommendations about integration of mental health into HIV/AIDS in PHC setting. You are free to withdraw at any stage without repercussions. There will be no risk attached to your participation. Participation in the entirely study voluntary. If you have any questions do not hesitate to contact Winnie Cele on the given address and numbers or contact Dr J.R.Naidoo on 031-260 2213

Advantage to you as a respondent

The findings of the study will be made available on completion.

Appendix 2: Informed consent form

Researcher: Mrs Winnie B.Cele

Student no : 209539990

Contact no. : 072 094 292 3

Email : celewinnie@yahoo.com

Supervisor : Dr J.R.Naidoo

Tel : 031- 260 2213

Email : naidoojr@ukzn.ac.za

Declaration

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

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

Signature of participant……. Date ……..

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

Appendix 3: Questionnaire for the study

Section A: Biographic /Demographic Data

Instruction: Please answer the following question by ticking (√) the appropriate box where needed.

1. What is your age in years? ☐

2. Indicate the number of years you have been practicing as a nurse

3. What is your gender? 1. Female ☐
2. Male ☐

4. Which nursing cadre do you belong to?

1. Registered nurse ☐

2. Registered midwife ☐
3. Registered nurse (community, psychiatry and Midwifery) ☐

4. Registered Psychiatric nurse ☐

5. Registered nurse (PHC) ☐

6. Other specify……..

5. Indicate your department

1. Primary Health Care services ☐

2. HIV/AIDS services ☐

3. Community health care clinic ☐
4. Other specify …….

6. Did you receive mental health lecturers as part of training? 1. Yes ☐

2. No ☐

Section B

Indicate whether you agree, disagree, neutral, strongly agree, and strongly disagree with the statement below

	Agree	Disagree	Neutral	Strongly Agree	Strongly Disagree
1. I am interested in the nature of mental health problems of people living with HIV/AIDS (PLWHA) and treating them					
2. I am prepared to attend to people who present with mental health problems in an HIV setting					
3. I feel ,I have enough knowledge ,skills about the relationship between mental health and HIV/AIDS					
4.I want to work with PLWHA who have mental health problems					
5. I have no negative attitude in working with people who are mental ill and HIV infected					
6. I have enough skills to handle mental health problems in PLWHA such as psychosis ,depression etc					
7. I have enough knowledge on how to deal with different types of mental health problems in PLWHA					
8. I am prepared educational to handle or to resolve mental health problems in PLWHA					
9. I feel that I have something to offer in PLWHA who have mental health problems					
10. In general, I feel that I can understand PLWHA who have mental health problems					
11. I feel that I have enough knowledge about factors that put PLWHA at risk of mental health problems					
12. I feel I have skills to assess, identify					

and treat PLWHA who have mental health problems					
13. I often have difficulty in assessing and identifying mental health problems in PLWHA					
14. I feel that guidelines on how to deal or handle with PLWHA and have mental health problems can assist me in treating or managing them					
15. I have the skills to work with PLWHA who have mental health problems					
16. I feel I know how to treat and manage people who have long term mental health problems and suffer from HIV/AIDS					
17. I feel I have all the rights to ask clients who are mental ill about their status of HIV/AIDS					
18. I often have difficulty in knowing how to communicate with mental ill people who live with HIV/AIDS					
19. I feel there is a need for basic training on mental health problems for me to be able to help PLWHA and have mental health problems					
20. I feel there is a need to talk about the attitudes that nurses have when facing PLWHA and having mental health problems					
21. When working with people who have mental health problems and PLWHA ,I receive adequate support from mental health services within my district					
22. When working with people who have mental health problems and PLWHA ,I receive adequate support from mental health services outside my district					
23. I feel uncomfortable and not secure when working with people who have mental health problems and HIV/AIDS					
24. I feel I have good qualities for working with people who have mental health problems and HIV/AIDS					
25. I find difficult in working with people who have mental health problems and HIV/AIDS					

26. I feel that there is total nothing that I can do to help PLWHA who have mental health problems					
27. I feel the department need to equip me with skills that are needed for me to be prepared to work with PLWHA and have mental health problems					
28. I feel it is good for mental health to be integrated into HIV/AIDS services in PHC setting					
29. I feel it is not good for mental health to be integrated into HIV/AIDS services in PHC setting					
30. I feel it is significant to get adequate information on the relationship that mental health and HIV/AIDS have					

Appendix 4: Letter requesting the permission to conduct a research study for KZN department of health

The Director
Private Bag x 01
Pietermaritzburg
3200

Dear Sir/ Madam

Re-Permission to conduct a Research Study

I hereby request permission to conduct a research study at Prince Mshiyeni Memorial Hospital(Primary Health Care, HIV/AIDS services).I am a student studying Masters Degree in Nursing (Mental Health) at the university of KwaZulu-Natal, School of Nursing ,Howard College Campus. I have received my ethics approval from the university of KwaZulu-Natal ethics committee, my protocol reference number is: HSS/0935/012M.

The Research Project title is: Exploring the knowledge, skills, attitudes and preparedness of nurses on the integration of Mental Health Care into HIV/AIDS services in eThekwini district, KwaZulu-Natal.

The purpose of the study: is to explore and describe the level of knowledge, skills, attitudes and preparedness of nurses regarding integration of Mental Health Care into HIV/AIDS services The objectives are to explore and describe the monitoring and evaluation of current mental health policies and plans and revisit the way how this integration can be successful done by having proper guidelines for treating people living with HIV/AIDS and Mental Illness.

I would like to commence data collection process by October 2012. This will be done at this institution during the working hours. The interview will behold confidentiality, anonymity, informed consent and freedom of choice as indicated in the attached information sheet and informed consent documents.

Attached please find a copy of the proposal document and ethics permission letter from the University of KwaZulu-Natal, faculty of Health Sciences Ethics Committee.

Yours Faithfully

_____

Mrs W.B.Cele
Student number: 209539990

Contact number: 072 094 2923

Appendix 5: Letter requesting the permission to conduct a research study for Prince Mshiyeni memorial hospital

33 Mons Road
Bellair
4094
01 October 2012
celewinnie@yahoo.com

The Chief Executive Officer
PRINCE MSHIYENI MEMORIAL HOSPITAL
Private Bag x10
Mobeni
4060

Dear Prof.Gumbi

Re-Permission to conduct a Research Study: Master's Degree

I hereby request permission to conduct a research study at Prince Mshiyeni Memorial Hospital(Primary Health Care, HIV/AIDS services).I am a student studying Master's Degree in Nursing (Mental Health) at the university of KwaZulu-Natal, School of Nursing ,Howard College Campus. I have received Ethics approval from the university of KwaZulu-Natal ethics committee, protocol reference number is: HSS/0935/012M.

The Research Project title is: Exploring the knowledge, skills, attitudes and preparedness of nurses on the integration of Mental Health Care into HIV/AIDS services in eThekwini district, KwaZulu-Natal.

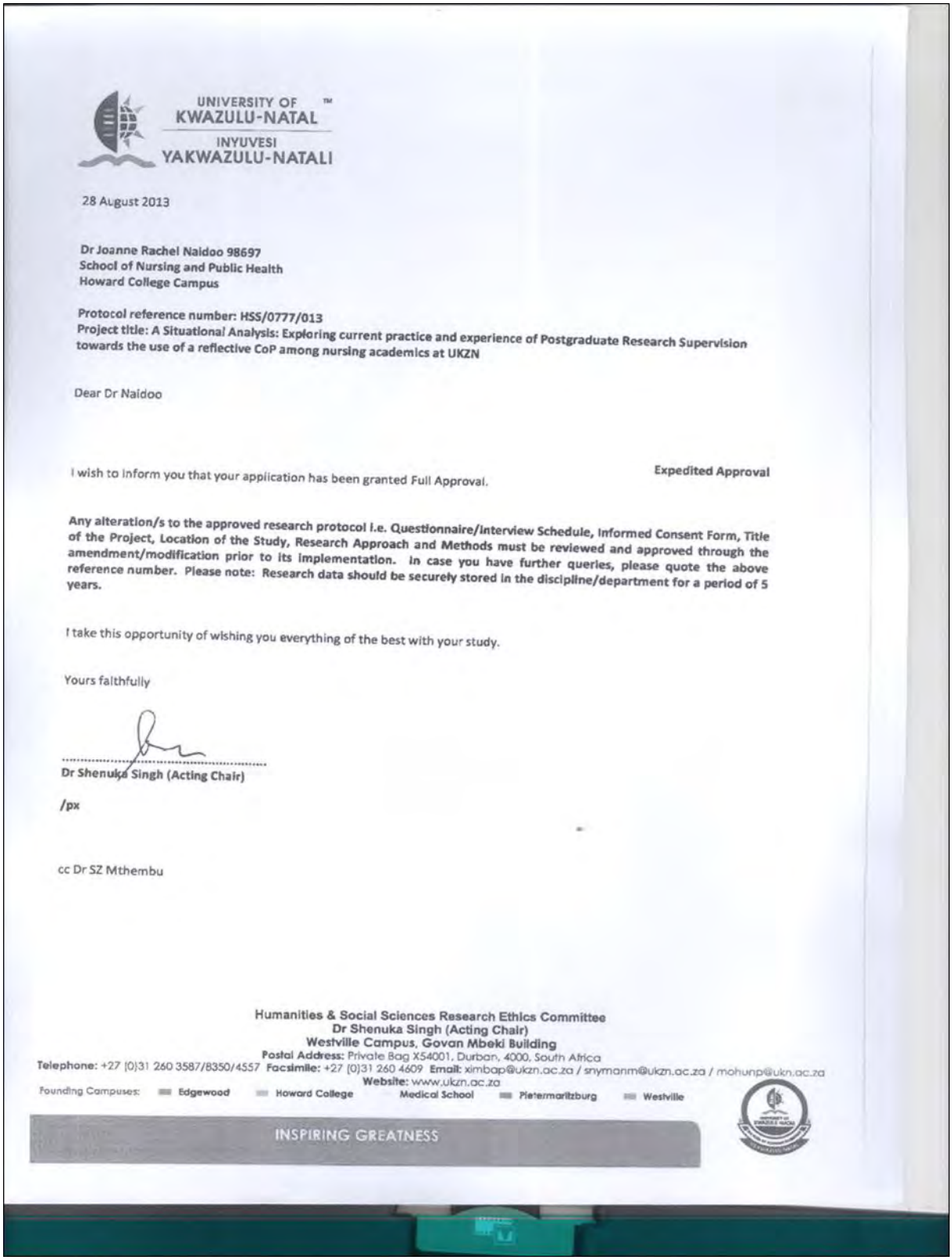
The purpose of the study: is to explore and describe the level of knowledge, skills, attitudes and preparedness of nurses regarding integration of Mental Health Care into HIV/AIDS services The objectives are to explore and describe the monitoring and evaluation of current mental health policies and plans and revisit the way how this integration can be successful done by having proper guidelines for treating people living with HIV/AIDS and Mental Illness.

I would like to commence data collection process by October 2012. This will be done at this institution during the working hours. The interview will behold confidentiality, anonymity, informed consent and freedom of choice as indicated in the attached information sheet and informed consent documents.

Yours Faithful

Mrs W.B.Cele
Student number: 209539990
Contact number: 072 094 2923

Appendix 6: Ethical clearance from ethical committee at UKZN



UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

28 August 2013

Dr Joanne Rachel Naidoo 98697
School of Nursing and Public Health
Howard College Campus

Protocol reference number: HSS/0777/013
Project title: A Situational Analysis: Exploring current practice and experience of Postgraduate Research Supervision towards the use of a reflective CoP among nursing academics at UKZN

Dear Dr Naidoo

I wish to inform you that your application has been granted Full Approval. **Expedited 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 (Acting Chair)

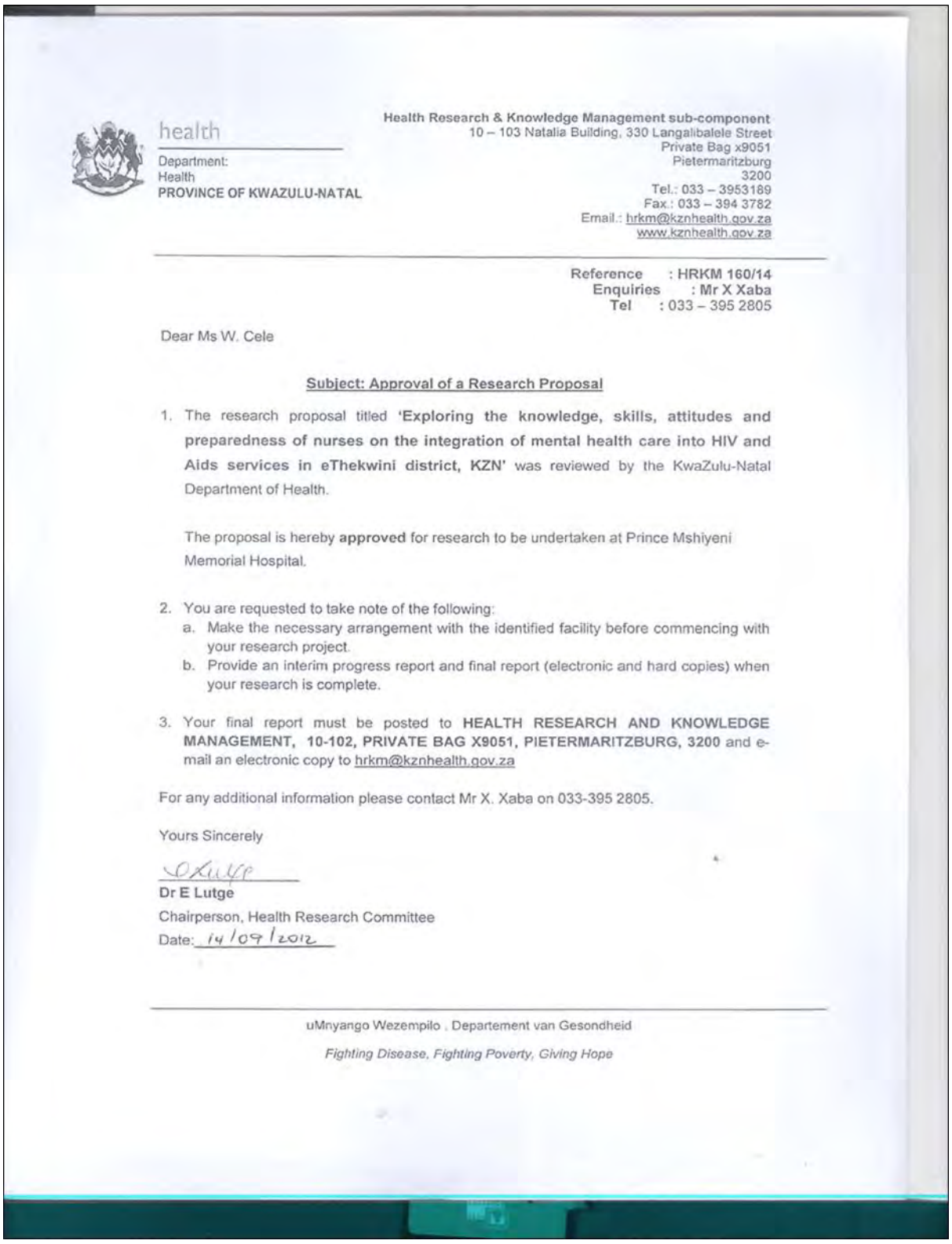
/px

cc Dr SZ Mthembu

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Acting Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350/4557 Facsimile: +27 (0)31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukn.ac.za
Website: www.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

Appendix 7: Permission to conduct the study from KZN department of health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 160/14
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms W. Cele

Subject: Approval of a Research Proposal

1. The research proposal titled **'Exploring the knowledge, skills, attitudes and preparedness of nurses on the integration of mental health care into HIV and Aids services in eThekwini district, KZN'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Prince Mshiyeni Memorial Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 14/09/2012

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 8: Permission to conduct the study from Prince Mshiyeni Memorial Hospital

HEALTH
KwaZulu-Natal

Prince Mshiyeni Memorial Hospital
Private bag X 07, MOBENI 4060
Mangosuthu Highway
Dr. M Aung: Senior Manager: Medical
Tel: 031-907 8304/8317, Fax: 031-9061044
Email: myint.aung@kznhealth.gov.za

Enquires : Dr. M Aung
Ref No. :26/RECSH/12
Date: 10.10.2012

TO:Mrs WB Cele

RE: LETTER OF SUPPORT TO CONDUCT RESEARCH AT PMMH

Dear Madam;

I have pleasure to inform you that PMMH has considered your application to conduct research on "**Exploring the knowledge, skills, attitudes and preparedness of nurses on the integration of Mental Health Care into HIV/AIDS service in eThekwini district, Kwa-Zulu Natal"** in our institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The institution will not provide any resources for this research.
5. You will be expected to provide feedback on you finding to the institution.

Should the following requirements be fulfilled, a Permission/ Approval letter will follow.

- Full research protocol, including questionnaires and consent forms if applicable.
- Ethical approval from a recognized Ethic committee in South Africa

Thank you.

Regards;

Dr. M Aung
Senior Manager: Medical & Specialist in Family Medicine
MBBS(Rgn), PGDip in HIV (Natal), DO(SA)
M.Med.Fam.Med (Natal)

Appendix 9: Editor's letter

Editing Declaration

P O Box 531
Hillcrest
3650
KwaZulu-Natal

2014-06-14

TO WHOM IT MAY CONCERN

Thesis Title: Exploring the knowledge, attitudes, skills and preparedness of nurses on the integration of mental health care into HIV/AIDS services in the EThekwini District of KwaZulu-Natal

Author: Winnie Baphumelele Cele

This is to certify that I have edited the above thesis from an English language perspective and have made recommendations to the author regarding spelling, grammar, punctuation, structure and general presentation.

A marked-up version of the thesis has been sent to the author and is available as proof of editing.

I have had no input with regard to the technical content of the document and have no control over the final version of the thesis as it is the prerogative of the author to either accept or reject any recommendations I have made. I therefore accept no responsibility for the final assessment of the document.

Yours faithfully

Margaret Addis