A descriptive cross-sectional study about the perception of Mental Illness among HIV Counselors in Bushenyi District.

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Abstract

Background

The HIV/AIDS pandemic has led to millions of deaths as well as disability and negative outcomes on HIV affected individual. One such disability is mental illness which has been found to lead to increased prevalence of anxiety, depression and substance abuse among people living with HIVAIDS as compared to the general population.

Methodology

A descriptive cross-sectional study was carried out to determine the perception of Mental Illness among HIV Counselors in Bushenyi District. A total of 30 respondents participated in the study and they were selected by use of purposive sampling procedure. Data was collected using questionnaires and (SPSS) was used to analyze the data.

Results

The study found that 50% of the participants said that HIV patient who had mental illness were not responsible for their illness, HIV patients who have mental illness are more dangerous to the general public, 70% said that it is not true, (73%) said that HIV and mental illness are related, (96.7%) said they would recommend pharmacotherapy, counselors (50%) found that clients with emotional problems was their major challenge about the patients, 12(40%) said clients with strange behavior and (54%) said they would confront the problem.

Conclusion

Although HIV counselors portrayed a sense of self-efficacy to manage mental health problems among their HIV positive clients, their interventions were limited by their lack of expertise to deal with specific mental health problems.

Recommendations

Training needs assessment for HIV counselors, enhancing integration of mental health care in HIV service provision, improving awareness needs to be built among HIV counselors about the mental health problems that affect people living with HIV/AIDS, HIV service provision policies to be revised to emphasize mental health aspects.

Keywords: HIV/AIDS, mental illness, counsellors, disability, effects, depression, Submitted: 18th/10/2022 Accepted: 02nd/12/2022

1. Background:

The HIV/AIDS pandemic has led to millions of deaths as well as disability and negative outcomes on HIV affected individuals (UNAIDS World

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AIDS Day Report, 2011). One such disability is mental illness which has been found to lead to increased prevalence of anxiety, depression and substance abuse among people living with HIVAIDS as compared to the general population (Joska, Stein & Flisher, 2008). The HIV virus affects the central nervous system which leads to many mental health challenges (Baingana, Alem & Jenkins, 2006).

The World Bank (2006) report on "Disease and mortality in Sub Saharan Africa" shows depression to be significantly higher in sero positive individuals than in the general population in Kenya and Zaire (Sebit, 1995). Furthermore, HIV is also linked to poorer cognitive development in HIV-infected infants in Uganda (Musisi & Kinyanda, 2009).

Previous research among individuals enrolled in HIV care and treatment in Cape Town, South Africa, revealed prevalence rates for depression, Post Traumatic Stress Disorder (PTSD) and Alcohol dependence/abuse to be 14%, 5% and 7% respectively (Myer et al., 2009). Studies conducted in Uganda also report mental health aspects of HIV, particularly mental health problems, at various HIV/AIDS disease stages (Musisi & Kinyanda, 2009). HIV related secondary mania (Nakimuli-Mpungu, Musisi, Kiwuwa-Mpungu& Katabira, 2008), HIV related Dementia (Kinyanda, 2009), and HIV psychosis and depression related to HIV infection (Nakasujja et al., 2009) have been reported. Suicidal behavior has been cited as a risk for people diagnosed with HIV (Musisi, 2009), as well as anxiety disorders (Kinyanda, 2009). It is important to note that in spite of these prevalence figures, the majority of HIV care and treatment centers do not employ a mental health worker or psychiatrist (Uganda Bureau of statistics, 2002).

On a regional level, this study is nested in the drive to improve the provision of mental health care in Uganda, as one of the participating countries in the Program for improvement of Mental Health Care (PRIME) (Lund et al., 2012). This program is premised on the fact that there is a high level of unmet need for mental health care in low and middle-income countries (LMCI's) (Kohn, Saxena, Levav & Saraceno, 2004). The aim of the PRIME project is to improve mental health service provision through non-specialized health care settings (Lund et al., 2012) with a focus on mental, neurological and substance abuse disorders (MNS) (Lund et al., 2012). The PRIME project situational analysis reports that although Uganda's health system is poorly equipped to integrate mental health services in general health care, existing care models for HIV provide an opportunity to expand mental health care (Hanlon et al., 2014).

At the forefront of HIV, treatment and management in Uganda are medical professionals such as clinicians and nurses, who work with a group of specialized 'HIV counselors' whose training in counseling is focused on psychosocial factors related to HIV infection (Uganda Ministry of Health, 2005). The counselors have the highest number of contact hours with HIV clients, as counseling is often part of routine clinic visits. An HIV counselor may be anyone who has undergone counselor training ranging anywhere from 3 days to 3 years (Senyonyi et al., 2012). In some cases, the HIV counselor is in fact an 'expert client', an individual living with HIV/AIDS who informally acts as a community resource for other clients (Kaleeba et al., 1997).

Anecdotal evidence suggests that HIV service providers and HIV counselors in Uganda lack knowledge and skills to recognize and treat mental illness among HIV patients (Uganda Ministry of Health, 2005). Training for HIV counselors in Uganda does not include a module on mental illness (The AIDS Support Organization (TASO) Uganda, 2012). There is also a lack of information about this group, due to lack of standardization and monitoring of HIV counseling in Uganda (Senyonyi, 2012). The HIV counselors' reach in HIV service provision however highlights the importance of exploring their perceptions concerning mental illness. The objective of the study is to determine the perception of mental illness among HIV Counselors in Bushenyi District.

2. Methodology

2.1. Study Design

This research was a descriptive cross-sectional study that was undertaken at five HIV clinics in the district of Bushenyi South Western Uganda.

2.2. Study setting

The study was carried out in the Bushenyi district, in five outpatient HIV clinics. These included; Kyabujimbi health center IV, Ishaka Adventist hospital, Kitagata hospital, Bushenyi health center IV, and Kampala international university teaching hospital, Bushenyi District is located in western Uganda, about 75 km by road North West of Mbarara town. The coordinates of the district are 00 32S, 30 11E. The district is part of the larger Ankole sub-region, consisting of approximately 2.2 million people. The hospitals provide among others the following services; Out-patient consultation, In-patients wards, TB screening and treatment, safe male circumcision Maternal Child Health Clinic, Immunization services, family planning, medical Laboratory services, minor surgeries, routine HIV counseling, testing and treatment, health education. Data collection was carried out for a period of 5 days in July 2017.

2.3. Study Population

The study population included 30 HIV counselors from the five hospitals above. These centers were chosen because they are the main treatment centers in the district.

The participants were recruited from five HIV treatment centers in the Bushenyi district including Kyabujimbi health center IV, Ishaka Adventist hospital, Kitagata hospital, Bushenyi health center IV, and Kampala international university teaching hospital.

2.4. ***Sample size determination***

This was purposive research. The researchers picked the HIV counselors that he found at the health center mentioned above until the number (30) was reached. The sample size was determined by the statistical formula of Keish and Leslie (1965)

n = Z2p (l-P)
d2

Where n is the sample size

Is the standard normal deviation at a 95% confidence level (i e 1 96

Is the proportion of the target population (which is 50% or 0 5

Is the acceptable degree of error (in this case 5% or 0 05

n= (1.96)2 x 0.5 x 0.5/0.052 = 384.16 = 384

Since the total population of respondents involved is less than 10,000 (33), the following formulae will apply.

Sample size estimation (nf) is calculated as follows;

nf = the desired sample size (when the population is less than 10,000)

n = the desired sample size (when the population is more than 10,000)

N = the estimate of the population size

nf = n

N = 33 (Average number of HIV counselors in the participating health facilities)

nf =
n = 384 384
1 + n 1 + 384 1 + 11.6
N 33
= 384
12.6 = 30.4 ≈30

Therefore, the sample size will be 30 respondents.

2.5. ***Sampling Procedure***

The respondents were selected by the use of a purposive sampling procedure. In this procedure, the researcher purposely selected the respondents who met the study criteria and consented to participate in the study. This method was used because it was the cheapest and most efficient sampling procedure available for this type of study. Data were collected using questionnaires, which were given to the counselors to fill in.

2.6. ***Inclusion Criteria***

Using a minimum of one year of working experience as an HIV counselor at one of the stipulated HIV treatment centers. The one-year work-

ing experience as an HIV counselor was assumed to have sufficient experience with the dynamics of HIV patients to allow the counselor to contribute to the discussions.

2.7. ***Exclusion Criteria***

Professional training in any mental health-related field. Since HIV, counselors are not routinely trained in mental health contributions from an HIV counselor with mental health training would have potentially biased results and not give a true depiction of Ugandan counselors.

2.8. Instruments

Initially, questionnaires were developed based on mental illnesses reported among HIV patients in Uganda including depression (with suicidal ideations), anxiety, substance abuse, PTSD, psychosis, mania, and dementia.

2.9. Data Collection Procedure

The data collection tool for the cross-sectional study component is of various structured questions, which were in English, carried out at the selected centers because the respondents being counselors are literate and can interpret questions on their own. The Questionnaire was given to the 30 HIV counselors. The fully filled questionnaires were then collected and organized for the data to be analyzed. At the start, each respondent was provided with a participant information sheet and an informed consent form.

2.10. Data Analysis

Data processing, editing, and tallying of results were done using Microsoft office and calculators. The statistical package for social scientists (SPSS) was used to analyze quantitative data.

2.11. ***Data Presentation***

The data was presented in the form of graphs, tables, and pie charts. The interpretation was done from the meaningful information on the charts and tables.

2.12. Ethical Considerations

The study obtained approval from the Dean, faculty of clinical medicine and dentistry of the Kampala international university, Western campus.

Approval was obtained from the in charge of various hospitals and district human resources. Consent was obtained from all participants at the HIV clinics.

Patient names or hospital numbers were not included anywhere on the questionnaires. The patients were instead referred to using signatures.

2.13. ***Voluntary participation****.*

Counselors working at the various study sites were invited to take part in the study. The voluntary nature of the study was clearly explained. Counselors were informed that they do not have to take part in the study if they do not want to and that they withdraw and stop the interview at any time without any adverse effect. However, all counselors were informed about the purpose of the study.

2.14. ***Confidentiality****.*

Counselors were assured that any information that may identify them or that may be linked to them was to be kept confidential.

2.15. ***Anticipated risks****.*

There were no physical risks associated with participation in this study. Possible risks were that individuals could experience pressure to enroll in the study from their supervisors. The interview format contained the risk of potential loss of confidentiality and interview fatigue, and some counselors could face discomfort over having to acknowledge a lack of knowledge about mental health issues. Study procedures were designed to reduce these risks.

2.16. ***Minimizing risk****.*

The voluntary nature of the study was clearly explained during the informed consent process and participants were reminded regularly that they would withdraw from the study at any time

without adverse consequences. Each participant's right to confidentiality was protected and the steps that were taken to maintain confidentiality were outlined.

2.17. ***Anticipated benefits.***

There were no direct benefits for participants. The potential benefit to the field of mental health and HIV/AIDS care and support was to gain a better understanding of the issues that HIV counselors face when supporting clients that may have a mental illness. This understanding would enable policymakers and counselor trainers to design interventions that promote the proper management of mental health issues in HIV counseling.

2.18. ***Reporting of Results***

Research results were presented to Kampala international university. Copies of the research results, including, recommendations, were provided to all the centers where this research was conducted.

2.19. ***Bias:***

There was no business encountered during the study and hence none was declared by both researchers.

3. Results and Findings

Introduction

The data was first collected from five health centers in the Bushenyi district using questionnaires. The health center included; KIU teaching hospital, Bushenyi health center IV, Kyabujimbi health center IV, Kitagata hospital, and Ishaka Adventist hospital. The research was purposive in nature and 30 HIV counselors were interviewed. The data were collected, tabulated, and analyzed by the researcher and presented in tables, pie charts, bar graphs, and narrations. The researcher after tallying the results and findings from the questionnaire, the information was used to analyze the data.

The above graph indicates that out of the 30, the majority of the respondents were females (20) and males 10, making 66.7% and 33.3% respectively.

In this study, the research found out that 14 counselors (46.7%) had between 1-5 working experience, 8(26.7%) had 6-10 years' experience, 3(10%) had worked for 16-20 years and 4(13.3%) had worked for over 20 years.

50% of the participants said that HIV patient who had mental illness were not responsible for their illness, 43% said that they were responsible for their illness and 7% said they were not sure.

The graphs depicts that 24 of those interviewed said that HIV patients who had mental illness were not less deserving of mercy while 6 of them said that they were less deserving of mercy.

About whether HIV patients who have mental illness are more dangerous to the general public, 70% said that it is not true while 20% said it is true and 10% didn't know they are more dangerous or not.

About the clients major challenges, 4 (13.3%) said stress is the most challenging, 5 (16.7%) said it is pain or poverty, 5 (16.7%) said it is lack of social support,12 (40) participants said it is stigma, 3.3% said it is denial and 3 (10%) said it is disclosure

Majority of the counselors (73%) said that HIV and mental illness are related, 20% said that they are not related while 7% did not know if they are related.

19 (63%) of the counselors said that HIV and mental illness are not related while 11 (37%) said they are related.

4. Table 3: The type of treatment the counselors would recommend for their clients.

Regarding what kind of treatment the participants would recommend to HIV patients who have a mental illness, the majority (96.7%) said they would recommend pharmacotherapy, and one person (3.3%) said she would recommend prayers. none of the participants would recommend African traditional healing, witchcraft, or ancestral spirits.

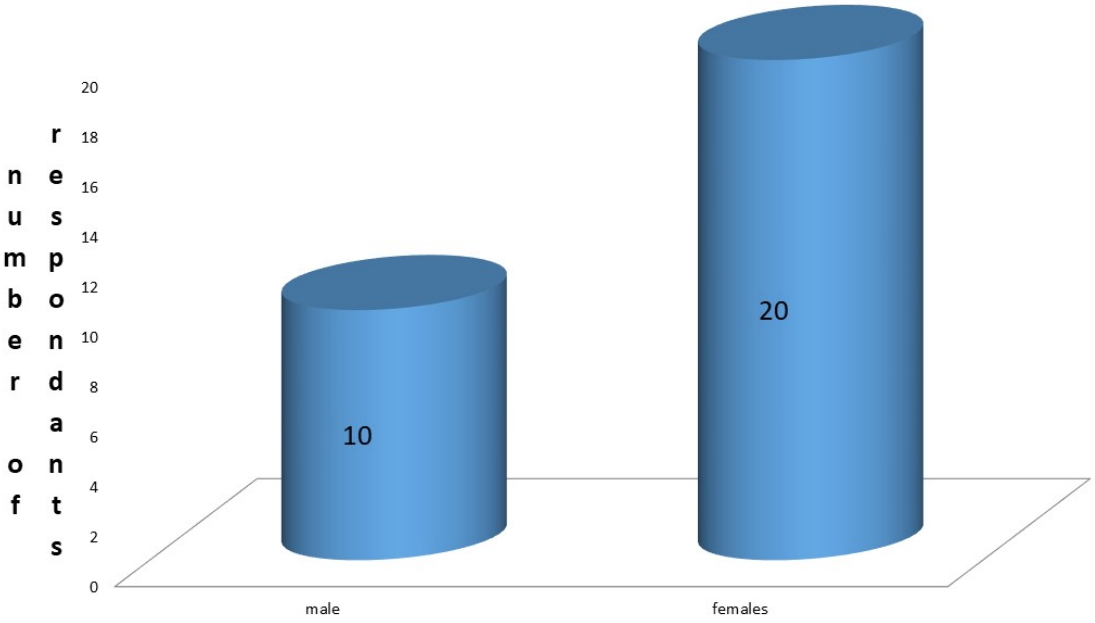

Figure 1: A bar graph showing the gender distribution of the participants.

Table 1: The years of experience of the counselors in service.

Years	**frequency**	**Percentage**
1-5	14	46.7
6-10	8	26.7
11-15	3	10
16-20	1	3.3
above 20	4	13.3
Total	30	100

Table 2: Clients' major challenges, according to the counselors.

Challenges	**frequency**	**percentage**
Stress	4	13.3
pain/poverty	5	16.7
social support	5	16.7
Stigma	12	40
Denial	1	3.3
Disclosure	3	10
Total	30	100

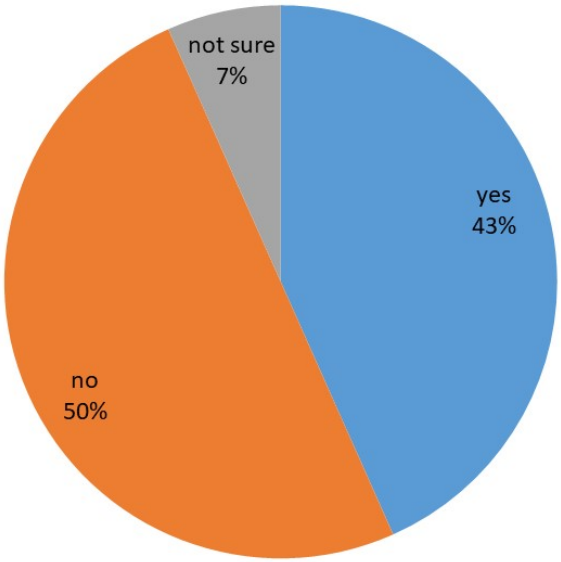

Figure 2: A pie chart showing if HIV patients who had mental illness were Responsible for their illness

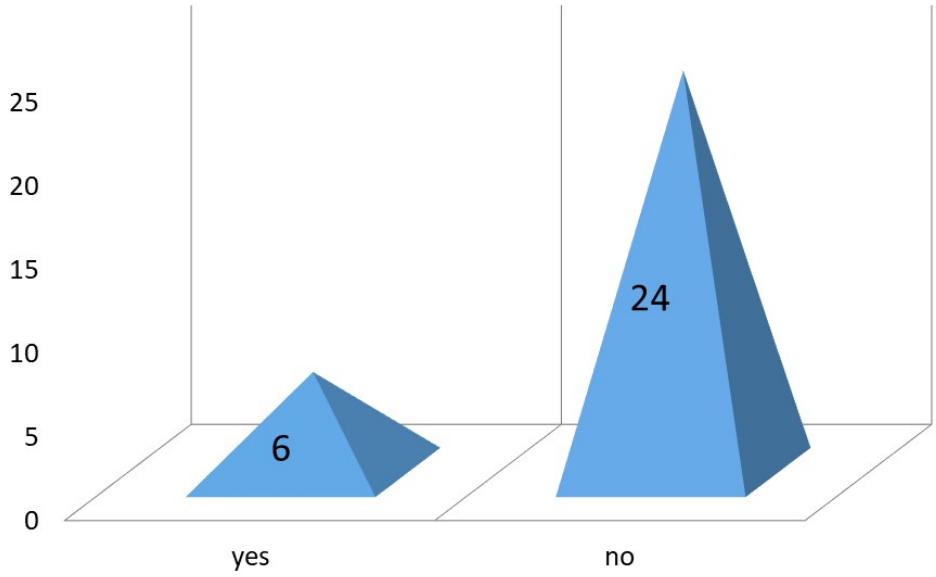

Figure 3: A bar chart showing if HIV patients who had mental illness are less deserving of sympathy.

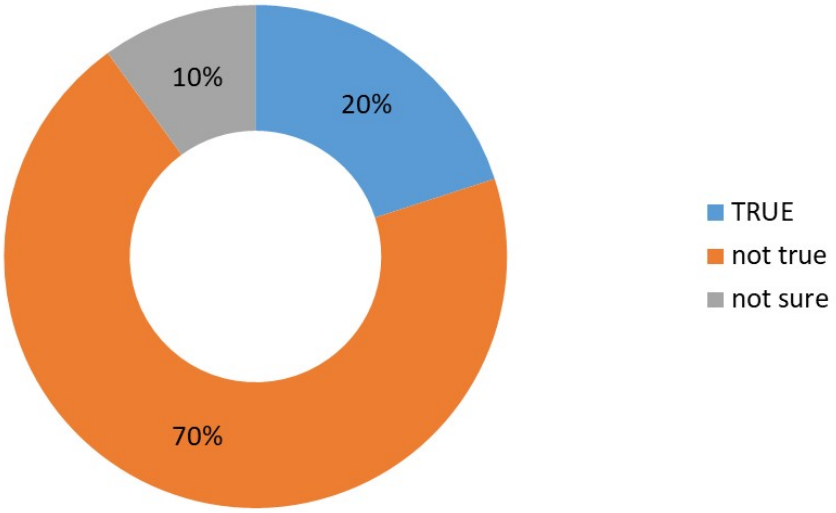

Figure 4: A pie chart showing if HIV patients who had mental illness are more dangerous to the public than cancer patients are.

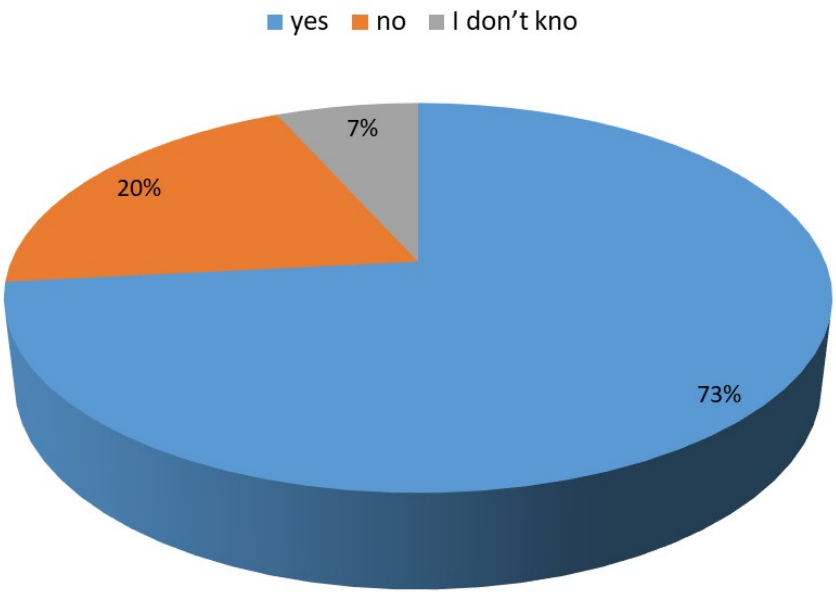

Figure 5: A pie chart showing if Mental illness and HIVrelated.

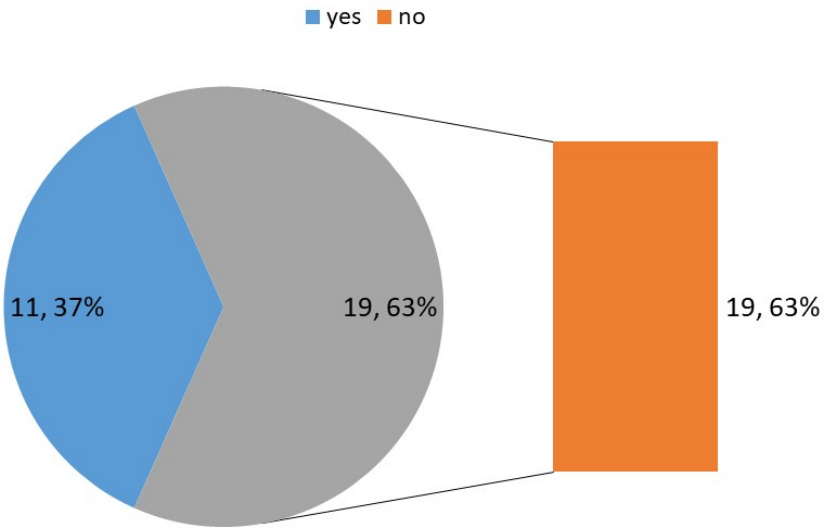

Figure 6: A pie chart showing if counselors think HIV drugs are related to mental illness

Table 3: The type of treatment the counselors would recommend for their clients.

type of treatment	**frequency**	**percentage**
Pharmacotherapy	29	96.7
African traditional healing	0	0
Witchcraft	0	0
ancestral spirits	0	0
Prayers	1	3.3
Total	30	100

From the chart 7, the majority of the counselors (50%) found that clients with emotional problems were their major challenge the patients, 12(40%) said clients with strange behavior was their major challenge while 3 (10%) had clients with physical manifestations as their main challenge about their clients.

19 (63%) said dealing with a difficult patient was their major weakness, 9 (30%) said having no enough time was their major weakness while 2 (7%) said it was having no expertise.

About what the counselors would do about the weakness; the majority (54%) said they would confront the problem, (33%) said they would refer the patient and (13%) said they would ignore the problem.

5. Discussion:

5.1. Clients' symptoms as an expression of the stress of living with HIV

A total of 13.3% of the counselors said that stress was a major challenge to their clients. Counselors commonly attributed clients' depressive symptoms to the stress of living with HIV/AIDS. Poverty (16.7%), stigma (40%), and

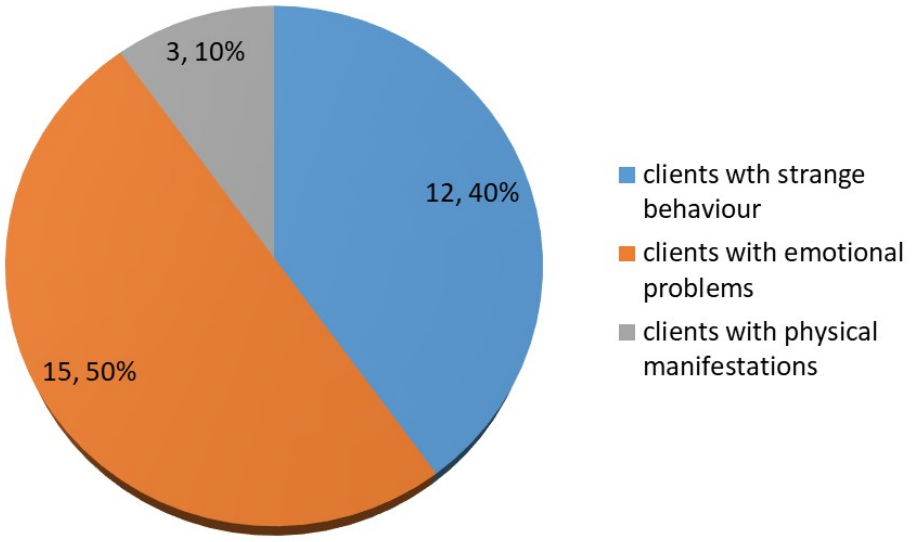

Figure 7: A pie chart showing what the counselors find challenging about their clients

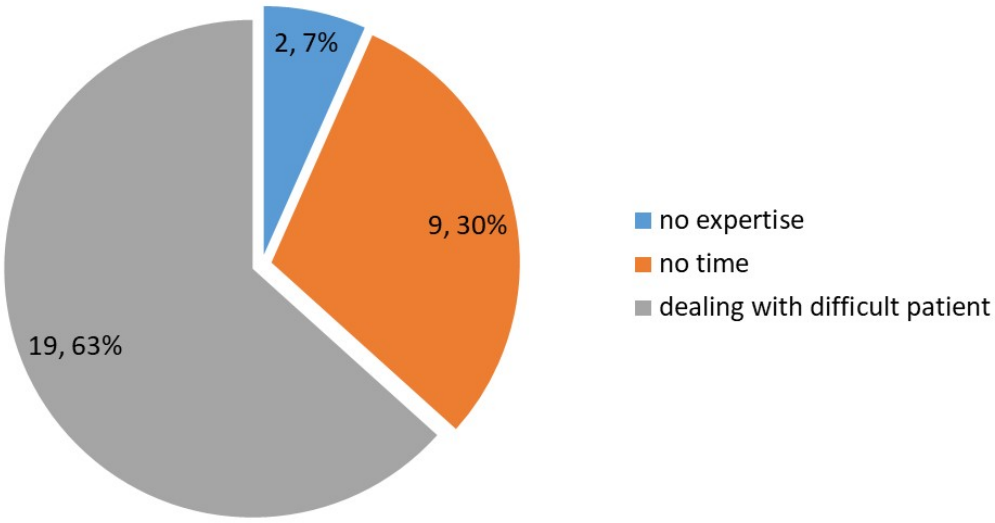

Figure 8: A pie chart showing the Counselor's weakness of when counseling clients.

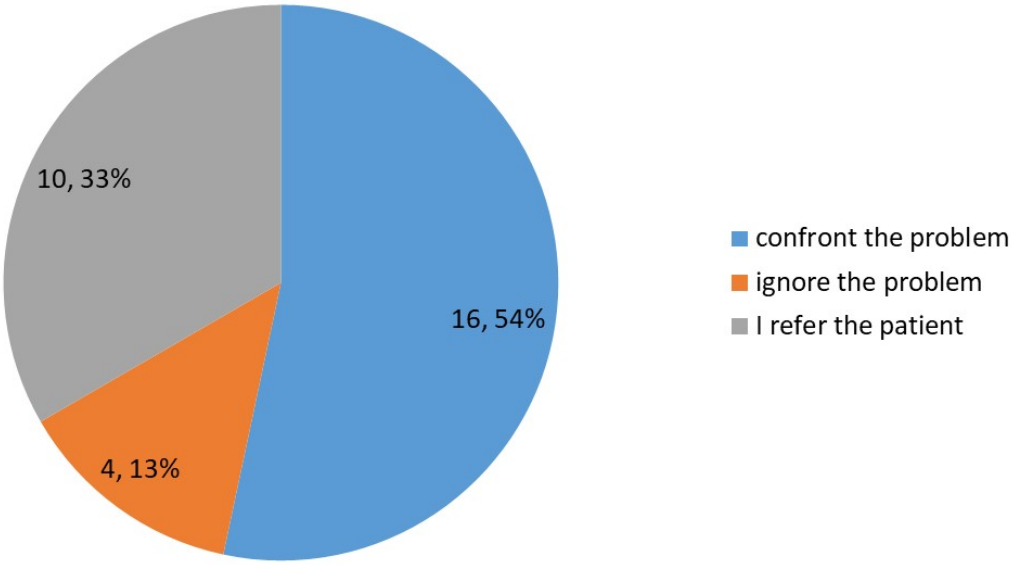

Figure 9: pie chart showing what the counselors would do about such a weakness.

lack of social support (16.7%) were said by counselors to be rife in the lives of HIV-positive individuals. In the counselor's understanding, this is what predisposed HIV clients to have symptoms like lack of appetite, low mood, and lack of sleep. This is a common finding, with symptoms of depression also being attributed to relational problems or the economic situation of the client (Aidoo &Harpham, 2001).

Some of the approaches HIV counselors may take to address mental health concerns may be unhelpful or even detrimental to the clients. For example, the counselors encouraged disclosure of one's HIV status for those clients that were having mental health problems. Although disclosure may gunner social support for the client who is depressed, it may not be necessarily helpful for the client with mania or psychosis; and even raises an ethical concern as to whether the client with a mental illness can understand the reasons and the limits for this disclosure.

5.2. ***Medical and biological explanations***

The majority 73% of the counselors agreed that HIV and mental illness are related, while 20% said they are not related. They said that symptoms of mental illness could result from increased HIV viral load; disease progression or they may appear as a side effect of medication (37%). This is a common finding in studies on the link between HIV/AIDS and mental illness (Maling, 2009; Musisi & Kinyanda, 2009; Nakimuli-Mpungu et al., 2006).

5.3. ***Counselors' stigmatizing perceptions***

A total of 40% said that client's major challenge was a stigma. This often made the counselors less likely to act in therapeutically helpful ways to their clients. Similar observations have been reported by others, including Lobban et al. (2003) who said that when service providers, for example, nurses thought that some patients were able to control their symptoms such as patients with depressive thoughts and negative self-perceptions it was common for such patients to be perceived

as a nuisance and be given less attention and assistance.

In addition, such stigmatizing perceptions also reduce the chances that clients will report their suicidal ideations during counseling sessions, which may lead to increased cases of attempted and completed suicide.

5.4. ***HIV counselor's perception of their role in mental health service provision***

HIV counselors described a sense of high self-efficacy and confidence in their ability to manage some mental health problems among their HIV-positive clients. According to Lobban and colleagues (2005), this increases the chances that they will endeavor to offer help to clients with mental health problems.

At the same time, however, some of the counselors believed that a client's psychotic or other mental symptoms were caused by HIV patients themselves, for example, 43.3% of those interviewed had said that HIV clients who had a mental illness were responsible for their illness, 50% said they were not responsible and 6.7 said they were not sure.

These authors additionally report that service providers will recommend treatment options that are in line with their explanatory model of the client's illness, consistent with this research, which found that 96.7% of the counselors said they would recommend pharmacotherapy to treat HIV patients who had a mental illness.

6. Limitations of the study

one of the limitations of the current study are that only counselors in the Bushenyi district were interviewed. This is an urban area, and some insights may have been left out from counselors working with HIV patients from rural areas. These results cannot, therefore, be generalized to all HIV counselors in Uganda. HIV counselors in rural areas may express firmer beliefs in the supernatural as compared to their urban counterparts, as is reflected in the study by Okello and Ekblad (2006) who depicted cultural explanatory models of mental illness as being widespread in rural Uganda.

Other factors affect HIV-positive people more in rural areas such as poverty and poor access to medical centers (MOH, 2005) and the effect of these factors on mental illness may not have been properly illustrated by this study, which focused on a convenient sample of counselors in an urban setting. Therefore, it would be beneficial to carry out another study with a larger sample in more diverse areas of Uganda (including rural areas) to be more representative of the Ugandan population of HIV counselors.

7. Recommendations for policy and practice

Based on the results of this study, the counselors' recommendations, policies, and interventions need to be put in place to help HIV counselors better manage mental health problems.

The first step in improving mental health service provision in HIV treatment centers would be a training needs assessment for HIV counselors in particular. Earlier studies have established that Uganda's health system in general is poorly equipped to support the provision of mental health services (Hanlon et al., 2014). One of the barriers to the provision of mental health services identified by the PRIME project in participating countries is a lack of awareness and stigmatizing views towards mental illness (Hanlon et al., 2014), and this is clearly illustrated by this study.

The urgent need to enhance the integration of mental health care in HIV service provision can be met through various interventions, and some interventions can be employed to achieve this in the short term, while others are long-term.

8. Short-term interventions

There is a need for the dissemination of the results of the current and similar studies, which should serve to help HIV counselors reflect on their practices, especially regarding their own

perceptions of mental illness.

HIV counselors need to understand how their perceptions of mental illness directly affect their service provision e.g. whether or not to refer a client for specialized psychiatric intervention. These results should therefore be disseminated to all HIV treatment centers in Uganda that provide counseling services. This can be done at the center level or during national HIV/AIDS conferences.

Furthermore, awareness needs to be built among HIV counselors about the mental health problems that affect people living with HIV/AIDS, including the symptoms of these problems and the indications for the wide variety of diversified treatments. This can be done alongside the dissemination of the results of the current study.

9. Long-term interventions

HIV service provision policies need to be revised to emphasize mental health aspects. The

training curriculum for HIV counselors needs to be reviewed to include mental health aspects of

HIV/AIDS. These should include symptoms of mental health problems of HIV and treatment procedures, particularly highlighting the role of the HIV counselor in the treatment process. This calls for the integration of mental health care in all HIV intervention services, including prevention services. HIV treatment centers need to streamline procedures for the integrated management of mental health problems among their HIV-positive clients.

The bulk of mental health problems cannot be handled by the counselor alone, given the overwhelming number of clients and their mental health problems, some of which require specialized psychiatric attention. As such, HIV treatment centers need to consider employing mental health specialists such as psychiatrists and clinical psychologists at their centers, or at least identifying nearby established mental health units where clients can be referred to receive specialized mental health care as the need arises.

10. Conclusion

HIV counselors were found to know some mental health problems affecting people living with HIV/AIDS, for example, depression and psychotic symptoms. However, they also held some explanations for the mental health problems displayed by HIV-positive clients that could potentially interfere with their service provision.

Although HIV counselors portrayed a sense of self-efficacy to manage mental health problems among their HIV-positive clients, their interventions were limited by their lack of expertise to deal with specific mental health problems. This indicates a need for training and streamlining of HIV treatment and support to target mental health aspects of HIV infection in the care of HIV-positive clients. The HIV counselor is in a unique position to provide mental health services and referrals within the HIV clinic, and to their community in general. Ultimately, all this all for a policy of integration of mental health care in all HIV care interventions including prevention strategies.

11. List of Abbreviation and Acronyms:

AD- Adjustment DisorderEM's- Explanatory modelsKCCA- Kampala City Council AuthorityMOE- Ministry of EducationMOH- Ministry of HealthTASO- The AIDS Support OrganizationPTSD-Post Traumatic Stress DisorderSCOT- Strengthening HIV counselor Training in UgandaSSA- Sub Saharan AfricaUCA-Uganda Counseling AssociationUNAIDS- Joint United Nations Program on AIDS.

11.1. Source of funding

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12. Conflict of interest

There were no conflicts of interest between the two authors and hence none were declared.

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