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SCHOOL OF NURSING AND MIDWIFERY

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA, LEGON

HEALTH PROFESSIONALS' SELF-EFFICACY IN MANAGING DEPRESSION IN PEOPLE LIVING WITH HIV: AN INTERPRETIVE DESCRIPTIVE STUDY AT TECHIMAN MUNICIPALITY

BY

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DECLARATION

I, Emmanuel Gyabaah, do hereby certify that this thesis is the outcome of my study, under the guidance and supervision of Dr Gladys Dzansi and Dr Gideon Puplampu, all of the School of Nursing and Midwifery, University of Ghana, Legon. This study has not been presented in any form for a degree or diplomat at any institution of higher learning. All authors and publishers whose works were used in this study have been acknowledged.

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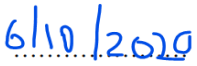
Dr Gladys Dzansi		
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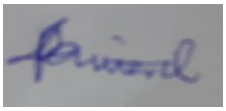
Dr Gideon Puplampu		06 / 10 / 2020
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ABSTRACT

The management of depression among People Living with HIV (PLWHIV) is a significant concern in the trajectory of HIV care. Healthcare professionals' competence in managing depression in PLWHIV will influence the integration of this aspect of care in routine HIV care activities. The self-efficacy of health professionals in managing depression among people living with HIV in Techiman, Brong-Ahafo was explored using Bandura's self-efficacy model. A qualitative interpretive descriptive approach was employed for the study. Purposive sampling technique was used to recruit sixteen (16) participants relative to data saturation. Face-to-face interviews were conducted using a semi-structured interview guide. All interviews were transcribed verbatim and analysed inductively and deductively using thematic content analysis approach. The rights of participants were upheld through ensuring voluntary participation and signing of informed consent. Methodological rigour included peer scrutiny and prolonged engagement. Findings revealed that participants lacked competence in managing depression in PLWHIV. They also had inadequate knowledge of mental health assessment and tools used for assessing depression. Mentoring and preceptorship developed the communication skills and relationships with the clients but did not build the competence of the mentees in managing depression in PLWHIV. Religious affiliation and dedication of experienced care providers were the primary sources of motivation. It was also found that the emotional states of the HIV care providers influenced the quality of care rendered to the clients. Limited knowledge of depression assessment tools hampered the detection and management of depression.

Health professionals need massive training on the management of depression to render holistic care to PLWHIV.

Key Words: self-efficacy, health professionals, depression, PLWHIV

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DEDICATION

I dedicate this study to my late mother, Elizabeth Mintaa, for her dreams and trust in me.

To my adorable wife, Emelia Owusu Ansah, and my children, Nana Kwame and Ewuraa Adwoa, for their sacrifices and inspiration throughout the study.

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LIST OF ABBREVIATIONS

PLWHIV: People living with HIV

ART: Antiretroviral Therapy

ARV: Antiretroviral Medications

HAART: Highly Active Antiretroviral Therapy

NMIMR-IRB: Noguchi Memorial Institute of Medical Research—Institutional Review Board

GHS-ERC: Ghana Health Service –Ethics Review Committee

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CHAPTER ONE

INTRODUCTION

This chapter highlights the global prevalence of depression, the burden of depressive disorders in HIV/AIDS and the significance of managing depression in people living with HIV (PLWHIV). It also describes the competencies required by healthcare professionals to detect and manage depression as well as elaborating on the factors that affect the management of depression in PLWHIV. The chapter further discusses self-efficacy and its importance on the management of depression.

1.1 Background to the Study

Doctors, nurses and other healthcare professionals in their line of duty encounter several patients whose countenance suggests one emotional problem or the other. Competence in assessing, detecting and managing emotional issues is an issue sparsely discussed among HIV care providers. Evidence shows that depression is one of the most prevalent psychological conditions that affect health delivery outcomes among persons living with HIV (Bess et al., 2013; Gaynes et al., 2015; Olisah, Baiyewu, & Sheikh, 2011). It is therefore reasonable that health professionals attain the requisite knowledge and skills to enable prompt detection and management of depression, particularly among persons living with HIV/AIDS.

The lifetime prevalence of depression among people living with HIV (PLWHIV) and AIDS is estimated to be within the ranges of 22% and 45%, almost threefold the prevalence rate among the general population (Murray, 2015; Su et al., 2013). In a related study, researchers found that among a population of about 2.4million individuals living with HIV in India, 19% to 56% suffer from major depression or depressive symptoms (Chan, Pradeep, Mayer, & Kumarasamy, 2016). More recently, a study by Betancur, Lins, Oliveira, and Brites

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(2017) revealed that depression and depressive symptoms were present in about 59.5% of PLWHIV and this reason significantly accounted for non-adherence to highly active antiretroviral (HAART) medications. Depending on the target group and the study design, the prevalence rate of depression among HIV positive individuals can reach as high as 81% (Arseniou, Arvaniti, & Samakouri, 2014). In the Republic of China, evidence from a cross-sectional study stipulates that the level of depression in people living with HIV is a function of the availability of support services. In areas where comprehensive medical and psychological services are provided for PLWHIV, the rate of depression was found to be 17.7%. In contrast, the rate is 92% in regions where these essential services were lacking (Su et al., 2013).

More so, depression in PLWHIV has been associated with disease progression, low CD4+ cell count, poor weight progression, high baseline viral loads, and poor medication adherence (Alemu, Haile Mariam, Tsui, Ahmed, & Shewamare, 2012; Grenard et al., 2011; Nyirenda, Chatterji, Rochat, Mutevedzi, & Newell, 2013). It is also linked with treatment failure and the evolution of drug-resistant viral strains, sexual dysfunction, and low quality of life (Su et al., 2013) and increased mortality (Murray, 2015). Also, several studies have found that depression among PLWHIV is connected with indulgence in risky behaviours including drug use, alcohol abuse and unsafe sex (Nduna, Jewkes, Dunkle, Nwabisa, & Colman, 2010; Othieno, Okoth, Peltzer, Pengpid, & Malla, 2014) and suicidal intents and acts (Thapar, Collishaw, Pine, & Thapar, 2012). There is also evidence suggestive of early onset of HIV-associated memory loss in depressed persons which further contributes to a low quality of life (Nyirenda et al., 2013). From the evidence above, it is clear that depression is a significant comorbidity of HIV and the management thereof can lead to substantial gains in the fight against HIV and AIDS.

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The emergence of anti-retroviral therapy brought about a significant gain in HIV/AIDS treatment efficacy and a marked cut down in the morbidity and mortality and has improved the quality of life of these patients. Webel et al., (2016) also found that antiretroviral drugs can primarily cut down the risk of vertical, sexual and blood-borne transmission of HIV.

However, the efficacy of ART's requires that the patient maintains a high adherence rate of 95% or more to bring about significant viral suppression, reduce the spread and elimination of resistant viral strains (Betancur et al., 2017).

However, among persons infected with HIV, depression has been a single principal factor that hinders the need to seek, access or adhere to treatment modalities that can improve quality of life and prevent further spread of the epidemic (Logie, James, Tharao, & Loutfy, 2013). In a bid to achieving the goals of "zero new HIV infections … and zero AIDS-related deaths"(UNAIDS, 2010), comprehensive management of depression in HIV positive individuals should be considered. Meanwhile, several studies have explicated the importance of incorporating the comprehensive management of depression as an integral part of HIV care such that managing depression with medications, psychotherapy or social support systems is significantly associated with reduced health delivery cost and use, increased antiretroviral drug use and adherence, lower HIV disease progression and reduced AIDS-related deaths (Bess et al., 2013; Cook et al., 2014; Ibrahim et al., 2014).

Despite these compelling evidence in support of comprehensive management of depression among PLWHIV, depressive symptoms are left undetected, undiagnosed and untreated by most healthcare professionals who provide primary health care to persons living with HIV. Of all the population of persons living with HIV who have been diagnosed with major depressive disorder globally, only 18% are obtaining depression treatment of any kind.

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Out of this, just 7% are receiving adequate treatment with 5% reaching remission of depressive symptoms (Ibrahim et al., 2014; Pence, O'Donnell, & Gaynes, 2012).

Even though the efficient medical treatment of depression in people living with HIV is in existence, adequate management of depression in this group is uncommon (Pence et al., 2012). Factors that have been attributed to ineffective clinical management of depression in PLWHIV include failure on the part of healthcare professionals to recognize depression, initiate treatment and to provide adequate treatment (Pence et al., 2012). Other factors are healthcare professionals' inadequate knowledge and lack of training concerning mental health issues in people living with HIV (Chan et al., 2016), the clients' belief or family's belief that prayers instead of anti-depressants can heal depression, being old and individuals from the Afro-American origin (Cook et al., 2014). These factors, among others, are responsible for the median treatment gap or untreated cases of major depression to be 67% in Africa. In Nigeria, only 16.9% of individuals living with depression had received any form of therapy for depression (Adewuya et al., 2017; Gureje, Uwakwe, Oladeji, Makanjuola, & Esan, 2010; Kohn, Saxena, Levav, & Saraceno, 2004). According to the world mental health survey report, 76.3-85.4% of severe cases of depression in less developed countries are untreated even though depression is treatable (Demyttenaere et al., 2004).

Moreover, in a continent that is plagued with HIV and other chronic epidemics, the adoption of pragmatic measures such as providing comprehensive and collaborative depression management modalities for people living with HIV can be a remarkable feat in taming the deadly menace. However, in rolling out such measures, healthcare professionals in general practice need to be abreast of the requisite knowledge, skills, and attitudes that can inure to the patronage of these provisions by the people who need it most. Findings of multiple studies have shown that a health professionals' attitude towards the management of depression is a crucial predictor of the probability that the health professional will treat the

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condition themselves instead of referring to a different facility (Mitchell, Rao, & Vaze, 2011; Ohtsuki et al., 2012). Thus, the higher the level of knowledge of the health professionals on depression management, the greater the chances that he/she will render adequate services for the depressed patients (Mitchell et al., 2011; Ohtsuki et al., 2012; Waszczuk et al., 2017). In a related study, it has been established that health professionals who are motivated, skilled and have a positive attitude towards depression care are more likely to provide high-quality depression care than their peers (Almanzar et al., 2014; Chan et al., 2016).

Also, Henke et al. (2008) found that self-efficacy of health professionals, among other things is a pre-requisite for the adoption of evidence-informed care for the management of depression in primary health care. According to the online Cambridge Dictionary of English, Self-efficacy is “a person's belief that they can be successful when carrying out a particular task”(Cambridge University, 2018). It is also defined as “a person’s belief in his/her ability to effect change in his or her life, achieve goals or produce desired results” (Oxford Dictionary, 2019). For Bandura (1982, p.16), self-efficacy is classified as “how well one can execute courses of action required to deal with prospective situations”. In dealing with depression in people living with HIV, healthcare professionals need to be self-efficacious to be able to detect and manage depression. They will need to rely on their experience in managing depression to envisage the dynamics of depressive symptom presentations in a variety of patients. Novice health professionals will require modelling and verbal persuasions from experienced hands. At every level of expertise, the emotional state of the healthcare professionals is essential in detecting psychological distress in the people who seek their services (Al-Hamdan, Oweidat, Al-Faouri, & Codier, 2016; Andonian, 2013; Codier, Freitas, & Muneno, 2013).

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1.2 Problem Statement

Individuals aged 15 to 25 account for 40% of persons newly infected with HIV with young women being double as likely to get infected as young men in many HIV endemic areas. Besides, about 67% of all persons living with HIV are situated in sub-Saharan Africa, and approximately 9% of maternal deaths have been attributed to the epidemic in the sub-region with over 15million orphans resulting from AIDS-related deaths (UKAID, 2011; UNAIDS, 2010).

However, depression, a significant barrier to antiretroviral therapy retention, affects about 18% to 30% of clients who are receiving HIV care in Africa (Udedi et al., 2018). Numerous studies have posited that suitable depression management scheme for persons commencing antiretroviral therapy is expected to be vital for initial and sustained engagement in the HIV care continuum (Pence et al., 2012; Petersen, Hanass Hancock, Bhana, & Govender, 2014). Research have confirmed the viability, suitability and efficiency of incorporating depression management into HIV care in sub-Saharan Africa (Pence, Gaynes, et al., 2012; Petersen et al., 2014), but there is a shortage of information on the self-efficacy of healthcare professionals in managing depression in PLWHIV.

With seven years (7) experience in bedside nursing and in-depth knowledge on the operations of ART clinics and primary healthcare, it has been observed that competence of health professionals to deal with depression in PLWHIV is lacking, even though the treatment protocol requires of them to assess for depression. The healthcare professionals' lack of confidence in managing depression can be ascribed to inadequate knowledge and skills in recognizing, diagnosing and treating depression in PLWHIV. Few healthcare professionals who are conversant with depression seldom act as models for their peers who are a novice as far as managing depression in PLWHIV is concerned. Novice health professionals are hardly persuaded by their more experienced counterparts to pace up in

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consciously assessing for depression in these vulnerable groups (Abrams et al., 2017; Alamgir et al., 2011; Roberts, 2010). There are limited specialised professionals involved in the care of clients diagnosed with HIV; hence, multivalent skills are expected, including the management of depression.

Techiman Municipal has a regional HIV prevalence of 2.65% and is among the districts where there is an urgent need to scale up focused interventions to stem the tide (Ghana AIDS Commission, 2017). Techiman is the capital of the newly created Bono-East region of Ghana. It is one of the busiest commercial centres in Ghana because of its markets that draw traders from all parts of Ghana and the neighbouring countries. It also serves as the only route by land that joins the rest of Ghana to the three (3) northern regions and the neighbouring northern countries.

It is for these reasons that the researcher wants to explore the self-efficacy of healthcare professionals in managing depression in PLWHIV in three (3) hospitals in Techiman.

1.3 Purpose of the Study

The study sought to explore the self-efficacy of health professionals in managing depression among people living with HIV in Techiman, Brong-Ahafo.

1.4 Specific Objectives

The specific objectives of the study were to:

1. Describe the performance accomplishments (experience) of healthcare professionals in managing depression among people living with HIV.
2. Explore the influence of modelling by experienced professionals on the ability of less experienced professionals to manage depression in PLWHIV.

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3. Explain the role of social persuasion on developing healthcare professionals' competency in managing depression in PLWHIV
4. Describe factors at the individual level (i.e. physical appearance and emotional factors) that shape healthcare professionals' ability to recognize and manage depression.

1.5 Research Questions

1. What has been the experience of health professionals' in dealing with depression among PLWHIV?
2. What role do experienced health professionals play in building the competency of young health professionals to manage depression?
3. What is the effect of social persuasion on the ability of health professionals to assess, detect and manage depression in PLWHIV?
4. How do physical appearance and emotional states of the health professionals' impact on their ability to recognize and manage depression?

1.6 Significance of the Study

The findings of the study have generated evidence that will inform the faculty members of nursing and medical schools in Ghana of the need to design and run courses on depression management in PLWHIV in the nursing and medical schools. The results will also provide a background for the integration of depression management into the in-service training/workshops as part of continuing professional development for healthcare professionals who provide services to PLWHIV. Also, the outcome of the study will inform stakeholders to encourage specialised healthcare professionals to provide regular and concise information on depression in PLWHIV to their novice counterparts to build their efficacy.

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1.7 Definition of Terms

Depression: is a common mental disorder, characterized by persistent sadness and a loss of interest in activities that you usually enjoy, accompanied by an inability to carry out daily activities, for at least two weeks (WHO, 2017).

Self-efficacy: one's belief in one's ability to succeed in specific situations or accomplish a task or personal judgement of how well one can execute courses of action required to deal with prospective situations (Bandura, 1977)

Healthcare Professionals: Registered Medical Officers, Physician Assistants, Registered General Nurses, Registered Midwives and Registered Community Health and Public Health Nurses, Pharmacists and Laboratory Technicians as well as social workers who offer services to PLWHIV.

Core services of HIV care: It includes a physical assessment of the client, eligibility assessment and issuance of antiretroviral medications and transmission risk factor analysis.

Anti-retroviral Therapy (ART) Clinics: Clinics where ART services are provided for PLWHIV.

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CHAPTER TWO

THEORETICAL/CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

2.0 Introduction

This section presents the literature that was reviewed based on the objectives of the study and the constructs of Bandura's Self-efficacy Model. The chapter also examined Bandura's self-efficacy model as the theoretical basis of the study. The literature search revealed that there is a shortage of information on healthcare professionals' self-efficacy in managing depression among PLWHIV in Ghana and sub-Saharan Africa as a whole. The literature focused mainly on the prevalence and management of depression among PLWHIV. The literature search enabled the investigator to explore and to gather enough data and knowledge about the area of the study. It also considered current knowledge about the scope of research and continued to find existing gaps and also provided evidence for the present study. Databases such as Medline, PubMed, Cochrane, EBSCOhost, Science Direct, CINAHL, SCOPUS, SAGE, and Tailor & Francis Online were explored to retrieve relevant evidence. Google Scholar search engine was also used.

Keywords such as depression, nurses, people living with HIV, self-efficacy, competence, attitudes, and knowledge were used. The keywords were combined using Boolean operators to search for relevant studies. A variety of sources, including books, journals, articles, published papers, and the internet were used. Studies and journal articles that concentrated on depression management in obstetric and gynaecological cases were excluded.

2.1 Theoretical Framework

According to Miles and Huberman (1994, p. 18), a conceptual framework is a visual or written representation that, " explains, either graphically or in narrative form, the main

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things to be studied----the key factors, concepts or variables---and the presumed relationships among them."

As such, the conceptual framework should be able to provide the structure and content of the study based on available literature. This idea is the basis for which a framework was sought to guide the study. Some potentially sound conceptual frameworks that were found having some vital elements or variables similar to what the study aims to observe were encountered.

The conceptual framework developed by McKean, Ross, Dressler, and Scheurer (2016) known as the Goals of Core Competencies though has essential constructs, there were no specific relationships between the constructs and therefore could not be used to guide the study. For UNIDO (2002), their conceptual framework dubbed; "Competencies: The KSA Framework" also failed to address all the research questions about the study. Hence, the Self-Efficacy Model modified by Driscoll (2004), which was adapted from Bandura's original Self-Efficacy Model was used since it provided constructs that could be used to answer the research questions. It also showed the relationship between the variables and concepts to be studied. For these reasons, this model was best suited for the study.

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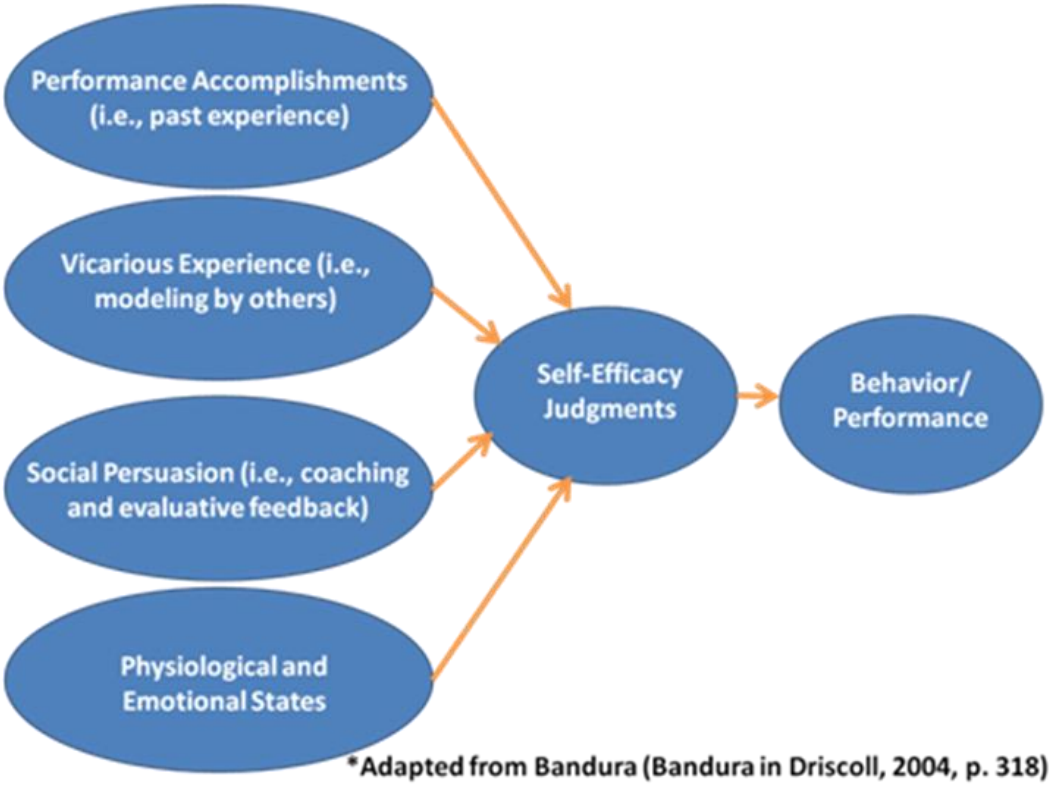

Figure 2.2: Bandura's Self-efficacy Model

2.1.1 Behaviour/Performance

According to the Oxford Online Dictionary (2019), "behaviour is the aggregate of responses, reactions or movements made by an organism in any situation". The patterns of a person's behaviour are mostly dependent on their knowledge base. However, an individual's ability to 'know-how' is not enough for him to achieve a set goal. In many instances, people may not behave optimally, although they may know very well what is expected of them. This could result from the fact that their intuitive thinking acts between their knowledge base and activity (Bandura, 1977).

An individual's capability in addressing challenging circumstances within his environment is not fixed or merely a matter of knowing what to do. Instead, it requires the combination of cognitive, social and behavioural skills to be incorporated into a concerted effort to accomplish the desired objective (Pajares, 2016). A person's capacity is a measure of

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his performance as such the ability to perform a task demands careful instrumentation and the incessant invention of multiple subskills to man situations that are continuously changing (Zimmerman, 2000). The commencement and controlling of dealings with the environment are therefore significantly influenced by decisions of functional competences. Perceived self-efficacy bears on the conclusions of how well an individual can perform sequences of activity essential to deal with forthcoming circumstances (Bandura, 1982). The perception of one's self-efficacy actively determines the course of action to be undertaken. Self-assessment of an individual's abilities serves as a couple of critical determining factors of how they will behave, their line of thinking and the emotional responses they experience under challenging conditions (Meral, Colak, & Zereyak, 2012).

2.1.2 Self-Efficacy Judgements

Humans continuously make their judgements concerning the line of action to follow and the duration within which to continue the task they have commenced. Self-efficacy appraisal/judgements, whether done correctly or mistakenly, shapes an individual's selection of activities and his/her surrounding circumstances. Since incorrect assessment about one's self-efficacy can have an untoward result, it is therefore indispensable to accurately appraise one's efficacy before accepting or undertaking challenging tasks (Boyle & Fearon, 2018). People grudgingly undertake responsibilities or duties they deem higher than they can cope but will freely admit to doing those they estimate themselves adequate to handle (Bandura, 1977; Schunk, 2003; Schunk & Pajares, 2002).

Self-judgement and the realization of one's efficacy influence the amount of energy that an individual uses and also determines the length of time they can persevere in the face of loathsome encounters (Latner, McLeod, O'Brien, & Johnston, 2013). In the face of challenging situations, persons who are unsure about their abilities to cope with the situation wavers or may even relinquish any single effort to persist, yet, those who believe strongly in

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their competence put in much effort than they have done initially to overcome the challenges (Bandura, 1982; Kadden & Litt, 2011).

Although a strong perception of one's efficacies underpins good performance, it lessens training concerning the acquisition of knowledge and skills. Likewise, persons who consider themselves incompetent in handling the demands in their surroundings settle on their insufficiencies and envisage future problems as more daunting than they are in reality (Pajares, 2016; Zimmerman, 2000). Such self-distrust generate stress and weaken accomplishments through the diversion of attention from how best to advance with the task to worries over weaknesses and misfortunes. On the other hand, people who possess a high perception of their efficacy put forth their concentration and energy to the demands of the situation and are incited to a more significant effort by obstacles (Bandura, 1977, 1982).

2.1.3 Performance Accomplishments

The development of self-efficacy is significantly shaped by individual achievements since such accomplishments are hinged on personal mastery experiences. As one succeeds in certain feats, mastery expectations rise, whereas recurrent let-downs deflate mastery prospects mostly when the failures occur in the early stages of the experience (Schunk & Pajares, 2002). However, when the strong foundation for self-efficacy has been built over time through frequent successes, the undesirable impact of occasional failures lessens. Once mastery is developed, intermittent failures can be overcome through determination and perseverance when the individual realizes that even the most challenging task can be mastered through persistence (Bandura, 1977, 1982; Bandura & Wessels, 1994; Bandura & Wood, 1989; Driscoll, 2004; Grace, Innes, Patton, & Stockhausen, 2017; Smith, Leslie, & Wynaden, 2015).

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Bandura (1977) also posited that self-efficacy is generalizable as well as transferable. In the management of depression, it requires an experienced or determined practitioner to detect, and manage the condition after several unsuccessful attempts. The misdiagnosis and under-recognition of depression is not the lot of novice healthcare professionals alone, but sometimes the condition eludes the most experienced hands (Bess et al., 2013; Chen, Evans, & Larkins, 2016). The failure of health professionals to detect psychiatric co-morbidities is usually attributable to the fact that the symptoms of depression that patients present mimic the classical signs and symptoms of tropical diseases and to some extent side effects of antiretroviral therapy for which the healthcare professionals are accustomed and therefore, tend to manage the symptoms (Mitchell et al., 2011; Ohtsuki et al., 2012; Waszczuk et al., 2017)

2.1.4 Vicarious Experience

The limit of self-efficacy an individual can attain is not solely dependent on one's mastery or experience (Roberts, 2010). Observing colleagues perform seemingly difficult tasks without any adverse consequences rekindles some sort of energy in the observer that they can also progress noticeably if they persist and intensify their efforts (Chamberland, Mamede, St-Onge, Setrakian, & Schmidt, 2015; Grace et al., 2017). The vicarious experience thus, relying on the inferences from social comparison, cannot be depended on to determine the abilities of an individual as compared with direct personal accomplishment. However, when a healthcare practitioner novice to the field of depression observes their experienced role models display tact and skill in detecting and appropriately diagnosing the condition in its sufferers, they learn quickly and become adept in recognizing the and diagnosing the same with little or no errors (Chamberland et al., 2015; Roberts, 2010; Schwellnus & Carnahan, 2014; Zadvinskis, Glasgow, & Salsbury, 2011).

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The belief becomes grounded in that if people of widely differing characteristics can succeed, the observing individual can have a sound background for increasing their sense of self-efficacy (Bandura, 1982; Bandura & Wessels, 1994; Bandura & Wood, 1989).

2.1.5 Social Persuasion

Persuasion is a very potent tool that has a tremendous influence on the day-to-day activities of humans and society as a whole. According to Perloff (2003, p. 4), persuasion is defined as "...a symbolic process in which communicators try to convince other people to change their attitudes or behaviours regarding an issue through the transmission of a message in an atmosphere of free choice." In most of the instances, the persuader intentionally encourages the audience to adopt an attitude, an idea or course of action through symbolic means.

It is also significant to note that for persuasion to be successful, the individual must freely choose to be persuaded and cannot be coerced (Cherry, 2018). More so, a person's awareness that he/she is a member of a particular social group in addition to some passionate and value significance to him/her of this group membership leads them to buy a behaviour typical to such a group. The medical profession, with its various dimensions, is a society and as such novice members, in a quest to feel a sense of belongingness adapt the behaviour of their more experienced counterparts through social influence. Characteristics that lure followers to social influencers include source expertise, leadership qualities, reference group influence and sometimes similarities in demography (Langner, Hennigs, & Wiedmann, 2013).

One of the most readily available and often used means of controlling the conduct of others is through verbal persuasion. Through suggestion, people with insufficient skill and knowledge on a particular subject are led to believe that they too can successfully undertake specific activities that were hitherto overwhelming to them. Even though the efficacy

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potentials bring on by persuasion is likely to be feebler than efficacy expectations that emanate from personal accomplishments, it cannot undoubtedly be glossed over. In as much as social persuasion may have limitations as a means of forming a lasting sense of personal efficacy, it can contribute to the feat attained through corrective performance (Bandura, 1977; Bandura & Wood, 1989; Burt, 2011). When individuals who are provided with aids to carry out efficient activity are socially persuaded that they possess abilities to master challenging situations, they are likely to harness sufficient effort than those who receive performance aids alone. Therefore, social persuasion has an integrative effect on self-efficacy to yield any meaningful substance (Ladyshewsky, 2010; Schwellnus & Carnahan, 2014).

2.1.6 Emotional and the Physiological States

The complexities associated with understanding the psychological underpinnings of patients' complaints present stressful and demanding emotional and physiological output of the healthcare provider. For Bandura (1982), emotional arousal virtually affects the healthcare provider's perception of self-efficacy in such challenging moments. Since high emotional arousal usually debilitates performance, individuals are more likely to expect success when they are not beset by aversive arousal than if they are tensed and viscerally agitated.

Implicitly, people rely heavily on their emotional and physiological state in judging situations. Hence, healthcare professionals who are stable emotionally and physiologically can undoubtedly recognize psychological distress and fluctuations in their patients and are even willing to spend much time to investigate socioeconomic dimensions of their clients' issues (De Vries et al., 2014). More so, the ability to control one's behaviour enables the individual to manage the loathsome facets of a situation. It is therefore noteworthy that potentially stressful situations that are being successfully managed are construed as less threatening and such cognitive appraisal further reduce anticipating emotional arousal.

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Cognitive assessment of arousal to a large extent determines the level or direction of motivational inducements to action. Within the clinical setting, the realization of a healthcare professional's physiological state has a significant bearing on their ability to meet the changing demands of their patients (Al-Hamdan et al., 2016; Andonian, 2013; Bakr & Safaan, 2012).

2.2 Literature Review

2.2.1 Assessment and Management of Depression in PLWHIV

Although the prevalence of depression is high in PLWHIV (Kennard et al., 2014; Sherr, Clucas, Harding, Sibley, & Catalan, 2011), it is poorly assessed and managed in this population (Logie et al., 2013; Webel et al., 2016). Even when the condition is detected at clinical settings, most cases are untreated and the few cases that the physicians attempt to treat, they do not comply with best practices in terms of dosing, duration and monitoring of anti-depressants guidelines (Pence, O'Donnell, et al., 2012). Despite its negative effect on the quality of life, wellness and therapeutic adherence on PLWHIV, depression in this population goes mostly unnoticed. Given the ambitious UNAIDS goals of 90-90-90 by 2020, one of the crucial roadmaps to achieving 90% viral suppression is through comprehensive management of psychiatric co-morbidities of which depression is predominant. However, despite the benefits of psychological support in HIV care, psychosocial and qualified social workers are almost extinct from most of the primary health care facilities that provide essential care to PLWHIV (Bain, Nkoke, & Noubiap, 2017).

The findings of a study by Bess et al. (2013) revealed that out of 72 HIV care providers, just 31% regularly assess their patients for depression. In many low or middle-income countries where the epidemic causes a severe threat to humanity, many of the non-psychiatric health care providers who offer health care services to the people have substantial

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stigma and misinformation concerning depression (Almanzar et al., 2014). In rural Kenya, a cross-sectional survey by Fekadu et al. (2017); (n=1014) found that the attending health care providers did not detect more than 98% of cases with the 9-item patient health questionnaire (PHQ-9) depression.

According to Adewuya et al. (2017), staff incompetence (67.5%), poor attitude towards depressed patients (>42%) and heavy work schedule (68%) accounted for the lack of routine assessment and management of depression by primary health care providers in urban Nigeria. In Fako Division of Cameroon, a cross-sectional study involving 226 primary health care providers found that 1.8% of the participants had any knowledge on standard tools that can be used to diagnose depression with 49.1% having formal training in mental health (Mulango, Atashili, Gaynes, & Njim, 2018). Even though, the Ghana Health Service patients' folder dedicated to PLWHIV has portions that require the health care provider to assess for depression in their patients at each visit, the researcher through his experience found that most HIV care providers fill out these portions without due diligence.

2.2.3 Doctors'/Physicians' Experience in Managing Depression in HIV

In an earlier systematic review and meta-analysis research by Cepoiu et al. (2008), it was found that more than half of all patients suffering from depression are undetected. The inability of many non-psychiatric physicians' to detect, diagnose and manage depression is multi-factorial. A systematic review by Chen et al. (2016) found that a physician's ability to see depression correlates with his speciality and the years of service. They discovered that obstetricians and gynaecologists, as well as paediatricians, are lacking in terms of identifying and managing depression whiles physicians with expertise in family medicine having the upper hand. Interestingly, they found that older and more experienced consultants are less likely to detect psychiatric co-morbidities than their younger counterparts. Further studies are required to investigate and understand this gap.

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Reasons that have been attributed to physician's unrecognition and therefore lack of management of depression in PLWHIV includes the fact that, the abnormality resulting from HIV infections or antiretroviral therapy such as opportunistic infections, fatigue, loss of appetite and other somatic symptoms mimic symptoms of depression and as such non-psychiatric physicians tend to focus on and treat the bodily symptoms instead of the underlying psychological malady (Simoni et al., 2011). Therefore, it is imperative to have a gold standard for assessing and diagnosing depression to be used by general practitioners to enhance the detection and recognition of depression in people living with HIV and AIDS.

A study in Nigeria found that out of 44 participants (among n=310 of HIV positive patients) who were found to have a major depressive disorder, none of these individuals had been diagnosed with depression before the study by their attending doctors. Unfortunately, these participants were among those who scored the lowest among participants with poor quality of life. The researchers found that attending physicians associated the depressive symptoms with other opportunistic medical conditions common to HIV. In circumstances where the attending doctor correctly identified the depressive disorder in these patients, they paid no particular attention since they assumed that it is common to find such symptoms in persons diagnosed with stigmatized and a terminal condition (Olisah et al., 2011). In a related study, out of 350 HIV positive participants recruited for the study, 20% were found to have depression according to Composite International Diagnostic Interview (CIDI) standard. None of these participants had had the diagnosis of depression being reported in their medical records by the attending physician before the investigation (Ibrahim et al., 2014). Although a study in Zomba, Malawi found the depression rate to be 30.3%, the rate of detection by primary healthcare health professionals was 0% (Udedi, 2014).

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In a multi-site cohort study of HIV disease progression, Cook et al. (2014) found that HIV positive depressed patients who consistently sought healthcare from the same physician are more likely to have their depression detected, diagnosed and treated. The study also suggested that the availability of mental health facilities facilitated the diagnosis and treatment of psychiatric co-morbidities in PLWHIV. The findings of the study emphasize that, in low or middle-income countries where patients are seen and managed by any available doctor, coupled with a severe shortage of mental health facilities (Ghana has only four psychiatric hospitals), the problem of under-diagnosis of depression wages on and has no end in sight except general practitioners are educated to assess for and treat depression in prospective patients routinely.

2.2.4 Nurses' Assessment and Management of Depression in PLWHIV

There is generally a lack of evidence on nurses' ability to lead the assessment and management of depression in PLWHIV. However, the few available data show that when nurses are empowered to lead such tasks, the results are encouraging. In a non-experimental study to test model-based task shifting, nurse-led measurement-based care in HIV clinics in Tanzania, the model was found to be feasible. The measurement-based maintenance required the nurse to routinely assess the depressed HIV positive patient and adjust the antidepressant dosage according to the assessment findings. The study also found that the nurses honestly complied with the treatment guidelines which led to a significant reduction in depressive symptoms in the participants (Adams, Almond, Ringo, Shangali, & Sikkema, 2012).

In a cross-sectional descriptive national survey to assess nurses' competence in managing and providing necessary care for chronically ill depressed patients, the researchers found that novice nurses had poor knowledge of the prevalence of depression in their prospective patients. The participants lacked competence whiles their attitude ranged from neutral to somewhat positive. Although the researchers found that the more experienced

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nurses had a positive attitude, had confidence and were interested in providing care for depressed patients, they lacked knowledge on depression (Chuang & Kuo, 2018).

The findings of a doctoral project presented by Huey (2016), suggest that providing continuing professional education for novice nurses significantly improves their professional competence and change their attitude on the use of validated tools to assess and manage depression. Abrams et al. (2017) also found that a lower rate of depressive symptom detection among primary caregivers in nursing homes and other long-term care facilities is attributed to a lack of formal training on depressive symptom recognition. The available literature illustrates that nurses, just like their physician counterparts, have limited knowledge and competence in assessing and managing depression in PLWHIV.

2.2.5 Factors Influencing Assessment and Management of Depression in HIV

Several factors have been cited as being responsible for the inability of primary healthcare providers to recognise, diagnose and treat depression among PLWHIV. Paramount among these include; the HIV depressed patients present with somatic symptoms of depression and as such caregivers tend to focus on these physical symptoms without probing to estimate any underlying psychological association (Niemi, Målqvist, Giang, Allebeck, & Falkenberg, 2013; Simoni et al., 2011). The findings of some studies suggest that doctors who have just completed medical school have a better attitude towards the detection and management of depression as compared to their senior colleagues who left medical school many years ago (Chen et al., 2016). Notwithstanding, evidence shows that experienced nurses with longer years of practice have a better attitude, more confident in managing depression, although they may have insufficient knowledge of the issue (Chuang & Kuo, 2018). Lack of formal training in mental health issues (Chan et al., 2016; Chuang & Kuo, 2018), non-compliance with treatment guidelines (Bess et al., 2013) among others have also been cited.

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2.2.5a Role of Performance accomplishment in assessing and managing depression in PLWHIV

Mastery in performing tasks is built over time. If health professionals can successfully detect and address psychological distress in patients suffering from chronic diseases, their confidence grows, and they become aware of the dynamics in which prospective patients present the conditions. However, when health professionals are unable to recognise and manage psychiatric co-morbidities, their competency dwindles, and it becomes much more difficult to detect the same subsequently. Smith et al. (2015), found that their experience and success determine the chances of having a peri-operative nurse participating in an organ procurement surgery.

In a quasi-experimental study using a pre-and post-test technique, the researchers found that the self-efficacy of medical students on consultation skills was positively augmented after they had been able to successfully conduct series of consultations for their clients (Aper, Reniers, Koole, Valcke, & Derese, 2012). A narrative review conducted by Grace et al. (2017) revealed that task accomplishment during experiential learning boosted the self-efficacy of nursing and medical students. Even though there is limited evidence on the impact of performance accomplishment on health professionals' self-efficacy in assessing and managing depression in PLWHIV, it can be inferred that the development of mastery in recognising depressive symptoms can have a significant positive effect on the self-efficacy of health professionals in their subsequent encounter with the other depressed patients.

2.2.5b Role of Vicarious Experience in Managing Depression in PLWHIV

According to Bruner (1986, p. 122), "most of our encounters with the world, are not direct encounters" and this presupposes that there are several ways of learning other than personal experience. Vicarious learning is the ability to discern or "listen in" on colleagues or experienced specialists as they deliberate on new issues about the field of study and

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learning through the experiences of peers. This type of learning takes place through professional discourse, case-based discussions and relating ones' experience. Novice professionals can adopt knowledge brought to bear during such deliberations. Notwithstanding, the effect of vicarious learning on nursing education is not fully understood (Roberts, 2010).

In academia, vicarious learning otherwise referred to as peer-learning is beneficial to classroom teaching. Since peers do not cause any threat to their fellows as compared to their instructors, other members within the peer circle aspire to reach knowledge level similar to their colleagues. This type of knowledge acquisition allows individuals with similar academic background or profession to adopt an accommodative relationship that employs observation of a task to affirm enforcement of changes. For significant change to be realized in people who are striving to gain knowledge through the experience of others, such individuals should endeavour to engage their peers in a relationship born out of a free will and collaborative. It is also imperative for participants of such relation to giving self-evaluative feedback which is reflective of their progress or otherwise because the goal of such union is to foster the amplification of strength of colleagues (Cox, 2012; Grant, Passmore, Cavanagh, & Parker, 2010; Ladyshewsky, 2010; Zadvinskis et al., 2011).

The findings of a systematic review conducted by Schwellnus and Carnahan (2014), indicated that learning from the experience of others is fundamental to implementing staff development workshops in continuing medical/professional education. Their findings illustrated that participants enjoyed the peer-to-peer collaborative uncompetitive relationship and was found to improve their learning and acquisition of skills. In a related study, evidence accrued suggested that instituting peer-learning as part of a daily staff development mechanism is worth the time and investment input (Alamgir et al., 2011).

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With the advent of technology, the field of healthcare has been extensively diversified. To meet the ever-changing health needs of clients, healthcare professionals are required to have top-notch, up-to-date and hands-on knowledge and skills in adopting research-informed practice and new technologies in a bid to satisfy the demands of their customers (Schwellnus & Carnahan, 2014).

The foregoing evidence implies that if experienced health professionals are abreast of trends in recognising and managing depression, their novice counterparts will copy their skills deliberately or subconsciously. But since primary healthcare professionals mostly pay attention to different specialities, their skills in assessing psychological distress die off and are unable to transfer their knowledge through their practice.

2.2.5c Impact of Social Persuasion on recognition of Depression

Novice health professionals are inevitably persuaded by the art and skill of their experienced colleagues to perfect behaviour or a task. Experienced health professionals influence their novice counterparts to directly or otherwise adopt an attitude or their skills in identifying depressed patients (Chamberland et al., 2015). It can be inferred that health professionals who have inadequate knowledge and attitude towards depression in PLWHIV or even think depressive symptoms are common features of patients diagnosed with stigmatized and terminal diseases and therefore needs no special attention, unconsciously persuade their colleagues to do the same (Cherry, 2018; Langner et al., 2013).

A scoping review study conducted by Schwellnus and Carnahan (2014) posited that, in the company of their peers, novice practitioners are motivated to rise to the same knowledge level as their peers through observation of tasks and feedback in a non-competitive atmosphere. In a related study, the investigator found that participants who were verbally persuaded in addition to the exposure to required tools performed optimally well

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than the control group who were only given the tools necessary to accomplish the same task (Ladyshewsky, 2010).

The evidence, as mentioned earlier, supports the assertion that, if health professionals are rightly persuaded by more qualified personnel, they will be able to detect and manage depression in PLWHIV with remarkable accuracy.

2.3 Summary of the Literature

Considerable evidence has shown that depression is highly prevalent in PLWHIV and is responsible for the low quality of life, medication non-adherence and disease progression among other debilitating effects. Again, several data have underscored the benefits of managing depression in PLWHIV, such that comprehensive depression management is positively correlated with positive HIV treatment outcomes (Gaynes et al., 2015). Nonetheless, the evidence upon evidence has shown that approximately 50% or more of the depressive symptoms in HIV positive patients are either undetected, under-diagnosed or misdiagnosed. Even if detected, a more significant percentage are untreated, although it can adequately be treated. The literature has cited low health professionals' knowledge, poor attitude, lack of formal training as health professionals' characteristics whiles the somatic presentation of depression as patients' characteristics that undermine recognition and management of depression.

In the studies that addressed the management of depression, according to the knowledge of the researcher, there is a shortage of evidence on the self-efficacy of health professionals in managing depression in PLWHIV, hence the goal of the study is to understand through the interpretive description, health professionals' self-efficacy in managing depression in PLWHIV.

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CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Research methodology deals with the principles and procedures a researcher adopts to understand a domain of inquiry and may help answer research questions and the objectives of a study (Creswell, 2014). This section outlines the methodological approach, research design, parameters of the study setting, sample proportion and sampling techniques employed. Also, data collection tools and data collection procedures, pretesting of the interview guide, data management and analysis are described. Methodological rigour and ethical considerations have also been discussed.

3.1 Research Paradigm and Design

The investigator understands that the self-efficacy in managing depression among PLWHIV is a phenomenon that is open to multiple interpretations and meanings. In light of this, the constructivist perspective underpinning the qualitative approach was employed. In this approach, humanity and subjective experiences were maintained, and appropriate meanings were ascribed (Creswell, 2014; Polit & Beck, 2009).

Interpretive description is the design that was employed to understand health professionals' self-efficacy in managing depression in people living with HIV. The Interpretive Description "is an analytical, inductive approach designed to create ways of understanding human health and aspects related to the experience of a disease that has consequences for the clinical context and practice in Health and which are of interest for nursing researchers." (Teodoro et al., 2018, p. 2). It is also defined as "a strategy for excavating, illuminating, articulating, and disseminating the kind of knowledge that sits

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somewhere between fact and conjecture, but which is of central importance to the applied disciplines … and the health professions" (Thorne, 2016, p. 15).

In employing interpretive description, the researcher drew on the experiences of health professionals in dealing with depression in PLWHIV for which available data is insufficient to offer. Relevant literature was reviewed to understand the phenomenon and conclusions were drawn on the existing situation about depression management among PLWHIV before the investigator entered the study site. By this time, analysis of the expected data has begun, and this enabled the investigator to consider, question the validity, assess and break down fragments of evidence till they were organized into segments that communicated something hitherto unknown (Teodoro et al., 2018; Thorne, 2016). The design allowed for the flexibility in collecting myriads of data from participants who were deeply embedded in rendering holistic care to PLWHIV.

It is noteworthy to mention that a quantitative method could have been an efficient approach to test the hypotheses and measure the specific variables of the study and their possible relationship (McCusker & Gunaydin, 2014). However, since little is known about the self-efficacy of health professionals in managing depression in PLWHIV, a qualitative method was chosen to comprehend the concept deeply under review using the health professionals as the frame of reference (Green & Thorogood, 2018; Taylor, Bogdan, & DeVault, 2015).

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3.2 The Study Setting

The study was conducted at three (3) ART centres in the Techiman Municipality, the capital of the newly created Bono-East Region of Ghana. The population of the Techiman Municipality, according to the 2010 Population and Housing Census, is 147,788 representing 6.4 per cent of the region's total population. Males constitute 48.5 per cent and females represent 51.5 per cent. A more significant percentage of the population (64.5%) live in urban areas as compared with 35.5 per cent in the rural areas. The population of the municipality is mostly youth (13.6%) of the 0-4 age group, depicting a broad base population pyramid which tapers off with a small number of the 70 plus years (3.0%). Health services from a blend of health facilities in both the public and private sectors provide the inhabitants of the municipality with their health needs (Ghana Statistical Service, 2014).

The study was conducted at Holy Family Hospital, Ahmadiyya Muslim Hospital, and Valley View Adventist Hospital, all of which are located in the Techiman Municipality.

Holy Family Hospital is the only major referral hospital in the Techiman Municipality. It has a bed capacity of about two hundred (200). The facility has a well-established Anti-retroviral therapy clinic that runs on Tuesdays and Thursdays. The clinic is operated by five (5) medical officers, two (2) physician assistants, three (3) pharmacists, two (2) social workers, and three (3) enrolled nurses. The clinic renders services to approximately four thousand three hundred and twenty (4320) persons living with HIV.

Ahmadiyya Muslim Hospital has a bed capacity of eighty (80). The facility runs an ART clinic on Wednesdays and renders ART services to approximately six-hundred (600) clients. The clinic has one (1) physician assistant, two (2) pharmacists and two (2) enrolled nurses.

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Valley View Adventist Hospital is a health centre with a medical officer. The facility has a capacity of fifty (50) beds. The facility runs ART services daily. The ART services are operated by one (1) Medical Laboratory Scientist and one (1) pharmacist. The facility renders care to about fifty (50) people living with HIV.

3.4 Target Population

These are people with specific features in whom the investigator has an interest (Polit & Beck, 2009). The population for this study was health professionals working in the Techiman Municipality who offer ART core services to PLWHIV. These include doctors, physician assistants, pharmacists, nurses, and social workers who have been trained to render core services to PLWHIV.

3.4.1 Inclusion Criteria

1. Health professionals with at least six(6) months post-qualification experience in the management of PLWHIV.
2. Health professionals who render HIV core services for PLWHIV in the Techiman municipality in either public or private health institutions.
3. Health professionals who render HIV care services with a minimum of diploma as their professional qualification.

3.4.2 Exclusion Criteria

Participants who qualify per the inclusion criteria but:

1. Who have taken study leave or annual leave.
2. Who has been diagnosed with any form of mental disorder.

3.5 Sample Size and Sampling Technique

The study recruited sixteen (16) health professionals who have a deeper understanding of the comprehensive management of PLWHIV. The interviews were

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truncated after the 16th participant when repetitive codes and categories were observed, and no new information emerged, a concept referred to as saturation (Creswell, 2014).

It is through intense involvement of the researcher with a relatively small number of participants who have in-depth knowledge and experience on the phenomenon under study that the researcher hopes to produce data worthy of note (Teodoro et al., 2018; Thorne, 2016).

Purposive sampling technique was used to recruit participants who met the inclusion criteria for the study. The sample size was determined during data collection when the 16th participants affirmed data saturation as no new views were elicited. No nurse was recruited as a participant because all the nurses who were found at the three study settings were health extension workers—a lower cadre of nurses who had six (6) months on-the-job training. This cadre of nurses did not have a requisite educational background and therefore, did not meet the inclusion criteria. Besides, they were only involved in retrieving patients' folders and monitoring of vital signs. They were not involved in the core services of HIV care as defined, hence excluded. Again, pharmacists, medical laboratory scientists or social workers were added to the sample because, in some of the antiretroviral therapy facilities, pharmacists and social workers alone provide core services for PLWHIV who access those facilities on an outpatient basis.

3.6 Data Collection Tools (Appendix E)

A semi-structured interview guide was used to explore the self-efficacy experiences of participants in managing depression in PLWHIV. The researcher constructed the interview guide under the supervision of two expert supervisors in consultation with current literature. The interview guide was developed based on the objectives of the study, composed of open-ended questions and comprised mainly of two sections. The first section describes the

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participants' demographic characteristics, whiles the rest focused on the constructs of the study. The section on the participants' profile was devoid of any identifier, and this empowered participants to give out vital information necessary to answer the research questions. Each interview lasted between 45 and 90 minutes for a participant.

3.6.1 Pre-testing of the Interview Guide

The interview guide was pretested with one physician assistant and a medical officer who met the inclusion criteria at St. Theresa's Hospital, Nkoranza near Techiman. The piloting of the interview guide enabled the researcher to refine the guiding questions and also tested the voice recorder. The data obtained from the pre-testing were excluded from the analysis of the final report. The interviewing skills of the researcher were also enhanced.

3.7 Data Collection Procedure

Ethical approval for the study was secured from the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB) and Ethical Review Committee of Ghana Health Service (GHS-ERC). An introductory letter was after that secured from the School of Nursing and Midwifery, University of Ghana, Legon. It was sent to the administrators who oversee the facilities earmarked for the study. Letters permitting the researcher to enter the field were administered by the various administrators and were sent to the HIV care coordinators who then introduced the researcher to the participants. Notice about the study was placed on available notice boards, conference rooms and at vantage areas to enhance the publicity of the study in the selected facilities.

Health professionals who met the inclusion criteria were contacted personally and where necessary contact persons were used to tracing potential participants. The researcher then established rapport and built trust and confidence with the participants who agreed to be part of the study. The purpose of the study was explained in detail to the participants to gain

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their cooperation. The participants were offered an information sheet that contained a summary of the study and other relevant information. A consent form was then completed by the researcher and the participants after the consent form has been read audibly to the participants. The participants were also given some time to digest the content of the consent form and agreed to be part of the research. The date and time for the interviews were chosen by the participants as well as the participants' preferred place for the interview.

On the day scheduled for the interview, participants were briefed about the purpose of the study and consent form were endorsed. As part of the consent, participants were assured of autonomy, confidentiality and safety and protection of privacy. The participants were reminded about the audio recording of the interviews, were made comfortable, and then the interviews commenced. "Please tell me what you know about depression" were questions that were used to begin the discussion as participants shared their general knowledge about depression. Participants were made to clarify unclear responses. Probes and follow-up questions were used when necessary. As part of the field notes, short notes were kept to record the non-verbal cues of the participants and to keep track of ideas for further exploration while observing the participants.

The researcher learned more about the self-efficacy of the participants in managing depression in PLWHIV and then focussed on concepts and issues pertinent to the participants' experience instead of the concepts that were identified before the study began. The data were transcribed verbatim and analysed concurrently as the data collection progressed. When initial codes were generated, some of the participants were contacted, and the outcome of the analysis shared with them to confirm the categories as representative of what they intended to communicate.

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3.8 Data Management

The information about the proceedings of the interviews, audio-recordings, and data analysis have been kept on a personal computer protected with a password. A separate file was created for each participant. No unique identifiers such as National Health Insurance Number, Social Security Number or Personal Identification numbers were used in categorizing the data to offer the highest level of anonymity to the participants. Again, the participants have been assigned codes that have no bearing on their identity. The demographic data of the participants and the consent forms bearing the identity of the participants have been stored separately from the transcribed data.

The raw audio-taped data and the softcopies of the transcribed data have been stored on google drive as a backup. Hardcopies of the transcribed data were printed and kept under lock and key in a safe for easy follow up. All the stored data will be available to the researcher and supervisors for a maximum of five (5) years.

3.9 Data Analysis

Thematic content analysis was used to analyse the data and field notes that were collected from the participants (Huberman & Miles, 1994). Analysis of the data was done concurrently with data collection. This method enabled the researcher to note areas of emphasis, clarified contradictions and disregarded irrelevant contents. Each audio-taped recording was listened to severally and then transcribed verbatim by the researcher. The transcribed data was then edited and reviewed for errors and omissions. The researcher read the transcripts repeatedly to internalise the data and become familiar with the recurring ideas. Some of the participants were contacted to clarify some of the narrations to ensure their credibility. In doing so, the researcher was cognisant of his stance and was careful not to mar the import of the emerging themes.

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The codes were organised and compared in terms of their resemblance and differences. A qualitative data analysis software, NVivo was used to organise the codes and the categorizations. Sorting of the codes was done and grouped according to their similarity. Phrases or short sentences reflecting the main ideas that the codes carry was used to label similar codes. Themes were identified through inductive and deductive approaches (Chowdhury, 2014) and crosschecked with study objectives. A detailed literature search began when data collection was completed to avoid biases. Variations in themes were described to facilitate transparency and trustworthiness and to enhance the transferability of the findings. Narrations that described and linked various themes were developed. Summary of findings was composed, and a comparison of results with literature was also made. This enabled the researcher to describe and interpret the findings of the study in light of existing knowledge and has been organised into a report.

3.10 Methodological Rigour

Methodological Rigour is “the quality or state of being very exact, careful or with strict precision or the quality of being thorough and accurate”(Cypress, 2017, p. 254). Considering that any study that employs the qualitative method goes through a series of descriptions and discoveries, it is somewhat difficult to fully yield to the rigid boundaries of rigour as the term is sometimes seen as an oxymoron.

Nevertheless, without rigour, a qualitative study is valueless, akin to a fairy tale and loses its meaning. Moreover, in ensuring rigour, the researcher should not be unnecessary rigid to deny the qualitative study its characteristic creativity (Noble & Smith, 2015; Sandelowski, 1993). The researcher, therefore, used the framework developed by Lincoln and Guba (1985); credibility, transferability, dependability, and confirmability to ensure rigour in this qualitative study.

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3.10.1 Credibility

Credibility is achieved through prolonged engagement and persistently observing the participants to discover the circumstance in which the phenomenon under study is rooted to reduce misrepresentations that might crawl into the data. To accomplish this, the researcher spent two (2) months with the health professionals who provided care to people living with HIV and became familiar with the issues surrounding the recognition and management of depression in PLWHIV and also established rapport and trust with the participants. Peer debriefing was carried out through frequent meetings with the researcher's supervisors and colleague researchers to allow for deliberations and critiquing of the research activities and field journals. Triangulation was attained by double-checking the data and the interpretations across the participants by the expert supervisors. Member checks were accomplished by frequently verifying the data and the interpretations with the participants from whom the data has been solicited (Cypress, 2017). The participants were allowed to read through the transcripts to ascertain the authenticity of the transcribed data and to confirm if the transcripts reflected what they intended to say. Iterative questioning and probing style were adopted to ensure consistency in the participants' narrations. Two independent supervisors also coded the transcripts to reduce disparities and to ensure that the codes are representative of participants' realities.

3.10.2 Transferability

Transferability of applicability was enhanced by using a purposive sampling method for recruiting the study participants. A detailed description and robust data with an extensive range of information through the thick and precise transcriptions and constant revisiting of the data have been offered. The researcher has provided a detailed and accurate description of all the research process and the context in which the processes occurred. Every aspect of the analysis, i.e. categorizing and ordering of the data in a meaningful manner and a final report

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that is true and accurate, has been documented. The sufficient background information of the study setting has been provided to enable readers to comprehend and compare the issues described in the study.

3.10.3 Dependability

Dependability is akin to reliability in quantitative studies (Lincoln & Guba, 1985). To accomplish this, the transcribed data was thoroughly reviewed by two (2) expert supervisors who verified the themes and the descriptors identified. An audit trail has been developed to enable reviewers to judge the reliability of the study through methodological and analytical reasoning. The research design and its implementation have been included as such similar results could be obtained if other researchers repeat the study.

3.10.4 Confirmability

It shows the objectivity of the researcher in ensuring that the findings are specific to the notions expressed by the participants. A reflexive journal was maintained during the study process to keep notes and document daily introspections that were beneficial to the study. An audit trail was developed to examine the data collection, analysis, and interpretation processes. The audit trail in the form of interview tapes, transcribed data and interview notes that were taken as well as a consecutive report of the process in the form of field notes were made available to the supervisors of the researcher. The researcher emphasised on triangulation in a bid to reduce biases and preferences.

The researcher guarded against his own biases through reflexivity and bracketing. The assumptions underpinning the decisions made, and the methods adopted have been acknowledged in the report. Again, a detailed description of the process has been provided to ensure that the results obtained may be accepted.

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3.11 Ethical Consideration

To enforce the principle of beneficence and non-maleficence and also to uphold the dignity and rights of each of the participants, ethical issues were duly considered (Polit & Beck, 2009).

3.11.1 Ethical Approval Process

Ethical clearance for the study was sought from the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIM-IRB) (appendix B) and the Ethical Review Committee of Ghana Health Service Research Directorate (GHS-ERC) (Appendix A) after a proposal has been submitted to them before the commencement of the research. A letter of introduction was obtained from the School of Nursing and Midwifery, the University of Ghana to gain access to the study sites to recruit participants. The researcher submitted copies of the introductory letter and the letters of clearance to seek permission from the administrators or human resource managers of the settings where the study took place. The administrators of the study settings then gave approval letters. These letters were forwarded to the HIV care coordinators who also acknowledged receipt and introduced the investigator to the health personnel who provide core services for PLWHIV.

3.11.2 Informed Consent (Appendix D)

The participants who agreed to join the study were given general information about the research and its objectives. The researcher informed the participants that, their experiences in the management of depression in PLWHIV were to be solicited through interviews. The participants were made aware of the potential benefits and risks that the study may bring to them. The only discomfort to them was that 45-90minutes of their precious time and energy was taken to complete an interview for which they were informed aforetime.

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The participants were also informed that the interviews were to be recorded on a voice recorder. Those who met the inclusion criteria and consented to be part of the study were asked to provide their signatures as proof.

3.11.3 Confidentiality, Anonymity, Possible Risk and Discomfort

The researcher exhausted all avenues to render a high level of anonymity to the participants. No personal identifier whatsoever was required from the participants. The researcher also coached the participants to avoid mentioning names or locations that can reveal the identity of a third party. Codes that have no link with the identity of the participants were used to identify the transcripts. The participants were informed that the data was going to be used for the purpose for which it was collected and would be accessible to the researcher and supervisors. They were also informed that the audio recordings, transcripts and other related documents would be kept for five (5) years and then be destroyed afterwards. They were assured of anonymity if any part of the study is to be published. The study brought no risk to the participants except that they had to spend some time on the interviews to be conducted.

3.11.4 Right to Freedom

The researcher informed the participants that, participation in the study is voluntary and that they reserved every right to withdraw from the study at any time without any loss or penalty. Contacts of supervisors and Ghana Health Service personnel in charge of enforcing the rights of participants were made available to the participants so that they could implement their rights if they felt at any point that they are being taken for granted and their rights infringed upon.

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CHAPTER FOUR

FINDINGS OF THE STUDY

4.0 Introduction

This chapter outlines the findings of the study, which seeks to interpret and describe the self-efficacy of healthcare professionals in managing depression in PLWHIV. The specific objectives of the study are to a. describe the performance accomplishments (experience) of healthcare professionals in managing depression among people living with HIV, b. explore the influence of modelling (mentoring and preceptorship) by experienced professionals on the ability of less experienced professionals to manage depression in PLWHIV, c. explain the role of social persuasion on developing healthcare professionals' competency in managing depression in PLWHIV and d. describe the factors at the individual level (i.e. emotional factors) that shape healthcare professionals' ability to recognize and manage depression.

The analysis of the data was accomplished using a thematic content analysis of the transcribed data. Both inductive and deductive approaches were employed in analysing the data. The chapter commences with the overview of the organization of the themes and the participants' demographic features. The main themes were then described and interpreted in addition to the relevant sub-themes.

4.1 Participants' Profile

Table 4.1 summarises the profile of the sixteen (16) participants recruited. The participants were made up of twelve (12) males and four (4) females with their ages ranging from twenty-seven (27) to seventy-five (75). The participants include five (5) Medical Officers, five (5) Physician Assistants, three (3) Pharmacists, one (1) Medical Laboratory Scientist and two (2) social workers who render HIV care services to PLWHIV. The

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participants have been with the ART clinic rendering core services for PLWHIV for at least six (6) months. The elements of the core services at the ART clinic include initial health assessment of the client, transmission risk factor assessment, diagnostic investigations, antiretroviral (ARV) eligibility assessment and selection and issuance of the ARV's.

Nurses who were found in the three (3) settings working with the ART clinics did not meet the inclusion criteria at the time of the data collection. The nurses were health extension workers: a lower cadre of nurses whose qualifications did not meet the inclusion criteria. Besides, they were not involved in providing core services to PLWHIV as defined. All the participants were Ghanaians and could speak the English language as such. All the interviews were conducted in English without the help of a translator. Codes represented participants for the sake of confidentiality and anonymity. Participants' demographic details have been summarised in the table below:

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Table 4.1: Demographic Features of Participants

Participant's Code	Age (years)	Gender	Months/Years of ART Clinic Experience	Profession
Hp001	75	Male	3years	Physician Assistant
Hp002	43	Male	3years	Medical Officer (Specialist in Internal Medicine)
Hp003	37	Male	2years	Medical Officer
Hp004	32	Male	8months	Medical Officer
Hp005	27	Male	6months	Physician Assistant
Hp006	38	Male	1 year	Medical Laboratory Scientist
Hp007	42	Male	1 year	Pharmacist
Hp008	40	Male	3years	Pharmacist
Hp009	57	Male	20years	Social Worker
Hp010	46	Male	2years	Social Worker
Hp011	30	Female	3years	Pharmacist
Hp012	50	Female	3years	Physician Assistant
Hp013	37	Male	8months	Medical Officer
Hp014	29	Female	6months	Medical Officer
Hp015	31	Male	1year	Physician Assistant
Hp016	33	Female	2years	Physician Assistant

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4.2 Organisation of the Themes and Sub-themes

The themes were deduced from Bandura's self-efficacy model. The sub-themes were framed in line with the description of the constructs of the model. Five (5) major themes with fifteen (15) associated sub-themes emerged. There was consistency in the coding of the themes between the researcher and his supervisors. Each major theme and the respective sub-themes that emerged have been supported with relevant verbatim quotes from the participants. The participants were represented with codes to conceal their identity.

The themes and their respective sub-themes are depicted in table 4.2

Table 4.2: Summary of Themes and Sub-themes

Depression Management Competencies	1. Knowledge of depression management
	2. Mental health assessment
	3. Inadequate exposure
	4. Attitude towards depression
Mentoring and Preceptorship Experiences	1. Observing experienced practitioners
	2. Peer influence (Social comparison)
	3. Supervision
Motivational Inducements	1. Reference Group Influence
	2. Religiosity
Personal Attributes influencing depression management	1. Emotional states and depression management
	2. Communicating with Physical Appearance
	3. Relationship with Clients overtime
Hindrances to diagnosing depression	1. Lack of Protocols
	2. Heavy Work schedules

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4.3 Depression Management Competencies

Depression management competencies is a theme that describes the ability and the experience of the participants in managing depression in people living with HIV (PLWHIV). It is common knowledge that participants' experience in managing depression is indispensable in making out the complexities with which depression is expressed in PLWHIV. From the narratives, it was observed that the participants had had little experience in managing depression. For some, the only encounter they have had with depressed clients before working at the ART clinics was through clinical practicum during their professional training. The four (4) sub-themes that summarised depression competence based on the narratives were: I. knowledge on depression management, ii. Mental health assessment skills iii. Exposure and iv. Attitude towards depression.

4.3.1 Knowledge on depression management

Knowledge about depression determines whether health professionals engaging PLWHIV will be interested in detecting and managing it. This sub-theme describes what the participants' knowledge about depression management upon which their capabilities in managing depression is self-evaluated. The sub-theme also defines the features the participants look out for in clients they suspect to be depressed. Generally, the participants observe the demeanour of the clients to detect the presence of depression. Some of the participants looked out for some signs and symptoms in their clients to conclude whether the clients have depression or otherwise. A participant narrated:

> "…*in general, depression is detected from their demeanour, some of them come in very down while others are also moody"* ***(Hp001)***

Some of the participants could not differentiate between the grieving process the clients go through upon knowing their HIV status and depressive states. Once the clients' mood or face

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change after learning their HIV status, the participants concluded that the clients were experiencing depression. A participant opined:

> "*Sometimes they remain calm, quiet and sad after the test result is made known to them. You will see that there is a change in their face, the face looks quite sad, that's when you realize that they have depression" (**Hp013)***

Only two of the participants mentioned that they assess depression in their clients based on the DSM-V criteria A for determining depression. The requirements are often remembered by the acronym "SIG E CAPS", for Sleep, Interest, Guilt, Energy, Concentration, and Appetite, Psychomotor, and Suicidal ideation. One of the participants had this to say:

> *"There's a diagnostic criterion for depression that we take them through to ascertain that these patients are depressed, that is the SIG E CAPS. That's a mnemonic for it so in this you will find, some of them will be in the state of guilt, some of them will be sleeping a lot while others also have insomnia and they also lose energy in doing anything they have to do" **(Hp003)***

Another participant mentioned some symptoms found in the "SIG E CAPS" as criteria he uses to confirm the presence of depression in the clients he manages. He said:

> *"they can come with what we health professionals term anhedonia; they are not interested in what previously they used to, they have a low mood, they are tearful, they can burst into tears at any time, they have bad dreams, morbid dreams, dreams of people chasing them around, I mean several others. Some will even have suicidal tendencies; they just want to end it all*." ***(Hp002)***

All the other participants base their assessment of depression on clients' adjustment reactions without considering any specific documented criterion.

Moreover, many participants managed depression in PLWHIV through psychotherapy, where they counsel the clients on the chronicity of the disease and the clients' need to comply with antiretroviral medications. According to a participant, although he is aware of the use of anti-depressants to manage depression, there is no clear-cut format for managing depression in PLWHIV and for that matter, he only counsels depressed PLWHIV. He said:

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> *"those we found to be depressed, what we do is that we just counsel them and (laughing) then tell them to continue with their medications just like I talked about earlier, there has not been any structured way to handle depression among the patients. We just counsel them although there is a treatment for depression, there are anti-depressant medications that we could give to these patients."* ***(Hp012)***

Some of the participants have not even thought of prescribing anti-depressants to the clients they suspect to be depressed because counselling works for them. A participant narrated:

> *"I have not had the reason to start anybody on the drugs because usually, the counselling works, it does the magic."* ***(Hp016)***

Another participant either prepares the depressed PLWHIV mentally or just refer them to the psychiatric unit as he does not see the need to prescribe anti-depressants to manage depression in PLWHIV. He had this to say:

> *"Somebody can think of anti-depressants for them but anti-depressants in these people? We don't see the need, just like to boost their morale… we just refer them to a psychiatric unit for thorough counselling if the person needs severe counselling to be done for him/her. The drugs will only do a little to get the person off the depression for a while, but if the counselling is very effective and if you can get them to understand the situation, I think you can get them out of the depression without the medication."* ***(Hp005)***

All the participants expressed that counselling is the most standard treatment modality for managing depressed PLWHIV, hence commonly used. However, none of the prescribers among the participants has ever prescribed an antidepressant to manage depression in PLWHIV, although they are aware it can be used to treat depression in PLWHIV.

4.3.2 Mental Health Assessment Skills

Mental health assessment also referred to as mental status examination, encompasses a format for evaluating the behavioural, mood, thought and cognitive functioning of a client. The components of mental health assessment are: a) general appearance and behaviour b) motor activity c) speech d) mood and affect e) thought process f) thought content g) perceptual disturbances h) sensorium and cognition i) insight and j) judgement. The participants used general appearance and mood and affect as the main determinants of the mental health status of their clients.

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For some participants, only physical appearance is a reflection of a client's mental status; therefore, they used clients' facial appearance and dressing to determine their mental state. Others asked probing questions to unearth challenges the clients' are facing in their relationships that has a toll on their mental health. Adherence to appointment dates and ART medications were also used as the yardstick for evaluating the clients' mental status, albeit unofficial. The participants used mental health status and psychological status interchangeably to mean the same thing. However, assessing the mental health status of the clients by the participants were infrequent. One participant narrated:

> *"…to assess the mental status of the client, you should first look at their physical appearance. In a depressed person, physical appearance is something that can give you about 60%-70% of what is going on in the person's mind. Most of them don't even have time for themselves, the way they dress, moody faces, and sometimes we need to have time to cheer them up. Again, the majority of what you can know about the depressed person is through your communication with the person."* ***(Hp008)***

Some participants use compliance with review dates and adherence to the medication regimen to determine the clients' psychological wellbeing. When clients default, they probe to understand why they did not come as scheduled. A participant recounted:

> *"One key thing we use to detect the mental health of the clients is their attendance to the clinic. We normally write their next review dates on their appointment cards, but most of them will not honour it. Even those who come as scheduled, you will realise that they have missed certain dates when they couldn't take their medication simply because they were lost in thoughts. These are some of the ways that I tell that they are going through one form of depression or another"* ***(Hp001)***

Notwithstanding the importance of mental health assessment in PLWHIV, healthcare professionals rarely perform it. There was no clarity of what they look out for in the evaluation as required by the DSM-V criteria A instrument for assessing depression. One participant recounted:

> *"…we don't normally do it. If you don't see it based on the communication you have with them, we don't normally do it."* ***(Hp004)***

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Others do not make conscious efforts to assess the clients' depression and blame it on the massive patient turn out, but even when clients are few, participants still do not spend enough time to evaluate the mental status of the client to know if they are depressed. A participant reported:

> *"I will admit to the fact that I am not good at making a conscious effort to assess depression in my patients, and I have to attribute it to the workload. Just like I said, sometimes you come, and about 100 or 150 who have come to the place but basically, ART patients are not that plenty, but sometimes when they come, we don't have time for them"* ***(Hp012)***

The participants use the Ghana Health Service (GHS) folder for PLWHIV as the standard tool for managing their clients. This tool has a health assessment portion which focuses mainly on somatic presentation in the clients. The follow-up health assessment portion has only one (1) item for depression; it is stated as "anxiety/depression" and does not even provide any means for assessing either anxiety or depression.

The narratives from the participants of the study indicated that mental health assessment in PLWHIV is rarely carried. Those who tried to assess the mental status of their clients observed the physical appearance of their clients which involves facial expressions, dressing and general appearance in the absence of a structured format for assessing mental health status in their clients. The participants' inconsistencies in determining the mental status of their clients are associated with their inadequate exposure in managing depression and lack of tools for assessing it.

4.3.3 Exposure

Exposure describes the frequency a participant has encountered and managed clients who have suffered episodes of depression. The level of exposure can determine a participant's success in accurately detecting and managing depression in PLWHIV. Most of the participants revealed through their narration that they had had insufficient experience as

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far as managing depression in PLWHIV is concerned, and when they are being supervised on the job by HIV program coordinators, mental health issues of the clients are not discussed. A participant narrated:

> *"We've not had much training on the assessment of the psychological issues of the patients and the supervision doesn't directly help us to address the psychological issues of the clients. So we just concentrate on their physical health, monitor the progression of the disease and then educate on how clients can control the spreading of the disease. When it comes to addressing the psychological issues, we do, but there has not been any structured format for addressing the psychological issues of the patients"* ***(Hp015)***

The only exposure most participants have had was through their clinical practicum during their professional training in school. Even that, many participants professed that there were no official courses they took concerning the management of depression. One participant commented:

> *"When I was in 6th-year medical school, we went to Pantang Psychiatric Hospital in Accra. There we met patients suffering from depression, and I had the opportunity to talk to them. Again, when I was in Sunyani for my internship, we had a workshop on depression, and the psychiatric unit carried it out. I think that's all I have had"* ***(Hp004)***

Another participant admitted that there has been limited or no access to programs targeted at improving depression management in their continuous professional development workshops. He mentioned:

> *"Actually, in my area of practice, there has been limited access to modules or programs that talk specifically about depression. Most of the Continuous Professional Development programs I've attended, we've not discussed anything related to depression."* ***(Hp007)***

All the participants established that their exposure to cases of depression has been insufficient. The formal professional training of most of the participants did not include courses on depression assessment or management. For a few of them, their knowledge of depression management was developed through their psychiatric affiliation whilst in school. Upon assumption of duty at the ART clinic, they indicated that they have not had any proper

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orientation and also lacked continuous professional development programs meant to train them on depression assessment and management. For this reason, the participants have a varying attitude towards depression.

4.3.4 Attitude towards depression

This sub-theme describes the attitude of healthcare professionals towards depression and its management in PLWHIV. Some of the participants were inattentive and apathetic. Others even were of the view that it is normal or natural for PLWHIV to be depressed. Only a few were passionate. It was observed that the extent to which the healthcare professionals rendering services to PLWHIV are willing to go to assess and manage depression in their clients was positively linked with their attitude towards depression. A participant expressed candidly:

> *"I think it's your research that has drawn my attention to the fact that depression amongst HIV patients is something we need to look at and then find a way and means to help them. Look, apart from monitoring their viral load, getting their medications for them, making sure that they are not having various complications, I don't think we pay much attention to the depression among them."* **(Hp013)**

Supporting this narrative, another participant recounted that depression in PLWHIV had not been given the needed attention. He confessed that depression and its management in PLWHIV had not been brought to the limelight and much needs to be done. This is what he has to say:

> *"Depression management in HIV is one area that has not enjoyed a lot of attention because look when you are slapped with a diagnosis of HIV; it carries a lot of psychological burdens. The psychological burden alone may be more than the organic problem that HIV brings. So, I think it's time the whole medical profession looked at it and found a lasting solution. I believe something better can be done for the patients than we are doing now"* ***(Hp002)***

Some of the participants showed apathy concerning depression in PLWHIV. One participant throwing up his hands in the air said with a lot of indifference:

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> *"There is nothing much we can do. We just counsel them and let them know that it's just like hypertension or diabetes. The only thing that can help the patients is for them to be compliant with the ARV medications"* ***(Hp015)***

Another participant commented:

> *"What can we do? The main cause of their depression is with the people within their surroundings, and here is the case that we don't live with them. We can only counsel them, and that's what we do at the clinic."* ***(Hp012)***

A medical laboratory scientist believes that for a PLWHIV to experience depression is natural.

He opined:

> *"…if, for instance, a person living with HIV doesn't know his status and then come to know of the current HIV status, some of them get depressed. It's real, and it is natural for you to see some, especially those who don't know much about HIV, they get depressed."* ***(Hp006)***

Despite the lack of attention and apathy towards depression in PLWHIV as expressed above, some participants were passionate and empathetic and viewed psychological aspect of their clients as an integral part of the care they are required to render to PLWHIV. One participant narrated:

> *"…one thing I say about HIV work is that if you don't have passion for the work, then there is no need for you to come to the clinic because these patients come in emotionally disturbed, they are down, and they expect us to boost their morale and to encourage them. This clinic is different from the other clinics such that ours is not about money, but we are impacting life. This is what we've all been told, and we've all come to accept that our work here is about moving somebody who is on the path of death to the path of life, so when we are coming here then we need to be open, we should be smiling, be receptive to be able to help our patients."* ***(Hp005)***

For another participant, he has learned through experience that clients' compliance with treatment modalities depends on healthcare professionals' ability to manage their emotional problems. The clients will seek solace from places other than the clinic if their worries are not addressed. He said:

> *"So, if they come in, they are worried, they are depressed, they are down, and you don't try to address their issues, they will go, and they will never come back. So what*

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> *my experience over here has taught me is that, when the patients come in and after being diagnosed with HIV, you need to spend time to counsel the patients well."* **(*Hp010*)**

4.4 Mentoring and Preceptorship Experiences

As far as the provision of quality health care is concerned, most encounters with cases are indirect. Thus, healthcare professionals gain knowledge to address clients' problems through the experience of others. This theme, therefore, describes the role experienced practitioners play in building the capacity of healthcare professionals new to HIV care in managing depression in PLWHIV. Mentoring and preceptorship are relationships in which more experienced and more knowledgeable healthcare professionals deliberately give instruction, training, and supervision to less experienced or less knowledgeable personnel. Preceptor and mentors support, informs and motivates the behaviour of the less experienced healthcare practitioners. These roles were assumed by participants who are more experienced in the field of HIV care in a bid to bring up their less experienced counterparts to care for PLWHIV. The novice professionals learned through observing the practice of experienced colleagues. Other participants who are new to HIV care admitted that their actions displayed in dealing with depression in PLWHIV were only a replay of what they have seen their experienced colleagues do.

4.4.1 Observing experienced practitioners

Learning by observation is critical in developing oneself from less knowledgeable or experience to an expert. The participants who were new to the ART clinic were assigned to more experienced practitioners where they were trained in the assessment of PLWHIV. Sometimes, the healthcare practitioners new to the HIV clinic are made to observe and reflect on what was being done by their preceptors. Some of the participants who are a novice to the ART clinic reported observing certain practices, and that has formed the foundation of the care to be given to PLWHIV. However, their mentors and/preceptors did not instruct them

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specifically on how to assess for and manage depression in PLWHIV. The narrations below illustrate the experience of one of the participants:

> *"When I came to this clinic, I was assigned to one medical officer who has been in the clinic for about 3years. He taught me the basic laboratory investigations to order for them and also how to assess these RVI clients (Retroviral infection referring to PLWHIV). So far, all the instances I have observed, he discussed the medications, weight changes and asked if they had any issues. There has not been much training in terms of assessing depression in these patients"* ***(Hp014)***

Others narrated that there were instances that the experts they looked up to displayed both positive and negative health professional-client relationships and had to rely on their judgement to decipher the best way to treat depressed PLWHIV. One participant commented:

> *"…as someone said, we learn from others and then based on our attitude, ok last week, for example, there was this senior colleague who was attending to a patient, and I thought the way he spoke to the patient wasn't good by then at another point in time another senior colleague attended to a patient nicely. So you have to judge for yourself and then pick out the best from your senior colleague."* ***(Hp013)***

Notwithstanding, some participants learned appropriate communication skills from clients who have lived with HIV for several years and are serving as models of hope. The models of hope are PLWHIV who have been on antiretroviral medications for some years and are doing well. These individuals voluntarily come to the ART clinics where they are assigned to counsel, support and encourage other PLWHIV to comply with treatment. His account is as follows:

> *"We have a model of hope, who is a known HIV patient who has been on medication for about 20yrs. If he comes around and speaks to the patients, how he assures them and encourages them is exceptional. I have learned a lot from him such that anytime, I also meet the patients. I can address their concerns and their worries, so it has helped a lot."* ***(Hp008)***

4.4.2 Peer Influence/Social comparison

Individuals with similar characteristics can help change the behaviour, attitudes, and values of their peers. Healthcare professionals who are inexperienced in HIV care can learn to be competent by socially comparing their performances with those of others (models,

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peers). People who are similar offer the most beneficial basis for comparison. Learners who observe similar peers perform a task are naturally disposed towards believing that they are also capable of doing the same.

Peer influence directly impacted the participants' behaviour towards the management of depression and other psychological issues in PLWHIV. At the ART clinic, most of the prescribers among the participants share the same consulting room and in fact, most times share the same desk. For some of the participants, the practice of their experienced colleagues in terms of dealing with depression in PLWHIV was considered as dogma without finding out reasons to do otherwise. Even though the use of anti-depressants to treat depression in PLWHIV is a viable option, none of the participants new to the ART chose it because they have not seen any of their experienced colleagues do the same. A participant puts it this way:

> *"I think basically, I don't have any reason but I haven't seen my senior colleagues doing it, prescribing anti-depressants because one of the things is that the condition is going to be there for life, so how long will you be giving the anti-depressants? Are you going to put them on anti-depressants for life? I have not seen it being giving and I have not had time to ask why it's not being given"* ***(Hp005)***

For some participants, their success in dealing with psychological issues in PLWHIV is brewed from 'listening in' on the experiences of colleagues who have been in HIV care for an extended period. A participant recounted:

> *"…I had the opportunity of calling a colleague who's been in it for years to discuss some issues about one client, so I think the experience with people around has helped so much. I also get the opportunity to talk to colleagues at the regional level also to find out what they've been doing to help clients that go through this, so working with the experienced people have been of immense benefit to us because we are just one year and people have been ahead of us"* ***(Hp007)***

One participant believes that some professionals might have experienced all complex situations at some point in time and as such drawing on the experiences of experienced colleagues is the ideal. He stated:

> *"…Because there are things I haven't come across, I haven't experienced, and so when I am confronted with such matters, I usually look to those who are more*

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> *experienced to help me. Because my primary aim is to make sure that all the clients that I come across are well and go home."* ***(Hp006)***

The above narrations depict how some participants covertly learned to build their capacity in providing care to PLWHIV. Other participants were openly supervised to take up the role of caring for PLWHIV.

4.4.3 Supervision

Supervision is a "combination or integration of processes, procedures, and conditions that are consciously designed to advance the work effectiveness of individuals and groups" (Onasanya, 2011, p. 3). It is the interaction between at least two people for the progress of an activity. Supervision of HIV care practices by mentors and preceptors should be able to develop new practitioners' knowledge in all aspects of the care continuum, i.e. physical and psychosocial. For some of the participants, their experienced colleagues played supervisory roles in helping them to build their capability in managing PLWHIV. Nonetheless, these supervisory roles were only geared towards the identification and management of somatic symptoms and complications of their clients with very little or no discussion on the management of the psychological and/or emotional challenges of the clients. A participant reported:

> *"…so, the supervision from our senior colleagues has helped us in detecting the complications and then addressing them as such, and it has helped us in giving them the right medications and educating them about the various side effects of the medications and how they can live with it"* ***(Hp012)***

Another participant mentioned that in addition to having oversight over the medications being prescribed for the PLWHIV, they also monitor the mandatory laboratory investigations, the healthcare professionals are required to order for the PLWHIV. He said:

> *"as for me, for all the time that I have been here, my boss mostly comes around to check on the medications we prescribe for them as well as the laboratory investigations we are supposed to request before the HIV people start their*

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medication. There has not been much discussion on the assessing mental state of the clients." ***(Hp013)***

4.5 Motivational Inducements

Motivation is the incentive that arouses an individual to act towards a desired goal. Usually, it is the reason for an action or that which gives purpose and direction to behaviour. Personnel may possess knowledge on the assessment of mood disorders but needs the energy to decide and sustain the will to carry out such assessment on clients regularly. A healthcare professionals' desire to initiate an assessment of depression, the choice to expend some effort and even the level of effort the individual will use to assess for depression in PLWHIV has internal and environmental drivers.

Their religiosity incites the quality of care that healthcare professionals are ready to render to PLWHIV and the influence impacted by the people they look up to.

4.5.1 Reference group influence

A reference group is a group to which another group or individual is compared. The healthcare providers who are new to the ART clinic looked up to their more experienced colleagues for guidance and even copied their way of caring for PLWHIV. The more experienced practitioners are expected to serve as role models for the new ones in terms of assessing the physical and mental status of the clients. The influence exerted by the participants' point of reference was immeasurably significant. For some, it was the only motivation for going the extra mile to assess the mental health status of their clients aside their routine. Generally, the experienced colleagues exerted a positive impact on the less experienced ones when it comes to practitioner-client relationship. One participant asserted:

"…one of my senior colleagues used to have time with patients, and at times beyond the clinical issues, he wants to look further. The way this man will interact with the patients or the way he will even talk to the patients will let the patient reveal other things. So I've also learned that we should have a good interpersonal relationship with the patients." ***(Hp005)***

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Another participant also narrated:

> *"I think my senior colleagues, one of them believes strongly that no matter the workload when the patient is in front of you, get the person relieved. Get the person to be calm and clear every misconception, let the patient ask their questions, just have time for them. Have a good relationship with the person, let the person know you are more interested in other aspects of his/her life apart from just giving the person his drugs."* ***(Hp013)***

One participant acknowledged that he is encouraged to adopt different approaches to discover subtle ways in which psychological problems are presented in PLWHIV by listening to the stories colleagues tell about their encounters. He opined:

> *"....also, when we when we speak to other colleagues, the experiences they get from other clients, they tell us, and it also encourages us that we have to be looking out for more because there has been one suicidal case that was told and we missed it, so I think being down to earth with the clients is critical."* ***(Hp007)***

However, the more experienced practitioners could not help the less experienced ones to build on their competency in caring for depressed PLWHIV since they could not assess and manage depression themselves.

4.5.2 Religiosity

The belief systems and the roles the healthcare professionals play in their religious denominations are closely associated with how they sympathised with traumatized clients. A medical officer illustrated:

> *"so, I think for me, apart from the fact that I am a medical officer here, I also play a role in the church as a church leader. That informs mine looking into their psychological state in addition to taking care of their health and all other aspects of their life. I get more interested in how they are faring because I know as a Christian (you know) living with such a condition will not be easy."* ***(Hp003)***

A social worker believes that PLWHIV is also children of God and deserves to be treated with sympathy. That has been his source of motivation to help depressed clients when possible. He recounted:

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> *"…if it were to be me, how would I have dealt with it? How would I have expected others to treat me? These people are also children of God and should be regarded as such. So when this thing is in our mind, it motivates us to help them if we can, as much as possible to get them off their depressed states"* ***(Hp009)***

From the perspective of a medical laboratory scientist, everyone is vulnerable to contracting HIV, and that makes him sympathize with PLWHIV. He narrated:

> *"My motivation comes from the fact that it can happen to even any of my relatives or me. So I would have to do my best for the patient. I would have to see this patient as if I am seeing my father, my mother or sister. I have to give out my best, that's my motivation."****(Hp006)***

Irrespective of the source of motivation or reward systems, personal attributes are a bedrock on which one's capabilities are laid.

4.6 Personal Attributes Influencing Depression Management

This theme describes the factors about the personality of the participants as well their working conditions that affect their competency in managing depression in their clients. The participants' emotional status, physical appearance, relationship with clients over time in dealing with depressed PLWHIV and their working conditions were found to impact significantly on their competence.

4.6.1 Emotional Status and Depression Management

The emotional status of the participants was found to be closely linked with the kind of relationship they exhibited towards their clients. Most of the participants expressed that their communication with the PLWHIV are more patient/client-oriented, exhaustive and empathetic whenever they are joyful and are in a good mood. However, they tend to gloss over a lot of details when they are going through some form of emotional difficulties. One participant commented:

> *"I think my emotional state affects my interaction with the patients. There are times you are very joyful, such that when you come to the clinic, and you meet them, you have a lot of time to talk to them. There are times too when you will be dealing with some personal stuff, so you don't have time to help them. There have been instances*

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> *that because emotionally I was not well, I just didn't pay attention to theirs at all"* ***(Hp005)***

A medical officer also verified that a health professional-client relationship is strongly influenced by the emotional state of the health professional. He gave his account:

> *"...At times too, you are also traumatized emotionally based on the stress you go through, and all these affect your relationship with the patient."* ***(Hp004)***

Despite the noticeable effect of the emotional status of the healthcare provider on his/her relationship with clients, physical appearance does the same or even worst.

4.6.2 Communicating with Physical Appearance

Participants suggested that to gain the confidence of the clients and properly assess depression, the appearance of the healthcare provider matters. The dressing, posture, tone of voice and even the choice of words used by the healthcare professionals were noted to be critical in determining the depth of information clients' will be eager to disclose. One participant said:

> *"...your ability to communicate, your dressing, your posture, your language, and your tone help you to get deeper into the clients to be able to know what he/she is going through so I think that is very important."* ***(Hp011)***

Other participant recounted that:

> *"Our physical appearance plays a lot of role in the management of patients, and to me, it does about 90% in trying to build trust with the clients. Some of the patients just consider your physical appearance before they confide in you"* ***(Hp009)***

Another participant asserted that the physical appearance of the healthcare provider could even influence the help-seeking behaviour of the clients. He remarked:

> *"...even your dressing alone, though you may be young, your dressing alone will give them some kind of confidence that they have met somebody who can help them. You can't just dress anyhow and look like a 'Rastafarian' with some kind of hair-cut, it will even add more depression to the person."* ***(Hp010)***

All participants concurred that physical appearance is vital to building confidence in the healthcare provider.

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4.6.3 Relationship with Clients overtime

All the participants were of the view that one's encounter with clients over a while counts much in terms of being able to understand the complexities surrounding the psychological trauma the clients suffer and the expression thereof. Healthcare providers who have spent more time at the ART clinic managing PLWHIV can detect subtle changes in the mental status of their clients and even understand them better over time. A medical officer specialised in internal medicine narrated:

> *"The thing about this HIV people is that they tend to have confidence in you the more you interact with them, and I'll say I've gotten better with how to handle them because over time you tend to know how they go about their things. With time, you tend to understand their language, you understand their plight, and you understand their emotional needs. Some way somehow you can meet them at the point of their needs, so over the years I have gained some experience and can manage their problems.* ***(Hp002)***

Some participants have learned to listen more and talk less if they want to have any meaningful conversations with their clients. Another participant emphasized:

> *"Over the years, I've come to realise that I need to listen more to detect problems or issues that our patients have. So over the years, anytime I do the counselling, I am open to listening to them such that if they raise any issue, I will be able to pick them up rather than bombarding them with information."* ***(Hp008)***

Other participants recounted that their experience at the ART clinic had changed the face of their profession. For one, he has become patient-centred and willing to go the extra mile to uncover clients' emotional challenges. He said:

> *"You know, with my area of practice we just dispense the medications and then the patient goes away! But with ART, when you do the adherence counselling, it allows you to go beyond what you just do, to have a one-on-one with the client and they open up with you. So I think that this one year experience has changed the face of my practice. It's allowed me to be more patient-oriented to find out what they go through and it has offered me the opportunity to also look at it in another perspective"* ***(Hp007)***

Besides these constraints, other factors derail the capability of healthcare professionals to detect and manage depression in PLWHIV.

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4.7 Hindrances to Assessing and Managing Depression

A lack of structured format or protocols for dealing with depression and the inadequate staffing of the ART clinic thwart their ability to detect and manage depression in PLWHIV.

4.7.1 Lack of Protocols

The Ghana Health Service HIV Clinical care folder for PLWHIV contains some assessment questions. Anxiety/depression is one assessment point the healthcare provider is required to tick yes or no. However, no specific instruction has been added to aid the healthcare provider in assessing these parameters. Participants, therefore, use their judgement to determine whether clients are depressed/anxious or otherwise based on what they observe. A participant said:

> *"…currently I don't know of any protocol that can be used to assess depression, perhaps, there are some in the system. For now, we only use our judgement. Perhaps, if I should have used a protocol, I would have been able to detect more cases. Without the protocol, some things might have been overlooked."* ***(Hp006)***

A different participant looking frustrated also narrated:

> *"…the time that I've been here has taught me how to identify those that are depressed and in our small way, we try to address their concerns. But just like I said, we don't have a protocol for helping depressed HIV patients, and we are going to look at it from this time onwards"* ***(Hp003)***

Another participant stated:

> *"I have not seen an algorithm or a guideline in assessing depression in PLWHIV, and I've not sighted it yet."* ***(Hp007)***

Insufficient staff strength and the high number of clients to be seen within a short period also impeded healthcare providers' success in managing depression appropriately.

4.7.2 Heavy Work schedules

High health professional-patient ratio, massive patient turnout and tight working schedules are constraints that deprive clients of the quality time with the healthcare provider.

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Healthcare professionals disclosed that their willingness to delve deep to uncover the psychological underpinnings of clients' complaints depends on their schedule and the number of patients they have to render services. The time of the day and whether the healthcare provider is tired or not, eaten or otherwise determines the quality of the client-healthcare provider relationship. A participant narrated:

> *"Yea I was even telling the patient, when the patients are many, me I won't even look at your face but when the patients are few I can have time to talk with you…I was exhausted and so, such a doctor, I don't think I can communicate with you. But then the doctor is exhausted and seeing a patient who is very depressed. I think according to Newton's third law of motion, he states that for every action, there's an equal and opposite reaction. So you could find the answer for yourself"* ***(Hp004)***

Another participant commented that quality time with the health professional is something some clients may never enjoy due to staff shortage. For that matter, the HIV care rendered at the ART clinic has been reduced to the monitoring of vital signs and re-writing of medications with a lot of details being glossed over. He remarked:

> *"If you just study yourself, when you start a clinic the way you interact with your patients and the quality of time you spent with them decreases as the clinic runs. Because at a point, you are tired, and at another point, you are either hungry, or you feel the work is too much. We are all humans; we are only on one side of the equation. So quality time is something that, I am afraid, some patients will never get because there's a whole crowd outside and you need to clear everybody" (Hp002) quickly*

He reiterated:

> *"…the bottom line is that we need more health professionals because that's about the only way I can think of having quality time. So that if am supposed to take care of ten (10) patients why not but if am supposed to take care of 100 patients, it won't take the same time. The reason being that one; am in a hurry, two; the patients are also in a hurry so we would end up glossing over a lot of details and quickly re-writing their drugs for them and then see the next patient just to finish up quickly. But I think time is the problem. I think we should have enough time for them, considering their peculiar situation you realize most of them are psychologically unstable."* ***(Hp002)***

Sometimes, counselling is being done partially because the healthcare provider has to return to work after closing. The clients are being re-scheduled in such instances. A participant mentioned:

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> "*Everyone has a limit. I quite remember there was a time I had closed, and there was a client to be counselled and disclose his HIV status. I took it upon myself to do that even though I had closed from work. I did the counselling to some extent and then gave another appointment so that at least I can have more time to counsel, to talk, interact and then break the news. More or less, I saw my patient all the same.*" ***(Hp006)***

Most of the participants have difficulty soliciting information on the mental and emotional status of the clients. It was observed that during consultations, healthcare providers use the set of assessment points found in the Ghana Health Service HIV care folder to assess the physical wellbeing of the clients. Healthcare providers ask questions such as, "do you think a lot?" "Is there anything that bothers you?" "what is bothering your mind?" Others even ask the clients to smile or laugh for them to see. When clients comply, they conclude that the clients are neither anxious nor depressed. These questions and techniques are inadequate to unearth the magnitude of emotional trauma these patients suffer, but the healthcare providers are at their wits end for want of protocols.

4.8 Summary

This chapter describes and explains the findings obtained from the data collected. Sixteen (16) participants, twelve (12) males and four (4) females, with their ages ranging from twenty-seven (27) to seventy-five (75). The participants were made up of five (5) medical officers, five (5) physician assistants, three (3) pharmacists, one (1) medical laboratory scientist and two (2) social workers. Five (5) significant themes and fifteen (15) sub-themes emerged from the analysis of the data. The major themes were: depression management competencies, mentoring and preceptorship experiences, motivational inducements, personal attributes, and hindrances to detecting and managing depression among PLWHIV.

On depression management competencies, the healthcare professionals could not manage depression in PLWHIV. Although counselling was used as a means of managing

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depression, the kind of counselling that was observed was mostly adherence counselling and had little to do with the emotional issues of the clients. Only a few of the participants were aware of any criteria that could be used to detect depression in their clients, and even those who knew, the criteria were seldom used. The rest have either forgotten or are not aware of any such criteria for detecting depression in their clients.

Mentoring and preceptorship roles assumed by more experienced healthcare providers did not improve the depression detection and management abilities of participants who were new to the clinic. This is because the mentors themselves were not conversant with depression detection and management in PLWHIV and could not train or supervise less experienced counterparts to do the same. At best, mentoring and preceptorship built the communication skills and personnel-client relationship.

Participants' belief that PLWHIV is also children of God and the influence of their reference group motivated them to go the extra mile in assessing the psychological status of their clients.

Concerning personal attributes that influenced depression management, when healthcare personnel are in a good mood and are not tired, they communicated effectively with their clients. They tried to consider the impact of HIV on the psychosocial aspects of their clients. When the participants are tired or are in a bad mood, many details were glossed over, and the clinic was turned to ARV medication collection point.

Major hindrances that hampered depression detection and management in PLWHIV were a lack of protocols for managing depression and inadequate staffing at the ART clinics. Participants largely depended on their judgement to detect depression, and this affected depression detection and its management in PLWHIV. Most of the clinics were manned by other professionals such as pharmacists, laboratory scientists and social workers who have no

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basic training in depression management. Even participants who were medical officers and physician assistants had inadequate exposure to detection, diagnosis, and management of depression. None have had continuous professional development training/education on depression, and this affected their ability to detect, diagnose and treat depression. Nurses found at the clinic were mostly health extension workers; a lower cadre of nurses who were given six months of basic training in the monitoring of blood pressure, temperature and weight of clients. As such, they were excluded from the study.

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CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

The chapter under review discusses the significant findings of the study in the light of relevant literature to place the results of self-efficacy in managing depression among PLWHIV in context. Throughout the discussion, the major findings were compared and contrasted with existing literature. The findings have been discussed according to the five themes that emerged from the study which are: (a) Depression Management Competencies (b) Mentoring and Preceptorship Experiences (c) Motivational Inducements (d) Personal Attributes influencing depression management and (e) the Hindrances to diagnosing depression.

5.1 Healthcare Professionals' Depression Management Competencies

The healthcare practitioners at the ART clinics displayed a lack of competence in detecting and managing depression among PLWHIV. The competencies of the healthcare professionals working at the ART clinics were described based on their performance accomplishments, knowledge on depression management modalities, mental health assessment skills, exposure to depression and its management and their attitude towards detection and management of depression among PLWHIV.

It was observed that there was no documented evidence of any client in whom depression has been detected and managed. There was no record of depression or its management in the medical records of the clients. Some of the reasons that could be attributed to unrecognition of depression among the clients by the participants are that the healthcare providers may fail to notice symptoms of depression in PLWHIV and usually regard them as symptoms of other somatic illnesses the clients may present. It was also

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revealed that some participants consider depressive symptoms as unavoidable and 'normal' in clients diagnosed with terminal and stigmatizing illness and as such healthcare providers see no need to offer any special attention and treatment for those symptoms. This is in agreement with studies conducted in Nigeria and Ethiopia that found a zero per cent recognition rate and 98% un-detection rate respectively for depression among PLWHIV (Fekadu et al., 2017; Ibrahim et al., 2014; Olisah et al., 2011).

The participants exhibited some knowledge on the therapies required for depressed PLWHIV. They mentioned counselling as the primary treatment modality they prescribed for clients they suspected to be depressed. However, the participants had limited knowledge of the types of psychotherapy that could be used to help depressed clients. It was also observed that the kind of counselling mostly done was pre-and post-test counselling and anti-retroviral medication adherence counselling. Petersen et al. (2014) report that using group-based counselling in PLWHIV is potentially useful in managing depression in such clients. Other evidence also supports the feasibility, efficacy, and acceptability of group psychotherapy as a treatment modality for depressed PLWHIV in Africa (Himelhoch, Medoff, & Oyeniyi, 2007; Lofgren, Nakasujja, & Boulware, 2018). This suggests that if counselling had been standardized, it could have been used as a useful tool for managing depression because HIV care providers in this study were found to be conversant with counselling than other methods for managing depression.

None of the healthcare providers had reportedly prescribed or suggested the use of anti-depressants for any of the suspected depressed PLWHIV. Although the participants are aware that anti-depressants could be used to treat depression, none had prescribed it hitherto or even suggested to the prescribers among the participants to choose that option. This finding is in contrast to results obtained by Bess et al. (2013). They found that almost all of the HIV care providers had a preference for medication therapy for depression in PLWHIV

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even though they did not object to the use of psychotherapy. Again, several studies have underscored the efficacy of anti-depressants in managing depression in PLWHIV and have recorded the impact of these medications on the quality of life and general wellbeing of these clients (Adams et al., 2012; Betancur et al., 2017; Himelhoch & Medoff, 2005; Wagner et al., 2014). It is, however, disturbing to learn that most healthcare personnel providing HIV care, including doctors and physician assistants, do not see the need to use anti-depressants to manage depression in PLWHIV. Even though Cook et al. (2014) reported that less than 50% of the respondents in their study received standardized depression care, such cannot be said of the current situation since there was no format for managing depression as reported by the participants. The possible explanation for this finding could be a result of inadequate knowledge and a lack of training on the management of depression in PLWHIV (Chan et al., 2016).

On assessing mental health status to detect depression, the healthcare providers demonstrated inadequate knowledge as they were unsure what to look for to confirm the presence of depression in their clients. Participants used criteria such as adherence to antiretroviral medication (ARV) and honouring appointment for reviews as the determinants of the clients' mental wellbeing. In as much as this practice is not the standard for assessing depression in PLWHIV, a study in Zimbabwe found that low mood is positively linked with poor adherence to ARV medications (Kidia et al., 2015). In contrast, anti-depressants and other mental health therapies improve compliance as reported in a multi-site cohort study in the United States (Cook et al., 2006) as such this finding lend some credit to existing knowledge.

The study also found that the healthcare personnel providing HIV care have had inadequate exposure to detecting and managing depression as a whole. It was revealed that almost all of them did not have any formal training in how to detect and manage depression

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during their basic professional training. They also revealed that there had been limited continuous professional development education programs or courses that dealt with depression. This is similar to the findings of a study by Olisah et al. (2011) where HIV care providers had not-enough exposure in the field of psychiatry to enable them to face problems relating to mental health disorders.

It was also identified that HIV care providers believe that depression is an important comorbidity in HIV. Still, their attitude towards depression and its management in PLWHIV ranged from inattentive to apathy. Most of the care providers had been glossing over the depressive symptoms the clients present and had taken no thought of its magnitude on the general wellbeing of the clients. Although all the participants agreed that depression is a significant co-morbidity that can and should be managed in PLWHIV, their belief was not commensurate with their output towards the detection and management of depression. It was the study that prompted HIV care providers to begin the assessment and management of depressive symptoms in their prospective clients. This finding agrees in part with Adewuya et al. (2017), who found that primary healthcare providers had a poor attitude towards depression. On the other hand, the finding is partially in tandem with studies conducted in India and Nigeria that suggested that HIV health professionals believe that depression is essential in PLWHIV despite lack of knowledge to detect and manage same in their clients (Chan et al., 2016; Olisah et al., 2011).

The possible explanation for these findings and lack of competence in detecting and managing depression in PLWHIV by the HIV care providers include inadequate exposure to psychiatric practice. Healthcare professionals have concise clinical practicum experience in psychiatry during their training and limited continuous professional development courses that deal with mental health issues. Secondly, the practice of psychiatry relating to primary healthcare is very elementary in Ghana; there are only four (4) poorly functioning psychiatric

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institutions in the country with many mental health issues being managed in prayer camps (Edwards, 2014; Sipsma et al., 2013). To add, the practice of consultation-liaison-psychiatry is poorly developed in Ghana and Africa as a whole, making it almost impossible to transmit knowledge and skills to other non-psychiatric professionals (Chen et al., 2016). Therefore, integrating mental health into primary health care can improve the detection and management of psychiatric disorders in PLWHIV.

5.2 Influence of Mentoring and Preceptorship on Improving Management of Depression

From the narrations, the ability to detect and manage depression among PLWHIV between the less experienced (those with 1year or less ART experience) and the professional healthcare providers (those with 2years or more ART experience) were similar. Conversely, Bess et al. (2013) found that HIV care providers with less number of years of experience; (less than 5years) complied with best-practice principles. They also had better scores for best-practice in treating depression in PLWHIV than caregivers who have spent more than or equal to 5years. Similarly, Chen et al. (2016) found that consultants with many years of working experience are less likely to detect psychiatric co-morbidities in their clients compared with younger ones.

Clinical mentors and/or preceptors are healthcare professionals who have knowledge, skills, and experience in patient care who offer to train, supervise and motivate less experienced healthcare providers. The relationship helps to build the expertise of the healthcare personnel new to an area of practice (Milne & Dunkerley, 2010). The number of years spent in providing healthcare is undoubtedly associated with the level of experience of the care provider. It was observed from the study that the participants' who have spent one (1) year or less at the clinic were mentored by the care providers who have been at the clinic for many years (those with 2years or more) of work experience. But the

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mentorship/preceptorship relationship did not help to improve the ability of the care providers new to ART clinic to detect and manage depression.

The possible explanation for this finding is that, in the current study, the less experienced caregivers did not have adequate formal training in psychiatry as revealed and depended mostly on the providers they came to meet at the clinic. As such, their management of depression in PLWHIV was a replay of what they have observed in their experienced counterparts. Supervision carried out by the older practitioners as well as observational learning that the new care providers performed did not yield any influence on the ability of the latter in detecting and managing depression in PLWHIV. However, it may have helped in other aspects of care.

Again, it was deduced from the narratives of the participants that social comparison (new practitioners comparing their care strategies to older caregivers) negatively affected the ability of the less experienced healthcare providers to manage depression in PLWHIV. It was observed that the care providers new to the ART clinic were unwilling to try anything new that they have not seen their mentors or supervisors do and did not also find out the reason to do something different. The experienced healthcare providers that the new ones compared themselves with were found to be lacking in knowledge and skills in detecting and managing depression in PLWHIV. As such, their relationship with the new ones could not build the efficacy of the latter.

This confirms the idea that individuals learn and assimilate the behaviour of groups that they identify themselves. When people see their peers perform a task, they are motivated to believe that they too can do the same (Cherry, 2018; Langner et al., 2013; Schunk, 2003; Schunk & Pajares, 2002). Hence, the mentorship and/or preceptorship roles assumed by the

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HIV care providers with more number of years of work experience did not contribute to building the capability of the mentees in terms of depression detection and its management.

5.3 Motivational Inducements

It was recognised that most of the healthcare providers new to the ART clinic were motivated by their mentors and other experienced colleagues at the clinic. These mentors and experienced colleagues are being referred to as the reference group. Motivation is "an unobservable force that directs, energizes, and sustains behaviour"(Van Iddekinge, Aguinis, Mackey, & DeOrtentiis, 2018, p. 250). Several studies have emphasized that the interaction between motivation and ability of an individual influences performance positively (Gerhart & Fang, 2015; Logan, Lundberg, Roth, & Walsh, 2017; Van Iddekinge et al., 2018).

Motivation is a crucial issue in academic performance, an essential ingredient in healthcare systems and can even decide the health and the wellbeing of an individual. Both extrinsic and intrinsic motivation have been hypothesized to impact the quality and quantity of performance (Cerasoli, Nicklin, & Ford, 2014; Gerhart & Fang, 2015) significantly. Although the motivation from the reference group did not develop the efficacy of the care providers new to ART in detecting and managing depression in their clients, it did help in building the communication and the HIV care provider-client relationship of the less experienced colleagues. The participants reported that they have learned to spend some time to discuss 'extra-clinical' issues concerning the client, such as socio-economic issues affecting the clients, albeit infrequent.

Again, the findings suggested that most of the care providers derive their motivation from their religious affiliation. Most of the healthcare providers cited their role in their religious denomination as a force that drives them to look into the psychological aspects of their clients. Even though those who expressed passion about the psychological issues of the

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client were few, they believed that PLWHIV are humans like themselves and such need to be given the highest standard of care. These participants reported that they usually spend much time with the clients to encourage them. This finding agrees in many ways with the assertion that both intrinsic and extrinsic motivation plays a fundamental role in performance (Cerasoli et al., 2014; Gerhart & Fang, 2015; Van Iddekinge et al., 2018; Zhu, Gardner, & Chen, 2018).

5.4 Personal Attributes Influencing depression management

The study found that emotional and physiological states of the caregiver influenced their relationship with the clients. The participants rushed through the care process and glossed over a lot of emotional and psychosocial details of the clients when they were tired and hungry. The findings also indicated that most of the HIV care providers tend to spend some time with the clients during the early hours of the clinic when the personnel are still fresh and energetic. During the late hours when fatigue sets in, the care providers usually become interested in 'clearing' the crowd from the out-patient unit so that they can also go home to rest. These findings show similarity to a study by De Vries et al. (2014) who found that the biggest challenge that impedes health workers' ability to detect depression in chronically ill patients is the high levels of fatigue and burnout.

The HIV care providers are humans with like passion and as such, have their characteristics that affect the outcome of their performance. A wealth of research has established that emotional and physiological states of an individual directly affect their performance (Bandura, 1977, 1982; Schunk, 2003).

It was also observed that the quality of the care provider-client relationship was subject to the emotional state of the care provider. It was identified that when care providers are happy or are in a good mood, they related well with the clients and even spent much time to investigate the clients' socioeconomic relationships and its impact on their wellbeing after

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being diagnosed with HIV. But this healthy intercourse is curtailed when the provider is emotionally unwell. Similarly, several studies have confirmed that the emotional state of the care provider and the care provider's ability to manage his/her emotions and that of their clients is positively associated with clinical performance (Al-Hamdan et al., 2016; Andonian, 2013; Codier, Kamikawa, Kooker, & Shoultz, 2009). The findings obtained from the current could be as a result of the participants' inability to manage their own emotions. Hence their capacity to engage in conversations that could unearth the psychological underpinnings of their clients' complains were lessened.

The study also found that the physical appearance of the healthcare provider, which includes dressing, posture, tone of voice, choice of words and other non-verbal cues influenced the help-seeking behaviour of the clients immensely. It was recognised that the depth of information PLWHIV were willing to disclose dependent on the health personnel's mannerisms and the quality of the communication as well as the appearance of the care provider. It was also observed that clients understood care providers who displayed appropriate non-verbal gestures such as head nods and eye contact as a display of unspoken concerns and emotional support for them. This confirms several studies that emphasize that non-verbal communication is an essential aspect of healthcare provider-client relationship and is positively linked with patients' satisfaction (Naina & Harris, 2010; Silverman & Kinnersley, 2010; Tanco et al., 2015).

Virtually, the posture of the healthcare provider was found to play a crucial role in caregiver-client interaction. The position the caregiver assumes on the chair even when sitting were interpreted as expressions of concern and emotional support for the client. Interestingly, this finding agrees with similar findings obtained by (Gupta, Harris, & Naina, 2015; Swayden et al., 2012) that patients prefer healthcare providers to sit when interacting

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with them and this helps to build their relationship with the care provider and improves client satisfaction.

From the accounts of the HIV care providers, as they engage the clients over time, they can understand the language, the plight and the emotional needs of the clients much better. The confidence of the clients in the health personnel develops with time. The finding suggests that healthcare providers took a long time to recognize psychosocial issues in their clients. This confirms a study in Latvia that found that physicians are unable to detect depression in their clients who present with somatic symptoms unless several consultations have passed without the symptoms resolving. The physicians required longer encounters with the clients to notice depressive symptoms (Leff, Vrublevska, Luse, & Rancans, 2017).

In this study, clients were assigned to see any available care provider. This made it difficult for a client to be seen by the same care provider for several consultations. Since different care providers see the clients at other times, they manage the clients' symptoms afresh having no idea how long those symptoms have persisted. Hence, the participants find it difficult to associate any psychological underpinning to the clients' complaints.

5.5 Hindrances to diagnosing depression

Several tools abound that enables the health worker to assess, detect and manage depression in their clients. As can be noted, the current study found that more than three-quarters of the healthcare providers do not know any tool that can be used to assess and detect depression. Only two (2) medical officers could mention some criteria for diagnosing depression. They said 'SIG E CAPS', a mnemonic representing Sleep, Interest, Guilt, Energy, Concentration, and Appetite, Psychomotor, and Suicidal ideation as a criterion for depression (American Psychiatric Association Division of Research, 2013; Najera, 2015; Regier, Kuhl, & Kupfer 2013). Some studies have confirmed the validity and specificity of the nine (9) item

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patient health questionnaire (PHQ-9) as a tool for screening for depression in sub-Saharan African countries; Nigeria, Cameroon including South Africa (Adewuya, Ola, & Afolabi, 2006; Cholera et al., 2014; Pence et al., 2012).

Centre for Epidemiologic Studies Depression Scale-Revised (CES-DR) and Schedule for Clinical Assessment in Neuropsychiatry has also been used in Nigeria (Olisah et al., 2011). Also, Composite International Diagnostic Interview (CIDI) has been widely used in the United States (Steven et al., 2003). In a systematic literature review and meta-analysis, Cepoiu et al. (2008) found that World Health Organization International Classification of Diseases, 10th edition of symptom checklist for depression (WHO, ICD-10), diagnostic interview for depression (DSM-III-R) and several other scales have been used to assess depression. Most of the studies in the review interviewed the primary care providers to ascertain if their patients were depressed using the tools. In all these studies, the authors found that there were several cases of depression which had not been detected by the care providers buttressing the fact that several healthcare providers are ignorant of scales or tools for assessing depression. This confirms the findings of the current study.

Also, it was observed that the healthcare workers at the ART clinic were using the Ghana Health Service (GHS) folder for managing their clients (Appendix F). The folder has several questionnaires. The questionnaires mainly focused on somatic symptoms associated with HIV, opportunistic infections and transmission risk factor assessment. The portion that deals with mental status has items such as slow mentation, memory loss, mood swings, depression, anxiety, suicidal ideation and seizures as an initial assessment for the beginners of ARV's. In the follow-up visits, the care provider is required to tick 'yes' or 'no' for an item listed 'depression/anxiety'. However, the folder does not provide any criteria by which the health care provider can assess the presence of depression or anxiety in their clients. Coupled with a lack of knowledge on tools for screening depression and lack of training, the

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healthcare providers were found to be significantly disadvantaged in assessing and managing depression in their clients. This is consistent with the findings of a study conducted by Mulango et al. (2018) in the Fako Division in Cameroon who found that lack of knowledge on standard tools for diagnosing depression and inadequate formal training in mental health accounts for un-detection and un-treatment of depression.

Lastly, the study found that the heavy work schedules of the healthcare providers impeded good communication and detailed assessment of their client, and this confirms a similar finding by Adewuya et al. (2017).

In summary, healthcare providers lacked knowledge and competence in assessing and managing depression. The health personnel admitted that they had had inadequate exposure in terms of assessing and managing depression during their basic professional training and continuous professional education. Mentors and preceptors could not help improve the ability of new healthcare providers to detect and/or manage depression. The personnel were motivated by their religiosity to delve into the psychosocial issues of their clients. The emotional and physiological states of the care providers greatly influenced their ability to assess depressive symptoms in their clients. Lastly, lack of protocols and/or structured format for assessing and managing depression in PLWHIV negatively affected the ability of the participants to detect and manage depression.

5.6 Application of Model to the Study

The self-efficacy model has been used to study, understand and modify human behaviour in various dimensions of life. According to Bandura (1986), self-efficacy varied across situations and suggested that the constructs of his model could be tailored to the field of interest. The strength of self-efficacy to predict behaviour is well documented in the literature. Self-efficacy is very influential in motivating learning, performance, goal

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achievement and self-regulation in academia (Al-Baddareen, Ghaith, & Akour, 2015; Ersanl, 2015; Pajares, 2016). In the field of health informatics, self-efficacy has been demonstrated to influence the acceptance and use of healthcare technology by healthcare providers (Anderson & Agarwal, 2011; Rahman, Ko, Warren, & Carpenter, 2016; Sun, Wang, & Guo, 2013). In Canada, nurses' adoption, actual use and satisfaction with electronic patient records were found to be a function of their self-efficacy on information systems (Maillet, Mathieu, & Sicotte, 2015).

The field of health psychology has long realized the impact of self-efficacy on people's choices to engage in behaviours that have a consequence on their health. Adhering to treatment prescriptions for individuals with chronic diseases (Martos-Méndez, 2015) and achieving and maintaining positive treatment outcomes in obese clients (Latner et al., 2013) have all been shown to be influenced by their self-efficacy scores. Self-efficacy predicts and/or mediates the outcome of treatment. Studies have revealed that self-efficacy of individuals is closely linked with substance use and/or abuse, and it also influences their choice to adopt treatment-related behaviours (Kadden & Litt, 2011). More recently, the intention of a pregnant woman to access and use antenatal care has been revealed to be strongly associated with their self-efficacy levels (Mardiana, Sipasulta, & Albertina, 2017).

In allied clinical health studies, self-efficacy has been proven to impact the general wellbeing, response to stress and quality of life of adults who stutter. It has been demonstrated that the level of a client's self-efficacy determines his indulgence in avoidance behaviours and preference for verbal communication. Research has shown that clients with higher self-efficacy tend to respond well to speech therapies and have little or no self-stigmatising attitudes. The higher the self-efficacy for verbal communication, the slower the stuttered speech and vice versa. Again, clients who demonstrated higher self-belief were found to be more fluent. (Boyle & Fearon, 2018; Carter, Breen, Yaruss, & Beilby, 2017).

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Healthcare professionals are the vehicle for delivering healthcare to the general populace and are considered indispensable to healthcare systems. However, the attitude of healthcare professionals to adopt and utilize specific techniques and treatment modalities has been shown to have a strong correlation with their self-efficacy. In Egypt, the ability of paediatric nurses to encourage and support breastfeeding was found to be associated with their self-efficacy born out of the personal experience (Farrag, Abdelsalam, Laimon, & El-Gilany, 2018). The use of self-hypnosis to control labour pains is gaining grounds in midwifery. McAllister, Coxon, Murrells, and Sandall (2017) found that the ability of healthcare professionals to endorse and assist a client who opts for this method depends on the knowledge of the personnel on the process but more essentially their confidence in their ability to support the method.

In the United Kingdom, self-efficacy has been demonstrated to be associated with the will to accept responsibility for prescription decisions, the accuracy of prescription, accuracy of the route of medication administration and duration of treatment by non-medical prescribers (Cope, Tully, & Hall, 2019). For PLWHIV, it is pervasive to have a serodiscordant couple (PLWHIV whose partner has tested negative for HIV). For such a couple, conception is a dilemma even though safe conception and timed unprotected intercourse methods abound. However, the willingness of an HIV care provider to counsel on safer conception methods without prejudice is positively linked with their self-efficacy for such approaches (Goggin et al., 2015).

Bandura's (1977) model of self-efficacy has been proven to predict behaviour in all fields of human endeavour accurately and hence was considered as a suitable framework to guide the current study. The researcher adapted the four components of the conceptual framework which suggested sources of information that shape the self-efficacy of an individual; namely performance accomplishments (experience), vicarious experience

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(modelling by others), social persuasion (coaching and evaluative feedback) and physiological and emotional states. The findings of the research were in line with the constructs of the model.

Consistent with performance accomplishment (experience), the HIV healthcare workers were found to have no or minimal prior experience in dealing with depressed clients. The participants showed through their narrations that they had inadequate exposure to managing depression during their basic professional training. According to care providers, continuous professional education has also been lacking in courses that mainly address depression. The study also found that health personnel working at the ART clinics had limited knowledge of assessment and management approaches for depression. Also, the health professionals demonstrated inattentiveness and apathy towards depression and its management in PLWHIV, and these greatly influenced their competency in managing depression in PLWHIV negatively.

In line with vicarious experience, the care providers who have spent 2years or more served as mentors and/or preceptors. The personnel who are new to the ART clinic, (those with up to 1year ART clinic experience) depended on the mentors/preceptors for instructions, training, and evaluation. The new care providers mostly observed their experienced partners and adapted their way of assessing and managing the PLWHIV as their own. It was also realized that the personnel who are new to the ART compared their assessment and management of the PLWHIV with what they have seen in the mentors/preceptors and seldom ventured to do or question anything new. The relationship helped build the communication skills of care providers new to the ART clinic. It also developed their knowledge on the antiretroviral medications (ARV's), patient's eligibility to initiating the ARV's and necessary laboratory investigations to conduct before prescribing the ARV's for a client. However, the mentorship/preceptorship experience did not improve their ability to assess and manage

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depression in PLWHIV since the experienced practitioners were also found to lack this expertise.

Of social persuasion, the health professionals were mostly motivated by the belief in their object of worship and the clinical mentors/preceptors. Some were also inspired by models of hope (PLWHIV who are doing well on ARV's and testifying to the benefits of ARV's). Their sympathy for the clients led them to investigate the extra-clinical affairs of the clients' such as socio-economic affairs and its influence on the wellbeing of the clients.

The personal attributes, such as physical appearance and emotional states of the care providers, influenced their relationship with the clients. The physical appearance of the care providers and non-verbal cues such as tone of voice, nodding of the head, eye contact and posture, essentially shaped the help-seeking behaviour of the clients as well as the client's satisfaction of the care rendered. In most instances, the quality of care clients received revolved around the emotional state of the care provider. When happy and stress-free, the personnel spent the time to investigate the impact of the client's condition on their socio-economic life. The clients felt cared for and satisfied when the caregiver goes to such an extent. However, the health personnel confirmed that, when they are emotionally unwell or tired, the clinic turns to an ARV medication refill and collection centre. The emotional states and physical appearance also negatively influence the care providers' capability to assess for and manage depression in PLWHIV.

Hindrances to diagnosing depression in PLWHIV was a finding that was not explicitly linked with the constructs of the Bandura's self-efficacy model. It was revealed that the healthcare professionals working at the ART clinics had had no training and access to any tool that can be used to assess and detect depression. Only two participants mentioned "SIG E CAPS", a DSM IV diagnostic criteria for determining depression. Hence, there was no

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medical record of patients showing the assessment or detection of depression. The heavy work schedule also cast a dark shadow on personnel-client relationship. Due to the tight schedules of the caregivers and high patient turnout, most HIV care providers rushed through the consultation process, leaving most emotional issues unattended.

In conclusion, the self-efficacy of healthcare professionals in managing depression in PLWHIV can be described as low. The participants were found to lack competency to assess, detect and manage depression in PLWHIV. The care providers had minimal knowledge, exhibited poor attitude towards assessing, detecting and managing depression in PLWHIV. This can be attributed to inadequate exposure to psychiatric conditions which could have prepared them to face mental health issues. Lack of continued professional education focused on depression management, absence of tools for assessing depression, and heavy work schedules played fundamental roles to affect the capabilities of the participants to manage depression in PLWHIV.

The constructs of Bandura's self-efficacy model, therefore, perfectly suited the study.

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CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary, implications for future research, education and practice of nursing, limitations, conclusions, and recommendations that emanated from the study.

6.1 Summary of the Study

In this study, the investigator sought to explore the self-efficacy of healthcare professionals in managing depression in persons living with HIV (PLWHIV). It was conducted to describe the performance accomplishment of HIV care providers, explain the vicarious role experience and social persuasion play in building the capacity of the personnel as well as exploring the influence of emotional and physiological states of the care providers in managing depression in PLWHIV. The study was conducted at three (3) ART clinics in Techiman Municipal.

Qualitative method of inquiry was used, and the design was interpretive descriptive. Bandura's self-efficacy model was used to guide the formulation of the study objectives. Purposive sampling technique was used, and by the 16th participant, data saturation has been achieved. Data collection began after ethical clearance was given by NMIMR-IRB, GHS-ERB and an introductory letter from the School of Nursing and Midwifery. The initial letter and the letters of clearance were used to gain access to the study site. Thorough face-to-face interviews were conducted using a semi-structured interview guide. The interviews were audiotaped, transcribed verbatim and analysed using thematic content analysis. Four (4) primary themes that centred on the main objectives and the constructs of the conceptual framework emerged. The themes were depression management competencies, mentorship

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and/or preceptorship experiences, motivational inducements and personal attributes influencing depression management. Hindrances to diagnosing depression were derived outside of the constructs of the model.

On depression management competencies, the care providers were found to lack competence to detect and manage depression in PLWHIV. They demonstrated limited knowledge of treatment modalities for depression, including the use of anti-depressants. Counselling was the only means the HIV care providers could use to help clients they perceived to be having emotional and psychological issues because of the diagnosis. The health professionals were not familiar with methods of assessing for depression. They had a poor attitude and had inadequate exposure to managing clients with mental health problems as such the services they provided was limited to the routines of the ART clinic (monitoring of vital signs, assessing for opportunistic infections, assessing the eligibility and issuance of ARV's and transmission risk factor assessment).

With regards to mentorship and/or preceptorship experiences, the participants who are new to the clinic (up to 1year ART clinic experience) were trained, supervised and evaluated by those who are more experienced (2years or more ART clinic experience). The relationship did not have any positive influence on the former's ability to detect and manage depression in PLWHIV. However, it did help in shaping their communication skills and care provider-client relationship. The healthcare professionals were also motivated by the religiosity to investigate the impact of the diagnosis on the psychological aspect of the clients' life. The emotional states of the caregivers were found to be significantly associated with the quality of care clients received. Lack of protocols and/or tools for assessing depression and heavy work schedules also negatively influenced the ability of healthcare professionals to assess, detect and manage depression in PLWHIV.

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6.2 Reflexivity and Insights Gained

Reflexivity is a process by which the researcher continuously engages in self-reflection and examines, recognises and understands how their background, geographical location, values, and predispositions can impact their research and out of that ensures rigour (Cypress, 2017).

The researcher has worked in the ART clinics for two (2) years in his seven (7) years of clinical practice as a nurse. This has moulded the reflexivity of the investigator on the self-efficacy of the healthcare professionals who render core services for PLWHIV. The investigator understood that to convey the due import of the study, personnel who are directly involved in rendering care to PLWHIV needed to be contacted. During coding and sorting of the results, the researcher was precise in identifying categories and themes and was also careful of detaching the researcher's interpretation during the processing of the data. The investigator appreciated the objectivity with which the participants conveyed their experience in dealing with depressed PLWHIV. The participants were informed that the findings of the study would be used to suggest recommendations to policymakers.

The study has enabled the investigator to understand the research process, starting from identifying a problem and developing a proposal through to the end of the entire process. Also, the employment of a conceptual framework to guide the formulation of objectives, literature search and discussion of findings has been insightful. The investigator has learned a lot in how to analyse and report qualitative data, primarily through the use of NVivo. The subject under study has also been a thought-provoking experience.

6.3 Implications of the Study

The outcome of this study has implications for policy formulation, nursing research, education, and practice.

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6.3.1 Nursing Practice

Nurses especially registered psychiatric nurses, should always be made to form part of the team of health professionals who care for PLWHIV at the ART clinics. A lower cadre of nurses (health extension workers) was found at the ART clinics and are engaged with retrieving of folders, monitoring of weight, blood pressure and temperature of clients. Preferably, psychiatric nurses should be made to man the nursing aspect of HIV care. With their in-depth knowledge of mental health problems, they can face the psychiatric comorbidities associated with HIV. The nurses at the ART clinics should be equipped with requisite knowledge on psychotherapy so that they can meaningfully assist in managing depression in PLWHIV.

6.3.2 Nursing/Medical Education

Psychiatry is included in the curriculum of all nursing and medical schools. However, depression has always been treated as the sign and/or symptom of other conditions and therefore has not received the needed attention. With depression being the leading cause of disability, nursing, as well as medical students, should be given enough exposure in terms of assessing and managing depression. There should be continuous professional development programs and short courses that can equip the HIV care providers with expertise in assessing and managing depression in PLWHIV.

6.3.3 Nursing Research

A study should be conducted to ascertain the cause of unrecognition and/or lack of skills in managing depression among HIV care providers. Establishing the prevalence of depression in PLWHIV would be a ground-breaking study that can unearth the complexities in dealing with depression in HIV. A depression scale should be adopted and validated to suit the Ghanaian environment to assist care providers in detecting depression. Intervention study

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exploring the use of psychotherapy and/or anti-depressants to manage depression is a viable option.

6.3.4 Policy Formulation

Mandatory assessment for depression in PLWHIV should be ensured to help cut down the co-existence of the condition. Ghana AIDS Commission should collaborate with the Mental Health Authority to inculcate proper mental health assessment into HIV care. HIV care should focus on dealing with emotional and psychological issues besides the issuance of ARV's.

6.4 Limitations of the Study

The findings of this study do not apply to nurses because the nurses who were found at the ART clinics were health extension workers and for that matter did not meet the inclusion criteria of the study. The study was conducted in only three (3) ART clinics in one municipality, and hence, the sample used may not be an accurate representation of HIV care providers. However, the findings of the study could be adapted to guide future studies.

6.5 Conclusion

Self-efficacy in depression management is low and mostly dependent on the experiences of the professionals and their colleagues. Therefore, adequate training on depression management is required for HIV care providers to render holistic care for PLWHIV. The integration of health professionals who have specialities in psychiatry will improve the quality of care rendered and the quality of life of PLWHIV. Routine assessment of PLWHIV for mental health illnesses will enhance appropriate care and improve treatment outcomes.

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6.6 Recommendations

- The Ministry of Health and Health Training Secretariat should design and run formal courses on depression management for all health professionals.
- The Ghana AIDS Commission should collaborate with Medical and Nursing Councils to incorporate depression management into continuous professional development programs of HIV care providers.
- The Ministry of Health should collaborate with the Mental Health Authority to develop consultation-liaison psychiatry services in Ghana to pass on knowledge and skills to other health professionals.
- The Ghana AIDS Commission, in conjunction with the Mental Health Authority and Ghana Health Service, should adopt a depression scale best suited for the Ghanaian environment and train care providers as such.
- The Ghana Health Service and the AIDS Commission should include psychiatric nurses as HIV care providers.
- The Ghana Health Service and the Ghana AIDS commission should offer regular mental health training and incentives for mentors at the ART clinics
- The Ministry of Health should increase the number and specialised professionals into the HIV care providers

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APPENDICES

APPENDIX A: **Ethical Clearance**

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com

MyRef. GHS/RDD/ERC/Admin/App 18/456
Your Ref. No.

6th December, 2018

Emmanuel Gyabaah
School of Nursing and Midwifery
College of Science
University of Ghana
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation your Study Protocol.

GHS-ERC Number	**GHS-ERC019/10/18**
Project Title	Self-Efficacy in Managing Depression among People Living with HIV
Approval Date	6th December,2018
Expiry Date	5th December 2019
GHS-ERC Decision	**Approved**

This approval *requires the following from the* Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

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APPENDIX B: **NMIMR Ethical Clearance**

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.ug.edu.gh
Telex No: 2556 UGL GH

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

7th November, 2018

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 009/18-19 **IORG 0000908**

On 7th November, 2018, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Clinicians' self-efficacy in managing depression among people with HIV: An interpretive descriptive study at Techiman**

PRINCIPAL INVESTIGATOR : **Emmanuel Gyabaah, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 6th November, 2019. You are to submit annual reports for continuing review.

Signature of Chair: .....

Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

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APPENDIX C: **Letter of Introduction**

UNIVERSITY OF GHANA
DEPARTMENT OF ADULT HEALTH
SCHOOL OF NURSING

Ref. No.: SON/A.12 October 10, 2018

The Chairman
NMIMR - IRB
P.O. Box LG 581
Univ. of Ghana
Legon.

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you Emmanuel Gyabaah, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic **"Clinicians' Self Efficacy In Managing Depression among People Living With HIV".**

I hope that the Institutional Review Board will approve the proposal to enable him collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Gladys Dzansi
Ag. Head, Dept. of Adult Health

COLLEGE OF HEALTH SCIENCES
• P. O. Box LG 43, Legon, Accra, Ghana. • **Telephone:** +233 (0) 302 513 250 / 0289 531 213
• **Email:** adulthealth.son@chs.ug.edu.gh • **Website:** www.nursing.chs.ug.edu.gh

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APPENDIX D: **Consent Form**

NMIMR-IRB CONSENT FORM TEMPLATE

Title: Clinicians' Self-Efficacy In Managing Depression in PLWHIV: An Interpretive Descriptive Study at Techiman

Principal Investigator: Emmanuel Gyabaah

Address: School of Nursing and Midwifery, University of Ghana, Legon

Contact: +233 249585135

Email: egyabfamily@gmail.com

General Information about Research

I am a second year MPhil Nursing student at the School of Nursing and Midwifery, University of Ghana, undertaking a study on Clinicians' self-efficacy in managing depression among people living with HIV (PLWHIV). This study is aimed at discovering the self-efficacy of clinicians' **(Registered Medical Officers, Physician Assistants, Registered General Nurses, Registered Midwives and Registered Community Health and Public Health Nurses, Pharmacists and Laboratory Technologists)** in managing depression in people living with HIV (PLWHIV) and is solely for academic purposes. You have been selected to voluntarily partake in the study. I would like you to provide me with an information about your knowledge and experiences concerning management of depression in PLWHIV. If you accept to participate in the study, you will be made to sign two copies of this form (I will keep one and the other will be kept by you). Thereafter, you will be required to provide a date and time convenient for you to grant an interview. The interview will be conducted in English Language and will be expected to last between 45 and 90minutes and will also be audio-taped. Before the interview starts, you will be required to consent to the proceedings. You reserve all the right to terminate your participation in the study without any consequences whatsoever.

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Possible Risks and Discomforts

You will not be exposed to any risks or discomfort. Yet, you have to offer your time for the interview to be conducted. There will be intermittent breaks as you deem appropriate for refreshment.

Possible Benefits

There is no direct monetary benefit for joining the study, however, the findings of the study will be used to inform policy regarding training clinicians on the management of depression in PLWHIV. You may cease this opportunity to add your voice in suggesting ways by which clinicians' competency in detecting, diagnosing and managing depression could be improved.

Confidentiality

In the course of the interview, no personal identifiers whatsoever will be required from you in order to render the information anonymous. You are also refrained from mentioning names or locations that can reveal the identity of a third party. The information you will provide will only be accessible to the researcher and the supervisors. The audio recordings will be stored on a password protected computer accessible only to the researcher and the supervisors. The transcribed data will also be stored in a cupboard under lock and key. The data collected will be destroyed after five (5) years.

Compensation

There will be no monetary compensation for the information you provide, however, at the end of the interview, you will be refreshed with a bottle of Malta Guinness and a pastry

Voluntary Participation and Right to Leave the Research

Your decision to partake in this study is strictly voluntary. You reserve every right to withdraw from the study at any time without any consequences. If you decide to withdraw from the study, all the data you have provided will be destroyed and nothing will be held against you.

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Contacts for Additional Information

All questions and concerns about the study can be addressed to the following persons:

Name: Emmanuel Gyabaah

Contact: +233 249585135

Name: Dr. Gladys Dzansi

Contact: +233 243 059 316 / Email: gdzansi@gmail.com

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 03029164 or email addresses: nirb@noguchi.ug.edu.gh

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VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "Clinicians' Self-Efficacy in Managing Depression in PLWHIV: An Interpretive Descriptive Study at Techiman" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Date Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ _____

Date Name Signature of Person Who Obtained Consent

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APPENDIX E: **DATA COLLECTION INSTRUMENT**

This interview guide is part of a study on the health professionals' self-efficacy in managing depression in People Living with HIV (PLWHIV). The research is to assess the competency of health professionals in dealing with depressed HIV positive persons. Information obtained from this study will be held confidential and used to improve HIV care.

PART 1: Demographic characteristics

1. Age (years): Less than 25 [ ] 26-35 [ ] 36-45 [ ] 46- 55 [ ] Above 55 [ ]
2. Gender: Male [ ] Female [ ]
3. Marital Status: Single [ ] Married [ ]
4. What is your highest qualification?
5. How long have you been practising as a health professional?

   1-3 years [ ] 4-6 years [ ] 7-10 years [ ] More than 10 years [ ]
6. How long have you been working in the ART clinic/unit?

   6months-1year [ ] 1-3 years [ ] 4-6 years[ ] 7-10 years[ ] More than 10 years [ ]

PART 2: Recognition and Management of Depression in PLWHIV

7. How often do you see depressed clients? (Probe to have an idea of the prevalence of depression in the facility)
8. How do you recognize or detect depression in your clients? (Symptom presentation, Any workshop on depression?)
9. How did you learn to recognize depression in your clients? (Probe means by which the health professional learned to detect depression, social persuasion, vicarious learning)
10. What is the impact of depression on the quality of life of your clients?

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11. How does your mood or physical appearance impact your ability to recognize depression in your clients?

12. What is the influence of work schedule on your ability to detect depression in your clients?

PART 3: SUMMARY AND CONCLUSION

13. What has been your experience in dealing with depressed HIV positive patients? (Probe to understand treatment modalities health professionals employ to deal with depression)

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APPENDIX F: **Adult HIV Follow up folder**

CLINICAL CARE

ADULT FOLLOW-UP VISIT FORM

Date: _____ Follow Up Visit Number _____

Scheduled Visit? Yes_____ No_____ If yes, did patient come on the date of appt.? Yes _____ No _____

VITAL SIGNS:

Weight (kg): _____.__	Temp (C°): _____.__	Pulse (bpm):_____	B/P: ____/____

Client on ART? Yes_____ No _____ *If No, DO NOT COMPLETE ART Sections*

Client on CTX prophylaxis? Yes__ No__ Client on Fluconazole prophylaxis? Yes__ No__ Client on TB Treatment? Yes___ No__

SKIP IF CLIENT IS ON TB TREATMENT

TB Screening: Yes____ No _____ If yes, Result: ☐TB____ ☐ Not TB ___

If TB, Treatment Initiated Yes __ No ___ Deferred ___ If 'No' or 'Deferred' state why: _____

PATIENT COMPLAINTS *(FOR ALL PATIENTS) TICK all that apply*

Symptoms		Symptoms		Symptoms	
Cough		Lipodystrophy/Lipoatrophy		Pain (Site:_____)	
Dyspnea on exertion		Nausea		Headache	
Haemoptysis		Vomitting		Dizziness	
Difficulty in swallowing		Diarrhoea		Insomnia	
Skin rash		Abdominal discomfort		Abnormal dreams	
Fever/chills		R quadrant pain		Anxiety/Depression	
Blood in urine		Myalgia/Arthralgia		Mental changes(cognitive acuity)	
Fatigue		Paresthesia		Others:_____	

PHYSICAL EXAM FINDINGS

General description of patient presentation:

System	Normal	Abnormal	System	Normal	Abnormal
General Appearance			Genitalia		
Lymphatic System			Gastrointestinal/Liver/Spleen		
Oral			Skin		
Respiratory			Neurological		
Cardiac			Mental Status		
Breasts					

Note any abnormal findings

Family Planning: Using Family Planning? Yes☐ No☐ If Yes, Method _____

Women only: Pregnant:? Yes☐ No☐ Duration of Pregnancy _____ (weeks) Exp Delivery Date____/____/____

Actual Delivery Date____/____/____

TRANSMISSION RISK FACTOR ASSESSMENT

Is Patient sexually active? Yes☐ No☐ *If Yes*, continue with questions below	
Disclosure to sexual partner? Yes☐ No☐	If no, refer to Adherence Counselor for prevention counseling
Regular condom use? Yes☐ No☐	If no, refer to Adherence Counselor for prevention counseling

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