UNIVERSISTY OF CAPE COAST

KNOWLEDGE, ATTITUDE AND PRACTICES OF HIV COUNSELLORS IN HIV COUNSELLING AND TESTING IN THE CENTRAL REGION OF GHANA

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2013

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BY

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Thesis submitted to the Department of Educational Foundations of the Faculty of Education, University of Cape Coast, in partial fulfilment of the requirements for award of Master of Philosophy Degree in Guidance and Counselling

NOVEMBER 2013

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature.....
Date.....

Name: Joseph Serebour Asante

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature.....
Date.....

Name: Prof. Frederick Ocansey

Co-supervisor's Signature.....
Date.....

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ABSTRACT

This study employed the descriptive survey to assess the knowledge, attitude and practices of HIV counsellors in HIV counselling and testing in the Central Region of Ghana. In all, 140 HIV counsellors from the Central Region were sampled through the use of the purposive sampling procedure. The convenient sampling procedure was adopted to carry out the observation sections. Questionnaires and observation guide were used to collect the necessary data for the study. Descriptive statistics such as frequencies and percentages were used to illustrate the demographic profile of the participants and the data on five of the research questions. The thematic approach was used to analyse the qualitative data. Inferential statistics namely Pearson Product Moment Correlation were used to compare relationship among variables.

It was found out that HIV counsellors in the Central Region had a good knowledge on HIV counselling and testing, counsellors have developed a positive attitude towards HIV counselling and testing, the HIV counsellors adhered to good practices in their field of work, to a large extent, most of the respondents adhered to the basic techniques in counselling among others.

It was recommended that periodic seminars and workshops must be organised for HIV counsellors, professional counsellors should be employed to solve the problem of shortage of staff. Also, test kits should always be made available at the health facilities at all times and finally, transportation and financial support should be available by the Ministry of Health, Ghana Health Service and National AIDS Control Programme to aid follow ups.

ACKNOWLEDGEMENTS

I am most thankful to my supervisors, Prof. Frederick Ocansey and Mr. J. K. Ofosuhene-Mensah for diligently and timely responding to me whenever I called on them. I also benefited from scholars whose materials I consulted in this research. I am also indebted to Dr. & Mrs. Mate Siakwa for their support and encouragement. Again, I am very thankful to Dr. D. Obiri Yeboah and Miss Ann Hayford Benjamin for their professional guidelines. Further, Mr. Atta Kwenin, Martin Owusu, Asante Afari, Elvis Adu, Dabone can never be forgotten for helping me with pieces of advice. I wished to have continued the list but for obvious space constraint. To all those who have supported me in any way in the course of my studies, I say thank you.

DEDICATION

To my lovely wife Vic and my children Kwaku, Nana Adwoa, Adom and Aseda.

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LIST OF ACRONYMNS

3Cs	-	Confidentiality, Counselling and Consent
ARRM	-	AIDS Risk Reduction Model
ANC	-	Ante-Natal Care
ART	-	Antiretroviral Therapy
BACP	-	British American Counsellors Psychotherapist
CD4	-	Cluster of Designation 4 cells
CDC	-	Centre for Disease Control and Prevention
CT	-	Counselling and Testing
ELISA/EIA	-	Enzyme-Linked Immunosorbent Assay
EUA	-	Exploration-Understanding-Action Model
FHI	-	Family Health International
GCE O/A	-	General Certificate Examination Ordinary/Advance Level
GHS	-	Ghana Health Service
HAART	-	Highly active Antiretroviral Therapy
HCSUS	-	HIV Costs and Services Utilization Study
HCT	-	HIV Counselling and Testing
HIV and AIDS	-	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HIV CT	-	Human Immunodeficiency Virus Counselling and Testing
IGF	-	Internally Generated Fund
KAPC	-	Kenya Association of Professional Counsellors
KYS	-	Know Your Status
MOH	-	Ministry Of Health
NACP	-	National AIDS/STI Control Programme

NGOs	-	Non-Governmental Organizations
OIs	-	Opportunistic Infections
OPD	-	Out Patient Department
PCP	-	Pneumocystis Jiroveci Pneumonia
PLWHIV/AIDS	-	PEOPLE Living With HIV and AIDS
PITC	-	Provider-initiated Testing and Counselling
PMTCT	-	Prevention of Mother to Child Transmission
PPAG	-	Planned Parenthood Association of Ghana
PPTCT	-	Prevention of Parent to Child Transmission
RCHN	-	Reproductive and Child Health Nurse
RCH	-	Reproductive and Child Health
RGN	-	Registered General Nurse
RGN/MW	-	Registered General Nurse/Midwife
RMW	-	Registered Midwife
SSSCE	-	Senior Secondary School Certificate Examination
STIs	-	Sexually Transmittable Infections
STIs/HIV	-	Sexually Transmittable Infections/ Human Immunodeficiency Virus
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Programme on HIV and AIDS
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

The Human Immunodeficiency Virus and Acquired Immune-Deficiency Syndrome (HIV and AIDS) epidemic is one of the greatest humanitarian and development challenges facing the global community in recent times (Abdi, Ahmed & Alemayehu, 2003; MAP Report, 2004; Osagbemi, Joseph, Adepetu, Nyong & Jegede, 2007; Adekeye, 2011). HIV and AIDS have brought unquantifiable suffering, confusion, dejection, uncertainty and hopelessness to humanity (Adekeye, 2011). As reported by the Joint United Nations Programme on HIV and AIDS [UNAIDS] (2010), sub-Saharan Africa remains the region most heavily affected by HIV and AIDS.

Nevertheless, the HIV incidence has declined by more than 25 per cent between 2001 and 2009 in 33 countries in the world. Twenty two of these countries are in sub-Saharan Africa, where majority of new HIV infections continue to occur. This decline rate represents an estimate of 1.8 million people who became infected in 2009, which is considerably lower than the estimated 2.2 million people in sub-Saharan Africa who were newly infected with HIV in 2001. The biggest epidemic in sub-Saharan Africa could be traced to Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe (UNAIDS, 2010). In all these countries, the epidemics have either stabilized or are showing signs of decline. However, in seven countries, five of them in Eastern Europe and Central Asia,

HIV incidence increased by more than 25 per cent between 2001 and 2009. These figures demonstrate that positive behaviour change can alter the course of the epidemic, while stigmatisation and discrimination, lack of access to health services and bad laws can make the epidemic worse. In both cases, the effects are often profound (UNAIDS, 2010). The decline of the epidemic reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics since 1999, the year in which it is thought that the epidemic peaked, globally (UNAIDS, 2010).

Factors contributing to the decline of HIV include strong leadership regarding the HIV issue, the involvement of people in the communities, various community organisation projects, and transparency regarding the disease. Other factors which have contributed to the successes in HIV prevention are that of a condom distribution project and network, effective treatment of sexually transmittable infections (STIs) at an early stage, and facilities for HIV counselling and testing [HCT] (UNAIDS, 2010). Counselling and testing continue to be the entry point into the whole continuum of prevention and care of HIV. It is one of the pillars to HIV national response to the HIV pandemic (Ministry of Health [MOH], 2008). HIV counselling and testing services and other HIV related support services to individuals, families and communities are measures to reduce transmission of HIV and AIDS and its impact.

Jerene, Endale, and Lindtjorn (2007), in looking at acceptability of HIV counselling and testing among tuberculosis patients in South Ethiopia, reported that in most Sub-Saharan African countries, many people still do not know their HIV status. The results of the study also indicated that treatment programmes have reported high early mortality in patients receiving

antiretroviral therapy because of late reporting to health facilities for the treatment. Therefore, early detection of HIV infection is not only useful in preventing further infection but also part of the strategy to improve treatment outcomes; HIV counselling and testing provides this avenue for both positive and negative clients.

Rachier, et al. (2004) reported that HIV counselling and testing has become a basic component in the provision of HIV and AIDS services, and the number of HCT sites in sub-Saharan Africa is increasing rapidly. Most of these sites are regulated and controlled by Ministries of Health, and given the present state of the epidemic, their primary concern is prevention (MOH, 2008).

HIV counselling and testing is acknowledged within the international arena as an effective and pivotal strategy for both HIV and AIDS prevention and care (Kipitu, 2005; Alemayehu, 2010). HIV CT has been identified as one of the essential components of a comprehensive strategy of preventing new infections (MOH, 2008). HCT is more than drawing and testing blood and offering a few counselling sessions. It is a vital point of entry to other HIV and AIDS services, including preventing mother - to - child transmission [PMTCT]; preventing and clinically managing HIV-related illnesses, tuberculosis control, psychosocial and legal support (Ethiopia, MOH, 2005). Counselling and testing provides benefits for those who test positive as well as those who tests negative. It alleviates anxiety, increases client's perception of their vulnerability to HIV, promotes behavioural change, facilitates early referral for care and support, including access to antiretroviral therapy and helps reduce stigmatisation in the community. It also offers holistic approach

that addresses HIV in the broader context of people's lives, including poverty and its relationship to risky practices (UNAIDS, 2000).

The critical importance of counselling as a means of behaviour change has been acknowledged in the international arena. A study in Kenya by Kenya Association of Professional Counsellors [KAPC] evaluated counselling and testing programme and concluded that counselling and testing has long been an essential component of HIV and AIDS programmes and is aimed at helping people to change their behaviour. The association added that the quality of counselling offered at any health facility can become a barrier to HIV testing (Family Health International [FHI], 2012).

HIV and AIDS counsellors are the implementers of HIV and AIDS counselling and testing programme in the various health facilities. According to UNAIDS (2001), HIV and AIDS counsellors are supposed to be trained under specified guidelines approved by the health institutions in a particular country. The role of counsellors in health education is very paramount in reducing HIV. This is the reason why counsellors need to be knowledgeable on issues of HIV and AIDS before they can share it with their clients. The findings of the study also added that shared knowledge about HIV and AIDS infection and the ability to live longer and healthier lives should be created between the counsellor and the client. Hlalele (2004) in a an exploratory study of the psychological impact of HIV and AIDS patients on the counsellor, reported that since HIV counsellors encounter HIV and AIDS clients in their daily routine, regular counselling education programmes should be organized for the counsellors to enhance their learning opportunities that will help them in their practice. It was further reported that lack of continuous training and knowledge

about issues relevant to HIV and AIDS is one of the reasons why many HIV counsellors are experiencing discomfort working with HIV and AIDS patients. HIV counselling, whether for prevention or before and after the HIV test, involves confidential dialogue between a client and a care provider (HIV counsellor) aimed at enabling the client to evaluate personal risk of HIV transmission and make decisions related to HIV and AIDS (Ministry of Health, 2008).

Knowledge of HIV counsellors is very important because HIV counsellors are required to understand and communicate to clients a number of facts about HIV. These include how HIV is transmitted, how it is diagnosed, how the disease progresses, and how HIV treatments work. It is also important that HIV counsellors understand how sexually transmitted infections (STIs) are transmitted, treated, and relate to HIV. As HIV fuels the tuberculosis (TB) epidemic, it is important that counsellors understand the relationship between HIV and TB, and the role counselling plays in addressing TB-HIV co-infection (UNAIDS, 2011).

In addition, HIV and AIDS counsellors need to be knowledgeable on issues relating to sexuality and STI/HIV counselling. This is because helping people to adopt safer sex practices may be more difficult than helping them to use contraception if it involves both partners in life style changes and requires discussing intimate sexual practices. Also, HIV and AIDS counsellors may need knowledge and skills on issues such as interventions to reduce HIV transmission from pregnant women to children (Dhadwal, et al., 2009). According to MOH, Uganda, (2005), a counsellor can feel very frustrated if not

equipped with adequate knowledge and skills to handle some difficult issues and emotions presented by their HIV and AIDS clients.

Attitudes are defined as convictions, opinions and thoughts about a person or an object (Damons, 2003). It is the favourable or unfavourable evaluative reaction toward something or someone exhibited in ones beliefs, feelings, or intended behaviour. Attitude may vary from good (positive), bad (negative), to neutral. For the purpose of this study, the counsellor's positive attitude will be anything that the counsellor does to promote accessibility of counselling and testing services and their own attitudes towards accessing counselling and testing. A negative attitude on the other hand will be anything the counsellor does to discourage or prevent people from accessing counselling and testing services. Britton (2012) said that therapists' attitudes and biases are very important to areas of study in counselling and psychology. This is so because the attitude and biases of a therapist impact on the process of psychotherapy

HIV and AIDS counselling staff are perhaps the most important assets of CT services. HIV counsellors need to be self-motivated to provide HIV counselling and they should therefore have the ability to show their clients that they respect and care about them (Adekeye, 2011). Attitudes of HIV and AIDS counsellors are very important when one is assessing knowledge, attitude and practices. Sexuality is a sensitive subject therefore unless HIV and AIDS counsellors show their clients that they care about and respect them, they will not be able to talk openly about their lives and feelings. Counsellors need time to explore their own attitudes to sexual issues and how these may affect their counselling. This presents new challenges in being tolerant and talking about

perhaps disapproved sexual practices (Dhadwal, et al. 2009). According to the British American Counsellors Psychotherapist [BACP] (2010), clients are entitled to good standards of practice and care from their practitioners in counselling and psychotherapy. Good standards of practice and care require professional competence, good relationship with clients and colleagues, and commitment to being ethically mindful through observance of professional ethics.

All counsellors are expected to possess the following qualities, along with a few attitudes they should develop in the course of their work. It is a counsellor's responsibility to make the client feel at ease with the counselling process. Again, counsellors are expected to build rapport and create a counselling relationship that uses trust as a solid foundation. Also, they must be able to demonstrate genuineness and empathy (The Counsellor's Guide, 2012). A counsellor must be able to show a positive, unconditional regard for the wellbeing of a client, if a successfully progressive counselling relationship is to be formed. It is the basis from which a client can explore his/her thoughts, feelings and experiences, develop an understanding and acceptance of his/her emotions, genuine openness, within the counselling relationship. A client must feel comfortable, safe and confident that confidentiality will be maintained, and also that the counsellor is committed to helping, encouraging and supporting the client to make a good decision. Empathic understanding and the ability to see things from the client's world is also important, as is the counsellor's ability to demonstrate an investment of his/her time and full attention (The Counsellor's Guide, 2012). Counsellors must at all times show respect for their clients and seek their welfare. They must also remain impartial and non-

judgmental. A client must feel comfortable, safe and confident that confidentiality will be maintained. Also, counsellors should be committed to helping, encouraging and supporting their clients (The Southern African Association for Pastoral Work, 2012). But Uys (2000) reported that health professionals regard this practice of maintaining confidentiality concerning HIV and AIDS at all costs as problematic.

Molefe (2005) in examining fears and attitudes of HIV counsellors towards VCT reported that some HIV counsellors were not willing to test for HIV. It added that some of the counsellors reported that they would test for HIV if the counsellor at post was HIV positive counsellor so that the person can handle the clients with experience. Some of the counsellors reported that they will go for HIV test only when they are sick, pregnant, having AIDS symptoms or when there is a cure for AIDS. This attitude is not good because according to the researcher, undergoing HIV test when people are pregnant, sick or when there is a cure for the disease might be too late for the benefits that clients could have achieved through diagnosis.

The HIV counsellor should be an agent of change, that is, he/she must believe that HIV counselling can make a difference for the individual, the family, and the community, Listens rather than preaches or admonishes, Balances well selected open-ended questions with statements, summaries, and reflections, Is comfortable in discussing specific HIV risk activities, Is able to assist individuals to develop realistic risk reduction plans (International Organization for Migration, 2006). Again, the HIV counsellor should be sensitive to culture and tradition and HIV counselling. As counsellor needs to examine his/her own beliefs and attitudes in order to counsel people from

different backgrounds, cultures, and religions openly and without judging. Tradition becomes particularly important during times of transition such as puberty or marriage, or at times of stress such as illness and death. A counsellor must appreciate the cultural importance of the behaviour that he/she might seek to change.

Counsellors experience burnout, which is a state of emotional exhaustion that results when the counsellor has reached his or her limit to deal with HIV and the emotional stress it causes. This may lead to a state of irritability and anger, often directed at supervisors, colleagues and even clients. Nulty (2003) found that due to the nature of HIV and AIDS counsellors work, management should recognise the stressful nature of the job and the valuable service HIV counselling and testing provides in order to help the counsellors feel appreciated and affirmed for this emotionally demanding work. Such acknowledgement could take various forms, but is only effective if combined with the on-going evaluation and improvement of present practices and the provision of emotional, professional and managerial support. Nulty added that the following factors related to counsellors work environment contribute to their attitudes and fears towards HIV testing: they are narratives of HIV positive clients, working with PLWHA, mistrust or lack of confidentiality among colleagues and the stigma associated with being an HIV counsellor. Another attitude and fear which the researcher found was lack of confidence by the counsellors, which stems from the inadequate training.

Hentgen, Jaureguiberry, Ramiliarisoa, Andrianantoandro and Belec (2002) reported from a study on knowledge, attitude and practices of health personnel with regards to HIV and AIDS in Tamatave in Madagasca that health

care professionals have negative attitudes towards people living with HIV and AIDS. In this study twenty per cent of the health workers mentioned that AIDS patients should be isolated by quarantine.

HIV counsellors are saddled with the responsibility of breaking news of the test result to clients and this presents the opportunity for them to witness the accompanying emotional and psychological pain that clients undergo. In this direction, the knowledge, attitude and practices of HIV counsellors are very important (Adekeye, 2011).

As part of their daily routine, HIV counsellors come across the HIV infected and by training, they are expected to promote acceptance, care and provide support systems. Van-Dyk (2001) noted that as part of their routine, HIV counsellors are also expected to counter the negative attitude displayed by the society towards the HIV infected. Thus, HIV counsellors are positioned to help people decide to undergo HIV test by giving HIV pre-and post-test counselling. Hoffman (1996) highlighted some themes common with people working with HIV and AIDS infected persons such as feelings of helplessness, fear of contagion, feelings of grief and loss, emotional reactions to repeated exposure to death and dying and emotion associated with stigmatization by others for doing this type of work

Statement of the Problem

Three decades into the HIV and AIDS menace, there has not been any discovery of medicine to cure the infection. Education and awareness creation have been identified as elements in comprehensive HIV prevention. It is believed that increased knowledge, along with positive attitudes and practice of

HIV counselling and testing will lead to positive behaviour change and thereby reduce the spread of the infection (Kululanga, 2006).

HIV counselling and testing constitutes a central part of HIV prevention efforts and it is performed in a variety of health facilities in Ghana. Counselling and testing has been identified as a prudent policy for HIV and AIDS control in many developing countries including Ghana. Knowing one's HIV status through CT is very important. This is because it enhances one's ability to reduce the risk of acquiring or transmitting the virus to others. It also helps the individual to access HIV specific care, treatment and support, and to make informed decisions about other aspects of one's life (MOH, 2008).

Despite its recognized importance in National AIDS Control Programmes (NACP), HIV CT is not fully developed in resource-constrained countries like Ghana, that is, inadequate human and material resources (Aquah & Emmart, 2011). This may affect the knowledge, attitude and practices of HIV counsellors as they work to improve HIV and AIDS counselling and testing programme.

HIV counsellors are placed in the health facilities in the country to help undertake counselling and testing activities by educating the public and also creating awareness for people to adopt positive sexual behaviours that can help them reduce high risk sexual activities (MOH, 2008). Due to the nature of work HIV counsellors perform, they experience burn out. This is so because most HIV counsellors perform both clinical duties as health care workers and HIV counselling and testing roles (MOH, 2008).

Also, USAID (2011) had reported that comprehensive knowledge of HIV and AIDS in Sub-Saharan Africa remains low and this is an obstacle to

reducing incidence rates in the region. Again, though counselling is an integral part of HCT process, HIV testing among Ugandan and Kenyan youth was not always accompanied by counselling, which prevented some of the youth from discussing some critical issues with counsellors (Horizons, 2001).

In recent times, the Ghana Health Service and Ghana Aids Commission have placed emphasis on HIV counselling. This is because pre-test information, post-test adherence and on-going counselling offer a lot of advantages to those who come for HIV test and those who are either infected or affected with HIV. HIV CT should help individuals to learn more about their status in a confidential environment. Further, HIV counsellors embark on "Know Your Status" (KYS) campaign to educate the general public on the need to know their HIV status. This brings them closer to the general public who may want to test for their HIV status.

Attitude of HIV counsellors is very important in the efforts to reducing the HIV pandemic. HIV counsellors' attitude towards people accessing CT services can encourage the clients to go ahead with the test or abandoned the idea. For instance, if clients observe that counsellors are too busy doing other work without paying much attention to their needs, they may be compelled to stop visiting the facility for both psychosocial and anti-retroviral therapy. Negative attitudes of HIV counsellors such as stigmatization, discrimination and unfriendliness to individuals coming for counselling may deter them from accessing HIV counselling and testing services (Galvan, Davis, Banks & Bing, 2008).

Similarly, the issues of shared confidentiality and privacy, which is central to good HIV and AIDS counselling and testing, should be looked at

properly by HIV and AIDS counsellors. This is because most of their clients find themselves in the hands of a team of health care professionals, that is, the counsellors, laboratory and pharmacy staffs, especially where there is a huge evidence of mistrust in the public health care system which is a huge stumbling block for people accessing healthcare system (Van-Dyk & Van-Dyk, 2003).

Further, in the year 2011, Central Region had the highest rate of HIV prevalence in Ghana (NACP, GHS & MOH, 2012). According to the regional trend analysis, Central Region had moved from 5.4 in 2003, to 2.9 in 2007, 2.0 in 2008, 3.0 in 2009 and 1.7 in 2010 (NACP, GHS & MOH, 2011). One would have expected the region to either experience a further decline or a slight increase in 2011, but the region was hit with the highest rate in the whole country, that is 5.4. The highest rate of the pandemic in the region was a 'shock' to stake holders since other regions in Ghana and other countries were showing signs of decline or stabilised condition.

The questions one may want to ask now are: First, are HIV counsellors in the Central Region able to keep HIV issues confidential and private in the face of shared confidentiality and lack of trust in the public health care delivery? Second, in what ways are the knowledge, attitude and practices of HIV counsellors contributing to the high HIV rate in the Central Region (NACP, GHS & MOH, 2012)? Again, are people comfortable with the attitude and practices of HIV counsellors at the various facilities in the Central Region of Ghana? Further, are these HIV counsellors able to use appropriate counselling techniques to assist their clients during counselling and testing

sessions to keep and motivate them? This study aims at finding answers to the questions above.

Purpose of the Study

The aim of the study was to examine the knowledge, attitude and practices of HIV and AIDS counsellors in the Central Region of Ghana on counselling and testing. Specifically, the study sought to:

1. Investigate the knowledge of HIV counsellors regarding counselling and testing in the Central Region.
2. Determine the attitude of HIV counsellors with regards to counselling and testing in the Central Region.
3. Investigate the practices of HIV counsellors in relation to counselling and testing in the central Region.
4. Find out counselling techniques used by the HIV counsellors during HIV counselling and testing sessions.
5. Find out the challenges HIV counsellors in the Central Region face.
6. Determine ways HIV counsellors in the Central Region manage the challenges they face during CT sessions
7. Establish the relationship between the knowledge and attitude of HIV counsellors in the Central Region of Ghana on Counselling and Testing.
8. Establish the relationship between knowledge and practices of HIV counsellors in the Central Region of Ghana on Counselling and Testing.

Research Questions

The following research questions were formulated to guide the study:

1. What is the knowledge of HIV counsellors in counselling and testing in the Central Region?
2. What is the attitude of HIV counsellors towards clients accessing HIV counselling and testing in the Central Region?
3. What are the practices of HIV counsellors regarding HIV counselling and testing in the Central Region?
4. To what extent do counsellors who practice HIV counselling and testing use counselling techniques during CT sessions?
5. What are some of the challenges HIV counsellors face in their work in the Central Region?
6. What strategies do HIV counsellors employ to manage the challenges they encounter in their work?

Hypotheses

1. H_o: There is no relationship between the knowledge and attitude of HIV counsellors in the Central Region of Ghana regarding counselling and testing.

   $H_{1:}$ There is relationship between the knowledge and attitude of HIV counsellors in the Central Region of Ghana regarding counselling and testing.
2. H_o: There is no relationship between knowledge and practices of HIV counsellors in the Central Region of Ghana with respect to counselling and testing.

H_1: There is a relationship between knowledge and practices of HIV counsellors in the Central Region of Ghana with respect to counselling and testing.

Significance of the Study

This investigation is aimed at assessing the knowledge level, attitude and practices of HIV and AIDS counsellors in the Central Region of Ghana. Thus knowledge obtained would be used to improve HIV and AIDS counselling and testing in the Central Region of Ghana. It is hoped that the results of the study can help HIV counsellors in the Central Region to avoid any forms of negative attitudes and bad practices they have been exhibiting during counselling and testing sessions. Further, since the Regional Health Directorate of Ghana Health Services is aware of the study and has provided certain guidelines to enrich the research, the findings and recommendations will be made known to the directorate to enhance the operation of HIV and AIDS counselling and testing in the Central Region. The study again can serve as a guide to policy makers and stakeholders of HIV and AIDS in Ghana such as Ghana AIDS Commission, Ghana Health Service and Non-Governmental Organizations (NGOs) in HIV and AIDS in the development of policy guidelines. Further, the study seeks to establish the loopholes and make good recommendations for effective HIV counselling and testing services that will better the lives of people. Finally, the study could contribute to research in HIV and AIDS counselling and testing by adding to the existing literature.

Delimitation of the Study

This study was conducted among HIV and AIDS counsellors in the Central Region of Ghana. Even though there are other health staffs in the

hospitals, the HIV and AIDS counsellors were selected, as they deal directly with the HIV and AIDS clients, especially as the number of HIV cases is on the increase in the Central Region. Again, there was one Regional and Metropolitan Hospitals, and many municipal and districts and health centres in the Central Region but the study was specifically defined to cover all hospitals/health centres with counsellors numbering five (5) and above. The study found out the knowledge level, attitude and practices of HIV and AIDS counsellors.

Limitations of the Study

Most of the HIV counsellors in the survey were too overburdened and so to meet them was very difficult. This did not permit me to meet all of them in the hospitals during the administration of the questionnaires. In view of this difficulty, a thorough discussion of the questionnaire was done with the HIV coordinators to enable them help administer the questionnaires. Some of the respondents were reluctant in providing accurate information concerning their attitude and practices towards clients. However they were assured of confidentiality and were not asked to put their names on the questionnaire. Also, the observation results may be influenced by the investigator since personal biases can influence what was observed. To address this observation checklist was used to guide the sessions held.

Definition of Terms

HIV and AIDS Counselling: It is a confidential dialogue between a client and a care provider that is aimed at enabling the client to cope with stress and take personal decisions including those regarding prevention and care related to HIV and AIDS.

Voluntary Counselling and Testing: The process by which an individual undergoes confidential counselling, enabling him or her to make an informed choice about being tested for HIV. It involves pre-test and post-test counselling.

Pre-Test HIV and AIDS Counselling: This is a dialogue between a client and a health care provider aimed at discussing the HIV and AIDS test and the possible implication of knowing one's status, which leads to an informed decision to take or not to take the test.

Post-Test HIV and AIDS Counselling: This is a dialogue between a client and a health care provider aimed at discussing the HIV and AIDS test result and providing appropriate information, support and referral, and encouraging behaviour that reduces the risk of transmitting HIV and AIDS on to others, if one is found to be infected.

Organisation of the Rest of the Study

The study is divided into five chapters. Chapter Two provides a review of related literature. Here, theoretical and model as well as empirical studies related to the study were reviewed. The chapter ended with a summary of the review of the related literature.

Chapter Three discusses the methodology employed for the study. The chapter dealt with the following: research design, target population, sampling procedures, research instrument, pre-testing of the instrument, data collection processes and data analysis procedures.

Chapter Four presents the results with their discussion based on the research questions/hypotheses/objectives. Chapter Five deals with the summary, conclusions and recommendations of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter constitutes the literature review. It focuses on conceptual issues, theoretical and empirical reviews. The conceptual issues looked at some general concepts in HIV and AIDS counselling and testing. The theoretical review highlights some relevant theories that explain what the HIV counsellor is expected to do during counselling and testing sessions. The empirical review on its part looked at studies related to knowledge, attitude, and practices of HIV counsellors. The review also covers works related to psychological, socio-cultural, economic and psychiatric dimensions of HIV and AIDS. Finally, the review covers the challenges HIV and AIDS counsellors encounter in the course of their work and measures they employ to overcome the challenges.

CONCEPTUAL REVIEW

HIV presents health workers and counsellors in particular, with unique challenges. While many health workers have worked with life-threatening illnesses, prior to the HIV pandemic few had to meet the challenge of working in an area of such sociocultural sensitivity (Herek, Capitanio & Widaman, 2002).

In Sub-Saharan Africa, many HIV clients come from marginalized groups with a range of psychosocial issues including histories of drug or alcohol use, sex work, and gender and sexual identity issues (Krenn & Limaye, 2009). Besides the varied backgrounds of clients who seek support, HIV

counsellors and mental health service providers themselves come from diverse professional backgrounds, and are often challenged by a complex array of HIV-related psychiatric and psychosocial conditions (UNICEF East Asia and Pacific Regional Office, 2009). Counsellors are expected to reduce transmission, facilitate knowledge of HIV status, provide psychosocial support, and address treatment adherence in the context of a highly stigmatised disease. HIV counsellors in Sub-Saharan Africa must meet these objectives with large numbers of clients, often with limited HIV counselling training, personnel support, and clinical supervision (UNICEF East Asia and Pacific Regional Office, 2009).

Meaning of AIDS and HIV

According to Encyclopedia.com (2005), AIDS is an acronym for Acquired Immune Deficiency Syndrome. AIDS is a group of diseases acquired as a result of a weakened defence (immune) system. Acquired means the disease is transmitted from person to person; immune is the body's system of defence or protection against diseases; deficiency means a lack of or not working to the appropriate degree; and a syndrome is a group of signs and symptoms. AIDS is the advanced stage of HIV infection. That is, it is when the individual has overwhelming symptoms and signs and meets the WHO clinical case definition for AIDS, which is two major and one minor symptom for adults and two major and two minor symptoms for children (UNICEF East Asia and Pacific Regional Office, 2009).

The human immunodeficiency virus (HIV) causes AIDS in humans. Researchers have identified two types of HIV: HIV-1 and HIV-2. HIV-1 and HIV-2 are transmitted in the same way and are associated with similar

opportunistic infections, though they differ in the efficiency of transmission and rates of disease progression (CDC, 2012). HIV-1 accounts for the majority of infections in the world; there are more than 10 genetic subtypes. HIV-2, found primarily in West Africa, appears to be less easily transmitted and progresses more slowly to AIDS than HIV-1. A person can be infected with both types of HIV simultaneously. NACP, GHS and MOH (2011) reported that in Ghana, 98% of HIV prevalence cases are of the type I, 0.7% is of the type II and 1.3% is of both type I and II.

HIV is a virus that causes AIDS. 'H' stands for human, which means that the virus attacks only human beings. 'I' stands for Immuno-deficiency, which means that the virus lowers immunity. 'V' stands for virus, which means that the virus is a Germ. HIV infection refers to when the individual has contracted the virus in his/her blood but may not necessarily have any symptoms and signs. HIV disease is when there are some symptoms and signs due to infection with HIV in one's body but this is not enough for a counsellor to conclude that the individual has AIDS (CDC, 2012).

Basic Facts about HIV and AIDS (What HIV Counsellors Need to Know about HIV, STI, and TB)

HIV counsellors are required to understand and communicate to clients a number of facts about HIV. These include how it is transmitted, diagnosed, the progression of the disease, and how HIV treatments work. It is also important that HIV counsellors understand how sexually transmitted infections (STIs) are transmitted, treated, and relate to HIV. As HIV fuels the tuberculosis (TB) epidemic, it is important that counsellors understand the relationship

between HIV and TB, and the role counselling plays in addressing TB-HIV co-infection (Ministry of Health, Uganda, 2005).

Transmission of HIV

According to UNAIDS (2011) and Ministry of Health, Uganda (2005), HIV is found in blood, semen, vaginal fluids, and breast milk. It can be transmitted in any of these four ways:

1. Unprotected sexual intercourse with an HIV infected person. 80% of HIV infections are transmitted through this mode.
2. An HIV infected mother to her child (referred to as vertical transmission). This mainly occurs during pregnancy, labour, delivery and after birth through breast milk.
3. Through infected blood and blood products (transferred via blood transfusions and organ transplants).
4. Through the sharing of needles, syringes, and other injecting equipment (including tattooing equipment).

How to Diagnose HIV

The diagnosis of an HIV infection is most often based on the detection of antibodies to the virus. An antibody test is rarely 100% sensitive (correctly able to categorize an infected person as positive) and 100% specific (correctly able to categorize a non-infected person as negative). Therefore, the Joint United Nations Programme on HIV and AIDS, the World Health Organization, and the US Centre for Disease Control and Prevention jointly recommend that all positive test results be confirmed by retesting, preferably using a different testing method. All testing done at HCT centres should be subject to external quality assurance. Usually 5%-10% of all samples–venous samples or samples

collected through a filter-paper method (commonly referred to as dried blood-spot specimens) should be sent out for external quality assurance testing.

According to Cohen, Gay, Busch and Hecht (2010), the detection of acute and incident HIV infections is critical to both prevention and treatment strategies. However, after 30 years of the HIV pandemic, laboratory tools are imperfect, and we are able to identify and care for only a very limited number of persons with recent infection. Cohen, et al. added that new diagnostic assays and new surveillance strategies should prove useful.

Types of Tests

There are two main types of HIV tests: antibody tests (e.g., enzyme-linked immunosorbent assay (ELISA or EIA), simple/rapid tests, saliva assays, urine assays, and the Western blot) and virological tests (e.g., HIV antigen test, polymerase chain reaction test, and viral culture).

Antibody Tests

Constantine and Zink (2005) state that HIV antibody tests detect antibodies against HIV; they do not directly detect the virus itself. Once HIV enters the body, it infects white blood cells known as T4-lymphocytes or CD4 cells. The infected person's immune system responds by producing antibodies to fight the new HIV infection. The presence of the antibodies is used to determine the presence of HIV infection.

Virological Tests

According to Constantine and Zink (2005) the HIV antibody tests discussed above are those most commonly used in HIV testing and counselling. Under special circumstances (e.g., in a recently infected individual, during the window period, or in the case of a child born to an HIV-positive mother), more

direct diagnostic methods may be used. Unlike antibody tests, virological tests determine HIV infection by directly detecting the virus itself. There are three types of virological tests:

1. Viral antigen detection tests (also known as p24 antigen tests).
2. Nucleic acid-based tests (specialised tests that look for genetic information on HIV through polymerase chain reaction [PCR]).
3. Virus culture, which isolates the virus.

Virological tests are rarely used to diagnose HIV in developing countries because they require sophisticated laboratories and are expensive. They may be used to monitor the progress of infection or response to therapy (e.g., by measuring viral load).

Interpreting HIV Test Results

UNAIDS (2000) reported that only suitably trained and authorized personnel should interpret and provide the test results. Such personnel are identified in the national HIV testing policies and vary across countries. All counsellors should, however, understand and be able to explain the meaning of a test result to a client.

A negative test result means that HIV antibodies were not detected in the person's sample, either because the person is not infected or because the person is still in the window period. The client must understand that a negative result does not necessarily mean that he or she is uninfected or immune to HIV infection. HIV counsellors should make it clear to their clients and the general public that an HIV-negative person who engages in risky behaviour is still vulnerable to HIV infection. A person who tests negative but has practiced

unsafe behaviours during the window period may be infected with HIV and may infect others (Nettleman, 2013).

A positive test result means that HIV antibodies have been detected in the person's sample. The person is infected with HIV and can transmit the virus to others if he or she engages in risky or unsafe behaviours. It does not necessarily mean that the person has AIDS (Nettleman, 2013). Neither the presence nor the absence of HIV antibodies is confirmed by an indeterminate test result for any one of three possible reasons: First, he person may be seroconverting. That is, he or she has had an exposure risk within the window period. Second, the person may have had an earlier inoculation that is cross-reacting with the HIV antibody test. That is, cross-reactivity does not necessarily mean that HIV is present and finally, the person may have a prior medical condition that is affecting the test, for example, arthritis or autoimmune problems (Constantine & Zink, 2005).

Cycle of the HIV Infection

AVERT (2005) on the cycle of HIV infection and its effects on the immune system stated that the HIV cycle can generally be broken down into four distinct stages: primary infection, clinically asymptomatic stage, symptomatic HIV infection, and progression from HIV to AIDS.

The Window Period

Constantine and Zink (2005) state that for an HIV-infected individual, the window period is a common term used for the time between the initial HIV infection (the acute infection) and the development of a measurable immunologic (or antibody) response to the infection. During this period, a person infected with HIV could still have a negative HIV test result. Within

this time frame, however, HIV is replicating in the blood and lymph nodes. The virus can be detected in this early phase only by laboratory tests used to identify the virus itself.

The window period varies from person to person and can range from as little as two weeks to as long as three months. Thus, if a person tests negative to HIV antibody tests, he or she may still be within the window period; if infected, that person's immune system has not yet begun making a detectable amount of antibodies against the virus. A person in the window period will test positive for HIV only if a virological test is used. However, virological testing is often not available or affordable. Post-test counselling should therefore be optimized to detect persons who may have an acute HIV infection. This is best done through retesting for HIV. When to retest those who are most at risk of infection or have had a recent incidence of exposure is generally determined by national guidelines.

Clinical Management of HIV

Individuals who are diagnosed with HIV should be referred to a specialist HIV physician for on-going medical follow-up (Anderson, et al., 2009). This follow-up may include regular immune system monitoring, antiretroviral therapy (ART), prophylaxis of OIs, the management of HIV-related neurological and psychiatric conditions, the management of common co-infections including tuberculosis and hepatitis B and C, clinical examination, family planning, and general health care (Anderson, et al., 2009).

Immune System Monitoring Tests

Immune system monitoring tests are performed as part of HIV care and treatment and may include viral load and CD4 tests. The CD4 cell count is an

indicator of the level of immune function at any given time, while the viral load is a measurement of the level of circulating virus in the blood. As the virus reproduces, it destroys CD4 cells and reduces the CD4 count (Anderson, et al., 2009). In general, the higher the viral load, the more quickly the CD4 cells are destroyed. Like CD4 counts, viral load measurement is important for disease staging and prognosis. Persons with a high viral load are more likely to progress rapidly to AIDS than persons with a lower viral load. Both tests are useful in guiding the use of ART, staging HIV disease, and determining a patient's prognosis.

Antiretroviral Therapy

According to Meintjes (2012), antiretroviral Therapy (ART) refers to medication that stops or inhibits the replication of HIV virus. Antiretroviral treatment in general is aimed at prolonging and improving the quality of life by maintaining the maximal suppression of HIV replication for as long as possible. Four types of ART drugs are taken in combination to suppress different stages of the life cycle of the virus. Huge reductions have been seen in rates of death and suffering when use is made of a potent antiretroviral treatment, particularly in early stages of the disease. Furthermore, expanded access to ART can also reduce the HIV transmission at population level, impact orphan hood and preserve families. In 2011, an estimated 34 million people were living with HIV. WHO and UNAIDS estimate that at least 15 million people were in need of antiretroviral therapy in 2011. By the end of 2011, over 8 million people had access to antiretroviral therapy in low- and middle-income countries. WHO is providing countries with on-going guidance,

tools and support in delivering and scaling up antiretroviral therapy within a public health approach (WHO, 2013).

Prevention and Management of Opportunistic Infections (OIs)

CDC (2009) stated that an individual with a low CD4 count is susceptible to OI. The prevention and treatment of OI decreases the mortality risk of HIV infection. Individuals with low CD4 counts are prescribed preventive medications called OI prophylaxis. Common OIs in HIV are TB, septicaemia, pneumonia (usually PCP), recurrent fungal infections in mouth and throat, meningitis, skin diseases and STIs. The clinical management of OIs may also involve nutrition counselling and treatment of HIV wasting and severe weight loss, chronic or intermittent fever, and chronic or intermittent diarrhoea.

Further, STIs are particularly prevalent in developing countries and among sexually active young people. Some of the most common STIs are gonorrhoea, syphilis, genital herpes, chlamydia, human papilloma virus (HPV), and trichomoniasis. Different pathogens are responsible for each STI. If left untreated, STIs can have serious consequences for men, women, and new born children. STIs are a powerful co-factor in HIV transmission. Their presence makes a person more vulnerable to HIV by a factor of 15%-20%. Genital lesions or inflammation caused by STIs enables HIV to enter and establish itself in the body. STIs, particularly if they are ulcerative, increase one's risk of contracting HIV because they may cause ruptures or micro-lesions in mucous membranes. Thus, to reduce the risk of HIV infection, one must avoid contracting other STIs. If other STIs do occur, they must be treated promptly and effectively to minimize the risk of acquiring or transmitting HIV.

General Issues in HIV Counselling

Counselling in general refers to an interaction in which the counsellor offers another person(s) the time, attention and respect to explore, clarify and discover ways of living more resourcefully. Egbochuku (2010) defined counselling as a face to face situation in which a counsellor, by virtue of his/her training and skill, helps the client to face, perceive, clarify, solve and resolve any adjustment problems or issues. According to NACP Training Manual (2009), HIV and AIDS counselling is a special kind of helping relationship in which there is a counsellor and a client and the counsellor helps the client alter his/her behaviour. Also, HIV and AIDS counselling can be seen as a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV and AIDS.

According to NACP (2009), HIV counselling is aimed at everyone. This is so because everybody is at risk but for cost effectiveness, it is targeted at the following groups of people who stand a higher chance of getting the disease. They include marriage couples, "High-risk groups" such as drug users, homosexuals, sex workers, truck drivers and mobile or migrant populations and other relevant target groups like those with sexually transmitted infections (STI), tuberculosis (TB), ante-natal care (ANC) attendants and those seeking help due to past behaviours.

NACP (2009) gave the following as goals that should guide HIV and AIDS counselling programme. This means that every HIV and AIDS counselling programme should gear towards the following. These are: first, preventing HIV infection by promoting behaviour change. Second, providing

psychosocial support to people infected and affected by HIV in improving their emotional, psychological, social, and spiritual well-being. The third point is helping HIV-positive clients and those close to them cope with the diagnosis. Fourth, discussing decisions that need to be made according to the client's life circumstances, and finally, referring clients to appropriate treatment and care services.

HIV counsellors should know that HIV and AIDS counselling is different from other interventions because it involves preventive intervention combined with psychosocial support. Also, clients who access HIV counselling hold opinions, values and worldviews that are different from counsellors and that giving HIV and AIDS test results is emotionally challenging and stressful. Finally, it requires consideration of reaction and needs of partner(s) and other family members. Since HIV and AIDS counselling is different from other interventions, there is the need for those who practice it to undergo training that can help them acquire the necessary knowledge and skills and also equip them face any challenge they may face.

According to NACP (2009), HIV counsellors often become fearful when they are faced with realities of people's lives. This means that the training of HIV counsellors should be taken serious so that they can help clients manage their life's well and cope with their emotional reactions. It is hoped that when HIV and AIDS counsellors get the needed training they will be able to accept and respect their clients, help the client explore and understand his/her own feelings and behaviour so that he/she can alter what is not effective for himself/herself, help the client to explore and discuss ways of coping with life effectively (behaviour change) and finally, should have respect

for individuals as people who are worthwhile in themselves irrespective of whatever they have done.

As a good counsellor you should have the following characteristics: First, be interested in clients as people, not as a medical problem. Second, be aware of your own feelings and values. Do not judge clients, moralise or impose your own values on them. Do not allow religious beliefs to interfere with helping clients to explore all their options, even if you personally do not agree with them. Do not show disapproval in your words or body language. Further, be approachable and easy to talk to and respect your client. Also, use empathy to make clients feel supported. Try to understand a situation from the client's point of view and express a caring response. Again, recognise client's strengths, knowledge and resources to cope with their problems. Do not feel superior to the client. Be open to learn from the clients as they know more about their lives. In addition, respect clients' different ideas on health and understand that we all have a mixture of scientific and more local knowledge about our bodies and health.

Moreover, be sensitive to inequality between males and females and how this may affect sexual health. The counsellor should be aware of his/her own gender biases. Try to be impartial, objective and do not impose your own opinion on clients. Be honest and trustworthy, provide accurate information and do not falsely reassure clients. Finally, maintain confidentiality and never discuss clients with others (UNAIDS, 2010).

UNAIDS (2010) reported that for HIV and AIDS counsellors to be effective in providing good counselling services, the following obstacles that

affect the effective delivery of HIV and AIDS counselling and testing should be addressed. These inadequacies include:

1. Insufficient space or resources provided for counsellors.
2. Unreasonable demands on the time of counsellors to perform other duties.
3. Difficult access to the service for clients.
4. Intimidating or inappropriate atmosphere within counselling clinics.
5. Lack of privacy and confidentiality.
6. No follow-up support for those infected with HIV and their families, spouses and partners.

Types of HIV Counselling

HIV prevention counselling (HIV transmission risk reduction)

The HIV counsellor assists infected and uninfected clients in identifying and exploring the difficulties involved in reducing transmission risk behaviour. Counsellors may use a variety of strategies ranging from the simple provision of information to the more therapeutic evidence-based strategies that can include motivational interviewing, structured problem solving, interpersonal and brief psychotherapy for risk reduction, cognitive behavioural therapies, relationship counselling, and infant-feeding counselling.

Prevention counselling is employed in pre-HIV test and post-HIV test counselling and in counselling across the disease continuum. It is recognized that it is difficult for clients to sustain changes in behaviour over extended periods of time. When providing counselling across the disease continuum, counsellors must continually assess the challenges that will face their clients as they strive to maintain behaviour changes, and provide practical strategies that

can help address these challenges. To change behaviour in the context of drug or alcohol dependency, for example, counsellors must assess whether the client is dependent (addicted) and whether he or she can implement harm reduction and substance dependency management strategies.

Pre-test Counselling

Pre-test counselling is a confidential counselling that will enable an individual to make an informed choice about being tested for HIV. According to WHO guidance, this decision must be left entirely to the individual and must be free of coercion. To make an informed choice about testing, an individual needs to consider the potential benefits and risks associated with testing. His or her personal risk history must also be considered. The counsellor supports the client in managing the potential risks and difficulties by considering the possible psychosocial, legal, and health implications of knowing the client's sero-status. The counsellor also assesses the client's capacity to cope with the possibility of a positive HIV antibody test, provides information on HIV, and engages in prevention counselling, mainly to reduce transmission risk behaviour and thereby reduce the risk of HIV transmission. While individual one-to-one counselling offers the best standard of support to clients, alternative models of providing pre-HIV test information are also available. Pre-HIV test counselling may be offered to couples. In some situations where there are many clients or where the HIV test is offered as part of provider-initiated testing and counselling (PITC) and opportunities for one-on-one counselling are limited (because of time or human resource constraints), group pre-test information may be offered. Information can be given in a group, but the informed consent component must always take place in a one-on-one setting to ensure that the

patient's choice is autonomous and not coerced (NACP, 2009). This is in agreement with the principle of HCT which states that "HIV test should be based on the '3Cs': testing must be confidential, accompanied by counselling and only by informed consent" (UNAIDS, 2004).

Post-HIV Test Counselling

Post-test counselling is done primarily to ensure that individuals understand the meaning and implications of their test results. If the client tests positive for HIV antibodies, post-test counselling must make it easier for him or her to adapt to life with HIV and STI infection. Suicide presents a significant challenge to counsellors. There are two periods when people with HIV are more likely to attempt suicide. When the person is first diagnosed, suicide may occur as an impulsive response to the emotional turmoil that follows. The second period of high risk occurs late in the course of the disease when complications of the nervous system resulting from AIDS develop, capacity to earn income declines, and people feel they are a burden to family members and carers. Consequently, after the diagnosis counsellors are required to conduct suicide risk assessments and to manage suicidal thoughts throughout the course of illness.

Post-HIV test counselling is typically provided by the counsellor who conducted the pre-test counselling. However, a counsellor may have to provide counselling to an individual who was tested without his or her knowledge and consent. Counsellors providing post-test counselling under the latter circumstances may report having to manage client anger, which is often projected onto the counsellor.

On-going Counselling for People Affected by HIV

The chronic and progressive natural history of HIV infection means that the psychosocial issues confronting both infected and affected individuals change throughout the course of the illness. In addition to issues directly related to HIV, patients may present with a range of psychosocial problems that are pre-morbid or only indirectly related to HIV. For many, becoming infected with HIV reactivates previously unresolved issues such as acceptance of sexual orientation, specific traumatic events such as sexual assault, or unresolved relationship problems. Infected and affected individuals may also need practical assistance such as referral to social support services, liaison with caregivers, the preparation of wills, and the organization of substitute care for children. Counsellors must work with multiple clients who present a range of problems that vary across the disease continuum.

Treatment Adherence Counselling

Patients are confronted with many difficulties when required to take medication. Those taking medication for HIV, TB, STI, or hepatitis in particular must deal with many psychological, physical, and practical barriers to treatment adherence. Non-adherence can lead to inadequate suppression of bacteria and, in the case of HIV, viral replication. Counselling for treatment is provided to improve the patient's knowledge of both the disease and the medications and their side-effects. Counselling helps the patient set goals, develop positive beliefs and perceptions, and increase self-efficacy in maintaining treatment.

Places for Providing HIV Counselling

HIV counselling and testing may be offered in a diverse range of settings, including testing and counselling centres that are free-standing or integrated into hospitals, sexual health centres, churches, out-patient clinics, blood donation centres, drug treatment centres, family planning clinics, prisons, community health centres, and a diverse range of health outreach or community-based programmes. Counselling alone may also be offered as part of mobile or outreach services.

Providers of HIV Counselling

Not every person who practices counselling skills can be considered a counsellor. Two broad groups of people use counselling skills: those who engage in counselling as a distinct occupation and those who use counselling skills as part of another occupation. The wide range of people who may play a role in providing HIV counselling services includes:

1. Nurses, doctors, social workers, and other care providers who have been specially trained in HIV counselling;
2. Full-time counsellors (including psychiatrists, psychologists, and family therapists) who have been trained in HIV counselling;
3. Community-based workers whose work consistently entails appropriate handling of confidential information and emotional issues; and
4. People living with HIV and AIDS (PLHIV).

It is essential, however, that counsellors have the specific training needed to support the different services they will have to provide. Increasingly, governments are requiring prospective counsellors to undergo standardized national training irrespective of their professional background.

Developing Appropriate Techniques for Effective HIV Counselling

According to NACP (2009), counselling is based on a set of techniques that the counsellor brings to the interaction to help the client to explore and better understand a problem, deal with related feelings, assist client to cope with stress and make personal decisions and help him/her cope with life. In order for counsellors to perform their tasks effectively, they must first understand what counselling is and also develop some basic techniques used in counselling.

For the counsellor to develop trusting relationship and motivate his/her clients to fully speak all that is on their heart, there is the need for him/her to establish rapport, ensure privacy and confidentiality. There are two forms of communication skills that the counsellor needs to develop. These are verbal and non-verbal communicative skills. Verbal communicative skills include (open-ended and closed-ended questions), summarizing, confrontation, probing skills, interjections, self-disclosure. Non-verbal communication also forms a key area that HIV counsellor needs to be abreast with, examples include: eye contact, facial expression, posture, body language and gestures and tone of voice.

Apart from the verbal and non-verbal communication skills, the HIV and AIDS counsellor also needs to develop the ability of giving simple and clear information to his/her clients. Again, he/she is expected to allow the client time to respond to issues or questions. Another major responsibility of the counsellor is to assist the client to clarify any misunderstanding that the client may have. Further, the counsellor is expected to assist the client to prioritise issues with the client so that the client can choose the best option that

will be favourable to him/her and the counsellor's ability to involve the client's partner as a result of issues related to partner notification.

Factors Facilitating Counselling

NACP (2009) stated the following as important factors that facilitate HIV counselling: acceptance, empathy, respect, that is, accepting client without any prejudices; genuineness, which means being honest with oneself and with the client; attentiveness, which deals with the use of both verbal and non-verbal communication skills; and accessibility, meaning, the counsellor should be available for the client.

THEORETICAL REVIEW

AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model (ARRM), introduced in 1990, provides a framework for explaining and predicting the behaviour change efforts of individuals specifically in relationship to the sexual transmission of HIV and AIDS. A three-stage model, the ARRM incorporates several variables from other behaviour change theories, including the Health Belief Model, 'efficacy' theory, emotional influences, and interpersonal processes. According to Catania, Kegeles and Coates, (1990) the stages, as well as the hypothesised factors that influence the successful completion of each stage are as follows:

STAGE 1: Recognition and labelling of one's behaviour as high risk

Hypothesised Influences:

1. knowledge of sexual activities associated with HIV transmission
2. believing that one is personally susceptible to contracting HIV
3. believing that having AIDS is undesirable
4. social norms and networking.

STAGE 2: Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities.

Hypothesized Influences:

1. cost and benefits
2. enjoyment (example, will the changes affect my enjoyment of sex?)
3. response efficacy (example, will the changes successfully reduce my risk of HIV infection?)
4. self-efficacy
5. knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs.

STAGE 3 is the action taking stage. This stage is broken down into three phases: information seeking, obtaining remedies and enacting solutions. Depending on the individual, phases may occur concurrently or may be skipped.

Hypothesised Influences:

1. social networks and problem-solving choices (self-help, informal and formal help)
2. prior experiences with problems and solutions
3. level of self-esteem
4. resource requirements of acquiring help
5. ability to communicate verbally with sexual partner
6. sexual partner's beliefs and behaviours

In addition to the stages and influences listed above, Catania, Kegeles and Coates (1990) identified other internal and external factors that may

motivate individual movement across stages. For instance, aversive emotional states (example, high levels of distress over HIV and AIDS or alcohol and drug use that blunt emotional states) may facilitate or hinder the labelling of one's behaviours. External motivators such as public education campaigns, an image of a person dying from AIDS or informal support groups may also cause people to examine and potentially change their sexual activities.

Limitations

A general limitation of the ARRM is its focus on the individual. For instance, many women in an ARRM-based study in Kampala, Uganda, felt at risk for HIV not due to their own behaviour but because of the behaviours of their sexual partners-an issue the women reported was beyond their personal control (McGrath et al., 1993). As a result of this research, McGrath et al. (1993) suggested that the ARRM take into greater consideration the sociocultural issues that influence and may limit an individual's behaviour choices and ability to take action.

Exploration-Understanding-Action Model (EUA) of HIV Counselling

The exploration-understanding-action model of HIV counselling is one of the models which are often used in HIV counselling (NACP, 2009). Under the EUA model, counsellors must first explore with clients their concerns or reasons for seeking counselling. Secondly, there is the need for them to develop a shared understanding of the situation, as the client sees it- this may take one or numerous sessions. Once the counsellor and client arrive together at this level of clear understanding, then they can embark on the third step: action. HIV counsellors should avoid the mistake of racing to attempt and gain

"action", prior to allowing adequate time to truly explore and understand the client's needs and concerns.

Developing individualized risk assessment plan:

i. Within the pre-test counselling phase, after counsellors have begun to explore the issues of HIV and AIDS with their clients and clients have increased their knowledge, counsellors will need to accurately assess a client's risk for HIV.
ii. This is very personal information
iii. Counsellors must show a great deal of sensitivity in encouraging clients to share such information, which they may never have shared with any other person.

For counsellors to assess a client's personal risk, the following could be explored:

i. Current and past sexual behaviour (number of partners, type of partners, frequency of partner change, unprotected vaginal and/or anal intercourse)
ii. Current and past sexual behaviour of client's sexual partner(s)
iii. Current and past drug and/or alcohol abuse behavior of client's partner(s), if known
iv. Client's history of blood transfusion (i.e. date and location, and whether the blood was screened for HIV)
v. Current and past exposure to non-sterile invasive procedures (injections, scarification, non-medical circumcision, tattooing).

Counsellors can use the following Counselling skills and techniques for the risk assessment. They include: empathy and acceptance, actively listening,

probing, repeating, paraphrasing and reframing. Based on the information elicited from clients, counsellors can help clients identify and recognize the connection between the modes of transmission discussed earlier and the particular behaviour or practices that may put them at risk of acquiring or transmitting HIV

Developing individualised risk reduction plan:

i. Personalised risk reduction plan is key to centre and behaviour change-oriented HIV counselling.
ii. The process is interactive and respectful of clients' circumstances and readiness to change
iii. Counsellors elicit from each client an individualised risk profile and, through discussion, assist the client in developing a specific risk reduction plan.
iv. Allow sufficient time to complete each step of the counselling process and not appear rushed or hurried.

At this stage, within the framework of the EUA model, clients will have explored and understood their risk level and are contemplating action. Counsellors should note the following:

i. The risk reduction plan should be challenging, but not so difficult that clients will fail to complete or become frustrated.
ii. Provide several goals, some of which should be easy to attain whiles others should be more difficult.
iii. The risk reduction plan may be written and given to clients to take home for practice.

iv. Open-ended questions should be used (for example, "What can you tell me about your current sexual relationships?") for eliciting detailed information and showing interest without judgment.

Steps for developing an individualized risk reduction plan:

i. The counsellor asks the client to propose some ideas about how to reduce her/his risk of exposure to HIV.

ii. The counsellor may initiate the discussion of risk reduction by listing several alternative risk reduction strategies for the client to consider.

iii. For each risk reduction behaviour, the counselor assesses:

   a. internal and external barriers to change,

   b. perceived efficacy in enacting the new behaviour, readiness to change and

   c. the availability of resources to support change.

iv. In supporting the client's enactment of the personalized risk reduction plan, the counsellor acknowledges and supports :

   a. the client's strengths (e.g. social support, self-efficacy, previous success in changing behaviour) and

   b. assists in problem-solving in areas of concern or expected difficulty in carrying out the plan.

v. If condom use is part of the risk reduction plan, the counsellor should ask the client to tell what he/she knows about condoms and invite the client to practice putting a condom on the penis/vagina model before the counsellor conducts the condom demonstrations.

vi. If the client does not mention condoms, the counsellor may introduce this topic as useful information to have, whether or not the client is planning to use condoms now.

vii. Finally, the counsellor elicits a commitment from the client to try to implement specific behaviour changes before the next counselling session

EMPIRICAL REVIEW

Knowledge of HIV Counsellors

Mahendradhata, Ahmad, Lefèvre, Boelaert and Stuyft (2008) in studying barriers for introducing HIV testing among tuberculosis patients in Jogjakarta, Indonesia, found that knowledge of TB patients on HIV and its transmission was strikingly poor with considerable misconceptions, particularly regarding transmission routes. In addition, they found that knowledge of providers regarding HIV and HIV-TB is also insufficient. A similar lack of knowledge, particularly regarding HIV testing among physicians, was documented in India.

Adekeye (2011) in a study in Nigeria on attitude of counsellors towards undergoing HIV voluntary counselling and testing, found that HIV counsellors had good knowledge of HIV yet some still engage in unprotected sex. This study recommends that periodic seminars and workshops be organized for HIV counsellors to update their knowledge on issues pertaining to HIV and AIDS. Ghana Statistical Service and Ghana Health Service (2009) reported in 2008 Ghana Demographic and Health Survey that awareness of HIV is high but most people need still need education on the issue and therefore, HIV counsellors

should take any opportunity they get to explain issues of HIV to the people they meet.

The conviction held by the National AIDS Control Organization (NACO) is that the clients accessing a voluntary counselling and testing (VCT), prevention of parent-to-child transmission (PPTCT) or ART centre need to understand the context of HIV and AIDS from prevention to treatment and care. Thus, the HIV counsellors are challenged not only to keep abreast with new trends in HIV and AIDS prevention but to continually fine-tune their skills to address various needs of their clients in comprehensive and sustainable manner (International Planned Parenthood Federation, 2002).

Dhadwal, et al. (2009) reported that counsellors need adequate training on all aspects of sexuality and STI/HIV counselling and supervised practice and support. He added that counsellors may not have covered so many issues in sexuality, STI/HIV and gender relations adequately in previous training or may not have applied the training. Helping people to adopt safer sex practices may be more difficult than helping them to use contraception if it involves both partners in life style changes and requires discussing intimate sexual practices.

Sanjana et al. (2009) reported that lay counsellors, when provided with the approved and appropriate training, can play a key role in HIV counselling services. While they can support the provision of good-quality counselling and testing services to relieve overburdened health care workers, they will require on-going supervision to further enhance their performance.

Family Health International (2005) enumerated the following necessary qualities, skills, and knowledge for counsellors. According to FHI, HIV and AIDS counsellor should have adequate knowledge in HIV and AIDS

information, policy frameworks and legal implications. Also, the counsellor should have knowledge of counselling models and skills and their applications. Again, he/she should have skills in pre- and post-test counselling for HIV counselling and testing. Furthermore, the person should have knowledge of how to give and receive feedback, should be trustworthy (honest, reliable and sincere), approachable (friendly, likeable and warm), and able to respond effectively to stress. In addition, the HIV counsellor should be empathetic, non-judgmental, specialist knowledge of where and how to refer clients for: bereavement and loss, reproductive health and infant feeding, prevention of mother-to-child transmission, sexually transmitted infections, tuberculosis treatment, antiretroviral therapy, marital/relational conflict, stress management, drug and alcohol issue and youth issues.

Attitude of HIV Counsellors

Adekeye (2011) in a study in Nigeria on attitude of counsellors towards undergoing HIV voluntary counselling and testing, found that HIV counsellors had negative attitudes towards HIV testing despite providing pre-and post-test counselling to clients who come for HIV test. It was also found that some HIV counsellors engage in unprotected sex in spite of their knowledge in HIV counselling and testing. The study again found that counsellors who by their training or job schedule encourage others to undergo HIV test were themselves unwilling to undergo HIV test. This is an irony because they preach what they do not practice. This study also reveals that counsellors are as vulnerable to HIV as the general population. This study recommends that periodic seminars and workshops be organized for HIV counsellors to update their knowledge on issues pertaining to HIV and AIDS.

A research by Letamo (2005) in Nigeria indicated that some health-care professionals discriminate against and stigmatise PLHIV and AIDS. He added that nurses are seen to relate poorly to people living with HIV. Nursing is a profession that needs a lot more commitment than other jobs. This is because of the interpersonal relationship needed to deal with very sick people for a long time since dealing with sick people is a stressful event. Nurses deal with the same patients for a long time and so need more commitment to work with them. The attitude of a nurse will help in successful nursing practice in such situations. Also, Studies by Bektas and Kulakac (2007) show that some nurses have negative attitudes and are reluctant to providing care to people with HIV and AIDS, resulting in poorer quality nursing support being provided.

From the code of ethics of nurses, the following attitude are to be born in mind: Respect for the rules and regulations of nursing profession, attitude of pride and desire to grow professionally, cheerfulness, optimism and the desire to learn new skills, interest in helping to solve the problems of others, motivation to search for new knowledge towards effective nursing care through various research projects and literature reviews, respect for the dignity and rights of each person, colleagues or client, family and friends and acceptance and understanding of others from different racial and religious backgrounds. These attitudes should guide the nurse and other health-care providers in relating to PLHIV. Further, Reis, et al. (2005) in a study on the attitude of health workers as important determinants of CT uptake reported that 59% of the health professionals who participated in the study said that people with HIV and AIDS should be in a separate ward and 40% believed a person's HIV

status could be determined by his/her appearance. Some of the health professionals in this study actually refused to attend to HIV positive patients. All these make it clear that any discriminating attitude exhibited by health workers will reduce CT uptake.

Attitudes of counsellors are very important. Sexuality is a sensitive subject, therefore, unless counsellors show their clients that they care about and respect them, they will not be able to talk openly about their lives and feelings (Zur, 2011). Counsellors will need time and help to explore their own attitudes to sexual issues and how these may affect their counselling. This presents new challenges in being tolerant and talking about perhaps disapproved sexual practices (Dhadwal, et al., 2009).

Adekeye (2011) in a study on the attitude of HIV counsellors towards HIV testing reported that HIV counsellors have negative attitudes towards HIV testing despite providing pre-and post-test counselling to clients who come for HIV test. As captured in the study, all the participants had good knowledge of HIV but some still engage in unprotected sex. Adekeye found that counsellors who by their training or job schedule encourage others to undergo HIV test were themselves unwilling to undergo HIV test. This is an irony because they preach what they do not practice. This study also reveals that counsellors are as vulnerable to HIV as the general population. This study recommends that periodic seminars and workshops be organized for HIV counsellors to update their knowledge on issues pertaining to HIV and AIDS and that a course dedicated to HIV and AIDS testing be made a part of the curricula for undergraduate studies in counselling education. It is recommended that in other studies, more counsellors should be involved and more settings (schools,

organizations, health-care centres, tertiary institution) could be explored (Britton, 2012).

HIV and AIDS Counsellors Training and Attitude

Counsellor biases can contribute or mediate counsellor's ability to diagnose and plan appropriate interventions. Matteson (2010) found, when assessing a client who had AIDS and endogenous depression, that counsellors who show biases in the kind of treatment they give to their clients may mistakenly overlook appropriate pharmacological and therapeutic interventions. Therapists with higher cognitive complexity were found to handle such issues appropriately.

In a related work, Crawford, Humfleet, Ribordy, Ho and Vickers (1991) found that mental health workers with HIV and AIDS training or education were less likely to hold biases. There is a need for training that includes a focus on content and counsellor attitudes. In addition, Norman, Carr, and Jimenez (2006) found that positive attitudes toward persons who are gay and toward persons with AIDS corresponded with high levels of knowledge. The results of their study suggested the importance of training that includes knowledge based material as well as exploration of attitudes.

Nulty and Edwards (2005) in an exploratory study on experiences and needs of HIV counsellor in South Africa, observed that counsellors need on-going in-service training to ensure that they are regularly equipped with additional skills and knowledge in the following areas: counselling older people without transgressing cultural customs, dealing with sexual matters and handling traditional beliefs with respect to bewitchment. Also, counsellors need training in couple and family counselling.

Practice and Acceptability of HCT

The practice of HCT has always had the following principles underpinning it: HIV test should be based on the '3Cs': testing must be CONFIDENTIAL, accompanied by COUNSELLING and only by informed CONSENT (UNAIDS, 2004). Confidentiality is of immense concern to clients and they must be assured of this during the counselling sessions. This is more so for a disease like HIV and AIDS whose victims are much stigmatised and discriminated against. Studies by Boshamer, et al. (1999) and Peltzer, Nzewi and Krishna, (2004) reported that clients are more concerned about the confidentiality of their HIV test results. The concerns with the privacy of test results were noted in these studies as one of the main reasons given by participants for refusing HCT.

Presently, there are four types of HIV testing: client-initiated/VCT; diagnostic HIV testing of those with symptoms and signs of HIV-related disease like TB; routine health care provider-initiated testing and mandatory screening of blood destined for transfusion or manufacture of blood products (Bekker & Wood, 2006). Data from the HIV unit of the Central Regional Health Directorate indicated that as at 2011, HCT is practiced at almost all health facilities in the region including CHPS centres. Though most of these sites are located within public health facilities, there are few private facilities offering HCT services.

Practice and Care of Counselling

All clients are entitled to good standards of practice and care from counsellors. Good standards of practice and care require professional competence, good relationships with clients and colleagues and commitment to

being ethically mindful through observance of professional ethics (BACP, 2010). HIV counsellors especially should exhibit professional ethics by showing respect, empathy, acceptance and genuineness.

Awuah (2009) in a study on knowledge, attitude and practice of VCT by HIV and AIDS counsellors in the Kumasi Metropolis, found that practitioners of VCT in Kumasi are aware of the UNAIDS guidelines and that the general practice of VCT in the Region, to a large extent, conforms with UNAIDS standards. This is very encouraging news since it is hoped that these counsellors should be able to put their knowledge into actual practice to assist their clients in the region.

Dapaah (2012) in a research in Ghana on HIV and AIDS treatment in two Ghanaian hospitals Experiences of patients, nurses and doctors, reported that HIV clients found the clinic a place where they can associate with and use it as a home outside their personal homes. Dapaah explained that acts of the HIV clients were due to the good practice of health workers who handle these HIV clients. This the clients see as patient-friendly clinic. Dapaah added that the clients see these health facilities as stigma free centres unlike their own homes where the people around them always discriminate against them. This is a little strange because in Ghana people normally are interested in only getting treatment in the hospitals and going back home. If these HIV clients want to make the hospital their home, then it is a call to all Ghanaians to reconsider the way we relate to our brothers and sisters who are suffering from HIV.

Counselling Techniques

HIV prevention counselling is a very important mode of behavioural intervention especially in the absence of an effective vaccine or a curative

treatment. It consists of dealing with a variety of issues such as medical, psychological and social. Wenger, et al. (1992) examined the effect of HIV antibody testing and AIDS education on communication about HIV risk and sexual behaviour and found that counselling strategies about condom use and negotiation, combined with HIV and/or STD testing have been proven effective at reducing risk for HIV and STD transmission when delivered in the context of HIV/STD clinics.

The use of appropriate counselling techniques and strategies in HIV and AIDS counselling is very necessary and important as it helps to build lasting and trusting relationship between the counsellor and the client. It is a relationship that cannot be established by force. It grows out of the warmth of the relationship (Nelson-Jones, 2005). Margolis, Wolitski, Parsons and Gomez (2001) reported that the relationship between healthcare providers and their clients in relation to HIV positive patients is ironically constrained as risk-reduction counselling falls woefully short of required standard. Similarly, counselling for HIV positive individuals who are on treatment for maintaining treatment adherence is also poor.

Thomason (2011) in a survey conducted on best practices in counselling Native Americans, on what counsellors and psychologist should do to make sure their work with Native Americans is culturally appropriate and effective, reported that the respondents in the survey stated that clients should be welcomed warmly and offered refreshments. Intake paperwork should be minimized and clients should be invited to describe the problem or issue from their point of view. The counsellor should use self-disclosure to elicit client talk, and the counsellor should be sure to address the role of culture in the

client's life. Counsellors should talk about confidentiality and expectations for counselling and let the clients determine the content of counselling sessions. Beach, Keruly and Moore (2006), in a cross-sectional study involving One thousand seven hundred and forty-three patients with HIV, indicated that clients whose counsellors know them "as persons" were more likely to receive HAART and also adhere to HAART. The researchers found that a single item measuring the essence of patient-centeredness, the patients' perception of being "known as a person" was significantly and independently associated with receiving and adhering to HAART. These results supported the hypothesis that the quality of client-physician relationship is directly related to the health of the client.

Rautalinkoa (2013) in a research conducted under the theme reflective listening and open-ended questions in counselling: Preferences moderated by social skills and cognitive ability, reported that most therapists preferred using open-ended questions more than other methods of eliciting information from clients. Rautalinkoa added that an effective use of open ended questions depend on the therapist's conceptual level, social skills, and counselling structure. Allyson (2007) on how open-ended questions are used in counselling, reported that clients are often at a loss to know where to start when they attend therapy sessions and open ended questions can widen the area of understanding and lead into a deeper examination of their feelings and emotions. Clarification is employed to make communication clearer so that the counsellor can understand the problem the client has presented for amicable solutions to be agreed upon. For example, the HIV counsellor should make it

clear to the client whose partner is HIV positive that HIV is not transmitted through sleeping on the same bed (Kanekar, 2011).

Rothenberg, Paskey, Reuland, Zimmerman, and North (1995) observed that counsellors regularly encounter ethical, legal and moral dilemmas between respecting patients' confidentiality and autonomy, and protecting patients' sexual partners at risk of HIV infection. Volmink (2002) reported that to prevent further transmission of infection or of re-infection of index patients, sexual partners should be referred for diagnosis and treatment. However, the potential negative effects of partner notification such as domestic violence and divorce raise doubts about its benefits. Van-Schaik and Hamerlinck (2008) stated that a summary in the counselling process presents to the client a brief synopsis of the client story from the counsellor.

Association Between Knowledge and Attitude of HIV Counsellors

Knowledge and attitudes of HIV and AIDS are very important for HIV and AIDS prevention, care and support. Especially, as awareness keeps on increasing. Obiajulu (2009) found that there was a significant but weak correlation between knowledge and attitude of health professionals towards VCT in South Africa.

Association Between Knowledge and Practices of HIV Counsellors

HIV counsellors go through training to sharpen their skills so that they can perform their duties effectively. This means that as HIV counsellors increase their knowledge in HIV counselling and testing, the counsellors should put up good practices during counselling and testing. Obiajulu (2009) in looking at the knowledge, attitude and practice of VCT amongst health

professionals in Umpumulo hospital, South Africa, found a moderately high correlation between VCT knowledge and practices.

Challenges HIV and AIDS Counsellors Face

Dapaah (2012), in a study on HIV and AIDS treatment in two Ghanaian hospitals, found that although up-take of HIV counselling and testing services were high in the two hospitals he used for the study, there is still a challenge with the staff strength, that is, the increase in the number of clients accessing HIV services does not correspondent to the number of HIV counsellors. Awuah (2009) also reported in a study in Kumasi that there is a challenge with staffing for HIV and AIDS counselling and testing. Bond (1995) also reported that shortage of counsellors who provide HIV counselling and testing at the health centres restricts the counsellors to offer only pre- and post-test counselling, rather than on-going counselling, which is regarded as an essential part of providing health care to those infected with HIV.

According to Dapaah (2012), the findings of his study also show that the persistent stigma and its unfavourable repercussions on positive HIV persons had a profoundly negative impact on the use of counselling, testing and treatment services. He added that this had led to concerns about the locations of centres and clinics in the hospitals, and the need for clients to use some services with other patients in certain units of the hospitals. The HIV clients were worried that in some locations, their status as positive persons could be exposed to other patients and people who visited the facilities. The study implies that certain structural or institutional factors in the hospitals such as locations of HIV centres and clinics constrained clients' use of services, while others enabled them to smoothly access HIV services and hide their status.

Another challenge that Dapaah (2012) found was that some health workers could not keep knowledge of clients' status private and breached confidentiality. As a result of this action by these health workers most of the HIV clients feared that HIV testing is not confidential and could lead to unwanted disclosure to spouses and relatives. To such people, silence and denial seemed the most appropriate reactions to fear of stigma. Others also thought that not knowing their HIV status is far preferable to being tested, but looking at the advantages HIV counselling and testing offer for clients, it will be better for these category of people to change their position. All these are signs that there is the need for an intensive education for both health-care providers and the general population at large. Nulty (2003) noted that HIV counsellors face a lot of challenges such as stress, difficulty to follow up on clients who do not come back for a session as the counsellors cannot go to their homes to locate them because of their other duties and transportation, shortage of staff and challenges with management due to lack of communication or even favouritism. The respondents explained that these challenges occurred due to conflict between performing their nursing duties and counselling work.

Gerber (2002) and Seidel (1996) both studied the workload of nurse-counsellors in health institutions and found that nurse-counsellors in health institutions have a demanding workload which makes them see counselling as an additional burden such that some of them either perform counselling "any how" or decide not to do it at all.

Awuah (2009) further found that though the counsellors in the sites are doing their best to promote HIV and AIDS CT, they are still facing financial and logistical problems, and these are preventing them from doing as much as

expected. Awuah again reported that although HIV counsellors in the metropolis have the requisite basic training for the job, they still need to improve on their performances. The study suggested that more staff could be trained if those with additional training would be made to serve as trainers of practitioners.

Hoffmann (2008) in a discussion with 171 HIV and AIDS health care providers in South Africa, reported the following as challenges the healthcare providers face: inadequate training and motivation for healthcare staffs, a lack of appropriately trained and motivated healthcare professionals and technical personnel. Also, loss of trained staff due to transfers was also noted as a major barrier. Again, improving the overall infrastructure of healthcare services was also considered important. The study participants reported that clinical practice is hindered by poor management structure, excessive bureaucracy and lack of resources. The participants added lack of diagnostic equipment and general laboratory facilities as some of the major challenges that prevent the provision of high quality care.

Family Health International (2005) identified burnout as one of the challenges counsellors face. FHI explained that burnout is the gradual process by which a person, in response to prolonged stress and/or physical, mental and emotional strain, detaches from work and other meaningful relationships. The result is lowered productivity, cynicism, confusion, a feeling of being drained and a sense of having nothing more to give. HIV counsellors experience burnout when they are overburdened with normal clinical duties and HIV testing and counselling. This report suggests that if HIV counsellors are not

supported, they may turn to rush clients through the pre-test and post-test counselling.

In a report by AVERT (2011), it was shown that, of those who had received counselling training, less than a quarter were reported to be practising HIV and AIDS counselling and testing. The report added that counsellors often leave their jobs, most probably because of burnout and lack of proper support. If counsellors are given proper support, the stresses which can build up and cause burnout can be reduced. Such support can take three forms:

First, administrative support - this includes the provision of better working facilities and timetables, and job descriptions that accommodate counselling. Second, professional support which refers to where a supervisor discusses cases with the counsellor or provides emotional support to the counsellor and thirdly, peer support which refers to all kinds of supports counsellors receive from their colleagues.

Burnout is a state of emotional exhaustion that results when the counsellor has reached his or her limit to deal with HIV and the emotional stress it causes. This may lead to a state of irritability and anger, often directed at supervisors, colleagues and even clients. The counsellor may also feel despair at the limited number of sources of social or medical support that can be suggested to the client, especially in communities starved of resources. The counsellor may have a privileged awareness of issues directly affecting the client's ability to cope and reduce future risk behaviour, and feel responsible for the client's welfare. However, because of lack of formal recognition and resources, counsellors may find that they have few options to assist the client. Basic counselling skills and processes that counsellors need to note when

dealing with clients who come to them for HIV and AIDS counselling and testing: the counsellors should be compassionate and patient with their clients, be concerned with upholding the rights of their clients. Be committed to clients' well-being and do everything they can to support them. Know your limits and when and where to refer clients for additional help, be willing to learn continuously, even from your mistakes, so that your counselling becomes increasingly helpful to clients. Also, counsellors should be ready to be counselled yourself and should know different cultures. Be aware of cultural differences and ask for a fuller explanation if you do not understand.

Further, De Bellis (1997) on burnout as a challenge for HIV counsellors reported that burnout occurs when the pressures of work erode a counsellor's spirit and outlook and begin to interfere with her personal life. Burnout affects many counsellors and can shorten their effective professional life (Grosch & Olsen, 1994). If the counsellor sees a large number of clients where most of them have history of trauma and does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counselling work of this sort may put her at personal risk (Courtois, 1988). Grosch and Olsen (1994) added that the situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. These complex cases often involve previously traumatized clients who present the counsellor with many personal and treatment challenges.

Other factors that influence individuals not to go for CT include: no need for the test because one is not promiscuous; not ready for CT; CT services are not available in the community; one trusts his or her partner; afraid of

living a stressful life if found positive; uses condoms consistently; and not sexually active (Maluwa-Banda, 2001; Kachingwe, Umar, Mandalazi, Jere, & Chizimba, 2001). In addition, fear of public disclosure has been implicated as an important barrier to HIV-testing and programmes aimed at assisting PLWHAs and their families (Central Statistical Office & ORC Macro, 2012). Kaponda, et al. (2004) found that barrier to HIV testing was associated with fear of testing positive; and no cure for HIV infection. Yoder and Matinga (2004) also established that people would not go for an HIV test if they think that they are not at risk; they do not want to be seen going to a VCT centre, for that would be recognized as that they may have HIV infection; and the fear of being told that they are HIV positive clearly keeps people from being tested. Other barriers to CT attendance include lack of perceived benefit when healthy; inability to communicate with partners; fear of stigmatisation and discrimination; and loss of hope among the ill; and inability to afford ART. In addition, unaware of policies regarding service provision to minors, and fear of legal or other repercussions if they counselled or tested adolescents; judgmental and lack of confidentiality by the health care workers, deter people from seeking VCT (Masingi et al., 2004; Manongi, Marchant & Bygbjerg, 2006) reported that lack of motivation or incentives and poor working conditions such as absence of PITC guidelines, HIV test kits and inadequate physical space were some of the challenges health practitioners faced in offering PITC. A study done in Kilimanjaro and Tanzania among health care workers showed that, motivation was among the important factor in health care performance.

A study by CDC on factors that prevent the provision of high-quality HIV prevention counselling included unavailability of trained counsellors at the setting in which the HIV test was conducted, client reluctance, and low rates of client return for test results after the test had been conducted (CDC, 2001).

Measures to Curb the Challenges HIV Counsellors Face

For HIV and AIDS counsellors to be able to deliverer effective HIV counselling services, there is the need for them to overcome all challenges that are impeding their work. In the first place, Awuah (2009) reported that though the personnel offering VCT services are supposed to be doing it voluntarily, it is envisaged that their 'voluntary' services could be recognized with some form of tangible rewards. It is therefore recommended to all health institutions providing the service to set apart a little of their Internally Generated Fund (IGF) to whip up the enthusiasm of the service providers. This incentive would go a long way to positively affect their delivery and motivate them to give out their best. Awuah (2009) further recommended that more volunteers should be sought to augment the staff.

Again, lay counsellors could be employed to give support to staff nurses and other clinical staff who become very busy with their clinic duties. It has been shown that lay counsellors provide very capable counselling services after they have been trained (UNAIDS, June 2002b).

Psychiatry Dimension of HIV and AIDS Counselling and Testing

RAND Corporation (2010), in a study on mental health and substance abuse issues among people with HIV lessons from HIV Costs and Services Utilization Study (HCSUS), revealed many challenges of mental health and

substance abuse problems among people with HIV. It was found that there was a relatively high access of people with HIV to mental health and substance abuse treatment. Most of the HCSUS participants in the study reported having made some positive changes in health behaviours since their diagnosis. The study added that some 80 per cent of substance users reported having quit or curtailed their drinking or use of other substances since getting to know of their status. This clearly means that if the patients get to know about their status and are counselled they can live normal life and avoid psychiatric problems.

RAND Corporation (2008) and Writer (2007), conducted studies on HIV and AIDS patients and mental health, reported that nearly half of the HIV positive individuals surveyed for the study tested positive for a major psychiatric problems such as depression, anxiety disorder, or panic attacks. The National Mental Health Information Centre says that individuals with simultaneous mental health and substance abuse problems tend to suffer from multiple health and social illnesses that lead to more expensive medical treatments, including hospitalization. The Centre also says that concurrent mental illness and drug abuse increase the risk of homelessness and criminal activity. The RAND study reported that more than 50 per cent of HIV positive individuals prescribed Highly Active Antiretroviral Therapy [HAART] did not take their medications as directed by medical personnel, and that individuals also suffering from mental health or substance abuse problems were the least likely to follow doctors' orders. A recent study by British scientists reinforced this finding, stating that 28 per cent of study participants declined HAART treatments recommended by medical doctors.

In addressing unsafe sexual behaviour, the RAND study says that violence frequently occurs in intimate relationships between HIV positive individuals, and violence and substance abuse often lead to unsafe sex practices. Studies into the factors affecting mental health and substance abuse among HIV positive individuals are continuing, Rand says, as are studies into ways to improve treatment adherence by HIV positive patients.

Galvan, Davis, Banks, and Bing (2008) on HIV stigma and social support among African Americans in a cross-sectional convenience sample of 283 HIV-positive African Americans found that HIV-related stigma and discrimination negatively impact African Americans living with HIV. Galvan, Davis, Banks, and Bing used the social support theory and hypothesized that social support can serve to protect individuals against the negative effects of stressors, such as discrimination, by leading them to interpret stressful occasions less negatively. The study found high perceived social support from friends was associated with less perceived HIV stigma and that information about the beneficial effects of perceived social support from friends and other factors can help to provide guidance to those working to decrease the negative impact of HIV stigma among HIV-positive African Americans.

Herek and Capitanio (1999) in a study in USA on stigma and sexual prejudices reported that a sizable minority of the public equates all male-male sexual behaviour with AIDS, even sex between two HIV-negative men. A substantial portion also expresses discomfort about touching an article of clothing or drinking from a sterilized glass used by a person with AIDS. These misconceptions and discomfort are correlated with sexual prejudice. It was

found that the link between AIDS attitudes and sexual prejudice impedes HIV prevention efforts and threatens civil rights of HIV and AIDS clients.

Again, Herek, et al. (1998) on AIDS and stigma reported that researchers, health care professionals, policy makers and political leaders should fight against stigma in HIV and AIDS since its effects on clients, their caregivers and love ones are not the best. It was also added that if stigma is not avoided all efforts by the populace to prevent the disease in our communities will not yield any results.

Economic Dimension of HIV

HIV and AIDS impose enormous economic, social, health, and human costs and will continue to do so for the foreseeable future. The challenge is particularly acute in Sub-Saharan Africa, home to two-thirds (22.5 million) of the people living with HIV and AIDS globally, and where HIV and AIDS has become the leading cause of premature death. But now, after decades of misery and frustration with the disease, there are signs of hope. HIV prevalence rates in Africa are stabilizing. Between 2001 and 2009, global funding for HIV and AIDS increased tenfold from US$1.6 billion to US$15.9 billion and more than 5 million people in developing countries are receiving treatment (Lule & Haacker, 2011). In many countries, the impacts of and the response to HIV and AIDS pose significant challenges from both a macroeconomic and fiscal perspective. This paper analyses the cost of HIV and AIDS from a fiscal angle, interpreting the HIV and AIDS response as a long-term fiscal commitment, and broadens the scope of the analysis to identify fiscal costs of HIV and AIDS (such as certain social grants) that are not normally included in HIV and AIDS

costing studies, but nevertheless contribute to the fiscal costs of HIV and AIDS (Lule & Haacker, 2011).

The NACP (2009) reported that the HIV epidemic exerts higher toll of mortality among the youth and the economically productive groups. This implies greater number of HIV orphans and its social ramifications and decreased economic productivity.

Social Dimension of HIV and AIDS Counselling and Testing

HIV Counsellors need to be sensitive to the client's world and culture and how HIV and AIDS are perceived within the client's world and culture. Counsellors should also explore with their clients prevailing beliefs about HIV infection and counselling. This will help the counsellor to clarify any misconception of the client (Theilgaard, et al., 2011). A study on addressing the fear and consequences of stigmatization - a necessary step towards making HAART accessible to women in Tanzania has shown that stigmatization of HIV infected women is still widespread and that fear of the consequences of stigma is a major threat to uptake of HAART by HIV infected women. The consequences feared by the participants were abandonment by their partners, loss of income and social degradation.

Combating stigma in the community, although essential, will take time. Therefore, necessary steps toward encouraging HIV infected women to seek treatment should be opted for. Theilgaard et al. (2011) reported that it is not surprising for the general public, as well as healthcare professionals, to assume that HIV diagnosis may lead to acute distress, including anxiety, depression, or suicide. This concern was confirmed in the literature, showing a high prevalence of emotional distress, psychopathology, and suicide among HIV-

infected people (Perry & Sieving, 1984; Chuang, Devins, Hensley & Gill, 1989; Dew, Ragni & Nimorwics, 1990).

Herek, Capitanio, and Widaman (2002) examined how illness-related stigma is symbolically expressed through public attitudes toward health policies. Data from a 1999 national telephone survey with a probability sample of English-speaking US adults (N = 1,335) were used to assess how support for HIV surveillance policies is related to AIDS stigma and negative attitudes toward groups disproportionately affected by the epidemic. Anonymous reporting of HIV results to the government was supported by a margin of approximately 2-to-1, but name-based reporting was opposed 3-to-1. Compared to opponents of name-based reporting, supporters expressed significantly more negative feelings toward people with AIDS, gay men, lesbians, and injecting drug users, and were significantly more likely to overestimate the risks of HIV transmission through casual contact. More than one third of all respondents reported that concerns about AIDS stigma would affect their own decision to be tested for HIV in the future.

In trying to find out the reasons why some adolescents (272 high risk aged 13-23 years) in the USA do not go for HIV test. Rotheram-Borus, Draimin, Reid and Murphy (1997) found out that the most common reasons included: Lack of importance of the test or result (14%), and fear of losing current housing (10%).

Increased violence after HIV infection is a reality (Zieler et al., 2000; Gielen, O'Campo, Faden & Eke, 1997; Sowell, Phillips, Seals, Murdaugh & Rush, 2002). In a study of 2864 HIV positive adults, Zieler, et al. (2000) found that 20.5% of women, 11.5% of MSM, and 7.5% of heterosexual men reported

physical harm since diagnosis, of whom half reported HIV status as a cause of physical harm. Violence is particularly common in women. Victorian Health Promotion Foundation (2008), in a research on violence against women in Australia as a determinant of mental health and wellbeing, found that violence against women is not only a serious breach of human rights, but has major health, social and economic consequences for women, their families and communities. This means that not only can gender-based violence lead to HIV infection, but it may also be a consequence of it.

Sowell et al. (2002) studied 275 HIV positive women between the ages of 17 to 49 years. Before becoming HIV infected, 65% of them reported having been physically or sexually abused. After HIV diagnosis, 33% of the women reported being physically abused. However, after reviewing the literature regarding violence and HIV status among women, Koenig and Moore (2001) found that violence is not statistically increased among HIV positive infected women compared to demographically and behaviourally similar uninfected women. They added that, for a small proportion of women, violence may occur around disclosure or in response to condom negotiation with their partners. Isaksen, Songstad and Spissoy (2002) in a research on the socio-economic effects of HIV and AIDS in African countries, reported that since majority of the population in Africa is already poor and vulnerable, the effect of the pandemic is serious. The poorer households and in particular women and children are the worst affected. Isaksen, et al. added that agricultural production, which is a key importance for incomes and food supply, has dropped from already low levels. Families and communities break apart and young people's future becomes insecure. The manufacturing sector, transport,

mining, construction, tourism and the financial sector has been hit in various ways. These effects have resulted to considerable reductions in the growth rate of GDP per capita as a result of the AIDS pandemic. The study argues that the fight against HIV and AIDS in Africa must come at the top of national and international agendas. Inungu (2008) on psychosocial issues associated with HIV Testing and OTC Home-Use HIV Tests came out with the following findings:

1. People seek HIV testing for various reasons. The fact that adolescents appear to seek HIV testing following a recent high risk exposure is a matter of concern. More HIV education is needed in this age group.
2. That majority of studies done on the topic were unanimous about the relief of emotional distress following a negative test.
3. Although death from suicide is common among people with advanced HIV infection, notification of a positive HIV test does not appear to lead to a sudden and substantial rise in suicide death.
4. Social adverse reactions do occur following HIV diagnosis. They are often associated with lack of knowledge and fear.

Singh and Banerjee (2004) reviewed social issues in HIV in India and reported that the unequal status of women in most societies makes them vulnerable to HIV infection. They found that gender inequities prevent women on insisting that male partners wear a condom during sexual intercourse even when they she suspects the man of high risk behaviour. Again, they added that since the spread of HIV is linked to certain patterns of human behaviour, which is linked to both biological and socio-cultural determinants, any attempt to

control its spread must take into account the complex social, cultural, economic and environmental factors in which the disease is embedded.

Further, at the family level, an adult with AIDS will severely compromise household resources as the functional capacity to work is reduced, medical expenditures increase and the income of both the infected individual and those who care for that person is lost. Reduced income in turn threatens food supply, the ability to pay for the education or health of surviving family members. The entire social fabric of the family is potentially disrupted. The AIDS pandemic has given a sharp focus to issues such as confidentiality, discrimination, access to health care, prenatal testing/abortion and the conduct of clinical/vaccine trials.

Singh and Banerjee (2004) found that although ideally, the disclosure of HIV status of the person should not affect the rights of the person to employment, position at the workplace, right to medical care and other fundamental rights, unfortunately, one of the biggest problems faced by HIV positive person is stigma which results from the issues above. It is so sad to note that even doctors were found to be discriminating against HIV positive clients, which leads to discrimination in medical care. This stigma can prevent people from being tested they added.

AVERT (2011) on HIV and AIDS-related stigma and discrimination reported the following examples of stigma and discrimination in the society. They include being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment.

UN Secretary-General, Ki Moon (2008) reported that social stigma has been the single most important barrier to public action. He added that stigma has become the main reason why many people are afraid to go for the HIV test or to seek treatment. According to him, this problem of stigmatisation helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

Research by AVERT (2013) also found the possible consequences of HIV-related stigma as follows: loss of income/livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of caregiving in the home, loss of hope and feelings of worthlessness and loss of reputation. People living with HIV are stigmatized leading to severe social consequences related to their rights, health care services, freedom, self-identity and social interactions. It also severely hampers the treatment and diagnosis of HIV contributing to further spread of the disease (Piot, 2002; Bharat, 1999; Mawar & Paranjape, 2002).

Psychological Dimensions

Majority of studies conducted have shown that people experience a high degree of distress at the time of testing (Perry & Tross, 1993, Sieff, Dawes & Loewenstein, 1999). Rotheram-Borus, et al. (1997) also reported that a lot of people do not go for HIV test due to fear of being under increased stress and fear of committing suicide.

According to Tomaszeski (2001), HIV and AIDS infected individuals and their families are forced to cope with a multitude of stressors. It is therefore important for doctors, mental health counsellors and HIV counsellors to

provide supportive psychotherapy to their HIV clients to help them improve quality of life, increase compliance with medical care and medication regimens, and address mental health disorders that may be threatening them.

Summary of Literature Review

This chapter examined literature related to the present study. Regarding the conceptual issues, general issues about HIV and AIDS counsellors and the expected knowledge they are supposed to possess were discussed. With respect to the theories that underpin this study, the AIDS Risk Reduction and Exploration-Understanding-Action Models were adopted. These two related models stress the importance the HIV and AIDS counsellor's knowledge in practising HIV and AIDS counselling and testing and putting the client at the centre stage of the counsellor's activities. Some empirical works were also reviewed, which covered issues relating to knowledge, attitude and practices of counsellors. Aspects of the psychological, economic and social dimensions HIV and AIDS were also discussed. The related works have been very useful in providing the needed background knowledge for the present study.

CHAPTER THREE

METHODOLOGY

In this section, the various methods that were used to collect and analyze data are discussed. The section also discusses the research design, the population, sample and sampling procedures, instruments for the data collection, the data collection procedures as well as the data analysis procedure.

Research Design

Descriptive survey was employed for this study. It is a type of designed that produces a 'snapshot' of a population at one or more points in time and is concerned with the present status of a phenomenon. The survey was used because it is comparatively quick and cheap to conduct and administer. It also enables researchers to identify the proportions of people in particular groups and controls the effects of subjects participating twice (Krejcie & Morgan, 1970). The study employed both qualitative and quantitative methods.

Although this design has some loopholes such as difficulty in getting respondents to answer questions thoughtfully and honestly, it is considered the best for the study since it deals with interpreting the relationship among variables and describing their relationships (Gay, 1992).

Population

The target population of the study consisted of all HIV counsellors in the Central Region. According to the Central Regional Health Directorate, there were 390 HIV counsellors in all the health facilities in the Central

Region. The accessible population however was all HIV counsellors in the Central Regional Hospital, Cape Coast Metropolitan Hospital, Municipal, District Hospitals or Health Centres in the Central Region.

Sample and Sampling Procedure

The sample for the study was 140, which included HIV counsellors in the Central Regional Hospital, Cape Coast Metropolitan Hospital, municipal and district hospitals and health centres in the Central Region as shown in Table 1. A criterion was set to guide the selection of the participants for the study, thus, apart from the Central Regional Hospital and Cape Coast Metropolitan Hospital, all municipal hospitals, district hospitals or district health centres with five or more counsellors were included in the study. The selection procedure for the respondents was that at each hospital, the HIV coordinators were informed to organize the counsellors for briefing, signing of the consent forms and filling of the questionnaires. An arrangement was then made for the observation.

Purposive sampling was used to select the respondents. Again, convenience sampling was used to select the respondents for the observation. According to Amedahe (2002), convenience sampling is used when it is impossible to select a random sample. I was able to observe counsellors from six hospitals, that is, Central Regional Hospital, Twiffo Praso Government Hospital, ST. Francis Xavier Hospital, Assin Foso, Saltpond Government Hospital, Our Lady of Grace Hospital, Breman Asikuma, and Abura Dunkaw Government Hospital. In all, 20 counsellors were observed for the study.

Table 1: Names of Hospitals/ Health Centres and the Number of HIV Counsellors used

HOSPITAL	NO. OF HIV COUNSELLORS
Central Regional Hospital	28
Kasoa Health Centre	17
Our Lady of Grace, Breman Asikuma	14
Twiffo Praso Government Hospital	13
Cape Coast Metropolitan Hospital	12
Saltpond Government Hospital	10
St. Francis Xavier Hospital, Assin Foso	10
Elmina Health Centre	9
Winneba Government Hospital	8
Swedru Government Hospital	8
Abura Dunkwa Government Hospital	6
Apam Catholic Hospital	5
TOTAL	**140**

Source: field work, 2011

Instruments

Questionnaire and observation guide were used to collect the data from the respondents. This is because both questionnaire and observation guides have proven to be very reliable when the items are carefully drawn.

Questionnaire

The main data collection instrument was a self-developed questionnaire (Appendix A). The questionnaire consisted of seven sections. The Section A of the questionnaire illustrated the goals and significance of the study, the rights of the participants, and some instructions on how to respond to the items. This was followed by items on demography. The Sections B, C, D, E, F and G were

structured along the following headings: Knowledge of HIV counsellors on HIV counselling and testing; Attitude of HIV counsellors on HIV counselling and testing; Practices of HIV counsellors on HIV counselling and testing; the use of appropriate counselling techniques during counselling and testing sessions; challenges HIV counsellors face; and measures to curb the challenges HIV counsellors encounter.

The use of the questionnaire was preferred because it ensures a wider coverage and enables researchers have personal contact with respondents. This minimizes the problem of no-contacts which other methods face. The questionnaire was also used in the study because, in comparison to other methods, it is characterized by its impersonality. In other words, the items were the same for all respondents, anonymity is respected, and there are no geographical limitations to its implementation. Although questionnaires have potential low response rate, it is relatively economical in both cost and time, and it allows time to carefully check the content of the items that are likely to yield more accurate information (Amedahe, 2010). According to Amedahe (2010), researchers can get the right responses from respondents when they use questionnaires.

The items in sections C, D, and E were structured along the lines of the Likert-type scale. This is because it enables the respondents to indicate the degree of their beliefs in a given statement (Malik, Mushtaq, Khalid, Khalil, & Malik, 2009). It is also easy to construct, administer, and score. The statement on the Likert-type scale was structured on a four-point scale which required the respondents to indicate the extent to which they agree or disagree ranging from Strongly Disagree (SD), Disagree (D), Agree (A), and Strongly Agree (SA).

The four point scale was used because it can help to avoid the mid-point which is undecided (Joshua, 2005).

Observation Check-List

The purpose for the use of the observation check-list (Appendix B) was to observe the techniques HIV counsellors use during the counselling session. The observation guide was chosen from UNAIDS, that is, a check-list used to observe HIV counsellors. Actually, the observation guide was used to corroborate or confirm the responses that were given in the questionnaire.

Pre-testing of Instrument

Scholars in research methodology advise that in order to test the validity and reliability of research instruments, the instruments need to be tested with a small sample similar to the potential respondents (Frankel & Wallen, 2003). The questionnaire was pre-tested at Ankaful General/Leprosarium and Planned Parenthood Association of Ghana (PPAG) Hospitals. Ankaful General/Leprosarium and PPAG Hospitals have HIV counselling and testing facilities and HIV counsellors who have similar characteristics as those in the other parts of the Central Region where I used for the study. The pilot-testing was very essential because it allowed the researcher to check the clarity, the applicability and acceptability of the items as well as the clarity of the instructions. Also, this exercise gave me the opportunity to ensure that the items yielded the desired information and what the results of the main study would be. In all 20 counsellors were used for the pilot-testing of the instrument. Cronbach alpha of 0.81 was obtained.

Validity and Reliability of the Instruments

Reliability according to Uys and Basson (1991) mean the degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure. Because all measurement techniques contain some error, reliability exists in degrees and is usually expressed as a form of correlation coefficient Folkman and Lazarus (1988) reported internal consistency coefficient of 0.61 to 0.79 on the ways of Checklist.

The face and content validity of the instruments were addressed by submitting the content of the questionnaire and the observation guide to the researcher's supervisors whose comments and recommendations were used to revise the initial items. The observation checklist has the following strengths: first, the observation guide is time and labour efficient. Again, the checklist is comprehensive, that is, it may cover many developmental areas. Also, the checklist is a documentation of development, thus, other researchers can adopt or adapt it to suit their situation. It is quick and simple to use and a fast way of presenting a great deal of information. It can assist the researcher to do follow up for respondents with difficulties. On the other hand, the checklist has the following weaknesses: The checklist loses details of the event. Also, the checklist may be biased by the recorder. The checklist depends on the criteria to be clearly observable. The checklist may have many items to check, making it time consuming. Further, it may allow for narrow and limited information. Finally, a checklist may not give a true picture on the day if the observer is upset or not feeling well.

Data Collection Procedure

Each hospital was contacted separately and an arrangement was made to administer the questionnaire and observe the respondents. The questionnaires were distributed to the targeted samples between 1st and 15th February, 2013 whiles the observation was carried out between 1st and 15th March, 2013. I distributed the questionnaires and did the observation myself in all the hospitals. This was done in order to (a) explain the goals of the study; (b) direct the counsellors' attention to their rights during the course of the study; (c) clarify the instructions for answering; and (d) obtain a good return rate and more accurate data.

The respondents were given consent forms to fill after an explanation of the rational for the study had been done. A copy of the consent form can be seen in the appendix C. In order to ensure successful collection and sorting of the questionnaires, each questionnaire was given a serial number according to the separate hospitals.

Data Analysis

The data was checked for mistakes committed by respondents. The questionnaires were given special serial numbers, coded and entered into the computer for analysis. The challenges the counsellors faced and measures they employed to overcome the challenges were captured and discussed. Data was coded and entered into the computer. A 10% random sample of questionnaire was checked against the data entered. Statistical analysis of the quantitative data was conducted using Statistical Package for the Social Sciences (SPSS) version 16. Descriptive statistics was used to illustrate the sessions A, B, C, E

and F. Frequencies and percentages were used to analyse the research questions.

Analytical statistics namely Pearson correlations was used to compare relationship among variables. Correlation analysis allows one to examine the extent of the interrelatedness of variables such as knowledge and attitude, knowledge and practices, as suggested by Noar and Zimmerman (2005).

CHAPTER FOUR

RESULTS AND DISCUSSION

The purpose of this study was to investigate the knowledge, attitude and practices of HIV and AIDS counsellors in the Central Region. A set of questionnaire was used to extract information from the respondents with regard to the objectives stated. An observation checklist was also used to find out whether the HIV and AIDS counsellors were really doing what they have been trained to do. Descriptive statistics was used to illustrate the demographic profile of the participants, their knowledge level, attitude and practices. Statistical tools such as descriptive statistics (frequencies and percentages) and Pearson Product Moment Correlations were employed to analyse the research questions and test the hypotheses respectively. Table 2 to 20 deal with the characteristics and background of the respondents.

Background Information on the Respondents

Table 2 looks at the unit/department of the HIV and AIDS counsellors in the Central Region of Ghana. Ghana Health Service and the National AIDS/STI Control Programme (NACP) train health professionals who work at the various units and departments of the hospitals. Though there are some health care personnel who are permanently stationed at the HIV counselling unit, majority of the counsellors work at the various units and departments in the hospitals. At places where special days are set up for HIV and AIDS clinic, HIV counsellors in the other units/department of the hospitals join the HIV

counsellors at the counselling unit to attend to the clients. This section was meant to gather information on the background of the HIV counsellors in the Central Region. This is presented in Table 2 to 7 below.

Table 2 presents the unit/department of the counsellors. It shows the various frequencies and percentages**.**

Table 2: Unit/Department of the Counsellors

Unit/Department	No.	%
HIV counselling /ART centre	47	33.6
Maternity Ward	28	20.0
Ante Natal Centre (ANC)	10	7.1
Reproductive and Child Health (RCH)	43	30.7
Out Patient Department (OPD)	3	2.1
Emergency unit	2	1.4
Male ward	1	0.7
Kids/children's ward	2	1.4
Female medical ward	3	2.1
Obstetric and gynaecological ward	1	0.7
Total	**140**	**100**

Source: field work, 2013

From Table 2, 47 (33.6%) HIV counsellors who were involved in the study came from the HIV counselling/anti-retroviral therapy (ART) unit. This was followed by 30.7 % from the reproductive and child health (RCH) unit, 20 % of the total respondents also came from the maternity unit which is in charge

of prevention of mother to child transmission (PMTCT) services. The rest of the respondents came from the various wards and out patients department (OPD). These were: ANC 7.1 %, OPD 2.1 %, emergency unit 1.4 %, male ward 0.7 %, kids/children's ward 1.4 %, female medical ward 2.1, obstetric and gynaecological ward 0.7 %.

This means that HIV counsellors in the various hospitals do not work at the HIV unit alone, but they can be found at the wards and OPD. Again, it also means that the GHS and NACP have trained counsellors who can be found at the HIV unit and the other wards/units of the hospital.

Table 3 discusses the profession of the counsellor. It shows the various frequencies and percentages**.**

Table 3: Profession of the Counsellor

Profession of Counsellors	No.	%
RGN	15	10.7
RMW	30	21.4
RCHN	59	42.1
RGN/MW	16	11.4
OTHERS	20	14.3
Total	**140**	**100**

Source: field work, 2013

Table 3 focuses on the profession of the HIV counsellor and shows that 42.1 % were registered community health nurses and they constitute the group of health care professionals who are more involved in the counselling and testing in the Central Region. This may be due to the fact that more community

health nurses are being trained to support the provision of health care in the region. Again, registered midwives formed 21.4 % of the total respondents. They represent the second highest profession. This could be so because most of the midwives provide PMTCT services, which is one of the means Ghana Health Service is using to prevent pregnant woman from transferring the disease to their babies. Registered general nurses and or midwives also form another group of health care professionals who provide HIV counselling and testing services. The others include all other health care professionals who are not part of the categories found on the table above and constitute 14.3 %. This includes medical officers, medical assistants, pharmacists, psychologist, data entry officers, disease control officers and social workers. Acquah and Emmart (2010), in their assessment of staffing needs for ART, PMTCT and VCT, reported that the following categories of health care professional should be allowed to help in the operation of HIV counselling services in Ghana. They include: Medical Officers, Medical Assistants, Nursing Officers, Midwives, Disease Control Officers, Community Health Nurses.

Table 4 talks about the academic qualification of the respondents. It shows the various frequencies and percentages**.**

Table 4: Academic Qualification of Respondents

Academic Qualification of Counsellors	No.	%
Master's degree	2	1.4
Bachelor's degree	11	7.9
Diploma	23	16.4
Certificate	94	67.1
SSCE/GCE O/A LEVEL	10	7.1
Total	**140**	**100**

Source: field work, 2013

Table 4 depicts the academic qualification of the respondents. This shows that 94(67.1%) HIV counsellors hold certificates as their highest academic qualification; this represents the majority of the respondents. 23(16.4%) were diploma holders in their fields of specialization, 11(7.9%) were bachelor degree holders, 10(7.1%) have Senior Secondary School Certificate/West Africa secondary school certificate or General Certificate in Education Ordinary/Advance Levels and 2(1.4%) hold master's degree.

Table 5 presents the work experiences of the HIV counsellors. It shows the various frequencies and percentages**.**

Table 5: Work Experiences of HIV Counsellors

Work Experiences of Counsellors	No.	%
less than 5 years	85	60.7
between 5 and 10years	49	35.0
above 10 years	6	4.3
Total	**140**	**100**

Source: field work, 2013

With regard to the number of years HIV counsellors have worked, 87(60%) respondents indicated that they have worked for less than 5 years, 49(35%) respondents have worked between 5 and 10 years, whilst 6(4.3%) responded that they have worked as HIV counsellors for more than 10 years.

Table 6 discusses whether the HIV counsellors have attended HIV counselling and testing training course before. It indicates the various frequencies and percentages**.**

Table 6: Have you Attended HIV Counselling and Testing Training Course Before?

Subscale	No.	%
No	20	14.3
Yes	120	85.7
Total	**140**	**100**

Source: field work, 2013

Table 6 focuses on whether HIV counsellors have attended HIV and AIDS counselling and testing training before. With regards to this question,

120(85.7%) of respondents said yes to the question. This indicates that majority of the counsellors in the region have gone through the required training and therefore are expected to have good knowledge on the issues, exhibit the desired attitude of HIV counsellor and finally put up good practices that can attract people to patronize HIV counselling and testing in the region. 20(14.3%) responded no to the question. Though the percentage seems to be small, looking at HIV and AIDS and the issues surrounding it, it is alarming since these people may not be able to understand the issues and put up the desired attitude and practices which may affect their performances.

Further, considering the role counselling play in HIV and AIDS counselling and testing, one may become confused about the counselling techniques that these counsellors may use to assist the HIV and AIDS clients who come to them. From table 4, one may be more confused considering the number of SSCE/GCE O/A Level holders who are involved in this technical area, should this group form part of those who have not attended training.

Table 7 discusses other roles of the HIV counsellor. It shows the various frequencies and percentages**.**

Table 7: Other Roles of the Counsellor

Other Roles of Counsellors	No.	%
Ward nurse	30	21.4
Nurse prescriber	29	20.7
Run HIV clinic	47	33.6
OPD	11	7.9
Specialist clinic	23	16.4
Total	**140**	**100**

Source: field work, 2013

Results in Table 7 show that 33.6% of HIV counsellors run HIV clinic. This category of counsellors could be seen in two ways. There is one category of HIV counsellors who are stationed at the HIV counselling/ART centre. They perform all their duties at the HIV unit. The other category of counsellors is those who perform their duties as health care providers but attend to HIV clients who come to their wards/unit and sometimes give helping hand to those at the HIV unit during HIV and AIDS clinic days. This implies that HIV counsellors perform more roles, which may cause burn out.

Research Question One: What is the Knowledge of HIV Counsellors in Counselling and Testing in the Central Region?

Table 8 displays the output on the items that looked at the knowledge of the counsellor on HIV counselling and testing. It shows the various frequencies and percentages.

Table 8: Descriptive Statistics on Knowledge of Counsellors in Counselling and Testing in the Central Region

Statements	No No (%)	Yes No (%)
HIV can be detected in the individual at any time of the infection.	115(82.1)	25(17.9)
All client who test negative for the first time are actually negative.	125(89.3)	15(10.7)
All clients who test positive for the first time are HIV positive.	120(85.7)	20(14.3)
Once tested HIV positive, the individual remains HIV positive for life.	12(8.6)	128(91.4)
HIV antibody test can detect positive case in children below 18 months.	23(16.4)	117(83.6)
Most HIV positive mothers may transmit the virus to their children when mother to child transmission intervention is not done.	4(2.9)	136(97.1)
Single sexual intercourse with HIV infected person can transmit the virus to one's sexual partner.	7(5.0)	133(95)
Sexual intercourse is the only way of acquiring HIV.	128(91.4)	12(8.6)

Table 8 continue

Heterosexuals are at equal risk of HIV infection as homosexuals.	19(13.6)	121(86.4)
Health workers can contract the virus through single needle prick injury.	19(13.6)	121(86.4)
Pneumonia is a common infection in HIV infected individuals.	66(47.1)	74(52.9)
Diarrhoea is one of the major problems for HIV infected individuals.	12(8.6)	128(91.4)
HIV infected individuals may lose more than 10% body weight without any underlying cause.	23(16.4)	117(83.6)
Cancers are common in HIV infected individuals.	90(64.3)	50(35.7)
Skin cancers and other dermatological conditions are more prevalent in HIV positive individuals than those who are HIV negative.	12(8.6)	128(91.4)
Is it possible for HIV infected individuals to live normal with family members without infecting them.	2(1.4)	138(98.6)
TB is a major cause of death for most HIV positive individuals.	6(4.3)	134(95.7)
Mental disorders are common in individuals with HIV infection.	79(56.4)	61(43.6)
Cardiac conditions are more prevalent in HIV positive individuals than people who do not have HIV.	95(67.9)	45(32.1)
A CD4 count (level of immune system) of less than 350 requires anti-retroviral therapy (ART) intervention.	10(7.1)	130(92.9)
CD4 level (level of immune system) checks are not necessary for all clinic attendance by HIV positive persons.	90(64.3)	50(35.7)
Hepatitis B testing is mandatory for all those coming for HIV test.	41(29.3)	99(70.7)

Table 8 continue

Syphilis screening is mandatory for all those who come for prevention of mother to child transmission (PMTCT) test in the Central Region.	52(37.1)	88(62.9)
Liver and kidney functioning test are necessary for proper management of HIV infected individuals on ART.	26(18.6)	114(81.4)
Zidovudine is not one of the major ARTs for HIV infected individuals.	123(87.9)	17(12.1)
An HIV positive individual cannot marry an HIV negative individual without infecting him/her.	100(71.4)	40(28.6)
Condom use provides 100% protection against HIV infections.	92(65.7)	48(34.3)
Sero–discordance (where one couple has HIV but the other does not) is becoming a common issue in HIV counselling and testing.	10(7.1)	130(92.9)
Confidentiality is absolute in HIV counselling.	9(6.4)	131(93.6)
Pre-test counselling sessions are organised to prepare the client for HIV test.	1(0.7)	139(99.3)
Post-test counselling is organised to prepare the client to receive and accept his/her HIV test result.	0(0.0)	140(100)
Counsellors are expected to help client explore ways of coping with life effectively.	0(0.0)	140(100)

Source: field work, 2013

From Table 8, regarding the issue of whether HIV can be detected in the individual at any time of the infection, 82.1% of HIV counsellors responded “no” and 17.9% responded “yes”. This means that majority of the respondents are of the view that HIV cannot be detected in the individual at any time of the infection. With the issue of whether all clients who test negative for the first time are actually negative, 10.7% responded “yes”, and 89.3% of respondents answered “no”. Thus, majority of the respondents are of the view that not all the clients who test negative for the first time are actually

negative. It was also evident that majority of the counsellors support the view that not all clients who test positive for the first time are HIV positive.

With respect to the issue of whether HIV Counsellors think that once tested HIV positive, the individual remains HIV positive for life, 12(8.6%) of respondents answered "no", and 128(91.4%) responded "yes". This means that most of the respondents supported this view. From Table 8, on the issue of whether antibody HIV test can detect positive cases in children, 23(16.4%) of respondents answered "no", and 117(83.6%) responded "yes" This means that majority of the respondents are of the view that antibody HIV test can detect positive cases in children. It was also found out that majority of the respondents were of the view that most HIV positive mothers may transmit the virus to their children when mother to child transmission (MTCT) intervention is not done. With this, 97.1 HIV counsellors answered yes to the item.

In connection with the issue of whether single sexual intercourse with HIV infected person can transmit the virus to one's sexual partner, 7(5.0%) of respondents answered "no", whilst 133(95.0%) responded "yes". It is clear that majority of the respondents are of the view that, indeed, a single sexual intercourse with HIV infected person can transmit the virus to one's sexual partner. The respondents were asked to state whether sexual intercourse is the only way of acquiring HIV; 91.4% of them answered "no", whilst 8.6% responded "yes". This indicates that most of the respondents are of the view that sexual intercourse is not the only way of acquiring HIV. This confirms the view that, HIV is found in blood, semen, vaginal fluids, and breast milk. In this case, it can be transmitted in any of these four media (Ministry of Health, Uganda, 2005; UNAIDS, 2011).

Regarding the view that heterosexuals are at equal risk of HIV infection as homosexuals, 13.6% of respondents answered "no"; a great majority of respondent, 86.4%, responded "yes". The issue of whether health workers can contract the virus through single needle prick injury also came up. Here, 19(13.6%) of respondents answered "no", whilst 121(86.4%) responded "yes". This means that majority of the respondents are of the view that health workers can contract the virus through single needle prick injury.

On the issue of whether pneumonia is a common infection in HIV infected individuals, 47.1% of respondents answered "no" whilst 52.9% responded "yes". This means majority of the respondents were of the view that, pneumonia was a common infection in HIV infected individuals. It was also evident that diarrhoea is one of the major problems for HIV infected individuals. With this, 91.4% of the counsellors supported it.

According to the respondents, HIV infected individuals may lose more than 10% body weight without any underlying cause: 16.4% of respondents answered "no" and 83.6% responded "yes". However, the respondents did not support the issue of cancers being common in HIV infected individuals: 64.3% of respondents answered "no" and 35.7% responded "yes".

Table 8 shows that majority of the respondents are of the conviction that skin cancers and other dermatological conditions are more prevalent in HIV positive individual than those who are HIV negative: 91.4% of the respondents supported this view. The respondents also supported vehemently the fact that it is possible for HIV infected individuals to live normal with family members without infecting them. In this case, a whopping 98.6% responded "yes". Again, a greater number of the HIV counsellors were of the

view that TB was a major cause of death for most HIV positive individuals: 95.7% held this view. These views are quite impressive as they correspond with the view of the Ministry of Health, Uganda (2005) that HIV counsellors are required to understand and communicate to clients a number of facts about HIV; these include how it is transmitted, diagnosed, progression of the disease, and how HIV treatments work. It is also important that HIV counsellors understand how sexually transmitted infections (STIs) are transmitted, treated, and relate to HIV. As HIV fuels the tuberculosis (TB) epidemic, it is important that counsellors understand the relationship between HIV and TB, and the role counselling plays in addressing TB-HIV co-infection.

Regarding the issue of whether mental disorders are common in individuals with HIV infection, 43.6% responded "yes" and 56.4% of respondents answered "no". This means that majority of the respondents are of the view that mental disorders are not common in individuals with HIV infection. On the issue of whether cardiac conditions are more prevalent in HIV positive individuals than people who do not have HIV, 32.1% responded "yes" whilst 67.9% of respondents answered "no". Thus, majority of the respondents did not support that view.

In connection with the issue of whether a CD4 count (level of immune system) of less than 350 requires anti-retroviral therapy (ART) intervention, 7.1% of respondents answered "no" whilst, 92.9% responded "yes". It is clear that majority of the respondents are of the view that, a CD4 count (level of immune system) of less than 350 requires anti-retroviral therapy (ART) intervention. On the issue of whether a CD4 level (level of immune system) checks are not necessary for all clinic attendance by HIV positive persons,

35.7% responded "yes" that, a CD4 level (level of immune system) checks are not necessary for all clinic attendance by HIV positive persons whilst 64.3% of respondents answered "no". Thus majority of the respondents do not agree that, a CD4 level (level of immune system) checks are indeed necessary for all clinic attendance by HIV positive persons. Also, majority of the respondents are of the view that, Hepatitis B testing is mandatory for all those coming for HIV test.

It was obvious that majority of the respondents (62.9%) are of the view that, Syphilis screening is mandatory for all those who come for prevention of mother to child transmission (PMTCT) test in the Central Region. Also, most of the counsellors supported the view that liver and kidney functioning test are necessary for proper management of HIV infected individuals. With this, 81.4% supported this view.

Table 8 also dealt with the issue of whether Zidovudine is not one of the major ARTs for HIV infected individuals. With this, 87.9% of respondents answered "no". This means that majority of the respondents are of the view that Zidovudine is not one of the major ARTs for HIV infected individuals. On the issue that an whether HIV positive individual cannot marry an HIV negative individual without infecting him/her, 40(28.6%) responded "yes" that an HIV positive individual cannot marry an HIV negative individual without infecting him/her whilst 100(71.4%) of respondents answered "no". This means that the majority of the respondents are of the view that an HIV positive individual can marry HIV negative individual without infecting him/her.

With respect to whether condom use provides 100% protection against HIV infections, 34.3% responded "yes" whilst 65.7% of respondents answered

"no". Thus, majority of the respondents are of the view that condom use does not provide 100% protection against HIV infections. This confirms the views of Adekeye (2011), in a study conducted in Nigeria on attitude of counsellors towards undergoing HIV voluntary counselling and testing, that HIV counsellors had good knowledge of HIV yet some of the HIV counsellors still engage in unprotected sex.

Most of the respondents were of the view that sero-discordance (where one couple has HIV but the other does not) is becoming a common issue in HIV counselling and testing. Here 92.9% of the counsellors supported this view. They also supported the view that confidentiality is absolute in HIV counselling. This confirms the views expressed by Boshamer, et al. (1999) and Peltzer, et al. (2004) as they reported that clients are more concerned about the confidentiality of their HIV test results.

Concerning the issue that pre-test counselling sessions are organised to prepare the client for HIV test, a whopping 99.3% responded "yes", meaning majority of the respondents supported this view. It was also found out that all the respondents supported the view that post-test counselling is organised to prepare the client to receive and accept his/her HIV test result and that counsellors are expected to help clients explore ways of coping with life effectively. In sum, it is clear from the data that the HIV counsellors in the central Region of Ghana have good knowledge on the issues discussed under research question one.

Research Question Two: What is the Attitude of HIV Counsellor Towards Clients Accessing HIV CT?

Table 9 discusses the attitude of counsellors during HIV counselling and testing sessions.

Table 9: Descriptive Statistics on the Attitudes of the Counsellors

Statements	SD No.(%)	D No.(%)	A No.(%)	SA No.(%)
All clients who come for HIV ct have trust in me because of the way I handle the information they share with me.	2(1.4)	2(1.4)	43(30.7)	93(66.4)
When I become angry with my clients I shout at them.	107(76.4)	20(14.3)	9(6.4)	4(2.9)
I make sure my clients feel welcomed to this facility.	2(1.4)		24(17.1)	114(81.4)
I remain non-judgmental during counselling sessions.	2(1.4)	3(2.1)	32(22.9)	103(73.6)
I give equal treatment to all clients who come for HIV counselling and testing.	4(2.9)	3(2.1)	30(21.4)	103(73.6)
I discuss the status of my clients with my family.	115(82.1)	19(13.6)	2(1.4)	4(2.9)
I do not like to render HIV test to commercial sex workers.	88(62.9)	33(23.6)	5(3.6)	14(10.0)
I am always ready to test for my HIV status.	11(7.9)	11(7.1)	45(32.1)	74(52.9)

Table 9 continued

I fear knowing my HIV status	55(39.3)	27(19.3)	28(20.0)	30(21.4)

Source: field work, 2013

From Table 9, concerning the issue of whether all clients who come for HIV counselling and testing have trust in their counsellors because of the way their counsellors handle the information they share with them, 66.4% of the respondents strongly agreed. This represents the majority of the respondents and so they strongly agreed to the view that all clients who come for HIV counselling and testing have trust in their counsellors because of the way the counsellors handle the information they share with them.

It was evident that most of the respondents strongly disagreed with the statement that when they become angry with their clients they shout at them, (76.4%). The rest of the counsellors occasionally do this. They also make sure their clients feel welcomed to the facilities. Here, 81.4% of the respondents strongly agreed. Again, majority of the respondents (73.6%) strongly agreed to the view that, they do not remain judgmental during counseling sessions.

It was found out that most of the respondents give equal treatment to all clients who come for HIV counselling and testing, and they did not discuss the status of their clients with their family. They also render HIV test and counselling to all manner of people, including commercial sex workers. Even though they were ready to offer their services to people, some of them, 15% are not ready to find out their own status. Close to 75% were ready to run HIV test for themselves. Better still, 69.3% were not afraid to know their HIV status.

From the above findings, concerning the attitude of HIV counsellors towards clients accessing the HIV counselling and testing in the Central Region, it was realized that majority of the counsellors had developed very

positive attitude towards their clients and the job they do. This has made them trustworthy. These views expressed by the respondents confirm the views expressed by Family Health International (2005), that counsellors should have knowledge of how to give and receive feedback, should be trustworthy (honest, reliable and sincere), approachable (friendly, likeable and warm), and able to respond effectively to stress. In addition, the HIV counsellor should be empathetic, non-judgmental, should have knowledge on where and how to refer clients for bereavement, reproductive health and infant feeding, prevention of mother-to-child transmission, sexually transmitted infections, tuberculosis treatment, antiretroviral therapy, marital/relational conflict, stress management, drug and alcohol issue and issues bothering the youth.

Research Question Three: What are the Practices of HIV Counsellors in HIV CT in the Central Region?

Table 10 discusses the practices of HIV counsellors in HIV CT. It presents the frequencies and percentages.

Table 10: Descriptive Statistics on the Practices HIV Counsellors

Statements	SD No.(%)	D No.(%)	**A** No.(%)	SA No.(%)
I ensure that the environment where I provide HIV counselling is conducive'	4(2.9)	3(2.1)	44(31.4)	89(63.6)
I ensure that counselling sessions are not interfered with other activities I perform in this facility		6(4.3)	57(40.7)	77(55.0)
I inform my clients on HIV infection and its implications		2(1.4)	52(37.1)	86(61.4)
I explain the risk factors of HIV infections to my clients	2(1.4)		47(33.6)	91(65.0)
I inform clients about the diagnoses of the HIV virus and the meaning of the test results	1(0.7)	2(1.4)	51(36.4)	86(61.4)
I make sure that signs and symptoms of the HIV infections are made known to my clients.	2(1.4)	3(2.1)	49(35.0)	86(61.4)
I educate clients on the treatment available to reduce viral load	1(0.7)		47(33.6)	92(65.7)
I explain opportunistic infections and their management to my clients	1(0.7)	6(4.3)	48(34.3)	85(60.7)
I discuss the need for regular check up with my clients		2(1.4)	48(34.3)	90(64.3)
I explain the need for family support to my clients	1(0.7)	1(0.7)	46(32.9)	92(65.7)

Table 10 continue

I inform my clients on the availability of a social support for PLWHA	1(0.7)	5(3.6)	59(42.1)	75(53.6)
I offer nutritional education to my clients		3(2.1)	54(38.6)	83(59.3)
I explain prevention of the infection to my clients		4(2.9)	39(27.9)	97(69.3)
I explain sero-discordance to my clients	1(0.7)	4(2.9)	65(46.4)	70(50.0)

Source: field work, 2013

The third research question was designed to find out the practices of HIV counsellors in the Central region of Ghana. Thirteen items were designed to assess their practices. On the subject of whether the counsellors ensure that the environment where they provide HIV counselling is conducive, a greater number of them (95%) supported this view. It is worthy to note that whiles the counsellors see their centres as conducive, the clients might have varied view because there was a lot of disturbances from co-workers during the observation sections.

Concerning the item "I ensure that counselling sessions are not interfered with other activities I perform in this facility", a greater number of them maintain that they ensured this. From Table 10, when the percentages for agree and strongly agree are added they amount to 95%. The percentage connotes a significant support for this view by the counsellors. Also, it was found out that the respondents informed their clients on HIV infection and its implications and explained the risk factors of HIV infections to their clients.

With respect to the statement, "I inform clients about the diagnoses of the HIV virus and the meaning of the test results", 61.4% of the respondents strongly agreed with it and 36.4% agreed. This means that a great majority were in support of the statement. It was also apparent that the respondents make sure that signs and symptoms of the HIV infections are made known to their clients and they educate their clients on the treatment available to reduce viral load.

The HIV counsellors were asked to state their position on whether they explain opportunistic infections and their management to their clients; only 7 out of the 140 respondents disagreed with it. Thus, a whopping majority supported this view. In a related development, only 2 out of the 140 respondents disagreed with the item "I discuss the need for regular check up with my clients". The rest of the respondents held up this assertion.

The respondents explained the need for family support to their clients and informed clients on the availability of a social support for PLWHA. They also offered nutritional education to clients and explained prevention of the infection and sero-discordance to their clients. A look at the percentages in Table 10 clearly shows that these counselling practices were highly put up by the HIV counsellors in the Central Region. The HIV counsellors are adhering to good practices in their field of work. In each of the cases stated in Table 10, it is very clear that they conform to best practices in their centres.

Research question four: To What Extent do Counsellors who Practice CT use Counselling Techniques During CT Session?

The forth research question was designed to find out the extent to which counsellors practice HIV counselling and testing techniques during CT sessions. According to NACP (2009), counselling is based on a set of techniques that the counsellor brings to the interaction to help the client explore and better understand a problem, deal with related feelings, cope with stress and make personal decisions and cope with life. Tables 11 to 18 deal with the fourth research question.

Table 11 presents data on whether HIV counsellors establish rapport with their clients at the beginning of each counselling session.

Table 11: Establishing Rapport with Client at the Beginning of each Counselling Session

	No.	%
Not at all	1	0.7
Sometimes	1	0.7
Often	24	17.1
Very Often	114	81.4
Total	**140**	**100**

Source: field work, 2013

Table 11 is on the issue of whether the respondents establish rapport with their clients at the beginning of each counselling sessions, one respondent, representing (.7%) of the respondents, responded "Not at all" and "Sometimes" respectively and 114 respondents, representing 81.4%, responded "very often". This means the majority of the respondents are of the view that they establish rapport with their client at the beginning of each counselling session very often.

Table 12: Listening Attentively to Client During Counselling Sessions

	No.	%
Not at all	2	1.4
Sometimes	1	0.7
Often	19	13.6
Very often	118	84.3
Total	**140**	**100**

Source: field work, 2013

It is clear from Table 12 that majority of the respondents are of the view that they listen attentively to their clients during counselling sessions very often. That is, 84.3% of the respondents practice this technique very often. Only 1.4 failed to adopt this technique.

Table 13 discusses the use of open ended questions to elicit information from their clients during counselling and testing.

Table 13: Use of Open Ended Questions to Elicit Information from Clients During Counselling Sessions

	No.	%
Sometimes	9	6.4
Often	41	29.3
Very Often	90	64.3
Total	**140**	**100**

Source: field work, 2013

Table 13 is on the issue of whether the respondents use open ended questions to elicit information from their clients during counselling sessions; Nine respondents representing (6.4%), answered "Sometimes" and 90 (64.3%), which represents the majority of the respondents, responded "Very Often". This means the majority of the respondents are of the view that they use open

ended questions very often to elicit information from their clients during counselling sessions.

Table 14 presents information on whether HIV counsellors summarize discussions with their clients.

Table 14: Summarizing Discussions with Clients

	No.	%
Not at all	3	2.1
Sometimes	4	2.9
Often	58	41.4
Very Often	75	53.6
Total	**140**	**100**

Source: field work, 2013

Table 14 is on the issue of whether counsellors try to summarize the discussions they have with their clients; three respondents, representing (2.1%) answered "Not at all" and, 75 (53.6%), which represents the majority of the respondents, responded "Very Often". This means the majority of the respondents are of the view that they try to summarize the discussions they have with their clients very often.

Table 15 discusses whether HIV counsellors give simple information to the clients. The result is discussed below.

Table 15: Giving Simple Information to Clients

	No.	%
Not at all	1	0.7
Sometimes	2	1.4
Often	47	33.6
Very Often	90	64.3
Total	**140**	**100**

Source: field work, 2013

Table 15 is on the issue of whether respondents try to give simple information to their clients; one respondent, representing (0.7%), answered "Not at all" and 90 (64.3%), representing the majority of the respondents, responded "Very Often". This means the majority of the respondents are of the view that they try to give simple information to their clients very often.

Table 16 presents information on whether HIV counsellors allow time for their clients to respond to questions.

Table 16: Allowing Time for Clients to Respond to Questions

	No.	%
Not at all	1	0.7
Sometimes	2	1.4
Often	31	22.1
Very Often	106	75.7
Total	**140**	**100**

Source: field work, 2013

Table 16 is on the issue of whether respondents always allowed time for their clients to respond to questions; one respondent, representing (0.7%) answered "Not at all" and then, 106 (75.7%) representing the majority of the respondents responded "Very Often". Therefore, majority of the respondents are of the view that they allow time for their clients to respond to questions.

Table 17 is on the issue of whether respondents assist their clients to clarify misunderstanding during counselling and testing sessions.

Table 17: Assisting Clients to Clarify Misunderstanding

	No.	%
Not at all	2	1.4
Sometimes	2	1.4
Often	36	25.7
Very Often	100	71.4
Total	**140**	**100**

Source: field work, 2013

Table 17 is on the issue of whether respondents assist their clients to clarify misunderstanding; two respondents, representing (1.4%) answered "Not at all". Again, two respondents, representing (1.4%), answered "Sometimes" and 106 (75.7%), representing the majority of the respondents, responded "Very Often". It is clear that majority of the respondents are of the view that they assist their clients to clarify misunderstanding concepts very often.

Table 18 is on the issue of whether respondents' prioritize issues with their clients during counselling and testing sessions.

Table 18: Prioritizing Issues with Clients

	No.	%
Not at all	2	1.4
Sometimes	15	10.7
Often	47	33.6
Very Often	76	54.3
Total	**140**	**100**

Source: field work, 2013

Table 18 is on the issue of whether respondents' prioritize issues with my clients, two respondents representing (1.4%) answered "Not at all" and

then, 76 (54.3%) representing the majority of the respondents responded "Very Often". This means the majority of the respondents are of the view that, they prioritize issues with their clients very often.

Concerning the extent that counsellors practice HIV counselling and testing techniques during CT sessions, it was obvious that most of the respondents adhered to the basic techniques in counselling such as establishing rapport, listening attentively, using open ended questions to elicit information, and try to summarise the discussions they had with their clients very often.

Report on Observation Checklist

The observation checklist was used to check whether the HIV counsellors adhere to the standards set by UNAIDS during counselling and testing sessions. According to NACP (2009), using counselling techniques and skills during interaction with clients maximizes the possibilities of clients exploring, understanding and taking actions of their behaviour.

Taking HIV test is a very traumatic event. Furthermore, this trauma reaches an extreme condition when the test result (positive or negative) is disclosed. It is therefore essential that the process of HIV testing be accompanied by counselling. For those who test positive, the trauma may increase, especially in our part of the world where HIV has a close link to socio-cultural issues. It is therefore important for HIV counsellors to use their counselling skills and techniques to offer an appropriate counselling to reduce the trauma clients may go through (NACP, 2009).

The checklist was divided into four themes: skills to build interpersonal relationship (counsellor establishes rapport, listens attentively to client and remains non-judgemental); skills for gathering information (counsellor uses

open-ended questions, seeks clarification and summarizes appropriately); counsellor giving information (counsellor gives clear and simple information, allows time for client to respond to issues, checks for (mis)understanding); and for special circumstances (counsellor discusses sensitively and appropriately, prioritizes issues with the client, manages client distress sensitively and appropriately and flexible in involving the client partner).

With regards to building interpersonal relationship, the first item on the list was establishment of rapport with the client by the counsellor. Rapport with clients is crucial in all forms of counselling. It is a key element for facilitating the development of a trusting relationship. It is also a skill used to welcome clients, make them feel comfortable and put them at ease (NACP, 2009). Rapport is a warm, friendly and understanding condition which is essential for an effective relationship between a client and a counsellor. It is a relationship that cannot be established by force. It grows out of the warmth of the relationship (Nelson-Jones, 2005). It is important that counsellors bring this skill to bear in counselling. Rapport establishment creates an understanding and a non-judgmental environment between the counsellor and the client. With this item, 17 out of the 20 counsellors who were observed established good rapport with their clients. This is seen as a good practice because most people who come for HIV counselling and testing already have certain reactions and perception about the activity. It is therefore important for HIV counsellors to find ways and means of welcoming their clients to make them feel relaxed as if nothing is at stake (NACP, 2009).

Though 3 out of the 20 is seen as a very small number, it was a bad practice on the part of the HIV counsellors for not welcoming the clients. In

one instance, a counsellor who was described as a senior counsellor by his colleague counsellors started questioning and warning a client who came to see him. His reason was that the client refused to turn up for appointment they booked. The counsellor started his questions and warning without establishing any form of rapport. The counsellor condemned the client and warned that the next time the client will commit that offence the client would not be given any medicine.

The second item on the check list was on the counsellor's ability to listen attentively to the client. Listening is an active process that requires not just quietly paying attention but it indicates that you are doing so through non-verbal and verbal ways (NACP, 2009). Just by listening, the counsellor says, without words, "I care about what is happening to you; you are important." This means that listening is very crucial, especially in HIV counselling, where the client is devastated with discrimination and stigmatization. Sixteen out of the 20 counsellors were seen to be using this skill during the counselling process. This was also encouraging because it is believed that the clients of these counsellors would see that their counsellors care about their situation. This may boost their morale to discuss any sensitive issue which they may want to discuss. Four out of the 20 were not using listening as a skill frequently. These counsellors were seen to be giving information but were not really ready to create an atmosphere for discussion. This prevented the clients from coming up with issues; rather, the clients only took the messages they received.

How a Counsellor remains non-judgmental was the next item on the list. Counsellors are all the time admonished to refrain from being judgemental.

Counsellors are there to help their clients and not to judge or blame them. HIV positive clients often feel "guilty" or "bad"; the clients therefore need the non-judgemental attitude of the counsellor to encourage the client to become more accepting of their situation (Van-Dyk, 2008). All the 20 counsellors exhibited a non-judgemental attitude, which is very encouraging to the promotion of HIV counselling and testing in the Central Region. With the exhibition of this skill, it is hoped that more people may be encouraged to visit the HIV counselling centres in the region. All the counsellors were seen encouraging the clients rather than blaming them for their predicament, even though, at the beginning of the counselling session, few counsellors attacked the clients for non-adherence, it was not on the lines of being judgemental.

Gathering information was the next theme and the first item was the use of open-ended questions by the counsellor. Open-ended questions facilitate and reinforce building rapport and establishing trust. Open ended questions assist the counsellor to explore areas of the client's life such as his/her daily life, family, school, or the case. These informal discussions encourage the client to provide more information, including key facts that otherwise the client might keep to himself.

Allyson (2007) in looking at how open-ended questions are used in counselling, reported that clients are often at a loss to know where to start when they attend therapy sessions and open ended questions can widen the area of understanding and lead into a deeper examination of their feelings and emotions. Allyson added that open ended questions encourage the client to talk more and open up a bit, therefore, the more the client can talk, the more confident he/she will be and the more confident, the more relaxed. During the

counselling process, open ended questions are employed to assist clients to talk on the issues presented.

Asking open ended questions makes conversations better because it allows a client to talk. It also develops a person's listening skill since the counsellor who is asking the question would have to listen as the client elaborate the issues. During the observation, it was observed that 18 out of the 20 counsellors used open ended questions to elicit information from the client. Due to individual differences, some clients do not like to talk. One good and powerful technique counsellors can use to help this category of clients is to ask them open ended questions which have the potential of forcing them in a way to give out information. The number of counsellors who used this technique was very encouraging considering the fact that HIV and its associated sexual issues are private matters. Therefore, counsellors should always employ such techniques to help them get more information from their clients. It was also observed that as a result of the questioning skills, the clients were active in the counselling process. This builds a very good rapport between the counsellors and their clients and allows the client to open up to the therapist. Two out of the 20 counsellors were found not to be using this technique effectively. Due to the sensitive nature of the issue, it will be more prudent for all counsellors to learn how to use this technique.

Seeking clarification from the client was the next item. Clarification as a technique is used by counsellors to help understand the issues their clients discussed with them. Clarification is employed to make communication clearer so that the counsellor can understand the problem the client has presented for amicable solutions to be agreed upon. For example, the HIV counsellor should

make it clear to the client whose partner is HIV positive that HIV is not transmitted through sleeping on the same bed (Kanekar, 2011). With this, 15 out of the 20 counsellors were observed using the technique, which was encouraging. Most clients sometimes beat about the bush and it is very important for counsellors to use this technique to help clients to give the right information so that the right therapy could be given to them. This is because clients always want solutions to their predicaments and until counsellors get the right information, it would be difficult for them to help their clients with the right therapy. Five out of the 20 counsellors were observed not using this technique or they were not using it appropriately. Though the number of counsellors who did not use this technique was small, it is still significant considering the role this technique plays in the counselling process.

Van-Schaik and Hamerlinck (2008) stated that a summary in the counselling process presents to the client a brief synopsis of the client's story from the counsellor. This is to make it clear to the client where both the client and the counsellor have come to. A good summary is short and gets to the essence of what the client has said. The summary can be done in the course of the discussion or at the end of the discussion. The summary should serve to evaluate the situation and it can stimulate the client to add to the counsellor's interpretation, to correct or change it. Summarization can be used to assure the client that the counsellor has followed the client's story. This technique can be applied throughout the counselling process, especially during the information taking stage and the closure or terminal stage. Summarizing also indicate that the client has been heard and understood. Looking at the importance of this technique, one would have thought that majority of the counsellors would

make use of it, but it turned out to be the opposite. Apart from only 2 counsellors who made use of this technique effectively, the rest, that is, 18 out the 20 counsellors did not use this technique either at the information seeking or giving stage or at the end of the sessions.

At the information giving stage, the first item that was observed was for the counsellor to give simple information. Counsellors are encouraged to give information in the simplest possible terms so that their clients will understand the exact message the counsellor wants to give. This means that counsellors need to use common words whenever possible and try to avoid technical terms. Again, it helps to correct misconception surrounding an issue. People have a lot of misconceptions about HIV and AIDS; it is important for the counsellor to correct these misconceptions. The information the counsellor gives should aim at educating the client to understand the HIV and AIDS disease. Also, it must aim at helping the client adhere to the anti-retroviral drug and its effects. All these information should be given in a very simple way as much as possible (Namale, 2010).

All the 20 counsellors used this technique effectively. It was observed that all the counsellors gave the clients simple information concerning the HIV and AIDS and the anti-retroviral drug. This was very helpful and good since it helped the clients to disabuse their minds on the misconceptions they had concerning the disease. On the anti-retroviral therapy, all the counsellors were seen spending their time to educate the clients on the pros and cons of the anti-retroviral drugs and its effects.

The next technique was whether the counsellor allows time for the client to respond to questions or not. According to Namale (2010), time has

several dimensions that can affect the therapeutic interaction. This relates to how both the counsellor and the client see time. Due to the nature of HIV and AIDS, most clients may not be willing to talk about their experiences, especially issues that relate to their sexual life since most people see it as private. During the counselling process, the counsellor asks the client some questions so that the counsellor can help the client to understand the issues better. Anytime the counsellor will need the client to give information, the counsellor will have to allow the client to respond to the question. The counsellor needs to motivate the client to talk by allowing the client to think about the issues. Allowing time for the client to respond to the questions can also afford the client the opportunity to ask any questions that is bothering his/her mind. This also helps to clarify issues and afford the counsellor to correct further misconceptions. The counsellor needs to take control the counselling process by motivating the client to talk, the time should not be too short and too long to cause breaks in the counselling process. During the observation, it was realised that 15 out of the 20 counsellors had good interactions with the clients by regulating the counselling process in terms of time for their client's to respond to issues. Five of the counsellors did not allow their clients time to respond to issues. It was found out that their sessions with their clients were more of information giving rather than interactive discussions. This was not encouraging since the situation may not give room for these clients to discuss sensitive issues they may have.

Counsellor assists client to clarify (mis)understanding was the next item on the checklist. Clarifying understanding and misunderstanding is very important in the HIV and AIDS counselling process. For the counsellor to

achieve excellence in the counselling process, the counsellor needs to help the client to be clear with all the issues at stake. Though Ghana Statistical Service and Ghana Health Service (2009) report of the 2008 Ghana Demographic and Health Survey shows that almost everyone in Ghana has heard about HIV and AIDS, majority of the population still have misconceptions regarding the HIV and AIDS menace. The counsellor may ask certain questions to ascertain the understanding of the client on the issues for the discussion. Ten of the counsellors were able to use clarification and questioning to help the clients to clarify (mis)understanding during the counselling process while the other 10 were found not using the technique to help their clients. The 10 who did not check for the understanding of their clients on HIV and AIDS issues needed to have done that since the clients may have gone home with certain misunderstanding which has the potential to affect their lives negatively. Also, since most HIV clients threaten to commit suicide, it is important for HIV and AIDS counsellors not to create the environment for their clients to take advantage to harm themselves.

Next on the checklist were items on special circumstances. On these, the first issue was on appropriate and sensitive discussion. Counselling techniques exist to help people gain awareness, insight and explore ways of solving their problems. The counsellor is therefore expected to use the opportunity provided to assist the client by employing all the necessary skills and acting professionally to discuss appropriate and sensitive issues. According to Namale (2010), the attitude and skills of a counsellor are important determinants of the quality of the counselling relationship. Clients' attitudes and behaviours also shape the relationship, therefore, the counsellor should

able to combine all factors to touch on appropriate and sensitive issues that will help the client to achieve fullness in life. This calls for the counsellor to enter into the "eigenwelt" of the client. Nine out of the 20 counsellors were observed to have made use of this skill. Though they were expected to use this skill in some special circumstances, it was observed that either due to time, increased number of clients attending the HIV clinic, or inadequate skills on the part of most of the counsellors, they did not explore certain sensitive issues their clients talked about. The performance of the rest of the counsellors was very poor regarding the way they hurriedly ended the session without touching on certain key and sensitive issues their clients raised.

The next item on the checklist was the counsellor's ability to prioritize issues with the client. Counsellors are expected to help their clients to identify and prioritize options that can help them overcome their problems and challenges. One of the important roles the counsellor needs to play is to help the client to prioritize the various options the client has suggested. This affords the client which of the options he/she needs to apply immediately and the ones to apply later.

Nine out of the 20 counsellors were observed assisting their clients to prioritize on issues of concern to them in relations to their HIV status. Since clients have an idea of what they want, but only need an expect to guide them, HIV and AIDS counsellors should always assist their client to come up with options they think can help them solve issues of concern to them so that they will not come back to blame the counsellor for giving them wrong guidance. The 11 counsellors who did not make use of the technique should be encouraged to make use of this skill so that they can effectively help their

clients to live healthy and enjoyable life. Also, due to the sensitive nature of HIV, issues relating to denial, partner notification and confidentiality, counsellors should always allow their clients to choose options they think are best for them.

Further, the counsellor's ability to assists a client to manage distress was the next item on the checklist. Since HIV has no cure, most people become distressed. The counsellor should therefore empathize with clients who exhibit such behaviours. To most victims, that is the end of the world and therefore they will want to try all means to committing suicide. The counsellor should make things clear to the client that with regular intake of anti-retroviral and good nutrition, coupled with good sexual practices, the client can live a normal life, even though there is no cure for the disease. Regular clinic attendance, drug adherence and effective counselling can help prolong the life of the HIV client. Nine out of the 20 counsellors assisted their clients to manage their distress. These counsellors educated their clients on the role counselling and regular intake of the anti-retroviral can play in their life. They were also able to assure them that the world has not come to an end and mentioned names of some key international figures who have also contracted the disease and are still living well. Eleven counsellors did not assist their clients in managing their distress. This group of people was more concerned about the anti-retroviral drugs. Their interest was on the drug adherence rather than other psychosocial problems the clients may be going through. Though the anti-retroviral drugs are very important, HIV counsellors should not forget about the other problems HIV may bring to clients such as socio-cultural, economic, psychological and the like, and should always try to assist their clients to manage such situations.

The counsellor's flexibility in involving the client's partner was the last item. Partner notification refers to identifying sex partners of someone with disease communicable through sex and informing them that they have been exposed to the disease. This is a very serious issue which has social, economic, cultural and medical dimensions. Especially when the effects associated with partner notification can result to domestic violence and divorce, it is important for the issue to be looked at again (Volmink, 2002). Also, the HIV protocol considers this notification as a human right issue; HIV counsellors therefore need to be flexible in guiding their clients towards this direction. Considering the effects of early diagnosis and treatment of HIV, most researchers suggest that HIV patients greatly reduce risky sexual behaviour. This is because it is believed that early diagnosis and effective HIV treatment of the virus can significantly reduce transmission risk, by around 96% in sero-discordant heterosexual couples. This therefore calls for affected partners to inform their sexual partners (Rothenberg, Paskey, Reuland, Zimmerman & North, 1995).

Though not all clients needed a discussion on this issue, 4 counsellors were able to discuss the importance of partner notification with their clients. Some of the clients, especially the females, were willing to inform their partners but were afraid that may be the end of their marital relationship. This was so because there are a lot of sero-discordance issues these days. Eight out of the 20 counsellors had clients with this issue, but did not flexibly assist the clients involved in addressing the issues. Rothenberg, et al. (1995), in a survey with 136 healthcare providers on domestic violence and partner notification, found that counsellors regularly encounter ethical, legal and moral dilemmas between respecting patients' confidentiality and autonomy, and protecting

patients' sexual partners at risk of HIV infection. In this research, the HIV counsellors were ask to list some of the challenges they encounter in the course of providing HIV and AIDS counselling and testing, majority of the counsellors stated partner notification as one of their challenges. In a post observation discussion with some of the counsellors, they said that in their monitoring, they realised that most of the men who have refused to inform the wives are having extra marital affairs, which means that they can easily spread the disease to their newly found partners. They suggested that there should be a law to allow counsellors to inform the partners of HIV patients.

General Observation and Comments

Most counselling sessions were organised in the same room where the data officers work. Again, most counsellors were sharing rooms together. This means that two counsellors received two different clients together with a little distance between them. The researcher thought that this kind of situation was not helping considering issues such as sex and sexuality surrounding HIV and STIs that affect most HIV clients.

In a post-observation discussion with a counsellor, she reported that privacy and confidentiality were some of the biggest challenges they face as counsellors. She added that what makes the situation worse was the fact that most clients refuse to report STIs due to absence of privacy. The few who are bold ask the counsellors to allow the other counsellor to excuse them before they share issues concerning their STIs.

Another issue that was observed was intrusion of other health staff during counselling, especially at centres where the counselling was done at offices and not counselling centres, or where the rooms are shared by two

counsellors. This was a very serious issue as health staffs were seen entering into the rooms whilst counselling sessions were going on. This could lead to invading of client's privacy, which goes against HIV and AIDS counselling and testing practice.

Lastly, a look at the responses from the questionnaire showed that most of the counsellors were using the appropriate counselling techniques to elicit information from their clients during counselling sessions. However, the observation revealed otherwise. It was observed that there were disparities between the responses from the questionnaire and the observation sessions.

Research Question Five: What Challenges do HIV Counsellors face in Their Work in the Central Region?

The fifth research question was designed to find out the challenges HIV counsellors face in their work; the responses gathered could be grouped under the following headings: administrative challenges, financial problem, challenges with training, challenges in Human resource, challenges at the work place as well as challenges from HIV clients.

In the first place, some of the administrative challenges included the following: shortage of test kits, HIV clients using folders that are different from other patients, additional work responsibilities, leading to burn out, unavailability of drugs, lack of means of transport for follow up, lack of motivation, lack of counselling rooms in the wards, inadequate rooms/space for counselling, inadequate logistics for effective running of the art clinic. Again, some of the financial problems or challenges given included the following: inability of some clients to pay for their drugs, problem of finance for some clients to use for transport during clinic days. Also, some of the clients do not

have health insurance, which makes access to health care services difficult. In addition, some of the challenges in training included the following: inadequate training for the counsellors making them exhibit low knowledge in counselling, inadequate in-service training, period of training as well as lack of in-service training. This confirms Nulty and Edwards (2005) who also found in an exploratory study on experiences and needs of HIV counsellors in South Africa that counsellors need on-going in-service training that will ensure that they are regularly equipped with additional skills and knowledge for their work.

Furthermore, some of the challenges in Human resource included the following; inadequate social/family support, inadequate counsellors making testing and counselling difficult for the few who are doing the work. Moreover, some of the challenges at the work place included the following: how some nurses handle HIV clients, stigmatisation from colleague workers, and place (room) for practicing as well as confidentiality and privacy. Finally, some of the challenges from HIV clients included the refusal of some client to accept test result, reporting late for treatment, partner notification and problem with monitors, client refusal to go to referral centres for further treatment, failure to adhere to drugs, some clients refuse to attend HIV clinic regularly, difficulty in dealing with mentally ill client, problem of sero-discordance, refusal of some client to be transferred to their districts, some of the clients refuse to do the test after counselling, difficulty in getting feedback from clients, relatives of critically ill patients demanding to know the status of their relatives as well as the problem that some of the clients stay at prayer camp.

From my own observation, I found out that most counselling sessions were organised in the same room where the data officers work. Again, most

counsellors were sharing rooms with their colleagues. This means that two counsellors received two different clients at the same time with a little distance between them. The researcher thought that this kind of situation was not helping, considering issues such as sex and sexuality surrounding HIV and STIs that affect most HIV clients. In fact, confidentiality and privacy were not ensured. In a post-observation discussion with a counsellor she reported that privacy and confidentiality were some of the biggest challenges they faced as counsellors. She added that what makes the situation worse was the fact that most clients refused to report STIs due to absence of privacy. The few who were bold asked the counsellors to allow the other counsellor to excuse them before they shared issues concerning their STIs. Another issue that I observed was intrusion of other health staff during counselling, especially at centres where the counselling was done at offices and not counselling centres, or where the rooms are shared by two counsellors. This confirms the fact that despite its recognized importance in National AIDS Control Programmes (NACP), HIV CT is not fully developed in resource-constrained country like Ghana, that is, inadequate human and material resources (NACP, 2009; Acquah & Emmart, 2010).

Research Question Six: What Strategies do HIV Counsellors Employ to Manage the Challenges they Encounter?

The sixth research question was formulated to find out the views of the counsellors on strategies that could be mounted to curtail the challenges they face when performing their duties. Their suggestions were basically on logistics and staffing. In terms of logistics, they called for supply of enough test kits, financial support to assist HIV clients, provision of good HIV counselling

rooms to ensure privacy, provision of vehicles to aid proper follow-up and regular supply of drugs in all the centres. They also called for adequate motivation of the staff. Again, they added that all HIV clients should be insured and also stated that effective social/family support should be provided for their clients.

With respect to staffing, they called for engagement of interpreters to deal with language barrier, adequate training in counselling and testing should be provided for counsellors, more HIV counsellors should be trained, the need for allowing the trained HIV counsellors to concentrate on only counselling and testing, and workshops/in-service training should be organised by GHS and NACP to equip the counsellors. Generally, the suggestion surrounds the various stakeholders in the counselling and testing enterprise. It needs a consented effort to implement these suggestions so as to curtail the challenges. Various stakeholders who are supposed to provide the necessary logistics should perform their duties effectively, and professionalism should be upheld in the HIV counselling and testing business.

Hypotheses

1. **H_o: There is no Relationship Between Knowledge and Attitude of HIV Counsellors in the Central Region of Ghana.**

Table 19 presents the association between knowledge and attitude of HIV counsellors.

Table 19: Correlations Between Knowledge and Attitude of HIV Counsellors in the Central Region of Ghana

		KNOWLEGDE	ATTITUDE
KNOWLEGDE	Pearson Correlation	1	.117
	Sig. (2-tailed)		.168
	N	140	140
ATTITUDE	Pearson Correlation	.117	1
	Sig. (2-tailed)	.168	
	N	140	140

Source: field work, 2013

From Table 19, the p- value of 0.117 which reveals that there is weak but positive relationship between knowledge of HIV counsellors and the attitudes of HIV counsellors in the Central Region. This may be due to the percentage of the counsellors who possess SSCE. Also, the weak but positive relationship between knowledge and attitude may be due to the dual roles the counsellors perform. This is in line with Obiajulu (2009) which states that there was a significant but weak correlation between knowledge of health professionals and attitude towards VCT for HIV and AIDS.

H_o: There is no Relationship Between Knowledge and Practices of HIV Counsellors in the Central Region.

Table 20 presents the association between knowledge and practices of HIV counsellors.

Table 19: Correlations Between Knowledge and Practices of HIV Counsellors in the Central Region of Ghana

		KNOWLEGDE	PRACTICES
KNOWLEGDE	Pearson Correlation	1	-.058
	Sig. (2-tailed)		.495
	N	140	140
PRACTICES	Pearson Correlation	-.058	1
	Sig. (2-tailed)	.495	
	N	140	140

Source: field work, 2013

Using Pearson's correlation coefficient, if the p- value is between -.1 to -.5 then there is an inversely weak relationship between the variables. Therefore, In Table 20, out of the 140 respondents covered, the p- value was -0.058 which reveals that there is a weak and inverse relationship between knowledge of HIV counsellors and the practices of HIV counsellors in the Central Region. This could be due to the many challenges the HIV counsellors encounter in the course of their work. The result contrast Obiajulu (2009) who found that there was no significant difference in VCT knowledge scores between the two VCT practice groups and this might also be attributed to the whole groups" very high knowledge of VCT.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Overview of the Study

This study employed the descriptive survey to assess the knowledge, attitude and practices of HIV counsellors in HIV counselling and testing in the central region. In all, 140 HIV counsellors from the central region were sampled through the use of the purposive sampling procedure. The convenient sampling procedure was adopted to carry out the observational sessions. Questionnaires and an observation guide were used to collect the necessary data for the study. Descriptive statistics such as frequencies and percentages were used to illustrate the demographic profile of the participants and the data on five of the research questions. The thematic approach was used to analyse the qualitative data. Inferential statistics namely Pearson Product Moment Correlation were used to compare relationship among variables. The following were the main findings of the study.

Key Findings

1. It was found out that HIV counsellors in the Central Region had a good knowledge about HIV counselling and testing. They have gone through the requisite professional training and so are familiar with the nuances of their jobs.

2. Also, it was evident that the counsellors have developed a positive attitude towards HIV counselling and testing. In fact, their attitude towards their job was very impressive.
3. The HIV counsellors adhered to good practices in their field of work. They adopted high professional skills in performing their duties, just that they are faced with many challenges
4. It was found that sixty (60%) per cent of the counsellors adhered to the basic techniques in counselling such as establishing rapport, listening attentively, using open ended questions to elicit information, and trying to summarize the discussions they have with their clients very often. Also, majority of the HIV counsellors render only adherence counselling without any attempt to touch on the emotions of their HIV clients. Further, counselling was not provided as confidential at most centres
5. HIV counsellors in the Central Region have been facing countless challenges in the field of work such as administrative, financial, training, human resource, logistics as well as challenges from HIV client.
6. The counsellors' suggestions were basically on logistics and staffing. These were the most prominent challenges and so needed urgent attention from the various key stakeholders.
7. There is a weak positive relationship between knowledge and attitude of HIV counsellors in the Central Region.
8. There is inversely weak relationship between knowledge and practices of HIV counsellors in the Central Region.

Conclusions

Based on the findings of this study, it could be concluded that the counselling centres within the hospitals in the central region are staffed with professional counsellors but their effort to carry out effective counselling is being thwarted by variables that the counsellors have little control over. They resort to using what they have and dealing with what they can in their own small way and leaving the rest to chance. Also, HIV counselling and testing is a multifaceted enterprise which needs a concerted effort by various stakeholders in order to achieve effectiveness.

Issues of certification, licensing, professionalism, training, and, in fact, knowledge acquisition are very important facets of HIV counselling and testing since they influence attitude and practices adopted by workers. Even though they may be seen as insignificant, they may serve as determinants of effectiveness or otherwise.

Recommendations

In order to improve upon the knowledge, attitude and practices of HIV counsellors in the central region of Ghana,

1. Periodic seminars and workshops must be organized for HIV counsellors to update their knowledge on issues pertaining to HIV and AIDS by the government, Non-Governmental organisations and other stakeholders.
2. It is recommended that more professional counsellors should be employed by the ministry of health and posted to the various hospitals and health facilities across the country as staffing was identified as a major challenge.

3. Also, it is highly recommended that test kits should always be made available at the health facilities at all times. It was identified that that particular logistic was in shortage at the time of the study.
4. Again, the finding of the study revealed that issues of finance and transportation were major challenges. It is therefore recommended that the Ministry of Health and the Ghana Health Service should make it a priority to provide these logistics to aid the work of the counsellors.
5. Further, HIV counsellors in the Central Region should provide counselling that will help address the emotional challenges of their client since HIV present its own challenges to the victims
6. Finally, counselling should be provided as confidential service to enable HIV clients share critical issues concerning their sexuality, infections, partner notification and discordance issues with their counsellors

Implication for Counselling

1. HIV counsellors in the Central Region should spent time to explore reasons why clients come to the hospital
2. Again, HIV counsellors in the Central Region should take their client through pre-test counselling to prepare them adequately for the HIV test result
3. Further, HIV counsellors in the Central Region should employ different kinds of counselling techniques so that they can deal properly with their clients
4. Finally, counselling activities should be made part of the training programmes and seminars for HIV counsellors in the Central Region.

Suggestions for Further Research

1 This research was conducted in the Central Region. Future studies on the matter should be conducted in other parts of the country.

2 Other researchers could work on the perceptions and attitudes of people towards HIV counselling and testing.

3 Also, researchers could look into the relationship between age, marital status, educational level, profession, and religious affiliation and decision to know ones HIV status.

REFERENCES

Abdi, D., Ahmed, A., & Alemayehu, W. (2003). *Perception of risks of sexual activities among out of school adolescents in South Gondar Administrative Zone, Amhara Region.* Paper presented on the 14th EPH Annual Public Health Conference, Addis Ababa. Retrieved from etd.aau.edu.et/dspace/browse-title?starts_with on November 12, 2012,

Acquah, S. A., & Emmart, P. (2010). *Application of staffing needs module for ART, PMTCT, and VCT in Ghana.* Washington, DC: Futures Group, Health Policy Initiative.

Adekeye, O. A. (2011). Attitude of counsellors towards undergoing HIV voluntary counselling and testing in Ado-Odo/Ota, Nigeria. *International Journal of Psychology and Counselling, 3*(3), 33 – 39.

Alemayehu, B. (2010). Knowledge, attitude, and practice of voluntary counselling and testing for HIV among university students, Tigray, Northern Ethiopia. *MEJS, 2*(1), 108-118.

Allyson, J. (2007). How open-ended questions are used in counselling. Helium Incorporated. Accessed from http://www.helium.com/items/350213-howopenended-questions-are-used-in-counselling on December 14, 2012.

Amedahe, F. K. (2010). *Notes on educational research methods*. Lecture Notes, UCC, Cape Coast.

Amedahe, F. K. (2002). *Fundamentals of educational research methods. Mimeograph*, Cape Coast: University of Cape Coast Press.

Anderson, J., McAllister, J., Willis, J., Keen, P., McCoy, R., Grulich, A., & Bourne, C. (2009). *HIV, viral hepatitis and STIs: A guide for primary care*. Darlinghurst: ASHM.

AVERT, (2013). HIV and AIDS stigma and discrimination. Author. Retrieved on November 15, 2013 from http://www.avert.org/hivaids-stigma-and-discrimination.htm

AVERT. (2011). HIV and AIDS in Zimbabwe. Retrieved on March 15, 2012, from http://www.avert.org/hiv-aids-zimbabwe.htm

AVERT. (2011). HIV and AIDS stigma and discrimination. Author. Retrieved June 7, 2012, from, www.avert.org/aids-hiv-charity-avert.htm

AVERT. (2005). Interim WHO clinical staging of HIV and AIDS and HIV and AIDS case definitions for surveillance. Author. Retrieved June 25, 2012, from, http://www.avert.org/stages-hiv-aids.htm

Awuah, J. (2009). *Knowledge, attitude and practice of voluntary counselling and testing by HIV and AIDS counsellors*. Unpublished master's thesis, University of Cape Coast.

Beach, M. C., Keruly, J., & Moore, R. D. (2006). Is the quality of the patient provider relationship associated with better adherence and health outcomes for patients with HIV? *Journal of General Medicine*, *21*(6), 661–665.

Bekker, L., & Wood, R. (2006). Is it time to change our HIV testing policy in health care facilities? *South African Medical Journal*, *96*, 1235-1236.

Bektas, H. & Kulakac, O. (2007). Knowledge and attitudes of nursing students toward patients living with HIV and AIDS (PLHIV): A Turkish perspective. *AIDS Care*, *19*: 888–894

Bharat, S. (1999). *HIV and AIDS related discrimination, stigmatization and denial in India - A study based in Mumbai and Bangalore.* UNAIDS, Geneva: TISS Mumbai.

Bond, T. (1995). The stress of working with clients with HIV and AIDS. In W. Dryden (Ed.). *The stresses of counselling in action*, (pp. 44-57). Thousand Oaks, CA: Sage.

Boshamer, C. B., & Bruce, K. E. (1999). A scale to measure attitudes about HIV antibody testing: Development and Psychometric validation. Aids Education and Prevention. *AIDS Education and Prevention, 11*(5), 400 - 413.

British Association for Counselling and Psychotherapy. (2010). *Ethical framework for good practice in counselling and psychotherapy*. Lutterworth, Leicestershire: Author.

Britton, P. J. (2012). Teaching tip sheet: Counsellor attitude bias. *American Psychological Association, 6.* Retrieved, March 10, 2012, from, http://www.apa.org/pi/aids/resources/education/counsellor

Catania, J., Kegeles, S., & Coates, T. J. (1990). Towards an understanding of risk behaviour: an AIDS risk reduction model (ARRM). *Health Education Quarterly, 17*, 381–399.

Central Statistical Agency & ORC Macro. (2012). *Ethiopia demographic and health survey 2011*. Addis Ababa: Ethiopia.

CDC. (2012). Basic information about HIV and AIDS. Atlanta: Author. Retrieved May 15, 2013, from, http://www.cdc.gov/hiv/topics/basic

CDC. (2009). Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. *MMWR, 58*(4), 198.

CDC. (2001). Guidelines for laboratory test result reporting of human immunodeficiency virus type 1 ribonucleic acid determination. *CDC Working Group, 50*(20), 1-12.

Chuaung, H. T., Devins, G. M., Hunsley, J., & Gill, M. J. (1989). Psychological distress and well-being among gay and bisexual men with human immunodeficiency virus infection. *American Journal of Psychiatry, 146,* 876-880.

Cohen, M. S., Gay, C. L., Busch, M. P., & Hecht, F. M. (2010). The detection of acute HIV infection. *Journal of infectious Diseases, 202*(2), 270-277.

Constantine, N. T., & Zink, H. (2005). HIV testing technologies after two (2) decades of evolution. *Indian Journal of Medical Research, 12*(1), 1 12.

Courtois, C. A. (1995). Assessment and diagnosis. In C. Classen & I. D. Yalom (Eds.), *Treating women molested in childhood: A volume in the Jossey-Bass library of current clinical technique,* (pp. 1–34). San Francisco: Jossey-Bass.

Crawford, I., Humfleet, G., Ribordy, S. C., Ho, F. C., & Vickers, V. L. (1991). Stigmatization of AIDS patients by mental health professionals. *Professional Psychology: Research and Practice, 22*(5), 357-361.

Damons, M. (2003). *Attitudes of learners towards teachers living with HIV*. Unpublished dissertation, Rand Africans University, Johannesburg.

Dapaah, J. M. (2012). HIV and AIDS treatment in two Ghanaian hospitals, experiences of patients, nurses and doctors. *African Studies Collection, 38*, 35-37.

De-Bellis, M. D. (1997). Post-traumatic stress disorder and acute stress disorder. In: R. T. Ammerman, & M. Hersen, (eds.), *Handbook of prevention and treatment with children and adolescents: Intervention in the real world context.* New York: John Wiley and Sons.

Dew, M. A., Ragni, M. V., & Nimorwics, P. (1990). Infection with human immunodeficiency virus and vulnerability to psychiatric distress: Study of men with haemophilia. *Arch Gen Psychiatry, 17*, 737-741.

Dhadwal, D., Bhardwaj, A., Gupta, A., Sharma, S., Parashar, A., Thakur, A., Mahajan, A., Chander, V., & Sood, A. (2009). Role of intensive training in strengthening the Skills of HIV counsellors for Imparting Quality ICTC Services. *Indian Journal of Community Medicine, 34*(3), 252 - 254.

Egbochuku, E. O. (2002). *Counselling communication skills: Its place in the training programme of a counselling psychologist.* Unpublished master's thesis, University of Benin, Benin City.

Ekuban, A. (2011). *Perception and attitude of students nurses towards HIV and AIDS patients*. Unpublished master's thesis, University of Cape Coast, Cape Coast.

Encyclopedia.com (2005). Acquired Immune Deficiency Syndrome. West's Encyclopedia of American Law. Retrieved on July 15, 2013 from www.encyclopedia.com.

Ethiopia Ministry of Health. (2005). *Guidelines for the Clinical Management of HIV Infection in Adults in Ethiopia (Ethiopia/MOH, 2000) and Guidelines for Use of Antiretroviral Drugs in Ethiopia.* Ethiopia, Addis Ababa.

Evans, B. G., Parry, J. V., & Mortimer, P. P. (1997). HIV antibody assay that gave false negative results: multicentre collaborative study. *BMJ, 69*(12), 29-37.

Family Health International. (2012). Counselling and testing for HIV and AIDS Prevention. Banjul: Author. Retrieved February 20, 2013, from, www.fhi360.org/countries/gambia

Family Health International. (2005). *VCT TOOLKIT trainer's manual: counselling supervision and training.* Banjul: Author.

Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology, 54*(6), 63-75.

Frankel, J. R., & Wallen, N. E. (2000). *How to design and evaluate research in education*. (4th ed.). Boston: McGraw.

Galvan, F. H., Davis, E. M., Banks, D., & Bing, E. G. (2008). HIV stigma and social support among African Americans. *Patient Care STDS, 22*(5), 423-436.

Gay, R. L. (1992). *Educational research: Competencies for analysis and application*. (4th ed.). New York: Merrill.

Gerber, B. (2002). The challenges of managing HIV counsellors in a rural district in the Eastern, South Africa. Unpublished master's thesis, Rhodes University, Grahamstown.

Ghana Statistial Service, Ghana health Service and ICF Macro (2009). Ghana demographic and Health Survey 2008. Ghana: Accra, ICF Macro, Calverton, Maryland, U.S.A.

Gielen, A. C., O'Campo, P., Faden, R. R., & Eke, A. (1997). Women's disclosure of HIV status: Experiences of mistreatment and violence in an urban setting. *Women Health, 25*(3), 19-31.

Grosch, W. N., & Olsen, D. C. (1994). *When helping starts to hurt: A New Look at Burnout Among Psychotherapists.* New York. *McGraw Hill.*

Hentgen, V., Jaureguiberry, S., Ramiliarisoa, A., Andrianantoandro, V., & Belec, M. (2002). Knowledge, attitude and practices of health personnel with regard to HIV and AIDS in Tamatave (Madagascar). *Bulletin for Social Pathology Exotica, 95*(2), 103-108.

Herek, G. M., & Capitanio, J. P. (1999). AIDS stigma and sexual prejudice. *Sage Journal, 42*(7), 1130-1147.

Herek, G. M., Capitanio, J. P., & Widaman, K. F. (2002). Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychology, 22*(5): 533-540.

Herek, G. M., Mitnick, L., Burris, S., Chesney, M., Devine, P., Fullilove, M. T., Fullilove, R., Gunther, H. C., Levi, J., Michaels, S., Novick, A., Pryor, J., Snyder, M., & Sweeney, T. (1998). Workshop report: AIDS and stigma: a conceptual framework and research agenda. *AIDS Public Policy J*, *13*(1): 36-47.

Hlalele, M. K. (2004). *An exploratory study of the psychological impact of HIV and AIDS patients on the counsellor*. Unpublished master's thesis, University of Pretoria, Pretoria.

Hoffman, M. A. (1996). *Counselling clients with HIV disease: Assessment, intervention and prevention.* New York: The Guilford Press.

Hoffmann, (La-Roche Ltd), (2008). *African healthcare professionals' perspectives on meeting the challenges of HIV and AIDS in Africa*. Retrieved March 15, 2013, from, www.roche.com/care_brochure

Horizons Programme. (2001). *HIV Voluntary counselling and testing among youth: Results from an exploratory study in Nairobi, Kenya, and Kampala and Masaka, Uganda*. Washington: Population Council.

International Organisation for Migration. (2006). IOM HIV counselling in the context of migration health assessment. Accessed on May 20, 2012, www.publications.iom.int/bookstore/free/Guide_for_HIV_Counsellor.

Inungu, J. (2008). *Psychological and social issues associated with HIV testing and OTC home-use HIV tests.* Unpublished master's thesis, Central Michigan University, Michigan.

International Planned Parenthood Federation. (2002). *Programme guidance on counselling for STI/HIV prevention in sexual and reproductive health settings for counsellors, health workers, educators and all those working in STI/HIV and AIDS.* London: Author.

Isaksen, J., Songstad, N. G., & Spissoy, A. (2002). *Socio-economic effects of HIV and AIDS in African countries.* Bergen: Chr Michelsen Institute.

Jerene, D., Endale, A., & Lindjorn, B. (2007). Acceptability of HIV counselling and testing among tuberculosis patients in South Ethiopia. *BMC International Health and Human Rights, 7*(4).

Joshua, M. J. (2005). *Fundamentals of test and measurement in education*. Nigeria, University of Calabar Press.

Kachingwe, S. I., Umar, E., Mandalazi, P., Jere, D., & Chizimba, E. (2001). *Voluntary counselling and confidential testing-baseline study report*. Lilongwe: UNFPA.

Kanekar, A. S. (2011). HIV and AIDS counselling skills and strategies: Can testing and counselling curb the Epidemic. *International Journal of Preventive Medicine*, *2*(1), 10-14.

Kaponda, C. P. K., Norr, K. F., Norr, J. L., Crittenden, K. S., Kachingwe, S. I., & Jere, D. G. (2004). *HIV testing attitudes and whether tested among adults in rural Malawi.* Paper presented at the meeting of the XV International AIDS Conference, Bangkok.

Ki-moon, B. (2008). The stigma factor. *The Washington Times, 2*(8), 35-37.

Kipitu, U. (2005). *Quality care of voluntary counselling and testing: Clients' experience, expectations and satisfactions in Mbeya Tanzania*. Geneva: Sexual Health Press.

Koenig, L. J., & Moore, J. (2000). Women, violence and HIV: A critical evaluation with implications for HIV service. *Maternal Child Health Journal, 4*:103-109.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activity. *Educational and Psychological Measurement, 30,* 607-610.

Krenn, S., & Limaye, R. (2009). *Building comprehensive HIV and AIDS care programmes in resource-limited settings*. Washington, DC: Elizabeth Glaser Paediatric AIDS Foundation.

Kululanga, L. I. (2006). Knowledge, attitudes and practices of Kamuzu college of nursing students towards voluntary counselling and HIV testing. University of Malawi, Desertation.

Letamo, G. (2005). The discriminatory attitudes of health workers against people living with HIV. *PLOS Med 2*(8), 261-264.

Lule, E., & Haacker, M. (2011). *The fiscal dimension of HIV and AIDS in Botswana, South Africa, Swaziland and Uganda.* Washington: The World Bank.

Mahendradhata, A., Ahmad, R. Y., Lefèvre, P., Boelaert, M., & Stuyft, V. P. (2008). *Barriers for introducing HIV testing among tuberculosis patients.* Jogjakarta: Indice House.

Malik, N. M., Mushtaq, A., Khalid, S., Khalil, T., & Malik, F. M. (2009). "Measurable and scalable NFRs using fuzzy logic and Likert scale." *International Journal of Computer Science and Information Security*, *2*(1).

Maluwa-Banda, D. (2001). *Baseline survey report on the sexual and reproductive health programme for the out-of-school young people.* Lilongwe, Malawi: Department of Youth, National Youth Council of Malawi and United Nations Population Fund (UNFPA).

Manongi, R., Marchant, T., & Bygbjerg, I. C. (2006) "Improving motivation among primary health care workers in Tanzania: a health worker perspective", *Human Resources for Health*, *4*(1).

MAP Report. (2004). *AIDS in Asia face the facts: A comprehensive analysis of the AIDS epidemic in Asia*. Retrieved October 10, 2012, from, www.fhi.org/en/HIVAIDS/pub/survreports/aids-in-asia.

Margolis, A. D., Wolitski, R. J., Parsons, J. T., & Gomez, C. A. (2001). Are healthcare providers talking to HIV-sero-positive patients about safer sex? *Public Medicine 15*(17), 2335-2337.

Masingi, N., Chabwera, C., Chauwa, F., Kandikole, L., Jumbe, A., Nkhalamba, T., Kanyama, C., Martinson, F., McCauley, M., Hoffman, I., & Hosseinipour, M. (2004, July). *Experience with couples attending voluntary counselling and testing in Lilongwe, Malawi*. XV International AIDS Conference, Bangkok.

Matteson, W. (2010). Missing the diagnosis: The hidden medical causes of mental disorders. Accessed on October 10, 2013, From http://www.continuingedcourses.net/active/courses/course067.php.

Mawar, N., & Paranjape, R. S. (2002). Live and let live: Acceptance of people living with HIV and AIDS in an era where stigma and discrimination persist. *ICMR Bull, 32,* 105-14.

McCauley, A. P., Crowley, S., Juma, M., & Denison, J. (2004). *Policy and programme barriers to equitable access to VCT services for young people.* XV International AIDS Conference, Bangkok.

McGrath, J. W., Rwabukwali,C. B., Sehumann, D. J. L., Person, M., Namande, B., & Mu-Kasa, R. (1993). Anthropology and AlDS: The cultural context of sexual risk behaviour among urban Rwanda women in Kampala, Uganda. *EFM and MNE, 36,* 429-439.

Meintjes, G. (2012). Guidelines for antiretroviral therapy in adults. *South Africa Journal of HIV Medicine, 13*, 3-7.

Ministry of Health, (2008). National guidelines for the development and implementation of HIV counselling and testing in Ghana. Ghana: Author.

Ministry of Health, Uganda. (2005). *HIV counselling and testing: A national counsellor training manual.* Kampala: Author.

Molefe, M. N. (2005). *Attitudes and fears of HIV counsellors towards voluntary HIV testing*. Unpublished master's thesis, University of Johannesburg, Johannesburg.

NACP, GHS & MOH. (2012). *2011 HIV Sentinel Survey Report*. Ghana Health Service. Ghana, Accra. Author.

NACP, GHS & MOH. (2011). *2010 HIV Sentinel Survey Report.* Ghana Health Service. Ghana, Accra. Author.

NACP. (2009). *Basic elements in counselling.* Accra: Author.

Namale, M. K. (2010). *The professional counsellor*. Cape Coast: Edsam Printing Press.

Nelson-Jones, R. (2005). *Practical counselling and helping skills*. London: Sage.

Nettleman, M. D., & Havlichek, D. (2013). What are the different types of HIV testing? Retrieved from www.medicinenet.com on November 15, 2012.

Noar, M. S., & Zimmerman, S. R. (2005). Health Behaviour Theory and cumulative knowledge regarding health behaviours: are we moving in the right direction? *Health Education Research J. 20*(3), 275-290.

Norman, L. R., Carr, R., & Jimenez, J. (2006). Sexual stigma and sympathy: Attitudes toward persons living with HIV in Jamaica. *Culture, Health & Sexuality*; *8*(5): 423-433.

Nulty, M. (2003). *The experiences and needs of HIV and AIDS counsellors at Settlers Hospital, Grahamstown: A multiple case study*. Unpublished Master's Thesis, Rhodes University, Rhodes.

Nulty, M., & Edwards, D. (2005). The experiences and needs of HIV and AIDS counsellors at a South African hospital. *Journal of Psychology in Africa, 15*(1), 1–10.

Obiajulu, C. O. (2009). A research report on Knowledge, attitude and practice of voluntary counselling and testing (HCT) for HIV/AIDS amongst health professionals in Umpumulo hospital, Mapumulo, Ilembe district, Kwazulu-natal province. Accessed on November 12, 2011 from http:u/.netd. ac.za/jspui/bistream/10386/ 209/1/Dr.Obiajulu final.

Osagbemi, M. O., Joseph, B., Adeputu, A. A., Nyong, A. O., & Jegede, A. S. (2007). *Culture and HIV and AIDS in Africa: Promoting reproductive health in light of spouse sharing practice among the Okun people in Nigeria.* Toronto: Longwood's publishing.

Peltzer, K. Nzewi, E., & Krishna, M. (2004). Attitudes towards HIV-antibody testing and people with AIDS among university students in India, South Africa and United States. *Indian Journal of medical sciences*, *58*, 95-108.

Perry, C. L., & Sieving, R. (1993). *Peer Involvement in Global AIDS Prevention among Adolescents.* Unpublished master's thesis, University of Minnesota, Minnesota.

Perry, S. O., & Tross, S. (1993). Psychiatric problems of AIDS inpatients at the New York Hospital: Preliminary report. *Public Health Psychiatry*. *90*: 200-205.

Piot, P. (2002). UNAIDS world AIDS day message. Retrieved June 6, 2012, from http://www.unaids.org/whatsnew/speeches/eng.

Rachier, C. O., Gikundi, E., Balmer, D. H., Robson, M., Hunt, K. F., & Cohenet, N. (2004). *The meaning and challenge of voluntary counselling and testing (VCT) for counsellors - report of the Kenya Association of Professional Counsellors (KAPC) conference for sub Saharan Africa.* Southampton: Sage.

RAND Corporation. (2008). HIV and psychiatric problems. *Rand Health Research Brief, 12*(4), 34-37.

RAND Corporation. (2010). Mental health and substance abuse issues among people with HIV lessons from HIV Costs and Services Utilization Study (HCSUS). *Rand Health Research Brief, 3*(7), 112-114.

Rautalinkoa, E. (2013). Reflective listening and open-ended questions in counselling: Preferences moderated by social skills and cognitive ability. *Counselling and Psychotherapy Research: Linking Research with Practice, 13*(1), 24-31

Reis, C., Heisler, M., Amowitz, L. L., Moreland, R. S., Mafeni, J. O., Anyamele, C., & Lacopino, V. (2005). Discriminatory attitudes and

practices by health workers towards patients with HIV and AIDS in Nigeria. *PLOS MEDICINE, 2*, 246-248.

Rothenberg, K. H., Paskey, S. J., Reuland, M. M., Zimmerman, S. I., & North, R. L. (1995). Domestic violence and partner notification: implications for treatment and counselling of women with HIV. University of Maryland, School of Law, Baltimore. USA. *Journal Am Med Women's Association*, *50*(3), 87-93.

Rotheram-Borus, M. J., Draimin, B. H., Reid, H. M., & Murphy, D. A. (1997). The impact of illness disclosure and custody plans on adolescents whose parents live with AIDS. *AIDS London, 11*, 1159-1164.

Sanjana, P., Torpey, K., Schwarzwalder, A., Simumba, C., Kasonde, P., & Nyirenda, L. (2009). Task shifting HIV counselling and testing services in Zambia: The role of lay counsellors. *Human Resource Health*, *7*, 44-46.

Seider, G. (1996). Confidentiality and HIV status in Kwazulu-Natal, South Africa: Implications, resistances and challenges. *Health Policy and Planning*, *11*(4), 418-427.

Sieff, E., Dawes, R. M., & Loewenstein, G. (1999). Anticipated versus actual reaction to HIV test results. *American Journal of Psychology*, *112*(2), 297-311.

Singh, C. Z., & Banerjee, A. (2004). HIV and AIDS: Social and ethical issues. *MJAFI*, *60*(2), 107-108.

Sowell, R. L., Phillips, K. D., Seals, B., Murdaugh, C., & Rush, C. (2002). Incidence and correlates of violence among HIV infected women at

risk for pregnancy in the South-Eastern United States. *Journal of the Association of Nurses in AIDS Care, 13*(2), 46-58.

The Counsellor's Guide. (2012). Attitudes and qualities of a good counsellor.

The Project RESPECT Study Group. (1998). Efficacy of risk reduction counselling to prevent HIV and STDs. *JAMA, 280,* 1161-1167.

The Southern African Association for Pastoral Work. (2012). *Attitudes and qualities of a good counsellor*. Kwazulu Natal: Author.

Theilgaard, Z. P., Katzenstein, T. L., Chiduo, M. G., Pahl, C., Bygbjerg, C., Gerstoft, J., Martha, M., Lemnge, M. M., & Tersbol, B. P. (2011). Addressing the fear and consequences of stigmatization: a necessary step towards making HAART accessible to women in Tanzania: A qualitative study. *Pub Med Central, 10*(11), 86-88.

Thomason, T. (2011). Best practices in counselling Native Americans. *Journal of Indigenous Research, 1*(3), 17-19.

Tomaszeski, L. (2001). *An overview of the psychosocial issues that impact family's affected by HIV and AIDS.* Mississippi: Jacksonsville Mdicine.

UNAIDS. (2011). Together for HIV and AIDS prevention, a toolkit for the Sports community. Retrieved on August 10, 2012 from http://www.olympic.org/Documents/Olympism_in_action/HIV_and Aids/IOC-UNAIDS-MANUAL-EN.pdf.

UNAIDS. (2010). *Report on the global HIV and AIDS epidemic*. Geneva: United Nations. Author.

UNAIDS. (2004). *UNAIDS/WHO Policy Statement on HIV testing*. Geneva: Author.

UNAIDS. (2002b, June). *HIV voluntary counselling and testing: A gateway to prevention and care*. Geneva: Author.

UNAIDS. (2001). *The impact of voluntary counselling and testing: A global review of the benefits and challenges*. Geneva, Author.

UNAIDS. (2000). *Voluntary counselling & testing (VCT), UNAIDS technical update. (1st ed.).* Geneva: Author.

UNICEF East Asia and Pacific Regional Office. (2009). *HIV counselling handbook; A comprehensive guide to voluntary counselling and testing,provider-initiated testing and counselling and treatment and care counselling*. Burma: Author.

USAID. (2011). *HIV and AIDS Health profile on Sub Saharan Africa.* Geneva: Author.

USAID & Central America Capacity Project. (2012). *Health education: HIV and other STIs, Teacher's manual.* Faculty of Nursing, Allied Health and Social work, University of Belize, Belize.

Uys, H. H. M., & Basson, A. A. (1991). *Research methodology in nursing*. Cape Town: Kagiso Tertiary.

Uys, L. R. (2000). Confidentiality and HIV and AIDS in South Africa. *Nursing Ethics*, *7*(2), 158-166.

Van-Dyk, A. (2001). *HIV and AIDS care and counselling: A multidisciplinary approach.* Cape Town: Pearson Education.

Van-Dyk, A. C., & Van-Dyk, P. J. (2003). What is the point of knowing? psychosocial barriers to HIV and AIDS Voluntary Counselling and testing programmes in South Africa. *South Africa Journal of Psychology*, *33*(2), 118-125.

Victorian Health Promotion Foundation. (2008). *Violence against women in Australia as a determinant of mental health and wellbeing*. Canberra: Author.

Volmink, J. (2002). *Strategies for partner notification for sexually transmitted diseases: RHL commentary*. Geneva: World Health Organization

Wenger, N., Greenberg, J., Hilborne, L., Kusseling, F., Mangotich, M., & Shapiro, M. (1992). Effect of HIV antibody testing and AIDS education on communication about HIV risk and sexual behaviour. *Annals of Internal Medicine*, *117*, 905-911.

WHO. (2013). HIV and AIDS consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Author.

Writer, A. C. (2007). *HIV positive patients more susceptible to mental health, substance abuse problems.* Dallas: Word Publishing.

Yoder, P. S., & Matinga, P. (2004). *Voluntary counselling and testing (VCT) for HIV in Malawi: Public Perspectives and Recent VCT Experiences*. Calverton, Maryland, USA: ORC Macro.

Zierler, S., Cunningham, W. E., Andersen, R., Shapiro, M. F., Nakazono, T., & Morton, S. (2000). Violence victimization after HIV infection in a US probability sample of adult patients in primary care. *American Journal of Public Health*, *90*, 208-215.

Zur, O. (2011). *Gifts in psychotherapy*. Portsmouth: Glaser Press.

APPENDICES

APPENDIX A

INTRODUCTORY LETTER FOR DATA COLLECTION

UNIVERSITY OF CAPE COAST

CAPE COAST, GHANA

DEPARTMENT OF EDUCATIONAL FOUNDATIONS

Telephone: 32440/4 & 32480/3 Direct: 042-36037
TELEX: 2552, UCC, GH
Telegrams & Cables: University, Cape Coast

University Post Office
Cape Coast, Ghana

Our Ref.:

Your Ref: 25/01/2012

THESIS WORK

LETTER OF INTRODUCTION

We introduce to you Mr./~~Mrs./Miss.~~ JOSEPH SEREBOUR ASANTE ..... a student from the University of Cape Coast, Department of Educational Foundations. He/~~She~~ is pursuing a Master of Philosophy (M.Phil) degree in GUIDANCE AND COUNSELLING .....
As part of his/her requirements, he/she is expected to work on a thesis entitled:
KNOWLEDGE, ATTITUDE AND PRACTICES OF HIV COUNSELLORS IN THE CENTRAL REGION OF GHANA
.....
.....
.....

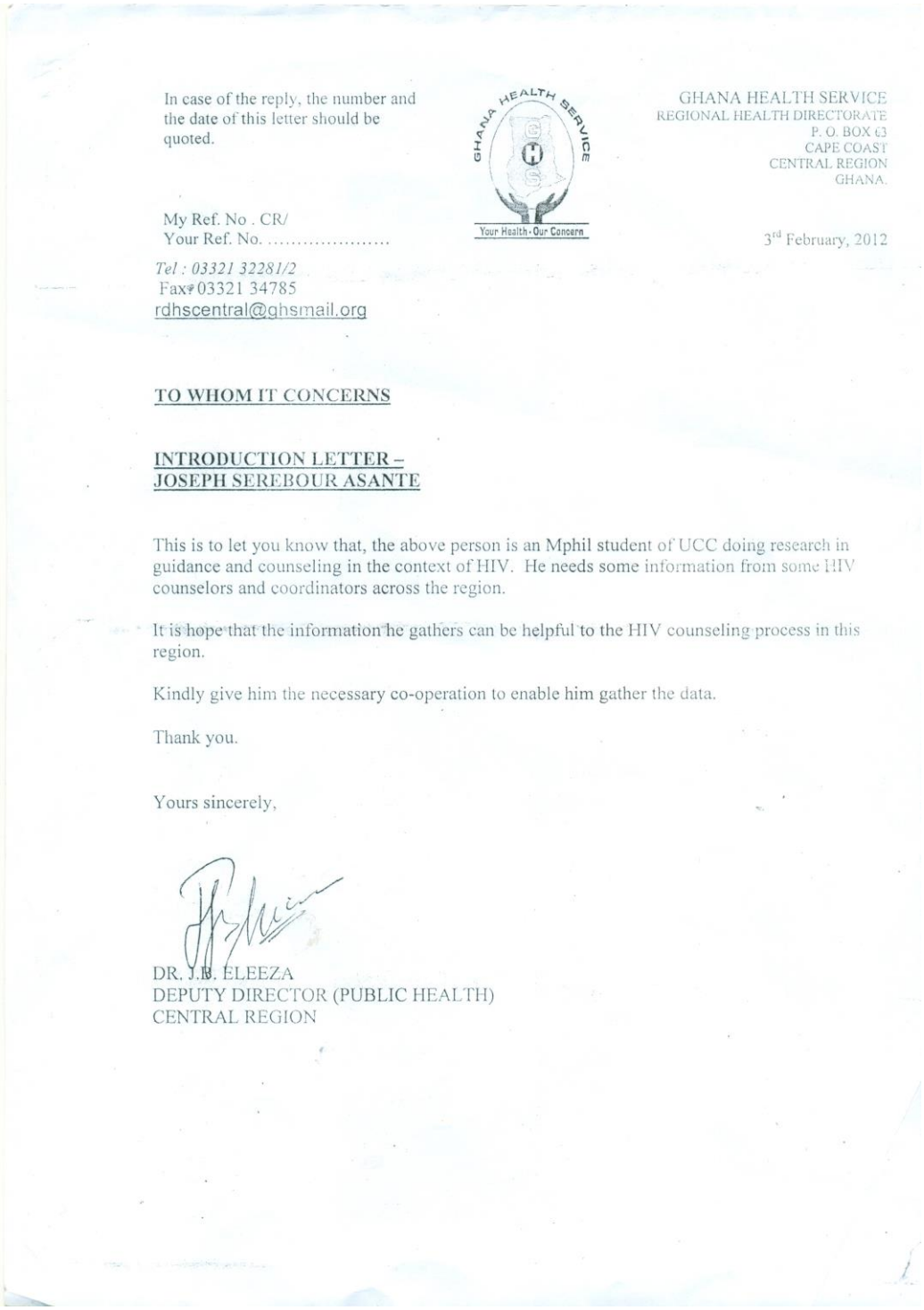
He/She has opted to make a study at your institution/establishment for the project. We would most grateful if you could provide the opportunity for the study. Any information provided will be treated as strictly confidential.

Thank you.

For (Dr. Emmanuel Kofi Gyimah)
HEAD

APPENDIX B

INTRODUCTORY LETTER FOR DATA COLLECTION FROM GHANA HEALTH SERVICE



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

GHANA HEALTH SERVICE
REGIONAL HEALTH DIRECTORATE
P. O. BOX 63
CAPE COAST
CENTRAL REGION
GHANA.

My Ref. No . CR/
Your Ref. No. .....

3rd February, 2012

Tel : 03321 32281/2
Fax: 03321 34785
rdhscentral@ghsmail.org

TO WHOM IT CONCERNS

INTRODUCTION LETTER –
JOSEPH SEREBOUR ASANTE

This is to let you know that, the above person is an Mphil student of UCC doing research in guidance and counseling in the context of HIV. He needs some information from some HIV counselors and coordinators across the region.

It is hope that the information he gathers can be helpful to the HIV counseling process in this region.

Kindly give him the necessary co-operation to enable him gather the data.

Thank you.

Yours sincerely,

DR. J.B. ELEEZA
DEPUTY DIRECTOR (PUBLIC HEALTH)
CENTRAL REGION

APPENDIX C

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD

INFORMED CONSENT FORM

Title: [Knowledge, attitude and practices of HIV and AIDS counsellors in the Central Region of Ghana]

Principal Investigator: [Joseph Serebour Asante]

Address: [Department of Educational Foundations, University of Cape Coast]

PROCEDURES

To find answers to some of these questions, we invite you to take part in this research project. If you accept, you will be required to fill out a questionnaire which will be distributed by myself or the HIV Coordinator in your facility.

You are being invited to take part in this study because we feel that your experience as HIV and AIDS counsellor can contribute much to this study.

If you do not wish to answer any of the questions included in the survey, you may skip them and move on to the next question. The information you will provide will be treated confidential, and will be used for academic purposes. We will protect information about you to the best of our ability. You will not be named in any report. Some staff of my department, especially, my supervisors may sometimes look at the progress of this research. The expected duration for filling this questionnaire is about 25-35 minutes. It is hoped that the results of this study will help improve HIV and AIDS counselling and testing in the Central Region of Ghana.

Apart from the questionnaire, I will observe some HIV counselling sessions in this unit.

Your participation is voluntary and you have the right to leave at any time you wish. You can call for further information or explanations:

Joseph Serebour Asante: Researcher (0243402740 or 0202437993)

Prof. Frederick Ocansey: Principal Supervisor (0244782783)

Mr. J. K. Ofosuhene Mensah: Co-Supervisor (0244961148)

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research "Knowledge, attitude and practices of HIV and AIDS counsellors in the Central Region of Ghana" by Joseph Serebour Asante, 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.

_____ Joseph Serebour Asante _____

Date Name/Signature of Person Who Obtained Consent

APPENDICE D

UNIVERSITY OF CAPE COAST

DEPARTMENT OF EDUCATIONAL FOUNDATIONS

QUESTIONNAIRE FOR HIV AND AIDS COUNSELLORS

Dear Counsellor, your help is needed in a research I am conducting to find out the knowledge, attitude and practices of HIV counsellors in the Central Region of Ghana. I would be very grateful if you would respond to the questions as objectively as possible for the success of the study. Your response will be treated with utmost confidentiality. Also the response would only be used for the purpose of the thesis and to help improve HIV counselling and testing in the Central Region.

Thank you.

Instruction: Please, respond appropriately to the following questions by ticking [√] or writing your answer (s) in the space (s) provided.

SECTION A: PERSONAL DATA

1) Unit/Department of the counsellor ……

2) What is your Profession?
   - i. Registered General Nurse [ ]
   - ii. Registered Mental Health Nurse [ ]
   - iii. Registered Midwife [ ]
   - iv. Registered Community Health Nurse [ ]
   - v. Registered General Nurse/Midwife [ ]
   - vi. Others (specify) ……

3) Highest Academic Qualification
   - i. Master's Degree [ ]
   - ii. Bachelor's Degree [ ]
   - iii. Diploma [ ]
   - iv. Certificate [ ]
   - v. SSCE/GCE O/A LEVEL [ ]

4) Experience as HIV counsellor
   - i. Less than 5years [ ]
   - ii. Between 5 to 10years [ ]

iii. Above 10years [ ]

5) Apart from HIV counselling and testing which other role (s) do you perform in this hospital?

i. Ward Nurse [ ]
ii. Nurse Prescriber [ ]
iii. Run HIV clinic [ ]
iv. Out – patient Department [ ]
v. Specialist clinic [ ]

6) Have you attended HIV counselling and testing training course before?
Yes [ ]

No [ ]

SECTION B: Knowledge of HIV counsellors:

Please state Yes or No to the following statements by ticking (√) in the appropriate box.

Knowledge on HIV test

7) HIV can be detected in the individual at any time of the infection.
Yes [ ]

No [ ]

8) All clients who test positive for the first time on antibody test are actually HIV positive.
Yes [ ]

No [ ]

9) All clients who test negative for the first time on antibody test are actually HIV negative.
Yes [ ]

No [ ]

10) Once tested HIV positive the individual remains HIV positive for life.
Yes [ ]

No [ ]

11) Antibody HIV test can detect positive case in children below 18 months of age.

Yes [ ]

No [ ]

Knowledge on risk factors

12) Most HIV positive mothers may transmit the virus to their children when mother to child transmission (MTCT) intervention is not done.
Yes [ ]
No [ ]

13) Single sexual intercourse with HIV infected person can transmit the virus to one's sexual partner.

Yes [ ]

No [ ]

14) Sexual intercourse is the only way of acquiring HIV.

Yes [ ]

No [ ]

15) Heterosexuals are at equal risk of HIV infection as homosexuals.

Yes [ ]

No [ ]

16) Health workers can contract the virus through single needle prick injury.

Yes [ ]

No [ ]

Knowledge on the signs and symptoms of HIV

17) Pneumonia is a common infection in HIV infected individuals.

Yes [ ]

No [ ]

18) Diarrhoea is one of the major problems for HIV infected individuals.

Yes [ ]

No [ ]

19) HIV infected individuals' may lose more than 10% body weight without any underlying cause.

Yes [ ]

No [ ]

20) Cancers are common in HIV infected individuals.

Yes [ ]

No [ ]

21) Skin cancers and other dermatological conditions are more prevalent in HIV positive individual than those who are HIV negative.

Yes [ ]

No [ ]

22) Is it possible for HIV infected individuals to live normal with family members without infecting them?

Yes [ ]

No [ ]

Knowledge on complications of HIV

23) TB is a major cause of death for most HIV positive individuals.

Yes [ ]

No [ ]

24) Mental disorders are common in individuals with HIV infection.

Yes [ ]

No [ ]

25) Cardiac conditions are more prevalent in HIV positive individuals than people who do not have HIV.

Yes [ ]

No [ ]

Knowledge on management practices of HIV

26) A CD4 count (level of immune system) of less than 350 requires anti-retroviral therapy (ART) intervention

Yes [ ]

No [ ]

27) CD4 level (level of immune system) checks are not necessary for all clinic attendance by HIV positive persons.

Yes [ ]

No [ ]

28) Hepatitis B testing is mandatory for all HIV infected individuals on ART.

Yes [ ]

No [ ]

29) Syphilis screening is mandatory for all those who come for prevention of mother to child transmission (PMTCT) test in the Central Region.

Yes [ ]

No [ ]

30) Liver and kidney functioning test are necessary for proper management of HIV infected individuals on ART.

Yes [ ]

No [ ]

31) Zidovudine is not one of the major ARTs for HIV infected individuals.

Yes [ ]

No [ ]

32) HIV positive individual cannot marry HIV negative individual without infecting him/her.

Yes [ ]

No [ ]

33) Condom use provides 100% protection against HIV infections. `

Yes [ ]

No [ ]

34) Sero–discordance (where one couple has HIV but the other does not) is becoming a common issue in HIV counselling and testing?

Yes [ ]

No [ ]

Knowledge on counselling issues

35) Confidentiality is absolute in HIV counselling?

Yes [ ]

No [ ]

36) Pre-test counselling sessions are organised to prepare the client for HIV test?

Yes [ ]

No [ ]

37) Post-test counselling is organised to prepare the client to receive and accept his/her HIV test result?

Yes [ ]

No [ ]

38) Counsellors are expected to help client explore ways of coping with life effectively?

Yes [ ]

No [ ]

Please state whether you Strongly Agree (SA), Agree (A), Disagree (D) or Strongly Disagree (SD) with the following statements by ticking (√)

Items	SA	A	DA	SD
SECTION C: Attitude of HIV counsellors				
39) All clients who come for HIV counselling and testing have trust in me because of the way I handle the information they share with me.				
40) When I become angry with my clients I shout at them.				
41) I make sure my clients feel welcomed to this facility				
42) I remain non-judgmental during counselling sessions				
43) I give equal treatment to all clients who come for HIV counselling and testing				
44) I discuss the status of my clients with my family.				
45) I do not like to render HIV test to commercial sex workers				
46) I am always ready to test for my HIV status				
47) I have fear of knowing my HIV status				
SECTION D: Practices HIV counsellors				
48) I ensure that the environment where I provide HIV counselling is conducive				
49) I ensure that counselling sessions are not interfered with other activities I perform in this facility				
50) I inform my clients on HIV infection and its implications				
51) I explain the risk factors of HIV infections to my clients				
52) I inform clients about the diagnoses of the HIV virus and the meaning of the test results				
53) I make sure that signs and symptoms of the HIV infections are made known to my clients.				
54) I educate my clients on the treatment available to reduce viral load				
55) I explain opportunistic infections and their management to my clients				
56) I discuss the need for regular checkup with my clients				

57) I explain the need for family support to my clients				
58) I inform my clients on the availability of a social support for PLWHA				
59) I offer nutritional education to my clients				
60) I explain prevention of the infection to my clients				
61) I explain sero-discordance to my clients				
SECTION E: The use of appropriate counselling techniques during counselling and testing sessions	Very often	often	Some Times	Not at all
62) I establish rapport with my client at the beginning of each counselling session				
63) I listen attentively to my client during counselling sessions				
64) I use open ended questions to elite information from my clients during counselling sessions				
65) I try to summarize the discussions I have with my clients				
66) I try to give simple information to my clients				
67) I always allow time for my clients to respond to questions				
68) I assist my clients to clarify misunderstanding				
69) I prioritize issues with my clients				

SECTION F: Challenges HIV Counsellors face

70). State any two (2) challenges you face as HIV counsellor in this facility.

1……

2……

SECTION G: Measures to Curb the Challenges HIV Counsellors Encounter

71). Please what measures could be taken to solve the challenges you have mentioned in item 70?

1.……..…

2.……

UNIVERSITY OF CAPE COAST

DEPARTMENT OF EDUCATIONAL FOUNDATIONS

CHECKLIST FOR HIV COUNSELLORS

Minimum quality checklists for pre- and post-test counselling skills by UNAIDS (2000). The scales are: very often (V.O), often (O), sometimes (S), not at all

Counsellor uses appropriate counselling techniques during CT session	V.O	O	S	Not at all
1) Establish rapport with the client				
2) Listens attentively to client				
3) Counsellor is non-judgmental				
4) Counsellor uses open ended questions				
5) Counsellor seeks clarification				
6) Counsellor summarizes discussions with the client				
7) Counsellor gives simple information				
8) Allow time for client to respond to questions				
9) Assist client to clarify (mis)understanding				
10) Counsellor discusses appropriate and sensitive issues				
11) Counsellor prioritizes issues with the client				
12) Assist client to manage distress				
13) Counsellor's ability in involving client's partner				