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KNOWLEDGE, ATTITUDE AND PRACTICE OF VOLUNTARY COUNSELLING AND TESTING BY HIV AND AIDS COUNSELLORS

JOSEPHINE AWUAH

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KNOWLEDGE, ATTITUDE AND PRACTICE OF VOLUNTARY COUNSELLING AND TESTING BY HIV AND AIDS COUNSELLORS

BY

JOSEPHINE AWUAH

Dissertation 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 Education Degree in Guidance and Counselling

JUNE 2009

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DECLARATION

Candidate's Declaration

I hereby declare that this dissertation 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: Josephine Awuah

Supervisor's Declaration

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

Supervisor's Signature………………… Date…………………..

Name: Prof. J. A. Opare

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ABSTRACT

The purpose of the study was to find out whether or not HIV and AIDS counsellors in Kumasi Metropolis in Ashanti Region are: aware of national HIV and AIDS policy and policy guidelines, have requisite minimum training in HIV and AIDS counselling and care, have the necessary human resources for VCT, and have the minimum level of conceptual knowledge about VCT. It was meant to ascertain whether VCT as practiced, conforms with the minimum guidelines set by the UNAIDS as well as finding out if VCT is widely available in all the selected hospitals for the study in the Kumasi Metropolis of Ashanti Region of Ghana.

The study involved 25 HIV and AIDS counsellors and 36 clients from three Kumasi Metropolis hospitals in the Ashanti Region of Ghana. Data were collected using questionnaire consisting of 60 items, some of which consisted of statements to which the respondents were to respond to.

The results of the study indicated that, there were national policy and some guidelines on VCT. Greater majority (78%) of the respondents did understand what the concept VCT entails. Lack of trained (volunteer) and designated staff to oversee the successful implementation of VCT and inadequate human resource base were some of the impediments identified. The general practice of VCT in Kumasi Metropolis hospitals to a large extent conforms with UNAIDS standards. It was recommended that the National Aids Commission (NAC) make available adequate number of trained voluntary and designated staffs to oversee the successful implementation of VCT in the Kumasi Metropolis.

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Lastly, I would like to thank my wonderful, supportive, and loving husband, Nana Amoako Poku and my children, Mary Sarpong, Aaron Awuah and Edward O. Assibey, who always provided uplifting words of encouragement to me.

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DEDICATION

This work is dedicated to all HIV and AIDS victims.

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CHAPTER ONE

INTRODUCTION

Background to the Study

The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) are believed to be one of the worst human catastrophes the world has ever known since World War II. Indeed a second hardly passes without an announced death due to the HIV and AIDS globally and this has put a lot of fear in people so that the name HIV and AIDS has become a jinx word which the populace trying to expunge from their vocabulary. As a consequence to this awed shivers that this problem has engendered, various literature has pronounced that a diagnosis of this malady HIV and AIDS profoundly and seriously puts the affected individual's psychological frame at low ebb (Dilley et al., 1985; Donlou et al., 1985; Nicols & Ostrow, 1984 cited in Bor, Riva, Isobul & Heather, 1991). It has been noted that HIV infection is one of the most significant health concerns the world has ever known (Pincting cited in Bor et al., 1991). It is decimating a lot of people especially those between the ages of 25 and 44 in New York (Morbidity and Mortality Weekly Report, 29 January, 1988 cited in Bor et al.). Many strategies have been evolved to help thaw out the rapid spread of the HIV and AIDS menace, and notable among these interventions

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include counselling which has been identified as a “sine qua non” when it comes to helping people come out of their psychological trauma.

As the HIV and AIDS scourge intensifies, Africa has not been spared the ordeal of daily funerals and interments due to HIV and AIDS. This HIV and AIDS pandemic has hit Ghana hard and according to Ghana AIDS Commission (GAC), HIV and AIDS cases first came into prominence when it was first announced in 1986 and it has since been spreading at a supersonic speed. The Ghana AIDS Commission recalled that the first cases of HIV and AIDS recorded in Ghana came from women who had gone to seek greener pastures outside the country especially those who lived in neighbouring countries like La Cote d’Ivoire.

The first cases started like an andante, recording a mere 42 cases in1986 but rose to 37,298 cases by the close of 1999 (GAC, 2001). The ages between 15 and 49 years form about ninety percent of cumulative cases of AIDS between 1986 and 1991.

The depth of indifference when it comes to safe sex especially among the youth is quite worrying if not alarming. The Population Report (2001) posited that, today’s young people are AIDS generation. They have never known a world without HIV. Millions have already died and yet HIV and AIDS epidemic among youth remains largely invisible to adults and to young people themselves.

Heterosexual transmission of HIV accounts for 75-80% of all HIV and AIDS infection. Vertical transmission (mother to child) accounts for 15% while transmission through blood and blood product for 5% (GAC, 2001).

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No one strategy against HIV and AIDS can apply everywhere. The approach in each country should reflect the epidemical pattern of infection. For, since HIV and AIDS came to public attention and started claiming lives of scientists and even herbalists who have tried in vain to find a cure, sex among the youth continues to go on with impunity. A survey conducted by the demographic and health surveys (1992 to 1999, USCDC productive health survey), shows that sexual activity among unmarried youth aged 15-19 between 1991 and 1999 in sub-Saharan Africa was very high. For example, in La Cote d'voire within 1994, the percentage of youthful female who had sex before marriage was 26% while that of Zambia was 15%. In Ghana the percentage of unmarried female youth who had sex before marriage was 10%. The percentage of unmarried youth who had sex before marriage was 57%, 27% and 44% for La Cote d'voire, Ghana and Zambia respectively. This trend is quite serious and shows the level of danger looming. Consequently, it becomes imperative that the only panacea for the time being to stem the continuous rise in infection rate is education. The rationale is to change people's attitude towards the ailment and those infected and in addition, encourage people not to needlessly pre-dispose themselves to the condition (Awusabo-Asare, 1995a). The latter is meant to motivate people especially young people whose appetite for sex knows no bounds to either avoid or shift from what is now referred to as risky behaviour (Orubuloye, Caldwell & Caldwell, 1992; Anarfi & Antwi, 1995 cited in Awusabo-Asare, 1995b).

In the year 2000, the Government of Ghana realising the alarming rate of new infections of HIV and AIDS, adopted a psycho-social approach in its bid to

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halt or at least slow down the spread of the disease. This culminated in the setting up of the Ghana AIDS Commission (GAC) under the auspices of the President of the Republic of Ghana to coordinate all activities relating to HIV and AIDS in Ghana. The Ghana AIDS Commission aims at containment of the disease through the prevention of new infections. Some of the activities lined up to kick start the preventive regime include reducing Mother -To -Child Transmission (MTCT) and Voluntary Counselling and Testing (VCT). The main objective of setting up of GAC was to substantially reduce infections among newborn babies of the age group 15-49 years and other vulnerable groups by the year 2005 (GAC, 2001).

It has been confirmed by research recently conducted by Family Health International [FHI] (2002) that Voluntary Counselling and Testing (VCT) for HIV is an essential link between HIV prevention and HIV care support. It is also known that VCT promotes and sustains behaviour change, and links with Intervention to PMTCT, prevents Sexually Transmitted Infections (STIs), and prevents and treats Tuberculosis (TB) and other Opportunistic Infections (OIs). VCT also facilitates early referral to comprehensive clinical and community-based prevention, care and support services, including access to Antiretroviral Therapy (ART). In September, 2009, a workshop organised by Ghana Education Service and sponsored by UNICEF to develop, pilot and scale up the implementation of the HIV Alert School Model as a school based HIV prevention programme for basic school children, reported that Ghana, unlike many countries in Sub-Saharan Africa, has not been extensively hit by the AIDS pandemic. The report indicated that the 2007 HIV Sentinel Surveillance (HSS) report shows HIV

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period, (i.e. 2002 to 2007) trend analysis graph shows an almost flat line. This is an indication that the HIV prevalence in Ghana is stabilising.

"VCT improves quality of life and may play a pivotal role in reducing the stigma" (Family Heath International, 2001, p.1). HIV and AIDS voluntary counselling and testing as a clinical task has its origin in the United Kingdom in a government directive (Department of Health and Social Security, 1985 cited in Bor et al., 1991), which indicated that, to seek an antibody test one should undergo counselling in order to be aware of the meaning, nature and implications of the test (Bor et al., 1991). Early testing for HIV and AIDS offers many benefits, especially for young people. Early testing and counselling could lead to timely care, improve the medical management of HIV-related illnesses, and provide an opportunity to reduce prenatal transmission of HIV. The importance of VCT cannot be over-emphasised. Initially it dwelt solely on testing but presently it has been expanded to include health education, the primary prevention of HIV infection and re-infection, effecting change of behaviour, provision of partner and family support, bereavement counselling and staff support, offering psychological interventions with the "worried well" and counselling for therapeutic drug trials and others. It is known that, HIV and AIDS counselling is relatively new when it comes to its availability for health care providers, yet it is affirmed counselling as a service has been there in the health sector for some time now (Novack, cited in Bor et al., 1991).

Miller and Bor (cited in Bor et al., 1991) asserted that people presenting themselves for HIV test with an AIDS associated worry or with AIDS itself, have

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a range of problems and anxieties which medical , nursing, paramedical and counselling staff need to address and manage appropriately.

The United Nations General Assembly Special Session (UNGASS) on HIV and AIDS had decided its commitment in June 2001, and this declaration of commitment indeed confirmed the urgent need for all concerned countries to either develop or scale up voluntary HIV counselling and testing services. This affirmed the commitment of participating nations' bid to see to it that several preventive schemes are made available to all countries including access to voluntary and confidential counselling and testing (UNAIDS Best Practices Collection, June 2002).

Presently VCT has been prioritised as a firm intervention effort by a host of nations, and this effort is seen as a collaborative scheme between those countries' developing partners and local and international organisations. VCT is conducted either independently or jointly by public and private sector organisations such as Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs). Most VCT programmes are guided by the following principles:

1. To aim for high quality VCT.
2. To obtain equity and equal access for all people demanding VCT services.
3. To allow referral and access to comprehensive range of prevention, care and support services.
4. To advocate cost-efficient services for clients.

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5. To aim for sustainable services with a focus on health impact.
6. To foster community ownership for VCT services (FHI, 2002).

Statement of the Problem

The HIV and AIDS menace has caused the whole world a lot of anguish and despair. Ever since it's outbreak in the early 1980s, all efforts to stop its spread and continued devastation has been met with just limited success. The world has spared no effort to eliminate or at least slow down its spread through medical researchers. Yet, neither antidote nor a breakthrough has been in sight. Presently, the world is left to brood and grope, as hopes fade for any medical success. The solution is for an adoption of option like education as a medical windfall cure for the ailment.

Voluntary Counselling and Testing has been a novel approach to stemming the tide of HIV and AIDS in the entire health delivery system both in Ghana and even hard hit African countries (Ego & Moran; Lamtey & Coates, cited in Awusabo-Asare 1995b). A myriad of problems is foreseen here. First, the level of knowledge of health care providers who are supposed to carry out the voluntary counselling and testing is not clear; secondly, the attitude of health workers towards VCT, the nature and how VCT is administered in health care facilities is suspect; and lastly, whether the way VCT is carried out conforms with UNAIDS standards is not known.

This research was designed to investigate into the knowledge, attitude and practice of voluntary counselling and testing by HIV and AIDS counsellors towards the disease and infected persons.

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Purpose of the Study

Voluntary Counselling and Testing has been a component of and a gateway to prevention and care programmes. Its implementation has been largely successful. The purpose of the study is thus to investigate whether HIV and AIDS counsellors in Kumasi metropolis in the Ashanti Region:

1. are aware of national HIV and AIDS policy and policy guidelines;
2. have requisite minimum training in HIV and AIDS counselling and care;
3. have the necessary human resources for VCT;
4. have the minimum level of conceptual knowledge about VCT;
5. have the minimum level of practical knowledge of VCT;
6. are satisfied with the VCT they are offering;

Another purpose is to find out if VCT, as practiced, conforms to the minimum guidelines set by the UNAIDS.

Research Questions

1. Are HIV and AIDS counsellors aware of the national policies provided for VCT on HIV and AIDS testing and counselling?
2. To what extent do HIV and AIDS counsellors in the Kumasi metropolis understand the concepts in VCT?
3. What are the main problems in the implementation of VCT?
4. How adequate is the requisite training in VCT implementation for HIV and AIDS offered to counsellors in the Kumasi metropolis?
5. To what extent is Voluntary HIV Counselling readily available in the Kumasi metropolis?

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6. To what extent are HIV and AIDS Counsellors in the Kumasi metropolis promoting VCT?
7. To what extent are HIV and AIDS Counsellors in the Kumasi metropolis satisfied with their job?

Significance of the Study

The result of the study will enable policy formulators and implementers to have insight into how much VCT workers know about their job. It will also enable policy makers and practitioners have insight into the way VCT is practised in the Kumasi metropolis.

This research will be carried out in collaboration with the regional HIV and AIDS coordinator and the regional director of health services, who will be debriefed after the research. The study will therefore be of great benefit to the Ghana AIDS Commission as a policy maker, and the National AIDS Control Programme (NACP) and the Ghana Health Service who are in charge of the fight against HIV and AIDS. This is because VCT has become a gateway to both care and prevention of HIV and AIDS.

Delimitation of the Study

The research is delimited to VCT as practised by HIV and AIDS counsellors in hospitals in the Kumasi metropolis of the Ashanti region of Ghana. The work will not involve other preventive measures such as condom use, promotion of safe sex, and transmission of HIV through transfusion of blood. The

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study will be delimited to the Ashanti region of Ghana and HIV and AIDS counsellors in hospitals within the Kumasi metropolis.

Limitations of the Study

Most of the VCT counsellors in the survey were too overburdened and so to meet them was very difficult. This did not permit the researcher to meet all of them in each hospital where the questionnaires were distributed. In view of this difficulty, some other auxiliary (health care) providers were roped in to help administer the questionnaires. It is expected that since in some cases the VCT counsellors could not be met by the researcher, other auxiliary health care providers such as senior nursing officers, had to be debriefed instead. So the answers provided may be affected. Consequently, some of the answers which needed expansion were not expanded, thereby leading to loss of some vital information.

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 decision 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.

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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

Chapter two consists of the review of literature related to the study. In the review, relevant previous studies, observations, opinions and comments on the issues are looked at. Specifically, it addresses issues like the nature of HIV and AIDS, Snapshot of the Global effects of HIV and AIDS, response of HIV and AIDS as well as the Conceptual Framework (Voluntary Counselling and Testing). It also looks at the UNAIDS Policy on VCT as well as VCT efforts in Ghana.

Chapter three explains the methodology used. It looks at the research design, the population, sample and sampling procedure, instrumentation, pilot testing of instrument, data collection procedure and data analysis in the context of a descriptive research survey.

The results and findings of the study are reported on in chapter four while chapter five presents the summary of key findings, conclusions, recommendations and suggestions for future research in this area.

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CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

The HIV and AIDS phenomenon has received a lot of attention in literature by politicians, researchers, and others concerned about the subject-matter. The review has been divided into sub-topics for the purpose of ensuring clarity and coherence. A summary of the review comes at the tail end of the chapter. The sub-topics are:

i. Nature of HIV and AIDS
ii. Snapshot of the Global Effects of HIV and AIDS
iii. Response to HIV and AIDS
iv. Voluntary Counselling and Testing: Conceptual Framework
v. UNAIDS Policy on VCT
vi. VCT Efforts in Ghana
vii. Summary

Nature of HIV and AIDS

The Human Immunodeficiency Virus (HIV) first enters the bloodstream of the person and attacks the white blood cells so that the person's ability to fight minor diseases is weakened. At this point, the virus breaks the person's immune system completely such that many diseases such as tuberculosis, fever, diarrhoea

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and many others attack him or her. Gradually, the person loses his or her ability to fight diseases and dies. A person infected by the HIV virus may have it between 12 and 15 years before it becomes manifested. However, when it develops into AIDS, it will take about 3-24 months for the person to die (National AIDS Commission, 2001).

There are two types of HIV, namely HIV-1 and HIV-2. Both have the same modes of transmission and cause the same danger: destruction of the human immune system HIV-1 is most common type of HIV, and is the one most commonly found in the West African regions. A research has shown that HIV-1 is the more virulent of the two, meaning it is able to replicate itself and destroy the immune system more rapidly than HIV-2. Both HIV-1 and HIV-2 have been identified in Ghana (USAID & MoE, 2006).

Snapshot of Global Effects of HIV and AIDS

The global HIV and AIDS situation has undermined socio-economic development at all levels of society-national, community, family and individual. The UNAIDS Report of December, 2007, estimated the global figure of People Living With HIV and AIDS (PLWA) as 33.2 million out of which more than 2.1 million lost their lives. Over twenty years after the first clinical evidence of the Acquired Immunodeficiency Syndrome (AIDS) was reported, it has become the most devastating disease mankind has ever faced and is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth biggest killer (UNAIDS, 2007).

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Statistics from UNAIDS 2000 painted a gloomy picture of the disease and indicated that 5.3 million people were newly infected with HIV in 2000 over half of them being young people. Africa is a home to over 70% of those adults and 80% of children living with HIV and AIDS in the world (UNAIDS, AIDS epidemic Update: December 2007). Peter Piot, UNAIDS Executive Director argues that "HIV will kill more than one third of the young adults of countries where it has its firmest hold, yet the global response is with a fraction of what it could be. We need to respond to this crisis on a more massive scale than what has been done so far".

HIV and AIDS has further slowed down economic growth in diverse ways by destroying human capital through increased mortality rates of the skilled population and labour force. A smaller labour force is left behind with reduced knowledge and work experience. Workers take time off to care for sick family members. Employees who are victims of HIV take sick leave resulting in loss of productive time. Additionally, HIV and AIDS weaken the taxable population and reduce resources available for development. A small tax base would have a devastating effect on an economy with an increased pressure to treat the sick, train people to replace sick workers, sick pay and care for AIDS orphans (Azungrah, 2008).

The United Nations General Assembly observed that Africa is worst hit by the HIV and AIDS epidemic, where HIV and AIDS is considered a state of emergency, which threatens development, social collision, political stability, food security and life expectancy. It imposes a devastating economic burden and that

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the dramatic situation on the continent needs urgent and exceptional national, regional and international action.

However, the incidence of HIV and AIDS spreading in sub-Saharan Africa is highly varied. For instance, Katajavivi and Ocala (2003) cited the WHO/UNAIDS Report (2002) that, at the end of 2001, the infection rate for adults in their productive years (15-40) was 5.0% for Uganda, 15.0% for Kenya, 5.8% in Nigeria and 3.0% for Ghana.

Table 1 shows an example of the global overview of the 2007 AIDS epidemic update for some regions of the World.

Table 1

Regional HIV and AIDS Statistics – 2007

World Region	Adults and children living with HIV	Adults and children newly infected with HIV	Adults and children deaths due to AIDS
Sub-Saharan African	22.5m	1.7m	1.6m
Western and Central Europe	760,000	31,000	12,000
North America	1.3m	46.000	21.000
Middle East and North Africa	380,000	35,000	25,000

Source: UNAIDS, 2007 AIDS Epidemic Update

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Table 2 shows an example of the global overview of the 2000 AIDS epidemic update for some regions of the World. The table shows a little decline from the 2000 report as in Table 1.

The problem of HIV and AIDS is further aggravated with the stigma attached to it. The stigma exists in a variety of ways around the world, including ostracism, rejection, discrimination and avoidance of HIV infected people, compulsory HIV testing without prior consent or protection of confidentiality, violence against HIV infected individuals or people who are perceived to be infected with HIV, and the quarantine of HIV infected individuals (UNAIDS, 2006).

Table 2

Regional HIV and AIDS Statistics and Features at the end of 2000

World Region	Adults and children living with HIV	Adults and children newly infected with HIV	Adults and children death due to HIV/AIDS
Sub-Saharan African	25.3m	3.8m	3.2m
North African and Middle East	400,000	80,000	45,000
Western Europe	540,000	30,000	20,000
North America	920,000	45,000	21,000

Source: UNAIDS, December 2000 (CDROM) cited in UNFPA (2001)

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Response to HIV and AIDS

Global Response: Response to the HIV and AIDS scourge has been swift and decisive. Various countries and international bodies drew up their programmes to find a cure to the disease. The then Secretary-General of the United Nations, Kofi Annan, proclaimed HIV and AIDS as his personal priority and issued a call to action that required as drastically and immediately scaled-up global response.

The United Nation's Population Fund (UNPF) focused intensely on HIV prevention, supported activities that promoted full spectrum of responses from immediate prevention such as abstinence or condom use to long-term behavioural change (UNFPA 2001).

In April, 2001, at a conference in Abuja, Nigeria, UN Secretary-General outlined five objectives to have and to reverse the spread of the virus and prevention of mother-to-child transmission; to put care and treatment within everyone's reach; to deliver scientific breakthrough for a cure of HIV and AIDS or a vaccine against it; and to protect those made most vulnerable by the epidemic, especially orphans. By the time of leaving office in 2006, much effort had been made in meeting their set objectives and this contributed significantly to the reduction in the 2007 statistics in Table 1.

Local Response: The Government of Ghana has responded to the HIV and AIDS epidemic by facilitating a multi-sectoral approach that focuses on mobilizing human, material and financial resources in the government sectors, civil society organisations, the private sector and communities to plan, implement and monitor appropriate prevention, care and support interventions. The Ministry of Health has

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played a leading role in these efforts, including the provision of strategic information for monitoring the magnitude of the HIV and AIDS epidemic and for planning and monitoring the national response.

The national response has been medically-oriented and directed by the Ministry of Health which established the National Advisory Commission on AIDS (NACA) in 1985 to advise government on HIV and AIDS control programme. In Ghana, the AIDS' Commission, a multi-sectoral oversight community itself was set up to seek to the overall co-ordination of HIV and AIDS activities at all levels-National, Regional and District. Since the beginning of the epidemic, there has been a flurry of activities to respond to it with many stakeholders including Non-Government Organisation (NGOs) implementing a variety of programmes and projects in different areas. Key interventions that have so far informed the control programme have been safer sex promotion, preventive clinical intentions, care for people living with HIV and AIDS (PLWAH). Among these programmes are prevention of new infections, care and support, creating the enabling environment for legal, ethical and workable places for HIV and AIDS programmes and Research, monitoring and evaluation, (GAC, 2001). Prevention of New Infection cover safer sex among the youth; prevention of HIV transmission through blood and blood product reduces Mother-to-child Transmission (MTCT) and Voluntary Counselling and Testing (VCT) of HIV and AIDS (GAC, 2001).

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Voluntary Counselling and Testing: Conceptual Framework

Voluntary HIV Counselling and Testing (VCT) is the process by which an individual undergoes confidential counselling, enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT is becoming an increasingly important area of HIV prevention and care programme. People who have chosen to be counselled and then have gone on to HIV test have, in limited studies, registered some behaviour change that should contribute to lower rates of HIV spread (UNAIDS Technical Update, 1997). The ready availability of VCT services is also thought to be a factor in reducing stigma surrounding HIV and in encouraging community support and care for those affected.

UNAIDS Policy on VCT

The global nature of the HIV/AIDS pandemic calls for a comprehensive approach as a sure panacea to thaw the spread of the disease through the promotion of supportive and preventive measures. VCT is among other wide range of measures to the benefit of sufferers and potential sufferers. This is done through the provision of good nutritional advice and timely access to care and treatment or prevention for HIV related anxiety, awareness of safer options for reproduction and infant feeding and motivation to initiate or maintain safer sexual and drug-related behaviours. Other benefits include safer blood donation. UNAIDS (1997) therefore encouraged countries to establish National policies along the following lines;

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- Make good quality, voluntary and confidential testing and counselling available and accessible. VCT should be provided in the non-stigmatising environment, and the services should include pre-testing and where possible post-test counselling.
- Ensure informed consent and confidentiality in clinical care research and donation of blood.
- Strengthen quality assurance and safeguards on potential abuse before licensing commercial HIV home collection and home self-test.
- Encourage community involvement in sentinel surveillance and epidemiological surveys.
- Discourage mandatory testing. HIV testing without informed consent and confidentiality is a violation of human rights. It is worthy of note that, there is no evidence that mandatory testing achieved public health goods (UNAIDS/ILO, May 2000a, p.3).

Suffice it to say that VCT service settings and management are among the most critical areas that have contributed immensely to VCT and more energy needs to be pumped in for these centres to attract clients.

Counselling rooms are meant to relax clients as much as possible and easy chairs used to clear barriers between counsellor and client. Not least important is the testing strategy, most VCT sites carrying on-site rapid testing, with result available within approximately one hour. Clients prefer to have results immediately as anxiety is alleviated (UNAIDS, 2002). VCT services vary in terms of models of service delivery. They include paid counsellors and

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volunteers. In addition, there are counsellors with sound medical knowledge and those benefits from critical medical insight. It is known that Kara Counselling and Training Trust (KCTT) Zimbabwe Aids Prevention and Support Organisation (ZAPSO) for instance, do employ medically knowledgeable personnel such as nurses who have had additional orientation in HIV and general counselling. Some of the VCT sites employ counsellors. Some health workers are prepared to cope with increased workload of VCT (UNAIDS, June 2002b).

The training of VCT personnel varies in depth, and space. For example, there is an aspect of training done in class as well as that of varying duration from a week to six weeks and is taken practically. At certain times, the in-class training is topped up with a practical six-week or so training. ZAPSO provides both in-class and out-class training practically, to fully equip counsellors with all the requisite skills and knowledge vital in its service delivery. Consequently, it is in partnership with the USAID funded 'New start' marketing project.

Post-test services are available to sero-positives and they include medical care, emotional care and prevention support through ongoing counselling and support groups. One very vital aim of all VCT service providers is their quest to offer support to the public more especially those who daily join the ranks of HIV and AIDS positives. The services provided by KCT and ZAPSO are very enormous. They both provided referrals to general counselling service for an on-going counselling, according to the manager. The post-test support groups at the site in Chritingwiza, Zimbabwe, have been very successful because VCT

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attendees are a cohesive group from a defined geographical area. ZAPSO again provides family counselling (UNAIDS, June 2002b).

Monitoring and evaluation are invaluable in every sphere of human endeavour. This is firmly acknowledged by all projects on VCT quality counselling to be maintained in the long term, as affirmed by project managers, the mechanisms to evaluate the content and quality of counselling that will be required. In the projects reviewed, the quality of counselling is generally monitored through case presentation and role-playing during sessions with mentors. It is incumbent on project managers to note the need for more objective assessment tools to complement this qualitative approach (UNAIDS, June 2002b).

VCT: A Gateway to Prevention and Care

Three main ways are being used for Voluntary Counselling and Testing. Among these are the pre-test and following-up services. In HIV counselling, the needs of the individual are very paramount. Counselling should be adapted to the needs and capacities of the settings in which it is delivered. It is worthy to note that the content and approach of the counselling services may vary tremendously considering the gender as well as with various groups like counselling for young people, Homo-sexual Injecting drug users (IDU) or sex workers. Content and approaches may also reflect the context of intervention (UNAIDS, June 2002b).

It must be emphasized that good rapport, consensus building, mutual respect and understanding create serene atmosphere, and make difficult situations less hostile and solvable. The manner in which HIV sero-status is given is very

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effective and significant in making adjustment fast and easy to new HIV infection.

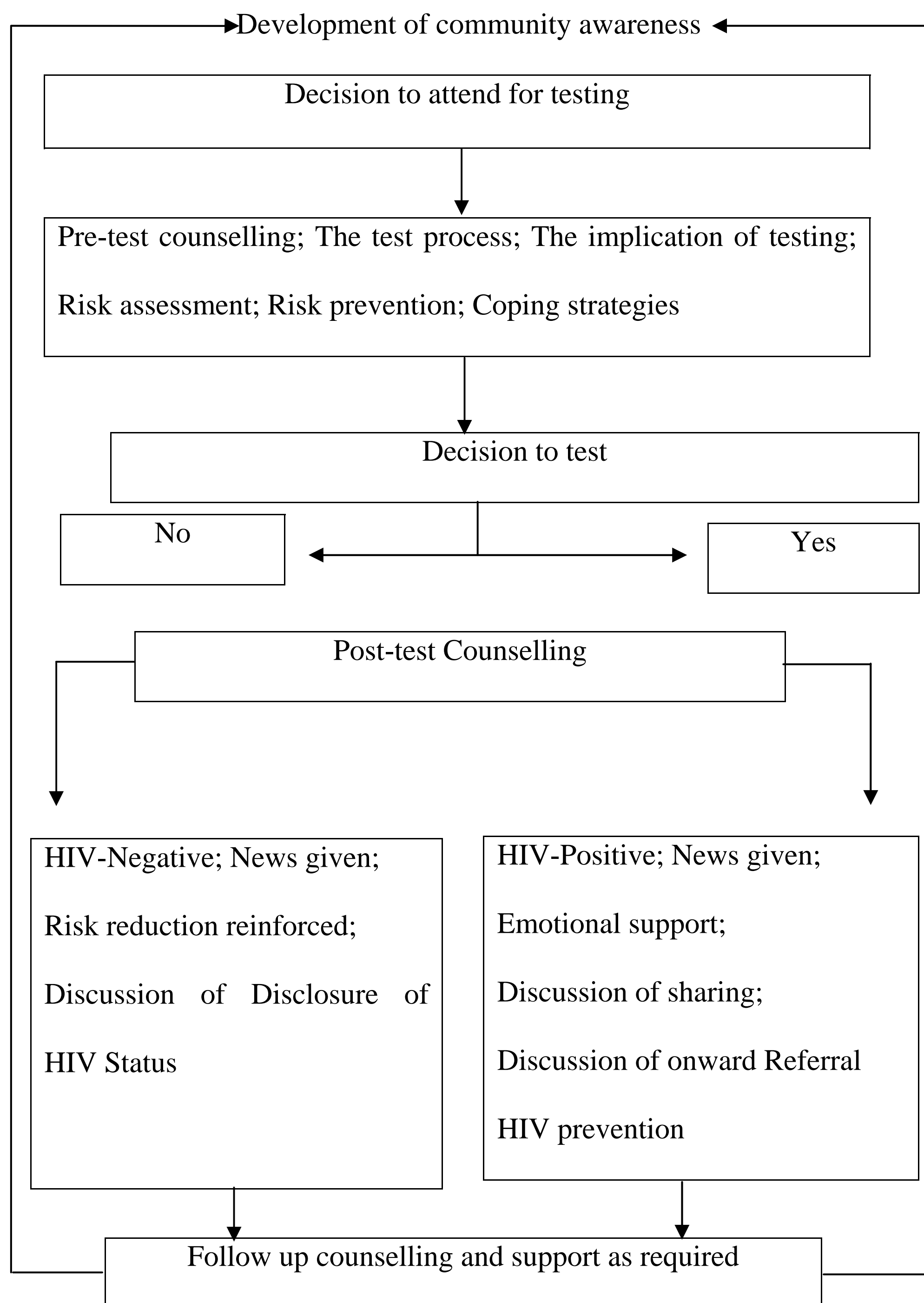

Fig.1: Pre-Test and Post-Test Counselling

Source: VCT UNAIDS Technical update; June 2002a, p.4 (modified)

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VCT sectional counselling ideally involves at least two parts (pre and post counselling). More sessions may be offered before or after the test, or during the time the client is waiting for test results (UNAIDS, June 2002a). VCT model as espoused by UNAIDS is presented in Figure 1.

VCT Counselling services are not absolute. There are some other clients who may need further therapies such as spiritual support, traditional medical care and social support groups for people living with HIV and AIDS.

HIV sufferers need arrangements to make life meaningful to them in the foreseeable future and thus VCT comes in to offer help not only to the sufferers but also to their dependants.

This brings to the fore the importance of equipping VCT counsellors with legal and sociological know-how, so that victims would be in a position to take decisions affecting themselves. Apart from these, victims may need both material and financial support.

Pre-Test Counselling

The after-effect of HIV is the psychological trauma which most often leads to rapid health deterioration. This has necessitated the need for an HIV counselling prior to taking any HIV test to ascertain the HIV status of a person. This is normally done to prepare the testee to face the coming event socially. Often, the nature of the test as well as all myths, misconceptions and misinformation are laid bare before the testee. Other issues such as the client's personal risk profile including discussion on sexuality, relationship, possible sex and or drug related behaviour that may possibly increase any risk of infection and

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HIV prevention methods are also dealt with. The counsellor discussed the implication of knowing ones status and the ways to cope with the new information. Groups could also be provided information on HIV and VCT as a cost reduction measure and back it up with written materials.

Post-Test Counselling

Post-test counselling is as important as any counselling service, because it is geared towards helping clients to understand their test results and initial adaptation to their sero-positive or negative status.

An HIV positive person needs emotional support from all manner of people whose care cannot be glossed over and, trans-missionary precautions must be drawn home into him or her. To all intents and purposes, counselling is very important whether one tests positive or negative because it may take 4-6 weeks immediately a person is infested before the antibodies are detected, thus a client should consider taking the test again in 3 months time (UNAIDS, 2002).

The Nature and Relevance of HIV and AIDS Counselling

Background: A counsellor is a person trained in the skills of the job to listen to client, asks supportive questions, discussion; discuss options, encourage client to make his or her own informed choice, give practical information and suggest follow-up.

The HIV counselling is a process and it is a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS. Counselling also includes evaluating

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the personal risk of HIV transmission and discussing how to prevent infection. It concentrates specifically on emotional and social issues related to possible or actual infection with HIV and AIDS. If the client so wishes, his or her partner(s) and relatives could also be captured. HIV counselling is an effective tool for helping people to accept and cope with the knowledge of being HIV-positive and make decisions affecting themselves in terms of reducing viral wad, re-infesting or transmission.

Counselling could be a process involving sessions and a follow-up and done in confidentiality. It could be client-based or community-based. The availability of HIV counselling even without testing may create a private environment for discussing sexual matters and personal worries. Counselling augments and AIDS education makes HIV related information personally relevant. Counselling of this type for behavioural change has been successfully provided in the medical Research Council in Western Uganda (UNAIDS, 1997). Counselling may benefit pregnant women and those women desiring to become pregnant and who are either HIV positive or who are unaware of their status. It makes them make informed decision as to become pregnant or not, with all its health implications. Counselling provided to a pair of sex partners as part of pre-marital counselling (UNAIDS, 1997). Studies have shown that groups in both Uganda and Rwanda such as the AIDS service organisation had helped people in many ways on HIV and AIDS counselling. However, Policy makers and service managers have not given counselling its due as a discipline, in which trained practitioners can produce measurable useful results (UNAIDS, 1997).

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Challenges and Responses to VCT

VCT has not been seen as a priority in HIV care and prevention programmes in many developing countries. Hence, VCT is not widely available. Its challenges according to UNAIDS, VCT, 2000 include:

- Complexity of the intervention;
- The relatively high cost of the various components,
- The lack of evidence of its effectiveness in reducing HIV as measured by the number of cases of HIV Avenal.

The impact of counselling on behavioural change is not easy to measure and it stands to reason that VCT will not have an easily measurable effect, because of the complexity of sexual behaviour and relationships as well as factors affecting them such as gender inequalities, and lack of empowerment of women in many high-prevalence settings (UNAIDS Technical Update, 1997).

The importance of VCT cannot be glossed over; yet its efficacy seemed limited by lack of funds, infrastructure and competent staff as well as clear policies on staffing. It has been observed that apart from his or her normal role, a VCT counsellor may also double as both a nurse and a social worker, a role which may affect his or her efficacy as a counsellor. One way to boost VCT services is to allow for the opening and location of the service to reflect the needs of that particular community. It is advocated that counselling services be monitored for quality and that the rules of counselling should be strictly adhered to. Again, counsellors should be given the best of training and ongoing support and

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supervision all geared towards good quality counselling services (UNAIDS Technical Update, 1997).

Another way of boosting VCT services is to scale up the service and make it more accessible and available. New testing methods such as simple or rapid testing will make VCT more available in rural areas and in other areas where laboratory services are lacking. Furthermore, linkages to crisis support, follow-up counselling and care for those testing sero-positive and strategies to enable people who test sero-negative to stay negative should be developed. Counselling should be holistic, in that, it should attend to different needs of people including mother-to-child Transmission and making the service ready to all women especially in pre-natal and post-natal situations. VCT could be provided for couples as part of pre-marital counselling. The service could also be scaled up to embrace commercial sex workers, injecting drug users (IDU) and young people.

Counselling HIV and AIDS Clients

Miller and Bor (cited in Irinoye, 1999) observed that the concept counselling has a litany of interpretations; yet whatever its goals, counselling is directed towards helping people make informed decisions affecting their lives. Hopson (cited in Irinoye, 1999, p.1), thus, from a problem-solving perspective, saw counselling as helping people to explore problems and clarify conflicting issues, and to discover alternative ways of dealing with the problems by taking appropriate decisions and actions.

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Presently, counselling has developed from being solely a test to now include health education, the primary prevention of HIV infection, effecting behavioural change, providing family support and bereavement counselling are a relatively new activities for many health workers, in spite of the fact that, counselling is not medicinal; NOVAC (cited in Bor et al., 1991). The nature of HIV and AIDS and its affect on those who test positive is so devastating that it becomes quite obvious that counselling on this field becomes so complicated. Perhaps one of the biggest problems in meeting the needs of people with AIDS is the fact that they must accept impending death while the health care model makes consistent and rigorous effort to increase life expectancy.

The World Health Organisation says "AIDS counselling is a confidential dialogue" between a patient and the counsellor or a care provider aimed at enabling the patient cope with the stress and to take personal decisions relating to HIV infection and AIDS morbidity and mortality (WHO cited in Irinoye, 1999, p. 129). Counselling is primarily directed at meeting the physical, psychological and socio-economic needs of the client to enable him or her to attain optimal physical, mental and social health, and functioning to provide continuous support and to prevent HIV transmission to others.

Counselling Approaches Involved in VCT

A wide range of problems and anxieties needing urgent solution from medical, nursing, paramedics and counselling staff with regard to would-be testee for HIV antibody has not been met (Miller & Bor, cited in Bor et al., 1997). Management and Communication problems may arise in the context of any

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illness. But their nature and complexity may be somewhat different in relation to HIV and AIDS, given the associational social stigma to the relative youth of the affected population. Also, the clinical problems which are present, and the rapidly evolving knowledge about the nature and history of HIV infection are all complexities (Bor et al., 1988a, cited in Bor et al. 1991). It is imperative then that a multiplicity of counselling approaches to HIV and AIDS and quite a variety of ways of passing on the skills of counselling approaches captured include psychodynamic and systemic orientations. Many clinical interventions in HIV and AIDS counselling have developed from serendipitous counselling experiences and discoveries. The need for formalized clinical teaching models is important in a climate when HIV and AIDS counselling practice and training will need to be evaluated (Namir, 1986 cited in Bor et al., 1991).

Bor et al., (1991) speaking on psychological aspect of HIV and AIDS posited that people make assumptions about the impact of HIV and AIDS on people. Psychological problems often seem to be regarded as inevitable and coterminous with an AIDS diagnosis. Bor et al., (1991) found that assumptions about reactions to a diagnosis on the part of the counsellor may impede rather than facilitate the clients' management. This may rather engender resistance and denial from both client and counsellor as both project their views and beliefs.

The Royal Free Hospital in the United Kingdom (U.K.) has modelled the Milan Systemic Approach [MSA] to counselling (Seluini, 1985; Porlozzoli et al., 1988b; Miller & Bor, 1988 cited in Bor et al., 1991). The approach guided the counsellor to be neutral on problems while asking interceptive questions as a way

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to facilitate the counselling conversation. HIV counselling from a systemic perspective may not be profoundly different from other counselling approaches in so far as the interaction facilitates defining problems, solving problems, and helping people to grow and develop and amplify clients' feelings.

Bor et al., (1991) identifies four recurring themes in HIV/AIDS counselling sessions. These are:

1. **Secrecy**: Counselling should include who should be informed or who should not be informed. This is because of associated social stigma.
2. **Complexity**: More professional and non-professional sub-systems would be engaged, biomedical and social point of view. Similarly, there is greater number of conversations through which problems may be defined or may arise.
3. **Relationship and Interaction**: Because of fear of 'contamination' and impact of these fears on sexual relationships, it often leads to anxiety about isolation and inability to enter into and sustain relationships
4. **Uncertainty:** Clients frequently seek reassurance, certainty and predictability from the counselling. Often this is impossible to provide.

Issues to be addressed in Counselling

It has been observed worldwide that the threat posed by HIV and AIDS affects the individual, the family and society. Its effect is so devastating to the affected, so much so that, it arouses diverse emotional reactions-fear, denial, loss, grief, anger, anxiety, rejection, isolation, self condemnation, depression and suicidal thoughts (Maymihan, WHO, cited in Irinoye, 1999). When HIV and

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AIDS strike an individual, its impact is so deep that every person in the society is affected. It is most difficult to contain it because of its unpredictability and uncertainty. The specific time-course of HIV infection is still uncertain, as does the overall progress to treatment, likely future infection, and life expectancy. In addition, there may be the possibility of an infected partner who may be the principal carrier (Irinoye, 1999).

Counselling needs to address issues of sexuality loss and anxiety realism. Working with people whose sexuality may be different from our own, raises issues to be addressed in supervision. The importance of client sexuality to the counsellors should be of prime concern especially homosexual supervision. Therefore, there is the need for counsellors to become aware of their own views including hidden prejudices regarding sexuality. Often when it comes to testing for HIV, people's anxiety heightens especially those exposed to HIV and would be couples. At certain times, these fear and anxiety become needless and irrational, yet it is part of most people's experience. It seems to be part of human personality and usually takes the form of "what if ...''. Anxious people are most in a quandary and waiting for the unknown (Stewart, 2001).

VCT Efforts in Ghana

It baffles many people especially health professionals as to the near passiveness of Government when it comes to the vital role VCT plays within the comprehensive range of measures for HIV and AIDS prevention and support. In fact, even health care providers and NGOs have taken this service for granted. In Ghana, most VCT services are provided as part of general health care provision.

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Thus, most VCT sites are found in general hospitals; and VCT facilities are available as part of general health care provision. What is heart-warming now, however, is that, recently, a few NGO's such as Action Aid and the Salvation Army mission have started offering VCT service to the general public.

As part of the World AIDS Day 2003, the Ghana AIDS Commission declared the month of November a free voluntary counselling and testing month, under the theme "Time is running out fast". From the 1st -30th November 2003 free VTC services were offered in the following centres:

- Police Hospital, Accra, 1st -8th November.
- West African AIDS Foundation, Accra , 10th -15th November
- Community Home Health Care, Accra 17th -22nd November
- Vital International, Accra, 22nd -29th November
- Salvation Army, Accra, 22nd -29th November (Daily Graphic November 12th, 2003).

It is most unfortunate that all the institutions that offered the free VCT services are based in Accra. The 2002 HIV sentinel survey indicated that there was no obvious difference in HIV prevalence between the 'major towns' and outside 'major towns'. Major towns are the district capitals which are developing rapidly in the wake of active decentralization policy of government (MOH, 2003).

Summary

The theoretical review looked at the urgent situation of HIV and AIDS, as well as the global and local response to the epidemic. The conceptual framework

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of VCT, UNAIDS policy on VCT and finally, some challenges to VCT were also examined.

It was evident from the literature that over the years after the first clinical evidence of HIV and AIDS, the disease has now become the most catastrophic phenomenon the human race has ever faced, infecting over 60 million people (UNAIDS, 2000). The disease has been so threatening that in 1996, the United Nations had to set up a global HIV and AIDS body in Geneva to coordinate UN activities on AIDS. The body initially was made up of UNICEF, UNESCO, UNFPA, WHO and the World Bank. UNDCP and ILO have also since joined the group. The purpose was to advocate global action, strengthen and support an expanded responses to those infected and affected, reduce the vulnerability of individuals and communities and alleviate the socio-economic and human impact of the epidemic (UNAIDS, July 2001).

In Ghana, the President of the Republic established the GAC and placed it directly under his office to coordinate HIV and AIDS programmes in the country. Among the programmes drawn to contain the disease by the UNAIDS and GAC is VCT. This is to help prevent new infections due to the absence of any tested medical breakthrough to deal with it.

The literature showed that VCT is increasingly becoming an area for HIV and AIDS prevention and care programmes. VCT has been observed as a factor for reducing stigmatization and encouraging support and care for the affected. VCT also provides people the opportunity to learn to accept their HIV status. HIV sero-positive can benefit from an earlier appropriate medical and social care;

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pregnant women who are aware of their status can also prevent transmission to their infants. VCT also enables people to have access to prevention programmes and condom supply as well as management of opportunistic infections.

Any programme should involve pre-test counselling, post test counselling (irrespective of results) and follow-up counselling. It is emphasised that counselling and testing should always be voluntary and confidential. The UNAIDS policy on VCT stipulates that:

- VCT should always be voluntary and confidential
- Consent should always be sought especially where individuals' identity will be linked to results.
- Quality assurance and safeguards against potential abuse should be put in place.
- Communities should be involved in surveillance surveys
- Mandatory testing should be discouraged

A host of challenges have been identified as confronting the efforts of VCT. Some of these are poor infrastructure, incompetent staff and poor policies on staffing. Low levels of training and poor ongoing support and supervision have also been identified as major challenges to VCT.

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CHAPTER THREE

METHODOLOGY

Introduction

A description of the procedure adopted during the study is presented in this chapter. It covers the areas of study such as population, sample or sampling techniques, method of data collection, description of the instrument used in the data collection and method of data analysis. The chapter also presents the findings of the pilot study.

Research Design

The study used a descriptive survey design, aimed at determining the knowledge base of health workers, attitude of health workers towards the implementation of VCT and practice of VCT in the Kumasi metropolitan hospitals in the Ashanti Region of Ghana. According to Gay (1992), a survey is an attempt to collect data from members of a population in order to determine the current status of that population with respect to one or more variables. Descriptive survey tells the nature of what exists; it also attempts to describe activities and attitudes. Information gathered from descriptive research can be meaningful or useful in diagnosing a situation since it involves description, recording, analysing and interpreting conditions that exist. They are directed toward determining the nature of a situation, as it exists at the time of the study. Unlike causal-

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comparative studies, descriptive research is not generally directed towards hypothesis testing. The aim is to describe what 'exists' with respect to a variable or conditions in a situation (Ary, Jacobs & Razavied, 1990). A descriptive study was chosen because the research seeks to determine the knowledge, attitude and practice of VCT in the Ashanti Region. Fraenkle and Wallen (1993) list the following as advantages of descriptive research:

1. It provides a good number of responses from numerous people.
2. It provides a meaningful picture of events and seeks to explain people's perception and behaviour on the basis of information obtained at a point in time.
3. It can be used with greater confidence with regard to particular questions which are of special interest and value to a researcher.
4. In-depth follow-up questions can be asked and items that are not clear can be explained.
5. It is very easy to analyse the responses obtained from the respondents.

They, however, provide the following demerits:

1. Answers can vary greatly depending on the exact wording of questions or statements.
2. It can produce untrustworthy results because they may delve into private and emotional matters that respondents may not be completely truthful about.

In spite of these demerits, the survey design was chosen, because it would enable more respondents to be questioned fairly quickly and observed at less cost

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and also since questions are structured, there would be fewer biases in analysing the data yielded. There would also be less influence from the dynamics of interpersonal variables such as personality influences. To mitigate the demerits of the design, respondents are usually assured of anonymity and confidentiality of their individual responses since their names are not required on the questionnaires. Besides, opportunity is given to the respondents to elaborate on their responses where they have other information to give.

The descriptive design was used because considering the purpose of the study, the nature of the research questions and the population, it was the most appropriate design to lead the researcher to achieve the purpose and draw meaningful conclusions.

Population

The research was conducted in the Ashanti Region of Ghana. The target population was all trained HIV Counsellors in the Ashanti Region of Ghana and HIV and AIDS victims. The accessible population, however, was all practising HIV counsellors and HIV and AIDS victims in hospitals in the Kumasi metropolis, Ashanti Region.

Sample and Sampling Procedure

The census survey and convenience sampling methods were employed to select three hospitals in the Kumasi Metropolis. Gay (1992) claimed that in a census survey, an attempt is made to acquire from each and every member of the population. Again, Ary, Jacobs and Razavied (1990) argue that a survey that

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covers the entire population of interest is referred to as a census. A census survey is usually conducted when a population is relatively small and readily accessible. The researcher was guided by the fact that practising HIV counsellors in the district hospitals were few but readily accessible. Convenience sampling was also used for HIV victims found within the Kumasi metropolis. According to Amedahe (2002), convenience sampling is used when it is impossible to select a random sample. The sample, therefore, comprised 26 trained and practising HIV/AIDS counsellors, 35 HIV victims and 3 hospitals.

Table 3 shows the distribution of trained and practicing HIV counsellors and clients in three selected hospitals in Kumasi metropolis in the Ashanti Region of Ghana.

Table 3

Distribution of Trained and Practising HIV and AIDS Counsellors and HIV Victims in the Selected Hospitals in Kumasi metropolis

Hospital	Trained/Practising HIV Counsellors	HIV victims
Hospital A	8	10
Hospital B	6	10
Hospital C	12	15
Total	**26**	**35**

Instrumentation

The instruments that were used for the study were questionnaires, observation and interview checklist. Craig and Metze (1986), posit that "a

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questionnaire is a series of questions or statements posed to individuals to obtain information about present or past conditions and behaviours which are then analysed to determine relationships among variables" (p.167).

A questionnaire adapted from UNAIDS entitled "Tools for Evaluating HIV/AIDS Voluntary Counselling Testing" (UNAIDS/ILO, May 2000a) was prepared to elicit participants knowledge, attitude and practice of HIV and AIDS voluntary counselling testing by health personnel in the Kumasi metropolis of Ghana. However, there were some modifications to suit this particular research. The items on the questionnaire were based on the variables: knowledge, attitude and practice of VCT in the Ashanti Region. Five-point Likert scale items were used. The options were "strongly agree", "agree", "uncertain", "disagree" and "strongly disagree". The options were scored as strongly agree=5, agree=4, uncertain=3, disagree=2 and strongly disagree=1 for positive items. On the other hand, the negative items were scored as follows; strongly agree=1, agree=2, uncertain=3, disagree=4 and strongly disagree=5.

Part 1 of the questionnaire for evaluating HIV/AIDS VCT looks at the background information of participants. Part 2 measured knowledge on National preparedness, VCT implementation guidelines and facilities for VCT, and finally, evaluated the practice of VCT site facilities, areas such as opening hours, privacy, linkages, cost and sustainability and services for special and vulnerable people. This section measured counsellors' attitude towards requirement and selection, counsellor training, counsellor support and counsellor satisfaction; it ranges from questions 6-60 (see Appendix A).

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Appendix B on the other hand, is a checklist that measured the minimum quality for pre-test and post-test counselling skills. Four themes were measured; these were interpersonal relationship, gathering information, giving information and handling of special circumstances. These skills were observed during the group counselling period. The same instrument was used for the interview. The reason was to confirm what had already been observed. Information gathered from the observation checklist and the interview guide was analysed qualitatively, to enable the researcher answer questions appropriately.

Pilot Study

Pilot study helps the researcher to decide whether the study is feasible and whether it is worthwhile to continue. Again, it provides the opportunity to assess the appropriateness and practicality of the data collection instruments. It permits a preliminary testing of the hypothesis (research questions), which may give some indication of its tenability and suggest whether refinement is needed (Ary et al., 1990). It will be able to demonstrate the adequacy of the research procedures and the measures that may have been selected for the variables. Unanticipated problems that appear may be solved at this stage, thereby saving time and effort later, (Ary, et al 1990). A pilot study was conducted using the adapted manual. This was done at the Assin Foso St. Francis Xavier Hospital in the Central Region. The reasons for the choice are that, similar facilities and resource persons exist at that Hospital. This enabled the researcher to clarify the feasibility and assessed the adequacy of the research procedure. It also tested the sensitivity of

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the instrument and offered the researcher the opportunity to grapple with the statistical analysis that was used in the main study.

The results of the study enabled the researcher modify the original instrument. Five open-ended questions were removed from the original instrument. To establish the reliability for the items in the questionnaire, the reliability analysis was done with the help of the computer software package called Statistical Package for Services Solution (SPSS). Reliability co-efficient obtained for the 3 sections in the questionnaire were: 0.70 for knowledge, 0.89 for attitude and 0.52 for practice of VCT (standardised item alpha).

Data Collection Procedure

The final draft of the questionnaire was administered to 35 HIV clients and 26 health workers with the necessary instructions on how to respond to the statements. Prior to the data collection the researcher collected a letter of introduction from the Head of Department of Educational Foundations (Appendix C) to the Regional Directorate of Health Services. The purpose was to seek their permission and co-operation. They were assured of confidentiality and anonymity. The researcher was then given a letter of introduction from the Regional Directorate of Health Services (Appendix D), introducing her and the purpose of the research to all Medical Superintendents in hospitals in Kumasi in the Ashanti region of Ghana. This enabled the researcher have access to the HIV and AIDS counsellors and facilities in hospital in the Kumasi metropolis.

The researcher visited the three Hospitals in the Kumasi metropolis, and then with the assistance of the Kumasi metropolis Medical Superintendents, the

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HIV and AIDS counsellors were briefed on the purpose of the research. The researcher then left the questionnaires with the HIV and AIDS counsellors to complete and return the same day. This was to avoid respondents consulting and comparing responses or falsifying responses. There was a 100% return rate of questionnaires. During the observation period, rapport was established (period of three month) with both counsellors and clients, for both were at case with the presence of the researcher. The group counselling session lasted for about 40 minutes and the interview lasted for about 7 minutes with each interviewee.

Data Analysis

The study was to determine the knowledge, attitude and practice of Voluntary Counselling and Testing of HIV Counsellors in Kumasi metropolis in the Ashanti Region of Ghana. Quantitative approach was used in analysing and interpreting the data from the questionnaire, while qualitative approach was used in analysing and interpreting information from the observation checklist and interview guide that was to confirm the responses to the questionnaire items.

Analyses of the data were done by using simple percentages. However, responses from the checklist and interview were analysed using the qualitative method. The data were grouped into frequencies and percentages, the emerging relationships between the variables were described and conclusions were based on frequencies and percentages.

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CHAPTER FOUR

RESULT AND DISCUSSION

Introduction

This chapter presents the findings on the study of knowledge, attitude and practice of HIV and AIDS voluntary counselling and testing by health personnel in the Kumasi Metropolis of Ghana. The findings are presented and discussed in relation to the research questions using frequencies and percentages. Responses from the checklist were analysed qualitatively.

Answers to the Research Questions

The various steps taken to seek answers to the research questions are discussed in this section.

Research Question One: Are HIV and AIDS counsellors aware of the national policies provided for VCT on HIV and AIDS testing and counselling?

To answer this question, data on participants' knowledge on national policy to provide HIV testing and counselling was obtained. The rationale behind this question was that those involved in VCT should the knowledgeable about the practice. This is because the declaration of commitment, adapted by the United Nations General Assembly special session on HIV and AIDS in June 2001,

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highlights global consensus on the importance of tackling the stigma and discrimination triggered by HIV and AIDS. The declaration states inter-alia that:

> By the year 2003, nations should ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV and AIDS that address the epidemic in forthright terms: confront stigma, silence and dismay; address gender and age-based dimensions of the epidemic; (and) eliminate discrimination and marginalisation (UNAIDS, June 2002a, p.6).

The document further states that:

> By (the year) 2003 (nations should) enact, strengthen or enforce, appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure full enjoyment of all human rights and fundamental freedoms by, people living with HIV and AIDS and members of vulnerable groups in particular to ensure their access to, inter-alia, education, inheritance, prevention support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma, and social exclusion connected with the epidemic (UNAIDS, June 2002a, p.6).

Table 4 shows the responses to the items on knowledge of National policies for VCT implementation in hospitals for HIV and AIDS testing and counselling. In view of this, counsellors were asked if they were aware of any national policy on the subject. The Table shows that about three-quarters of the

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respondents indicated that they had knowledge on National Policy on HIV and AIDS. This result is inconsistent with Ardayfio's (Daily Graphic, July 9, 2003) observation that despite the establishment of a multi-sectoral agency, that is, the GAC, the nation has not adopted any legislation for combating HIV and AIDS in forthright terms. It also contradicts the UCC HIV and AIDS Draft policy that "it is disheartening to note that currently, Ghana has no policy or legislation covering HIV and AIDS... (UCC HIV Draft Policy, 2003).

Table 4

Availability of National Policies and Guidelines on HIV and AIDS Testing and Counselling by Hospitals

Items	Percentage of Positive Responses			
	Hospital A	Hospital B	Hospital C	Average
National policy on VCT	75.4	74.3	74.1	74.3
National (guide lines) for HIV	69.3	80.4	70.3	74.0
VCT as part of HIV prevention	62.3	60.7	64.1	62.3
VCT as priority in all hospitals	57.3	58.2	55.5	57.0
MOH and AIDS/STI control programme	67.2	68.6	64.1	66.7
HIV and AIDS testing available	75.0	74.9	74.1	75.0
Average	**67.7**	**69.5**	**66.1**	**67.7**

As an elaboration on the research question above, respondents were further asked to indicate if there were guidelines for their practice in support of the national policy or in the absence of the nation's policies. This is because the

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UNAIDS recommends that where political commitment to HIV and VCT does not exist, various bodies can advocate the concepts and set up projects to demonstrate the need for and benefits of HIV and VCT (UNAIDS, 2002). About 67.7% of the respondents from all the hospitals indicated they were aware that there are national policies and guidelines. The highest number of responses to availability of national guidelines was in Hospital B with about 80.4% with the least (69.3%) in Hospital A. This suggests that national guidelines have been developed for successful HIV counselling. The Table shows that over half the health personel in the study reacted positively to all but one of the six variables on knowledge of national preparedness measured. The highest score expression of knowledge was on guidelines for their practice in Hospital B. Notably, Hospital B had highest in three out of the six variables to rank highest in all the dimensions. Personnel in Hospital C expressed the least knowledge in VCT as part of HIV prevention and in all the dimensions measured. Besides these national policies, individual corporate organizations and institutions have prepared their own HIV and AIDS policy, in conjunction with the national policy. Some of these organizations are the Ghana Employers Association (G.E.A), the Bank of Ghana, Ghana Police Service, and the Coca Cola Bottling Company of Ghana. The University of Cape Coast has also prepared a draft policy pending acceptance by the University Council. The Trade Union Congress (TUC) has workplace policies on HIV and AIDS as well.

As a further elaboration on the research questions, respondents were asked to indicate if in their view, the Ghana Health Service attached importance to VCT.

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Views expressed show that about half of all the respondents reported that it is a priority in all the hospitals. However, a few stated that even though it is a priority it is not functioning well in all the hospitals. A manual for Training Counsellors showed that the Ministry of Health has developed guidelines for controlling the HIV and AIDS menace. This was supported by the 64.1% responses on MOH and AIDS/STI controlling programme. The manual document deals extensively with ethical issues on HIV counselling and recommended resources needed for the successful setting up of HIV counselling units. The document, which is used in training HIV Counsellors, also addresses issues such as behaviour change, basic counselling skills, pre-test and post-test counselling as well as stages in HIV and AIDS counselling (Ministry of Health, 1991).

Table 4 indicates that about three quarters of the respondents responded that HIV and AIDS testing were available. The National AIDS/STI Control Programme also includes HIV counselling as an aspect of intervention to control the spread of HIV. According to Bor et al. (1991), HIV and AIDS is currently a major public health problem. This together with the nature of the disease elevates the need for VCT so that a major priority makes the tasks of the counsellor complex and challenging.

In sum, the result showed that the counsellors in all the three hospitals were aware of the National Policies and availability of national guidelines on VCT.

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Research Question Two: To what extent do HIV and AIDS counsellors in the Kumasi metropolis understand the basic concepts on VCT?

The purpose was to find out whether HIV and AIDS counsellors understood the concepts associated with VCT, especially the conceptual definition of VCT. Key words expected were, it is voluntary, and it involves pre-test counselling and post-test counselling. To this end respondents were asked to offer a detailed description of what VCT entails.

Table 5 shows percentage responses of HIV and AIDS counsellors' understanding of VCT. The Table indicates that over three quarters of the respondents in hospitals A and B stated that VCT should be voluntary in hospitals while 69.8% in hospital C indicated so. This view confirms UNAIDS position. According to the UNAIDS, VCT is the process by which an individual undergoes confidential counselling enabling him or her to make an informed choice about being tested for HIV. This choice must be entirely the choice of the individual (voluntary). Again, UNAIDS policy on VCT stipulates that, VCT must be accessible, voluntary, confidential, and should have quality assurance to safeguard abuse. Community involvement is emphasised and mandatory testing is discouraged.

The data in Table 5 indicate that pre-test counselling as an important component of the processes is known by most counsellors. Over three quarters of counsellors in the three hospitals responded positively to all the items under the variable. The Table also shows that majority (or about 94.2%) of the respondents stated that post-test counselling is very important in any VCT activity. In recent

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years, voluntary HIV testing, in combination with Pre and Post-test counselling has become increasingly important in national and international prevention and care efforts. The intervention also facilitates access to prevention services for sero-negative people and is a key entry point to care and support services for those who are HIV-infected and affected. This includes access to intervention to reduce mother-to-child transmission (MTCT) of HIV and other medical and supportive services that can help HIV-positive people to live longer and healthier lives. The responses were revealing as well as interesting as a review of the training manual showed that the counsellors have been trained on the meaning and scope of VCT (Ministry of Health, 1991).

Table 5

Counsellors' Understanding of VCT

Items	Percentage of Positive Responses			
	Hospital A	Hospital B	Hospital C	Average
Client must offer self voluntarily to VCT	87.0	78.1	69.8	78.3
Pre-test counselling is important in determining HIV status	97.4	96.0	88.6	94.0
Post-test counselling must be done	95.1	96.5	91.0	94.2
Average	**93.2**	**90.2**	**83.1**	**88.8**

The responses from the respondents are very much interesting. This is because until recently, there was a paucity of information on VCT. However, new studies available show that VCT has both HIV prevention and counselling,

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for people with HIV infection, as any entry point to care (UNAIDS/ILO, May 2000a). This means that counsellors must be well-versed in VCT operations.

The answer to this research question is that majority of the respondents (over 88.8%) do understand what the concept VCT entails. Their understanding is that;

1. VCT should be voluntary (78.3%).
2. VCT should have pre-test counselling (94.0%)
3. VCT should have post-test counselling (94.2%)

Research Questions Three: What are the main problems in the implementation of VCT?

Research question three was designed to find out problems and challenges encountered in the implementation of VCT. For a successful implementation of VCT, it is very pertinent that anything that will be an impediment to its smooth implementation is removed or addressed.

To this end, one problem that has been identified is the fact that VCT has not enjoyed political and social support from the Government of Ghana. This is because even though there is national policy, there is no legislation on its implementation. This makes HIV counsellors susceptible to many difficulties. This was evident in counsellors' open-ended questionnaire. Respondents were asked to list some of the problems and challenges they face in the implementation of VCT. Some of the problems mentioned by the clients are summarised as follows:

1. Lack of facilities

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2. Attitude of public towards victims
3. Lack of volunteer counsellors for both sexes
4. Lack of material resources
5. Perception of counsellor nurses

When compared to earlier research, lack of trained volunteer and designated staff was a widespread obstacle to successful implementation of VTC. An equally important obstacle to VCT implementation as mentioned by counsellors was the absence of clear policies on staffing, as counsellors often have other responsibilities within the health system. For instance, a health care system such as nursing or social work reduces the time available for counselling as part of HIV testing. According to UNAIDS (2000), without adequate staffing levels and policies guaranteeing counselling as a priority, counselling is often not delivered at all, or it is done so hurriedly that clients are not given the time and attention they need. The fact that these obstacles are seen as problems by the respondents suggest that the observation of the respondents and UNAIDS (2000) are similar. The position of UNAIDS (2002) is that inadequate preparation of the setting in which VCT services are offered may also be a problem. This often results in insufficient privacy during counselling sessions, inconvenient opening times or difficult physical access.

Finally, some of the respondents were of the view that their colleagues often viewed them with suspicion and resentment due to the fact they (HIV counsellors) often interact with “contaminated” people. This suggests that nurses also at times become objects of discrimination.

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It was clear that there are some impediments militating against the successful implementation of VCT in the Kumasi metropolis of the Ashanti Region of Ghana. The greatest problem was lack of trained volunteer and designated staff to oversee the successful implementation of VCT and lack of human and material resources for the implementation of VCT in the Kumasi metropolis. Lack of human resources affects the successful implementation of any well meaning or intended programme. This is recognized by WHO/UNAIDS technical consultation on VCT implementation and strategies. Many VCT services report that counsellors cannot generally see more than 7-10 clients per day (WHO/UNAIDS, 2001).

Availability of only a few HIV and AIDS counsellors will lead to a heavy workload per head in all VCT centres. Such situation often leads to 'burnout' and high counsellor turnover and loss (UNAIDS, July 2001). There is a need to formulate a clear policy on staffing and service sustainability.

A further question was asked to determine which categories of people are trained as HIV counsellors. It was clear from the respondents that all the counsellors were nurses; however, in some cases clinical officers, social workers and people living with HIV and AIDS (PLWA) have been trained as counsellors. VCT Programmes that have been reviewed showed different models of VCT service delivery. Shortage of clinical staff and a high number of clients may compromise the quality of VCT services. According to UNAIDS case studies (June 2002b), adequate pre-and post-test counselling in clinical settings, in

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particular combination with rapid testing and same-day test results, can only be ensured by dedicating additional counsellors to VCT.

It is very urgent for the Region to address its human resource needs as regards VCT implementation. A clinic co-coordinator in Uganda is reported as stating, if the additional counsellors had not been here, especially in the beginning, nurses would have been far more stressed and burnout would have been much high. He went on to state that, when you are dealing with huge uptakes, you need additional staff. The important thing with VCT is that if it is going to be used, it has to be available. Working via an appointment system does not work in places where there are no phones (UNAIDS, June 2002b).

Implicit in the statement is that personnel are very much needed at every time to make VCT available and accessible. In this light, lay counsellors become handy. It has been shown that lay counsellors provide very capable counselling services after they have been trained (UNAIDS, June 2002b). They should be integrated into the clinics and should be included in staff meetings. The background of lay counsellors' range from secondary school leavers to pensioners. It is important that lay counsellors need on-going training, support and supervision, if they are to remain motivated, well-informed and do not suffer "burnout".

From the data so far analysed the conclusion we draw is, that the Kumasi metropolis of the Ashanti Region does not have enough human resources to effectively provide VCT services.

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With regard to material resources for VCT counselling in the region, respondents were asked to provide information on the availability of certain materials. Table 6 shows percentage of health personnel selecting responses to questionnaire items on availability of facilities and other services. The most important was adequate space (counselling room) for counselling to be carried out. From the Table, we find out that one section, forming the majority, agrees that there is adequate waiting area while the minority on the other hand disagrees to the statement in contention. This implies that, there is still something more to do to improve on the space available.

Privacy is a very important pre-requisite for a successful implementation of VCT. In view of this, respondents were asked to give an idea about some specific materials in providing privacy that are available in the counselling session. The highest availability of facilities and other services was in linkages. About half of the respondents agreed that they have waiting areas. The least service on rendered was on HIV testing methods. The three most expressed disagreements were in curtained-off area, consulting room and privacy. However, less than half (43.25%) were not certain about cost and sustainability. To determine the type of rooms being used as office, 63.6% of the respondents stated that they were private offices, 6.1% of the respondents stated that it was a curtained-off area, 9.1% of the respondents stated that they were using cubicles as office. Further, only 9.1% of the respondents again stated that they had official counselling room. However, 12.1% of the respondents could not give the description of their offices.

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All projects seek to ensure privacy during the counselling sessions, as lack of space, particularly in clinics, presents a challenge. The location of the counselling room often does not provide for adequate privacy. According to the UNAIDS case study (June 2002b),counsellors reported that where VCT and other clinic service share the same waiting room, clients are sometimes reluctant to use VCT services, because they fear being seen when entering the waiting room. In one clinic, new counselling rooms have, therefore, been created. In the waiting rooms HIV and AIDS education brochures are available for reading, health education posters decorate the walls and a variety of HIV and AIDS and other locally produced health education videos are shown.

Table 6

Percentage of Health Personnel Selecting Responses to Questionnaire Items on Availability of Facilities and other Services

Items	Percentage of Responses			
	Agreed	Uncertain	Disagree	Total
Privacy	30.3	6.10	63.60	100
Curtained-off area	6.10	10.0	83.90	100
Counselling room	9.10	20.0	70.90	100
Waiting area	51.50	18.20	30.30	100
Linkages	72.7	18.20	9.10	100
HIV testing methods	20.64	18.36	61.00	100
Cost and sustainability	24.04	43.25	32.71	100
Services for special and vulnerable groups	32.40	9.0	58.60	100

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Results of the analysis of the data show that there are facilities that offer a guarantee of privacy. However, human resources are not enough but HIV counsellors can manage with the limited material resources available.

Research Question Four: How adequate is the training in VCT implementation offered to HIV and AIDS counsellors in the Kumasi metropolis?

This research question is aimed at assessing the respondents' perception of the quality of counselling training counsellors have had, the number of training programmes they have been exposed to, and the quality of counselling being offered to clients. To confirm the responses from the HIV counsellors, a checklist was used as a supplement to the instrument. The checklist enabled the researcher to observe a "live" group counselling session, which lasted for about 40 minutes. Thereafter, the researcher used the same checklist to interview 27 HIV clients after their consent were sought for the study. The reason was to determine whether HIV counsellors were delivering quality service and also whether the clients were satisfied with the quality of counselling they were receiving. The respondents were asked to indicate the type of training they had been offered separately, from basic to advanced counselling and follow-up supervision.

Table 7 shows Percentage of requisite training in VCT implementation HIV and AIDS counsellors in the Kumasi metropolis had.

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Table 7

Type/Level of Training for VCT Counsellors

Types of Training	Percentage Response		
	Yes	In preparation	No
Basic	97.0	0.0	3.0
Advanced	18.2	30.3	51.5
Follow-up supervision	24.4	18.0	57.6
Follow-up assessment	21.2	18.6	60.0

The data in Table 7 suggest that, almost all the counsellors have had basic training, a few have had advanced counselling, some (24.4%) have had follow-up supervision training while about 21.2% of the respondents have had follow-up assessment training. This falls short of what pertains at VCT establishment centres. At Kara Counselling and Training Trust (KCTT) in Zambia, counsellors' training includes one-week of classroom training. The counsellors also participate in additional training in more specific related areas (UNAIDS, June 2002b).

In Uganda, AIDS Information Centre (AIC) provides training for all counsellors, supervisors, laboratory technicians, data entry clerks, peer educators and reproductive health volunteers. Counsellor training has four phases: the first phase lasts for two weeks and covers HIV and AIDS basic facts, as well as communication and counselling skills. This is followed by a four-day practical training after which the trainee is supervised while at work for a period of not less than six months. The last phase of training lasts for one week and covers advanced counselling skills. All ALC Branch Managers and Heads of Department

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including the Directorate train HIV and AIDS counsellors. This has been helpful in planning and supervising VCT services. All staff, irrespective of their jobs, is given orientation in basic counselling skills to improve their interaction with clients (UNAIDS, June 2002b).

WHO/UNAIDS also suggest that counsellors need on-going training in skills necessary for assisting clients with issues of disclosure, risk reduction and violence avoidance. Counselling discordant couples poses particular difficulty for many counsellors and so calls for constant and frequent re-training of counsellors. They also suggest expanding the pool of potential counsellors beyond those who already have formal counselling and or health background, but identifying and training should be included in the curriculum of health workers and social workers to develop a much bigger pool of trained counsellors (WHO/UNAIDS, June 2001).

Training and re-training is a very important ingredient for any successful VCT. Responses from the research suggest the need for further training of HIV counsellors. An HIV and AIDS counsellor comments that: “as everybody was trained, it made it easier for the whole programme to become integrated. Nobody felt left out and we all knew what was going on. I would recommend that everybody in a clinic goes through the same training” (UNAIDS, June 2002b, p.14).

Lessons from the Uganda AIDS Information Centre (AIC) suggest that, good counsellors need basic training in one of the helping professions: social work, teaching, nursing or medicine. Intensive training in HIV and AIDS

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counselling, specific training in other areas such as couple counselling sexuality and bereavement and period refresher courses is also advocated. Managers who are trained as counsellors can better understand and supervise counselling services, and build team spirit.

On the quality of counselling services being offered, the checklist on counsellors' skills showed that counsellors were offering the requisite services. Counselling should enable the patient cope with the stress and take personal decisions in relation to infection and AIDS morbidity and mortality. Irinoye (1999) states that AIDS counselling means giving information, facilitating risk reduction, behaviour change and providing unconditional emotional support to the affected people.

An observation of the responses from the checklist shows that the counsellors were very clear in giving information; they also corrected misunderstanding. They used open-ended questions, sought clarification and summarized appropriately the questions clients posed.

Some of the responses from the checklist were: 'counsellors accept us as we are', 'we are able to confide in our counsellors', 'they are very courteous when talking to us', 'we are able to approach them because they are always ready to listen to us'. Some also stated that; 'when we become confused they assist us', 'they give us up-to-date information of HIV and AIDS', and 'our needs are considered over and above other issues'. The HIV and AIDS counsellors inspire confidence and hope in us whenever we come to clinic. In fact they are very good,

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they do not shout on us but encourage us to live, we are very grateful for their care and support.

The counsellors also adopted many counselling approaches in their work, some cognitive, others psychodynamic. This is consistent with the assertion of Bor et al., (1999) that many clinical interventions in HIV and AIDS counselling have developed from serendipitous counselling experience and discoveries.

Counselling observation and subsequent interview showed that the four (4) themes in HIV and AIDS counselling identified by Bor et al., (1991), were present. The HIV counsellors observed were emphatic about secrecy, (who should know of their status?). They also attempted to address their current situation. Issues of anxiety and isolation and entering into relationships were discussed. They also constantly reassured the clients, which suggested that they had minimum skills for counselling persons with HIV as well at the basic training for the counselling job they were doing.

It could, therefore, be concluded that there is ample evidence that HIV and AIDS counsellors involved in this study have minimum skills required for HIV counselling. This suggests that their training is quite adequate. It is also plausible to conclude that, HIV counsellors have requisite basic training for the job. The situation could, however, be improved if those who have additional training would be made to mentor those below them. In other words more staff could be trained if those with additional training would be made to serve as trainers of practitioners.

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Research Question Five: To what extent is Voluntary HIV Counselling readily available in the Kumasi metropolis?

This research question was designed to assess the availability and accessibility of VCT in hospitals in the Kumasi metropolis. Table 8 shows percentage responses on the availability and accessibility of VCT in hospitals in the Kumasi metropolis. The researcher was particularly concerned with opening times or days, appointment systems, services for special and vulnerable people, and the cost of VCT. To answer this question a series of minor questions were asked. Responses to these questions are presented in the Table 8.

Table 8

Availability and Accessibility of VCT in Hospitals in the Kumasi Metropolis

Accessibility of VCT	Percentage Response		
	Yes	Uncertain	No
Evening (5.00 pm)	30	4	66
Lunch break time	60	1	39
Weekends	61	3	36
Appointments	45	1	54
No appointment	54	5	41
Special appointment	12	3	85

Table 8 shows that VCT is not available in most hospitals in the evening as 66% indicates ‘no’. The three most accessible and available times were: ‘weekend’, ‘lunch break time’ and ‘no appointment time (at any time) ’. As many as 85% never booked ‘special appointment’. This state of affairs contrasts with

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the situation in KCTT, Zambia. In Zambia, a drop-in-centre was established to provide information and counselling to the general public. It worked full day to make provision for workers and farmers. The advantage here is that, individuals can work the full day and visit VCT sites in the evening. Providing VCT services in evenings reduces counsellors' stress, as it enables counsellors to see clients at their convenience. In Uganda, trials in 1995 showed that same-day services were desired by clients, preferred by staff, and feasible to implement, even at rural sites (Dowing et al., cited in UNAIDS, 1999). As a result the rapid testing and the same day protocol were implemented in 1997. This has made VCT highly accessible in Uganda and Zambia.

When asked whether clients needed an appointment to visit the VCT site, about half of the respondents (54%) indicated that clients did not need any appointment. To probe further, the respondents were asked how they handled the case if anyone just called in and requested for service. More than half (54%) indicated that whenever that happened, such clients were served on the same day. About 18% of the respondents, however, indicated that whenever it was too late, that is, if there were too many clients in waiting, clients who just arrived were often requested to re-appear early the following day. About 12% of the respondents indicated that, special appointments are scheduled for such clients if the latter liked it so. At AIC in Uganda, for example, appointments are not strictly enforced as they operate a 'drop-in centre' system. This allows clients to walk in for a same-day service. In Zimbabwe, ZAPSO, for example, offers a freestanding VCT site in Central Harare, which serves as a housing for the population working

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in the Central city. The second model is a VCT service attached to a busy primary health care clinic in a high-density Harare suburb. The third model that ZAPSO has used is freestanding sites in rural or semi-rural settings (UNAIDS, June 2002b).

In 1998 the first VCT set-up in the city centre of Harare was established to make VCT accessible to working people. It is a freestanding VCT service which people can attend for anonymous VCT without an appointment, (UNAIDS, 2002). With this facility in place, VCT services were easily available and accessible in Zimbabwe and Uganda. From the discussions so far, it is obvious to the researcher that the walk-in system does not operate in all the hospitals in the Kumasi metropolis. This is in contrast with the practice in Zimbabwe.

With regard to services for vulnerable groups, an overwhelming majority of the respondents (85%) indicated that no special time has been set aside. Special and vulnerable people are defined as high-risk population, which include would-be couples, young couples, sex workers, refugees, migrant people and pregnant woman. In other words all clients are offered uniform attention.

The responses differ from what the established VCT service providers say. As of now, there is no VCT service for such category of people in Kumasi metropolis in the Ashanti Region of Ghana. Carol Bellany, the Executive Director of UNICEF is reported to have advised African leaders in Abuja, Nigeria on April 6, 2001 that, "In addition, we must also ensure young people's access to youth friendly health services that provide HIV testing and counselling, treat sexually transmitted diseases and offer frank and unabashed information and services on

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how sexually active young people can protect themselves and their partners from infection" (UNAIDS, 2002, p.37).

Majority of new HIV infections in developing countries occur among young people aged 15-24 through unprotected sex; with girls being particularly vulnerable (UNAIDS, 2002). The reason for greater emphasis on young people and would-be couples is that, in many cultures it is socially unacceptable for young people to be sexually active unless they are married. As a consequence, sexually active young people do not openly talk about their experience with adults, including health workers. Other barriers obstructing service for young people include misconception, fear and low risk perception. It is to reduce the level of vulnerability that UNAIDS recommends VCT for young and special people.

Results of the data analysis show contrarily to the UNAIDS recommendation that the vulnerable especially, pregnant women, should have special slot for counselling, in the hospitals in Kumasi; such groups are not given the exclusive attention they deserve.

The last section of the research question deals with the cost of VCT provision. Responses were very clear: while none of the VCT sites charged fees for HIV counselling, some sites did take money for blood testing. The literature shows that in most developing countries free testing is not an option. AIC reports that, it is feasible to adopt cost sharing, although it is difficult to introduce fees in a service that is originally free. Fees-for-service may discourage some VCT

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services, so it is important to have exemption policies as well as “free days”, “two for one” days or price reduction strategies to encourage clients.

From the research we conclude that, even though VCT services do not go beyond 5.00 pm and that vulnerable people are not offered special schedules, yet to a large extent, the service is fee-free and available during a greater part of the day. This conclusion means that, the practice of VCT in the hospitals of the Kumasi metropolis is largely not consistent with UNAID recommendations.

Research Question Six: To what extent are HIV and AIDS Counsellors in Kumasi metropolis promoting VCT?

This question was to determine the effort VCT service providers were making in attracting people to VCT sites. To answer this question effectively, three sub questions were asked. The questions bordered on linkages that VCT sites have with other analogous institutions, inducements offered to prospective clients and clients who come to VCT site, and finally outreach programmes undertaken to attract people to the VCT sites.

First, respondents were asked whether their clinics had links with other analogous institutions through which they could be supplied drugs and other needs when necessary, and for referral of cases they could not handle. Table 9 shows the percentage responses on links with other analogous institutions in hospitals the Kumasi metropolis.

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Table 9

Links with other Analogous Institutions in Hospitals in the Kumasi Metropolis

Items	Percentage of Responses			
	Yes	Uncertain	No	Total
Partnership with others	18.2	34.4	57.4	100
Induction in place	27.3	0.7	72.0	100
Reaching out to members	51.0	3.0	46.0	100

The Table shows that more than half (57.4%) of the respondents indicated that their institutions are not in partnership with other institutions. A few (18.2%) indicated that they occasionally link up with other VCT providers and NGOs. About 34.4% indicated that they were not certain of being in partnership with some organisations in providing VCT service.

Partnerships and linkages are also very necessary for successful implementation. VCT providers need to foster healthy relations with analogous institutions fighting against HIV such as Medical Services, Social Services, Counselling Services, NGOS, and Family Planning Services, TB/Chest Clinics, traditional healers and spiritual and religious groups. From the responses, it was clear to the researcher that such partnerships were not strong in the VCT sites under study.

The literature reviewed showed that all successful VCT providers had partners with whom they collaborated successfully. An example is AIC in Uganda Social Marketing for Change (a USAID funded programme) which trains PTC

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members as AIC asserts, such as TASO (UNAIDS, 1999). All projects reviewed can be characterized as placing high priority on partnerships with other service providers, community groups and governments. A KCTT partnership with NGOs and PLWA support organizations is paramount. ZAPSO's social marketing VCT service is funded by USAID. Again, ZAPSO also has close linkages and counsellors are invited from other sister programmes.

The next step was to ask respondents to indicate whether or not their respective VCT centres have inducement in place to encourage people to visit their sites. In answer to this question, a large majority (72%) indicated that they did not have inducements in place. Only, 27.3% stated that they had inducement in place as in Table 9. The few who indicated that inducements were in place were asked to name what those inducements were. The inducements they mentioned were, free transportation to and from the VCT centres, provision of lunch to clients, and sometimes money. It is obvious from this study that it is only in a few instances or cases that inducements are offered to clients. Financial, administrative and logistical problems could account for this state of affairs.

Respondents were asked to indicate whether or not their centres had any means of reaching out to a larger member of people. Table 9 shows that, about 51% of the respondents indicated that a strategy of reaching out to more people had been put in place while others had not. There is every indication that reaching out to the public is one very important condition for a successful VCT practice. For any successful VCT implementation, communities where services have been introduced should be sensitised about its activities. In Uganda for example, many

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admitted that they were afraid to go for an HIV test. Community outreach through Post-test Club (PTC) members involved in drama group and peer education had been performed to mobilize community support and sensitize people about AICs activities (UNAIDS, June 2002b).

All four AIC branches have a drama group, which performed in English and local languages at primary and secondary schools, churches, as well as gatherings arranged by community groups. At KCTT, for example, outreach programmes with PLWA and community mobilisers carry out activities to educate and encourage VCT use in the communities (UNAIDS, June 2002b).

At KCTT, programme managers reported that the number of clients had increased with the active promotion of VCT services through outreach programmes. ZAPSO has developed a new venture with churches and religious organizations not only to advocate VCT but also to foster a better understanding of the needs of PLWA and to challenge stigma.

From the analysis so far it is noticed that there are linkages with other VCT providers but these are not enough. There is organisation-to- organisation linkages but these are not enough. Finally outreach programmes of the health institutions are not enough. Other governmental and non-governmental organisations, however, as observed, have taken up the bulk of the outreach programmes.

The conclusion one draws from the data analysis so far is that, VCT sites have made some attempt to promote their activities. The answer to the research

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question, therefore, is that to a limited extent, HIV and AIDS counsellors in Kumasi are promoting VCT.

Research Question Seven: To what extent are HIV and AIDS Counsellors in the Kumasi metropolis satisfied with their job?

Job satisfaction of workers is one of the necessary conditions for the increased productivity of any organisation. Well-motivated, valued and satisfied personnel are an asset to any organisation. The purpose of this question, therefore, was to find out whether or not HIV and AIDS counsellors are satisfied with their work. To answer this question, four sub-questions were posed to the respondents.

Table 10 shows percentage responses of HIV and AIDS counsellors, indicating their attitude towards motivation to work.

Table 10

Distribution of HIV and AIDS Counsellors' Motivation to Work

Items	Percentage of Responses		
	High	Moderate	Low
Superior support as a counsellor	15.2	84.8	0
Decision to do counselling	90.9	9.1	0
Continuity with HIV counselling	88	12	0
Societal support	35.8	33.3	30.9

The answer to the first question is that, a large majority (84.8%) of the respondents indicated that they had moderate superior support and nomination as counsellors; the remaining (15.2%) had high self-motivated and volunteered themselves. Regarding whether the respondents were pressurised to accept to play

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the role of a counsellor, an overwhelming majority (90.9%) responded that they entered into the practice voluntarily and willingly. At least everybody was moderately either self-motivated or motivated by a superior and hoped to continue. About 30.9% of the respondents indicated low motivation from societal support.

The answer to the third sub-question was that, an overwhelming majority, (88 %) of the respondents indicated their preparedness and willingness to stay in the VCT profession until they retire. Slightly above one-tenth indicated moderate motivation.

About 35.8% of the respondents pointed out that they were gratified by the fact that their contribution was highly valued by their superiors and society. Besides, 33.3% of the respondents indicated that they were moderately supported by society and valued by their clients. Finally, 30.9% of the respondents indicated low motivation from society and their colleagues.

With regard to the interview checklist, respondents were to comment freely on their feelings about their work.

1. 6.1% of the respondents indicated that they always felt emotionally drained.
2. 51.5% of the respondents indicated that they occasionally felt emotionally drained.
3. 18.2% of the respondents indicated that they never felt emotionally drained.

Still on their feeling about their work, respondents indicated the following:

1. 45.5% of the respondents stated that their work was occasionally stressful.

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2. 18.2% of the respondents stated that their work was never stressful.

Further on their feeling about their work, responses were that:

1. 18.2% indicated that their work was never rewarding.
2. 12.1% indicated that their work was occasionally rewarding.
3. 30.3% indicated that their work was often rewarding.
4. 33.3% indicated that their work was always rewarding.

The answers to the last sub-question suggest that though VCT can be stressful it has its own rewards. When programme managers give emotional support to counsellors, there is greater likelihood that, they would stay on the job and can be encouraged to continue with their job. Lessons from established VCT centres show that where VCT services are integrated into clinics, projects and clinic managers made it a priority to prepare health workers for the impact of VCT on their workload. When nurses participate in decision-making about the new counselling roles, there is easy adjustment, and friction is reduced. Besides, "burnout" is barely experienced (UNAIDS, June 2002b).

To ensure job satisfaction, most VCT sites have set up membership programmes for VCT counsellors to prevent burnout, and to provide psychological support and identify problems in service delivery. KCTT and ZAPSO receive mentoring colleagues and in most cases, mentors also monitor the quality of counselling. Counsellors and programme managers agree that VCT service provision could be emotionally stressful. As one of the counsellors reported "The first week after the training, I could not take the positive result especially when very young people came in and it turned out to be positive,

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because I compared them with my own children. Even now, it is difficult but the membership programme helps a lot. We tell our problems, sometimes we joke and we discuss difficulties at a work as well as our problems at home" (UNAIDS, 2002, p.68).

According to programme managers, membership and on-the-job training are critical components for ensuring quality assurance and at the same time providing support to the service providers. At ZAPSO, the director organizes in-house stress management training to prevent burnout. The senior nurse counsellors from the Harare site reported that, working in a team and being able to discuss cases with colleagues also enormously benefited them. Counsellors emphasised that VCT should not be introduced without psychological support to practitioners. Counsellors found that off-loading stress when interacting with their mentors was essential for good service delivery (UNAIDS, June 2002b).

From answers to the five minor questions, the conclusion one can draw is that, in spite of the stressful nature of VCT and the fact that about 50% of the trained counsellors have left making the retention of this calibre of staff problematic, most counsellors left on the job are quite satisfied with their job and are likely to remain in it till retirement. The answer to the research question is that, practising HIV and AIDS counsellors are to a large extent satisfied with their work.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter deals with the summary of research findings, conclusions drawn from the findings, implications and recommendations based on the findings. In addition, the chapter suggests areas for further research.

Overview of the Study

Since the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) were first diagnosed as a problem in the early 1980s, a lot of programmes, activities and projects have been designed and implemented to halt the spread of the pandemic. It was to halt the spread of the disease that the United Nations established the UNAIDS in 1996. The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources, and networks of influence that the co-sponsors offer.

In Ghana, HIV was seen as a disease rather than a developmental issue. However, with the establishment of the Ghana AIDS Commission in the year 2000, a holistic approach has been adopted in trying to halt the spread of the disease. One of the major programmes adopted to halt the spread of the disease is Voluntary Counselling and Testing (VCT). This was supported by the Declaration of Commitment, which resulted from the United Nations General Assembly

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Special Session on HIV and AIDS in 2001. The declaration urged countries to scale up VCT services as part of wide range of prevention programmes for the spread of HIV and AIDS.

According to Family Health International (2002), VCT is an essential link between HIV prevention and HIV care and support. VCT promotes and sustains behaviour change, and links with those interventions to prevent PMTCT, STIs, and it prevents and treats TB and other opportunistic infections (OIs). VCT also facilitates early referral to comprehensive clinical and community-based prevention, care and support services. This includes access to antiretroviral therapy (ART), VCT and improving quality of life. This may play a pivotal role in reducing stigmatisation (Family Health International, 2002).

The researcher's determination to undertake this study was influenced by the fact that there was inadequate research on VCT in Ghana in general and Ashanti Region in particular. Also, research on delivery and impact of VCT can help convince decision-makers and service managers to endorse and provide resources in support of VCT. The purpose of this study was to investigate whether HIV and AIDS counsellors in Kumasi metropolis:

1. were aware of national HIV and AIDS policy and policy guidelines;
2. had requisite minimum training in HIV and AIDS counselling and care;
3. had the necessary human resources for VCT;
4. had the minimum level of conceptual knowledge about VCT;
5. had the minimum level of qualification of VCT;
6. were satisfied with the VCT they are offering;

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7. had positive attitude towards VCT; and
8. to find out if VCT as practiced, conformed to the minimum guidelines set by the UNAIDS and if VCT was widely available in all the district hospitals in Ashanti region of Ghana.

The sample consisted of 26 practising HIV Counsellors and 25 Clients in hospitals in the Kumasi metropolis of the Ashanti Region of Ghana. The Descriptive Survey design was used.

A tool developed by UNAIDS was specifically adapted for the purposes of this study. It was pilot tested at the St. Francis Xavier Hospital, Foso. The tool is in two parts. Part A (which constitute Appendix A) is in three (3) sections: Section 1 was to establish national preparedness towards the establishment of VCTs. Section 2, was to evaluate VCT site facilities and Section 3 was to measure Counsellor requirement and selection and Counsellor training. Part B (Appendix B) is a checklist which measured the minimum quality for pre-test and post-test counselling skills. Four themes were measured; these were interpersonal relationships, gathering information, giving information and handling of special circumstances. These skills were observed during the group counselling period. The Same instrument was used for the interview. This was to confirm what had already been observed. Information gathered from the observation and the interview was analysed qualitatively, to enable the researcher answer research questions appropriately.

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Reliability co-efficient obtained for the 3 sections of Appendix A in the questionnaire were: 0.70 for Section 1, 0.89 for Section 2 and 0.52 for Section 3 (standardised item alpha). All questionnaires were answered and returned.

Summary of Main Findings

The study revealed that:

1. There is national policy on VCT.
2. Some guidelines have been instituted and that the practice has been enforced in most district hospitals.
3. Greater majority (78%) of the respondents do understand what the concept VCT entails. Their understanding is that, VCT should be voluntary; VCT should have pre-test and post-test counselling services.
4. There are some impediments against the successful implementation of VCT in the Ashanti Region of Ghana. The foremost problems are lack of trained voluntary and designated staff to oversee the successful implementation of VCT in the district.
5. There are facilities that offer a large guarantee of privacy. However, human resources are not enough. All the same, HIV counsellors are working with the limited material resources available.
6. HIV counsellors have the requisite basic training for the job. The situation could, however, be improved if those who have got additional training would be made to train those below them. In other words, more staff could be trained if those with additional training would be made to serve as trainers of practitioners.

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7. Even though VCT services do not go beyond 5.00 pm, and vulnerable people are not offered special schedules, to a large extent, the service is fee-free and available during a greater part of the day. It means that the practice of VCT in the 3 hospitals in Kumasi in terms of accessibility is largely not consistent with UNAIDS recommendations.
8. VCT sites are doing their best to promote their activities, but probably owing to financial and logistical problems, they are unable to do as much as expected.
9. To a large extent, practitioners of VCT in Kumasi are aware of the UNAIDS guidelines. The general practice of VCT in the Region to a large extent conforms with UNAIDS standards.

Conclusions

From the study, it is concluded that HIV and AIDS counsellors in the Kumasi Metropolis of the Ashanti Region of Ghana possess a fair knowledge about VCT, and have positive attitude towards VCT implementation. Furthermore, VCT practice in the Ashanti Region of Ghana meets the minimum standard established by UNAIDS.

Recommendations

From the study, five major problems came to the fore and the following recommendations are made to help address them:

1. The problem of inadequate staff:

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It is recommended to the National Aids Commission (NAC) to make available to all the health facilities adequate number of trained voluntary and designated staff to oversee the successful implementation of voluntary counselling in the Kumasi Metropolis. It is an undeniable fact that the health sector in our country suffers from a dearth of manpower generally but that cannot be an excuse to support VCT implementation with full staff strength. The NAC should therefore impress upon central government to increase budgetary allocation to it to be able to carry out its mandate.

2. Motivation to the "Volunteers":

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.

3. The problem of limited operational hours:

The study revealed that most VCT sites do not run a 24-hour service and again do not have special opening and closing times. It is recommended to the Ghana Health Service and NGOs offering VCT services that, VCT sites should be accessible around the clock, in terms of its location, opening hours and ready availability of counsellors. Most of the clientele are occupied during the normal working hours and so the possibility of their accessing the facility after 5.00 pm would go a long way to prevent long queues and frustration. Above all, this arrangement would be in perfect conformity to UNAIDS standards.

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4. Attachment of VCT sites to Hospitals:

An observation which I made during the visits to the hospitals facilities which this study covered is that most of the VCT sites were within the hospitals premises and this did not promote effective patronage. VCT services are most effective when they are established outside hospital settings. In view of this, it is recommended to Ghana AIDS Commission, Ghana Health Services, NGOs and other organizations that offer VCT in Ghana that, sites should as much as possible be detached from hospitals. There should also be forthright policies on confidentiality for clients to have a sense of anonymity and privacy.

5. The problem of ineffective linkages with other VCT service providers was perceived from the study:

To this end, it is recommended to the Regional Health Directorate that VCT sites in the region should established links with other service providers within and without Kumasi so as to be able to provide quality service. Links should be established with other NGOs and healing centres. Before any VCT facility and counselling Centre is established, every effort should be made to equip with the requisite logistical base.

6. It was also observed during the visit that the lean staffs at most of the sites were over-stretched:

It is, therefore, recommended to the hospitals administrations that that more volunteers should be sought to augment the staff.

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Areas for further Research

To further extend literature on the knowledge, attitude and practice of Voluntary Counselling and Testing (VCT), the following recommendations for further studies are made.

1. The training manual for VCT counsellors should be evaluated to establish the appropriateness or otherwise of training schedules for HIV counsellors.
2. A study could be made to compare VCT services in Ghana to VCT services in Uganda. This is because Uganda has been very successful in implementing VCT.

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APPENDIX A

QUESTIONNAIRE FOR HEALTH PERSONNEL

Dear respondent,

This is an M. Ed. Research Work Titled "Knowledge, Attitude and Practice of HIV/AIDS Voluntary Counselling and Testing (VCT) By Health Personnel in the Kumasi Metropolis of Ghana". You are one of the respondents selected for the purpose of this research work. It is the wish of the researcher that you respond to each question as directed by the instruction.

I wish to assure you of maximum confidentiality of your responses. Besides, the responses will be used only for the stated purpose. Thanks in advance for your co-operation.

Josephine Awuah

Researcher

Abbreviations used:

ARV Antiretroviral

FGD Focus Group Discussion

GAC Ghana Aids Commission

GHS Ghana Health Services

IDU Injection Drug User

MSM Men Who Have Sex with Men

MCH Maternal and Child Health

MTCT Mother to Child Transmission

NGO Non-Governmental Organization

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STI Sexually Transmitted Infections

TB Tuberculosis

TBPT Tuberculosis Preventive Therapy

TOP Termination of Pregnancy

PART 1

Background Information/Personal Data

(Tick one, or fill in on the blank line for others if appropriate):

1. Name of Hospital.......................................
2. Sex : male [ ] female [ ]
3. Level of training for VCT
4. Years in counselling

PART II

The following are series of statements. They have been set up on a five point scale in a way that permits you to indicate the extent to which you agree or disagree with the ideas expressed. Please tick [√] the box that best describes your response as you read the statement.

Key:

The five points are:

Strongly Agree (SA) as 5

Agree (A) as 4

Uncertain (U) as 3

Disagree (D) as 2

Strongly Disagree (SD) as 1

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Statement	SA 5	A 4	U 3	D 2	AD 1
5. National Policy on VCT exist in my centre					
6. There is no National guidelines for implementing HIV counselling					
7. VCT is promoted as part of HIV prevention and care services					
8. HIV/AIDS testing is a legal pre-marital requirement					
9. HIV testing is frequently performed in Pre-operative screening					
10. HIV testing is frequently performed in Pre-employment					
11. HIV testing is frequently performed in general antenatal care					
12. HIV testing is frequently performed as part of MTCT intervention					
13. HIV testing is frequently performed in prisons					
14. HIV testing is frequently performed in military recruitment					
15. HIV testing is frequently performed in IDU Treatment					
16. HIV testing is frequently performed in STI clinic					
17. HIV testing is frequently performed in TB clinic					
18. General VCT service is available in my hospital					
19. VCT services are available for sex workers					

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20. VCT services for injecting drugs users (IDUs) are available					
21. Condom supplies are available countrywide					
22. Service for IDU not available countrywide					
23. Ongoing counselling countrywide					
24. We keep records of all counselling service and sessions we have with clients					
25. HIV/AIDS testing is a legal pre-marital requirement					
26. The status of the General VCT service our hospital is adequate					
27. We have VCT for men who have sex with men (MSM)					
28. VCT services are available for Sex workers					
29. IDUSs are available					
30. VCT Services are available for others					
31. Condom supplies are available countrywide					
32. Service for IDU not available countrywide					
33. Ongoing counselling countrywide					
34. HIV/AIDS counselling training course being run					
35. Our Opening time is at Early evening (after 5.00pm)					
36. Our Opening time is at Lunch hour					
37. Our Opening time is at Weekends					
38. We have an appointment system					

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39. We have adequate space to ensure counselling sessions can be private					
40. We have a written policy on confidentiality					
41. We received referrals from other centres and Institutions					
42. We refer clients to other centres and institutions					
43. We have external quality control for HIV testing					
44. We charge for counselling services only					
45. We charge for any services rendered to our clients					
46. Measures are in place to ensure the sustainability of funding for the services rendered					
47. An inducement is given to people attending our site					
48. I feel emotionally drained by my work					
49. My work is very stressful					
50. My work environment is very stressful					
51. I feel isolated in my work					
52. I have problem communicating with my colleagues					
53. I cannot help my clients					
54. My work is very rewarding					
55. I learn something new in my work everyday					
56. I can help my clients					
57. I have been pressurised into counselling					

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58. I don't intend to stay long with VCT					
59. I do not feel valued by clients					
60. I do VCT work because I am afraid of HIV/AIDS					

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APPENDIX B

OBSERVATION CHECKLIST/ INTERVIEW GUIDE FOR COUNSELLOR SKILLS

The following checklist suggests a minimum quality for pre-test and post-test counselling skills.

PART A

S/NO	FUNCTION	SKILLS	
		Yes	No
1.	Good inter-personal relationship:		
	Does counsellor introduces him/her		
	Counsellor listens actively and supportively		
	Counsellor is not judgemental		
2.	Counsellor's method of gathering information:		
	Counsellors uses open-ended questions		
	Counsellors seeks further clarification		
	Counsellor summarizes appropriately		
3.	Counsellor's approach to information giving:		
	Counsellor's statements are clear and simple		
	Gives the counselees time to respond		
	Checks for any misunderstanding on the part of counsellees		
	Summarizes information appropriately for the benefit of counsellees		
4.	Special circumstances:		
	Counsellor display sensitivity in discussions		

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	Counsellor prioritizes issues with client		
	Counsellor manages clients' distress sensitively and appropriately.		

PART B

1. What training has been given to you as HIV/AIDS counsellor?

   ....

   ....

2. What was the duration of the training?

   ....

   ....

3. What significant benefits has the training(s) equipped you with?

   ....

   ....

4. What has been the response of the counselees towards the services you have rendered to them?

   ....

   ....

5. What major achievements can you recall in rendering services to your counselees?

   ....

   ....

6. What major challenges do you encounter in the discharge of your duties?

   ....

   ....

7. How do you ensure confidentiality for your clients?

   ....

   ....

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8. Do you collaborate with other counsellors within and without this facility?

   ....

   ....

9. Have the hospital authorities been supportive of your activities?

   ....

   ....

10. What one recommendation do you want to put across for the upliftment of your services in this facility?

   ....

   ....

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APPENDIX C

UNIVERSITY OF CAPE COAST

DEPARTMENT OF EDUCATIONAL FOUNDATIONS

RESEARCH WORK

LETTER OF INTRODUCTION

Ms. JOSPHINE AWUAH is a student pursuing Master of Education (Guidance and Counselling) programme in this department. As part of her degree requirements, she is expected to work on a research entitled ***"Knowledge, Attitude and Practice of Voluntary Counselling and Testing by HIV and AIDS Counsellors"***. She has opted to make her study at your Institution/Establishment for the research project. We would be most grateful if you could afford him/her the opportunity to make the study.

Any information provided will be treated as strictly confidential.

Thank you.

(DR. E.K. GYIMAH)

HEAD

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