HIV/AIDS counselling program: a rural Ghana experience

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Abstract

This paper describes an HIV/AIDS counselling training program which has run for two-and-a-half years at the Holy Family Hospital, Berekum. The training is designed to teach para-professionals active listening skills to cope with the spiritual and emotional dimension of the person who is HIV-positive. Parallel to this training, the Hospital established counselling services which have been extended to include home visiting. Difficulties have been the need for emotional support of counsellors, a lack of time and staff, and the lack of financial resources. The overall success of the program, however, has indicated that this form of counselling training is an effective way of addressing the emotional care of persons with HIV/AIDS.

Introduction

The challenges of providing health care in a rural Ghanaian context are continuous. The provision of trained staff, medical-surgical equipment and supplies, and physical buildings, is in itself a major undertaking. When the impact of HIV/AIDS began to be felt in our institution, it placed a significant burden on the already stretched infrastructure.

Holy Family Hospital, Berekum, Ghana, is a Catholic Diocesan Hospital and is also a designated District General Hospital. The Hospital has a capacity of 162 beds and 14 casualty beds and serves an estimated area of 400 square miles with a population of 108,051 (1991).

Attached to the Hospital are a Midwifery Training School and Nurses Training College for State Registered Nurses. These two schools are the only professional training programs in the Region of Brong-Ahafo which has a population of over one million.

In 1991 Holy Family Hospital had 123 patients and eight blood donors who tested HIV positive using HIV Chek. In 1992 these numbers increased to 202 patients and 11 blood donors.

Design of training program

In March of 1990 we developed a counselling training program. This training was initiated in response to the needs of the staff and the growing number of HIV/AIDS patients in the hospital. The first program was offered to the Ward Nursing Supervisors and later was extended to include interested staff at all levels including drivers, physical therapy staff, ward assistants, translators for the Outpatients Department (OPD), doctors and nursing school tutors.

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* The authors wish to thank the dedicated Holy Family Hospital staff for asking for this counselling service and being courageous enough to learn how to provide the special care needed by persons with HIV/AIDS and their families. We also wish to thank the clients for letting us share and learn with them new ways to face life and death. The encouragement and support of the Administration enabled this new venture to be initiated and continue. The funding obtained through CAFOD (Catholic Aid for Overseas Development) has facilitated the beginning of this service.

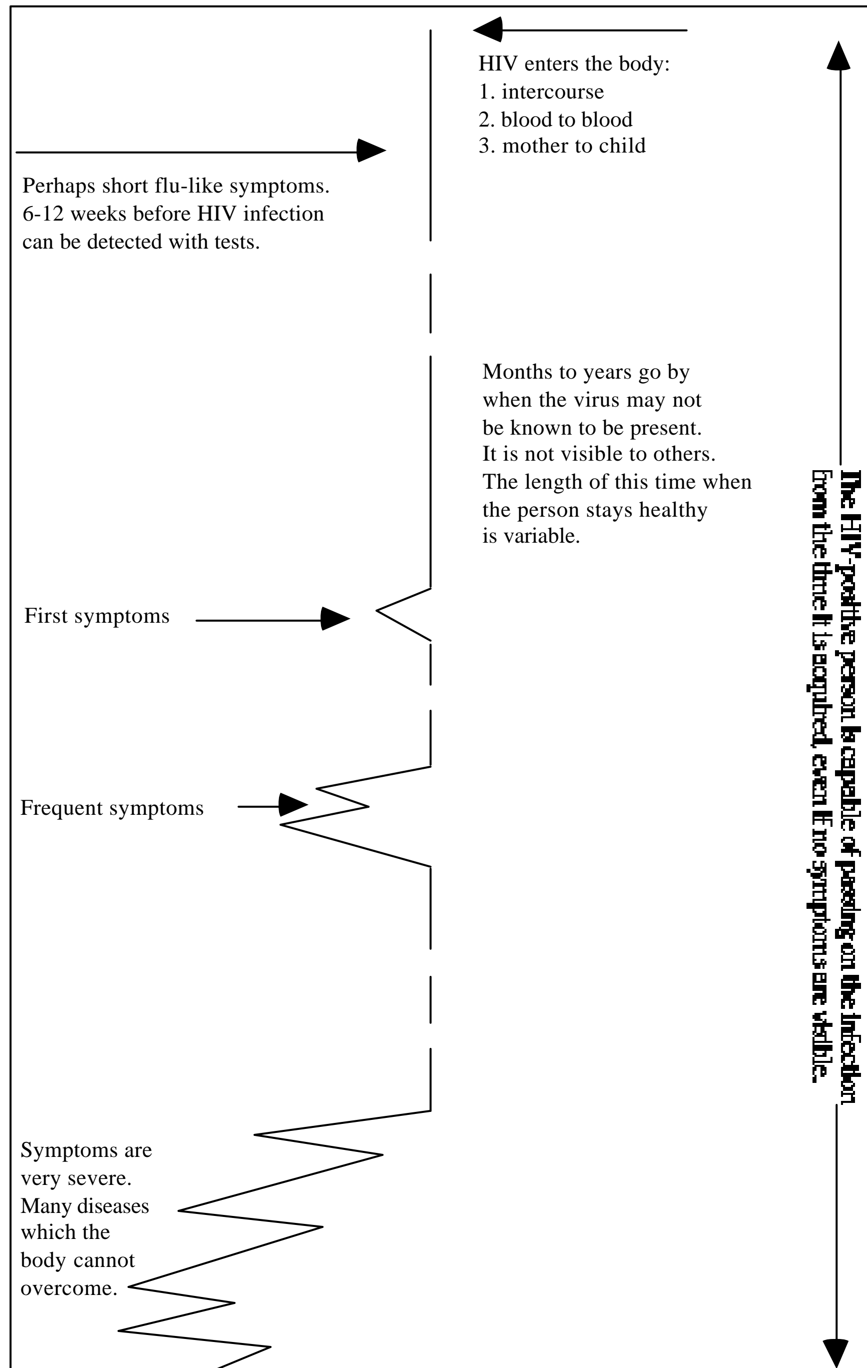
The course consists of three days of training with a one-day follow-up six weeks later. In the initial three days the content is presented in an experiential mode and the participants are offered opportunities to practise counselling skills as they learn the content. On the first day of the course the topics covered are an introduction to basic counselling skills, personal issues of death and dying, and an opportunity to bring to the surface the staff's own fears and worries about HIV/AIDS.

The approach to counselling is to teach staff active listening skills (Carkhuff 1987). There is an emphasis on each person becoming aware of their own feelings and becoming attuned to the feelings of others in the group. This skill is then practised immediately with a partner as each person shares their own personal experience with death. There is a group discussion around the stages of dying that clients may experience. The group is invited to reflect on their own experience in the light of these stages.

The second day includes a response to the questions of the group about HIV/AIDS information. This is presented through discussion using the following: an HIV/AIDS Time Line (Figure 1); clinical signs and symptoms; prevention and education with Ugandan posters; action of the virus in the body (biology); and testing methodology. Additional counselling skills, involving the observation of body language and paraphrasing, are introduced before role play where participants practise telling someone they are HIV-positive. The role plays use a variety of situations such as: telling a T.B. patient he or she is also HIV-positive; telling the parents of a child who is not thriving that the child is HIV-positive; telling a healthy blood donor that he or she is HIV-positive; telling a person who is very ill that he or she has AIDS. The day ends with the group experiencing for themselves the use of Therapeutic Touch (Krieger 1979) so that they can also use this healing skill with clients.

The content of day three includes a discussion of feeling words as they are spoken in the local languages used by the group. Because it is necessary to discuss sex with clients and because the staff are often reluctant to engage in a discussion using words that are clear, there is an activity to desensitize the staff in the use of sexual words. In our program we make use of small brass figurines (Ashanti goldweights) which can be obtained in the local markets. The figurines that are used depict many different sexual positions and practices. Because Ghanaians often insist that only one or two positions are used, we confirmed with a local prostitute that all 18 of the brass weights exemplify positions that are used in Ghana. The value of this exercise is that the participants overcome their shyness and accurate vocabulary is learned and practised in a safe environment. We also ask participants to translate sexual terms into the local languages.

Figure 1
HIV/AIDS time line.



Because several patients have threatened to kill themselves when they hear they are HIV positive the issue of suicide is discussed from both a theoretical and an experimental view. Role plays are again used around this topic to enable the participant to learn a variety of ways to deal with a suicidal client.

Attention is also given to the topic of confidentiality, and the counselling environment in the hospital and home. We continue to emphasize empathic listening throughout the three days. There is an assignment to use their new counselling skills and to report to the group on the follow-up day.

The follow-up day reviews and emphasizes the skills taught in the first days through the continued use of role plays and discussion. Videos are an important tool used throughout the training process. Through stopping the video at strategic points where counselling responses are called for the group is challenged to explore and expand their counselling skills. The method provides a safe way to combine the emotional response evoked by the video with actual practice of skills.

Because of the increasing needs within the whole district, this training was extended to include staff from government departments of Social Welfare, Community Development and Environmental Sanitation, other health institutions, both Church and Ministry of Health, as well as religious leaders. We have offered seven courses at Holy Family Hospital which have trained 87 persons. Not all of these people are currently active counsellors; however, we feel this training has value in increasing the compassion toward persons with HIV/AIDS whether the person is active in counselling or not. It also has educational benefit to the staff who then become more conscious of the prevention of HIV/AIDS in the hospital and home. Further, this training gives a basis for entering into a deeper dialogue with the people throughout the community as the specific need arises with individuals.

Design of hospital HIV/AIDS counselling services

After the training the nursing supervisors began to have skills to counsel the patients with HIV/AIDS who were in the hospital. Simultaneously some patients were only seen through the OPD and services were extended to help them. As the patient load increased the services needed more organization.

A Hospital HIV/AIDS Committee was established which included the trained counsellors as well as those who had given educational training in the community. This committee is useful in providing an ongoing forum for case discussion, problem solving, planning, and the continuing education of the members.

It became apparent through individual supervision that some of the counselling staff were obviously more skilled. These eight staff are the core counselling group. Newly trained staff are teamed up with more skilled counsellors. This teaming of counsellors provides on-the-job training, gradually increasing the pool of staff available and skilled in counselling.

In spite of the number of staff trained, the amount of time needed to cover the service soon became an issue. Often staff would do counselling after their regular working hours. This became a hardship, in spite of their concern for the patients, because of the economic situation which often requires salaried workers to have other means of earning income. The burden fell on fewer staff to carry on the counselling. This issue was brought to the HIV/AIDS Committee for discussion. There were already in place grant funds available to begin our work with HIV/AIDS which allowed for start-up 'salary' for staff; this enabled the Hospital to provide funding for after-hours counselling.

Further organization included the design of a Confidential Information Sheet for the progress of each client. These sheets are filed in a book which is available for counsellors to record continuing information.

In 1992, some 213 clients were diagnosed as HIV-positive at the Hospital. Of these, 152 clients were seen for counselling; 81 were male, including one child; 71 were female, and five of these were children. The distribution of clients seen at Holy Family Hospital is: 47 from the District, 60 from other

Regions and 45 from other countries, (41 from C™te d'Ivoire and four from Burkina Faso). The Hospital is located about 30 miles from the C™te d'Ivoire border.

The entry point for counselling occurs after the HIV test has returned positive and the doctor requests counselling services. The clients are seen individually and told they are HIV-positive. In the counselling which follows they are asked which family members they wish to include in the counselling session. Initially, some are afraid to tell anyone. Gradually, through the counselling, many clients come to see a value in sharing with family members. We offer to support the clients with the family members while they tell them their diagnosis. Although a few clients still refuse to tell any family or friend, the majority have someone with whom they want to share the information. The counselling sessions have included spouses, siblings, parents, older children, and friends. This networking can establish the initial support needed within the family. It also offers the family education and begins to establish the groundwork for the continuing emotional care of the patients and the family members themselves.

Often we use more than one counsellor with each client. This provides support for the counsellors themselves in knowing what to say, especially in high-pressure situations such as suicide, and continuity for the client if one counsellor is not available on a subsequent visit. In our Ghanaian context, where family systems are important, clients seem to accept readily multiple counsellors.

Home visiting

Early in the program it was an expectation of the staff that some clients could be followed up in their homes. Clients were asked if they would tell other people in their compound if hospital staff came to visit. Staff do not visit in uniform in order to call less attention to their visit. During the counselling training practice was given on how to use their counselling skills to respond to neighbours and extended family who ask questions about the visit. Those who were visited expressed gratitude and told the staff that the contact helped them.

There have been a few cases where the client requested no home visit and the staff have respected that desire. In those instances the client is urged to come to the hospital when they can for continued follow-up. If the client lives outside our catchment area and is near another counselling program a letter of referral is giving to *the client* to present to the other health facility in order to continue counselling. We know that clients have used this referral through the feedback from staff at other institutions and the clients themselves.

We have made home-visits to 43 out of a total of 145 clients during 1992. Twenty-five were seen 1-5 times, twelve were seen 6-9 times, six were seen more than ten times.

As the case load increased more time was needed for such visits. Nursing Service agreed to allow two nurses to devote two days a week for the visiting. A hospital car is available if needed. As we worked with this service one driver requested training so that he could help with the visiting. He has been trained and greatly enhances the staff utilization. If the client is in Berekum town the staff walk to the home.

Holistic approach

The majority of our clients come to the hospital because they are already significantly ill. This places a special burden on the counsellor to deal with the issues around dying. Because this program is situated within the context of a Catholic mission hospital we choose to attend to the spiritual needs as well as emotional and physical needs of the patient. The counsellors have also learned and been able to use Therapeutic Touch and Imaging skills. Adding these modalities to the counsellor's repertoire promotes a more holistic concept of counselling. The response of the counsellors to learning and experiencing these skills themselves has been enthusiastic. There was an initial shyness on the part of the counsellors

to using these skills with clients; however there are a few who are beginning to try Therapeutic Touch and Imaging and their reaction has been positive.

The reactions of the clients for whom it was used have been very favourable; their repeated request for Therapeutic Touch or Imaging has encouraged the counsellors.

We have observed in the counsellors that there is a growing awareness that these skills offer hope and comfort in spite of the lack of the usual medical interventions. There is a profound learning in how to walk with someone through the dying process to their death and how to continue to be a healing presence to the family after the death of their relative.

Problems encountered

As with any developing program there are problems that are encountered and fears of the organizers. This pandemic of HIV/AIDS places new levels of emotional and physical stress on staff, makes new financial demands on the institution, and poses the dilemma of hidden future needs.

It is becoming obvious already that, as the numbers of clients increases, the staff themselves need more emotional support. Efforts to address these issues so far have included debriefing counselling sessions with the supervisors, and monthly HIV/AIDS Committee meetings where the counsellors' concerns can be raised. As the level of need for staff support increases, we wonder how we can meet the need and maintain the quality of the counselling.

As is true in most of Africa, the Holy Family Hospital is plagued with the problem of insufficient numbers of adequately trained staff at all levels. Attending to the patients' physical needs often overwhelms the staff's ability to attend to emotional needs. There continues to be a conflict of time and trained personnel to meet both of these needs in the growing HIV/AIDS population.

Although not the last word, finances do have a significant role to play in the continuation of the program. Currently we have grant funding available for start-up efforts in training, educational materials, staff stipends and monetary assistance to clients for medicines, food, or transport when needed. Our concern focuses on the inability of local resources to even attempt to meet adequately the HIV/AIDS financial needs at this time. The projected financial burden is even more cause for general anxiety at the Hospital and in the local community in the light of all the other pressing developmental needs. The strain to Ghana as a nation is only a reflection of this local dilemma.

Implications

In reviewing our work to date we see the following implications: an organizational system can be established to handle care for persons with HIV/AIDS in a holistic manner; para-professional counselling training is an effectual and feasible way to address the emotional and spiritual care of persons with HIV/AIDS; and local hospital staff can be trained to be effective counsellors which also enhances their ability to be good educators with individuals and groups.

Dreams

As we get more experience with counselling we are struck by the potential for the further development of this program. We would like to build on our experience with one person with HIV who has become an effective counsellor and have more persons with HIV on the counselling team.

We have fostered the development of a Support Group among clients with HIV/AIDS in the local area and wish to continue and expand this self-help concept.

A Woman's Clinic has been established for a group of prostitutes in order to attend to their health needs, establish rapport and provide education for them on HIV/AIDS. It remains an organized group in the town with whom to continue efforts at behaviour change. We wish to expand the number of women reached through this group. They themselves have expressed concern about preventing

HIV/AIDS among another younger, less organized group of girls, and therefore serve as a catalyst for contacting and educating others.

Conclusion

This program has been functioning for two-and-a-half years. The increasing numbers of clients calls for constant training and expansion of our services. The medical model is geared to offer potential cure. Presenting needs of persons with HIV/AIDS, an incurable disease, challenged the nursing and medical staff in new ways. Counselling training was requested and begun to deal with the spiritual and emotional dimension of the person in this unique situation. Parallel to the training, an organizational system within the Hospital was established to deliver counselling services. The system expanded to include home visiting services, which became a very valuable aspect of the total program.

Educational efforts within the community and among the staff have been essential to the total hospital services offered. We have been able to share our expertise and exchange ideas with nine other health institutions in various parts of the country that have gone on to develop some of their own programs.

The next step, which is to develop Training of Trainers workshops, is scheduled for the coming year.

In summary we believe that paraprofessional counselling training offers a skilful way to enhance medical and nursing care for persons with HIV/AIDS. The benefits extend to those who offer this new skill as well as to those by whom it is needed.

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Videos

AIDS The New Facts of Life

Canadian Public Health Association

1565 Carling Ave., Suite 400

Ottawa, Ontario, Canada

Born in Africa: The Story of Ugandan Musician Philly Bongoley Lutaaya.

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