

HIV/AIDS education and counselling: experiences from Ghana*



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The emergence of HIV/AIDS in sub-Saharan Africa presents a challenge not only to public health paradigms but also models for public health education. Although the nature and spread of the disease have common features with a number of known diseases, the initial reactions to the disease have contributed to produce what Jeanneney (1987) refers to as 'a collective emotional hysteria' characteristic of the debate on syphilis in the early part of the twentieth century.

Fear and ignorance associated with the hysteria have led to various reactions such as panic, scapegoating, stigmatization and denial (Jeanneney 1987; Awusabo-Asare and Agyeman 1993). As with some previous epidemics, the strategy has been to make factual and understandable information accessible to people (Carballo and Kenya 1994). The basic philosophy is that people should not die from ignorance.

For sub-Saharan Africa, some of the pertinent questions are: how do we provide culturally relevant and socially acceptable information within the existing socio-economic constraints? Given the high illiteracy rate how should information be presented so as to reach as many people as possible? How should audience segmentation be approached in view of the limited resources available for educational campaigns on HIV infection? What are some of the socio-cultural constraints to the counselling of AIDS patients and their relations?

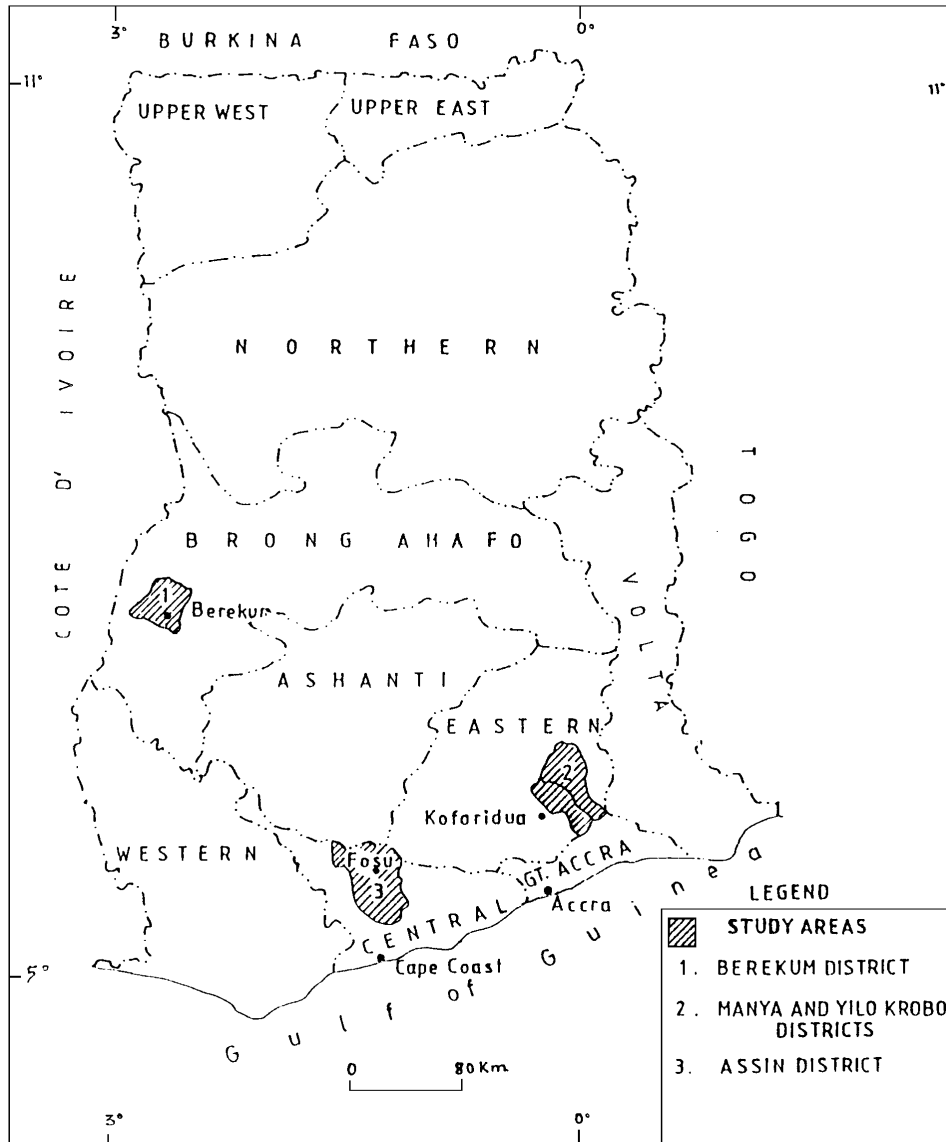
The aim of this paper is to describe some of the approaches adopted in three settings in Ghana to provide community education and counselling for communities, patients and their relatives on HIV/AIDS infection. The three areas are Berekum District of Brong-Ahafo Region, Manya and Yilo Krobo Districts of Eastern Region and Assin District of Central Region (Figure 1). The services are operated from the Berekum Holy Family Hospital, the Agomanya Saint Martin de Porres clinic and the Assin Fosu Saint Francis Xavier Hospital. All three hospitals belong to the Catholic Church.

HIV/AIDS education and counselling

Nearly a decade and a half after the outbreak of HIV infection, education continues to be the main strategy available for controlling the spread of the disease. The aim is to change people's attitudes not only towards the disease and infected persons, but also to the adoption of lifestyles that will not predispose people to infection. The latter is meant to motivate

* The Ghana segment of the Social Dimensions of AIDS in Africa Project has been financed by the Swedish Agency for Research and Economic Co-operation with Developing Countries (SAREC). The project has also received institutional support from the National Centre for Epidemiology and Population Health (NCEPH) of the Australian National University. I am grateful to J.C. and P. Caldwell for their support.

Figure 1
Ghana: administrative regions and study areas



people to either avoid or shift from what is now referred to as 'risky behaviour' (Orubuloye, Caldwell and Caldwell 1992; Anarfi and Antwi 1993). Advocating behavioural change to prevent the spread of the disease, particularly in sub-Saharan Africa, is based on at least three reasons. First, a 'fix-it' approach through biomedical prevention and intervention is not possible in the next five years or so, particularly with the withdrawal of the United States from the mass immunization trials (WHO 1992). Secondly, even if a cure is found, African countries, confronted with major economic crisis, poor infrastructure (including health) and other health problems are less likely to benefit, at least initially, from any technological

breakthrough. Thirdly, even when a cure becomes available education will continue to be an important aspect of any prevention program.

The first set of information, education and communication (IEC) on health promotion is always in the form of general education through the mass media: television, radio, newspapers, distribution of leaflets etc. This is based on the model of an initial general information (through the mass media) to be later reinforced by other sources of information flow, and with person-to-person contact (counselling) at the bottom of the spiral of IEC activities (Figure 2). The general assumption is that

Mass media channels are often more effective at creating awareness and knowledge of a new idea, whereas inter-personal channels are more important in changing attitudes and social norms concerning the adoption of new behaviours (Lamptey and Coates 1994:522).

The initial IEC on HIV/AIDS gave basic information about the aetiology and mode of transmission of the disease. Subsequent messages have been geared towards achieving behavioural change, and dispelling rumours and misconceptions about the disease. As observed in other parts of the world, serious misconceptions about the origin and transmission of the disease. Witchcraft, act of God, punishment for disobedience, insect bites, continue to be quoted as sources of HIV infection in Ghana (Ametewe 1992; Anarfi and Antwi 1993) similar to those reported by Carballo and Kenya (1994) in other parts of sub-Saharan Africa.

Figure 2
Spiral of IEC activities



Adopted from Pistrow (1987:16)

Counselling is a relatively new concept in the overall health care system not only in Ghana, but also in the health care delivery system of a number of African countries (Ego and Moran 1993; Lamptey and Coates 1994). Generally, counselling in the health system in sub-

Saharan Africa has been mostly in the form of advice from 'experts' to patients and their relations.

On the other hand, within the traditional African system, counselling is offered informally by a plethora of people depending upon the situation and circumstances. These include parents, some family members, traditional healers and other influential persons within the community. For instance, Twumasi (1975) observed that in Ghana some amount of counselling exists within the traditional healing system. Counselling forms part of the holistic approach to healing. But, as pointed out by Lamptey and Coates (1994), the impact of traditional healers on preventive health care is yet to be systematically described.

The demand for counselling has become more pressing given the nature of AIDS and the inadequacy of the existing support services for sick people generally. Providing medical care in Ghana is itself a major task. The health system is plagued with shortage of staff, inadequate remuneration for the few overworked staff, poor logistic support (e.g. vehicles, equipment) and shortages of essential items. The 1991 *Annual Report* of the Epidemiology Division of the Ministry of Health, for instance, noted that guinea worm eradication in the Volta Region 'ran into transport difficulties making it impossible to cover all sites regularly on a monthly basis...' (Ghana, MOH 1992a:31), and 'One of the factors identified [to hinder the clinical management of HIV/AIDS infection] was the perennial shortage of disinfectants, globes and other supplies' (Ghana, MOH 1992a:37). Any program on HIV/AIDS education and counselling in sub-Saharan Africa will have to not only confront long held beliefs and practices, rumours and misconceptions, but also deal with basic institutional and logistic problems. Evidence on these aspects abounds from campaigns on issues such as family planning, female genital mutilation and STDs.

Intervention strategies

Since the outbreak of the disease, various behavioural and biomedical intervention strategies have been developed or suggested to address the challenge posed by the disease. Table 1 attempts to summarize some of the intervention strategies adopted so far. These range from community-based strategies meant to sensitize whole communities, through small-group intervention programs, to approaches targeting the individual. While it is not easy to measure the effectiveness of the various strategies and approaches, they represent the attempts being made to stem the spread of the disease and to bring relief to those already infected.

Table 1
Types of intervention strategies

Intervention strategies	Target
Community level intervention	Entire communities Peer-based, e.g. truck drivers Identifiable groups - e.g. religious groups etc. Opinion/Community leaders
Small group interventions	Health care based, e.g. STD clinic attendants; needle-exchange patients Work-site/group location-based, e.g. workers at work sites; street youth
Individual level	One-on-one counselling

Derived from Lamptey and Coates (1994)

National response to HIV infection in Ghana

Ghana acknowledged the potential public health hazard associated with the disease even before the first case of HIV-seropositivity in the country was diagnosed in 1986. In 1985, the government set up the National Technical Committee on AIDS. The Committee was charged with the responsibility of developing strategies for the prevention and management of HIV infection in Ghana: one of their immediate tasks was the establishment of an HIV/AIDS surveillance system. Guidelines for AIDS prevention and control were developed through the Epidemiology Division of the Ministry of Health in the mid-1980s and subsequently revised and expanded in 1992 (Ghana MOH 1992b). One of the strategies put forward in the initial document was the formation of District AIDS Committees within the Primary Health Care structure.

As indicated above, the first case of AIDS was diagnosed in Ghana in March 1986. Only 26 cases were reported by the end of 1986, but the number rose to 3,140 in December, 1991 and by September, 1993, the number of reported cases was 11,835. With the increase in the number of reported cases, districts began to set up AIDS committees. The scope and nature of activities of these committees vary greatly. There are a few that have developed intervention strategies in response to the number of diagnosed cases in the district. The intervention strategies adopted by three of such districts in the country are described in the next section.

Community-based care at Agomanya-Krobo

The community-based care of the Krobo district, originally known as the Domiciliary AIDS project, is based at the St Martin de Porres Clinic at Agomanya. Initiated by a team of medical personnel from the Korle-Bu Teaching Hospital in Accra in 1987, the project is aimed at studying the epidemiology of the disease in the district and assessing the efficiency of two herbal medicines from Korea and Zaire. The two districts were chosen because in 1987 the areas had reported the highest number of AIDS patients in the country. In fact, even so far the district has the highest incidence of HIV infection as well as the highest HIV prevalence rate among pregnant women attending prenatal clinics in Ghana (Antwi personal communication). This is not strange since females from the area have been found to predominate in the commercial sex trade both in and out of Ghana (Anarfi 1990).

Between 1987 and 1988, community and public health nurses and paramedics in the Yilo and Manya districts assisted in mobilizing 210 patients through churches and community members. These patients were identified, treated and followed-up in their homes. Most of the patients died and the project lost contact with the rest because of stigmatization (Safo 1993a,b). The lessons learnt led to an expansion of the project to include home-based care and with the following objectives:

1. To involve community members in education and support for HIV/AIDS patients and their relations;
2. To provide care for AIDS patients at home in order to avoid isolation and discrimination;
3. To use the home visits to educate the other household members and the immediate community about the disease;
4. To provide avenues for training and income-generating activities for the youth in the area as well as some of the HIV-seropositive patients.

The strategies adopted to achieve the above objectives are:

1. Case identification and follow-up;
2. Pre- and post-testing counselling for patients;
3. Pastoral care;

4. Social and economic support services: financial support for patients, support for the children of some patients in school, income-generation activities;

5. Community and small group education.

The team at Agomanya is headed by a Ghanaian medical officer who is a nun; because of her background she has been able to attract support from various sources in and out of the country. The project receives support from the hospital itself, individuals in Germany and the Medical Institute of Wurzburg. The Institute has consistently provided grants, and items such as reagents for testing and gloves. The Canadian International Development Agency also paid for two cassava-grating machines, two corn-mills and 100 bee-hives through the Ghana Regional Appropriate Technology Institute Services. In spite of these sources of funding, the project faces financial problems.

The continuity of the project, the first in the country to study and institute a community-based intervention project on HIV/AIDS in Ghana, will depend upon the continuous support and goodwill of its benefactors.

The Berekum Project

The community education and counselling activities in the Berekum district of the Brong-Ahafo Region are based at the Holy Family Hospital at Berekum, the town from which the district derives its name. The district borders Côte d'Ivoire, a location which has implications for the spread of the disease in the sub-region.

The Holy Family Hospital is the designated district hospital and has a Nurses Training School and a Midwifery Training School, the only nursing training institutions in the Brong-Ahafo Region (Ego and Moran 1993). The estimated population of the district in 1991 was 110,000. Given its location, it serves more people than those in the district.

In 1991 and 1992, 123 and 202 HIV-seropositive patients were diagnosed at the hospital (Ego and Moran 1993). The increasing number of HIV-seropositive patients prompted the beginning of the intervention activities. The project on community education was started in the late 1980s by two American nuns, one a nurse and the other a psychologist. As in the case of the Agomanya-based project, this also involves:

1. Case identification and follow-up;

2. Pre- and post-testing counselling for patients;

3. Pastoral care;

4. Social and economic support services: financial support for patients, support for the children of some patients in school, income-generation activities;

5. Community and small group education.

The activities at the Hospital are supported by a number of international organizations, notably the Catholic Bishops' Conference of Germany and the Catholic Organization for Overseas Development.

The project at Berekum has one of the best developed counselling services because of the involvement of a psychologist. They have produced a manual on home-based care. A feature of the counselling service at the hospital is the addition of emotional support for the staff involved in the counselling service.

¹ This section draws on Ego and Moran 1993.

The community-based project at Assin-Fosu²

This project is based at St Francis Xavier Catholic Hospital at Assin Fosu in the Central Region. The town is located about 80 kilometres north of Cape Coast. The district, the largest in the region, shares boundaries with a number of districts in adjacent regions.

The project started in 1990 with the formation of a District AIDS committee. Initially the project concentrated on community education, management and follow-up of HIV-seropositive patients. In 1991, some of the patients asked not to be visited at home because of the stigma. In response, the management set up a pastoral care team in 1992. The approach is to visit and pray with all sick people and the elderly in a given community but target AIDS patients for counselling, care and support for the carers. The view of the hospital management team was that 'We shall be associated with any licit effort aimed at assisting AIDS patients and promoting good pastoral care for the people infected with HIV' (Sanz et al. 1992:2). In 1991, the SAREC team in Ghana teamed up with the District AIDS Committee in community education and counselling. As in the other projects Catholic organizations in and out of the country support the project.

Discussion and conclusion

The strategies described constitute major innovations in public health education and counselling in Ghana. Pettigrew, Ferlie and McKee (1992) have identified four potential and alternative sources for initiating change in a health system. These are: social and social movement organizations; District Health Team members; general management; and individuals (clinical product champions). While it may not be easy to identify the source of innovation the breakdown provides an important starting point for analysing the source of innovative action.

The project at the St Martin de Porres clinic was initiated by a team of medical doctors based at the Korle-Bu teaching hospital in Accra in 1987. The initial impetus, therefore, was innovation injected from outside. These were individuals who championed a certain course of action. While the Berekum project was initiated by the management, that of Fosu was by the AIDS Committee. These represent different sources for innovation. In Ghana, the contribution of social organizations to AIDS education and counselling is yet to be developed.

All three projects depend on external assistance. This has implications for continuity and sustainability. This is a critical issue for a number of projects of that nature. Religious or spiritual support is also an important element in the counselling, an issue important for medical personnel. These are 'private' initiatives; governments need to examine how these can be extended. But, in general, replication of small-scale initiatives tends to have more complications than can be envisaged. In spite of these problems, these offer prototypes of intervention programs that can be used in HIV/AIDS education.

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² See Sanz et al. 1993

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