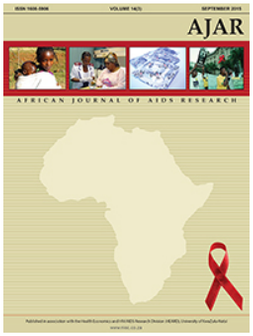

African Journal of AIDS Research

ISSN: 1608-5906 (Print) 1727-9445 (Online) Journal homepage: http://www.tandfonline.com/loi/raar20

Wisdom and counselling: A note on advising people with HIV/AIDS in Ghana

Sjaak van der Geest

To cite this article: Sjaak van der Geest (2015) Wisdom and counselling: A note on advising people with HIV/AIDS in Ghana, African Journal of AIDS Research, 14:3, 255-264, DOI: 10.2989/16085906.2015.1055580

To link to this article: http://dx.doi.org/10.2989/16085906.2015.1055580

African Journal of AIDS Research 2015, 14(3): 255–264

AJAR
ISSN 1608-5906 EISSN 1727-9445
http://dx.doi.org/10.2989/16085906.2015.1055580

Wisdom and counselling: A note on advising people with HIV/AIDS in Ghana

Sjaak van der Geest

Sociology-Anthropology Department, University of Amsterdam, Amsterdam, The Netherlands
Email: s.vandergeest@uva.nl

This article raises the question of whether the practice of HIV/AIDS counselling in Ghana can be linked to the wisdom that older people are said to have and use when they give advice to younger family members. Older people believe they have wisdom and life experience that young people should listen to; counsellors hold an opposite view about their work, insisting that it is they who listen to people with HIV/AIDS to help them make their own decisions. In actual practice, however, HIV/AIDS counsellors predominantly give information and advice, for at least three reasons. Firstly, clients urgently need a substantial amount of medical information about the causes and prevention of HIV in order to assess their situation and make decisions. Secondly, the traditional hierarchy between nurse and patient is difficult to reverse when the two meet during counselling. Thirdly, encouraging the client not to lose hope often takes the form of a pep-talk, which leaves little room for listening by the counsellor. This paper pleads for peer counselling, as a format that combines a relative equality between counselling partners with the authoritative knowledge of the counsellor. This article is based on anthropological fieldwork among older people in a rural community and counsellors in a hospital in the Kwahu region of southern Ghana.

Keywords: anthropology, peer counselling, traditional advice-giving, elders, stigma, trust, hospital

Introduction

In Ghana, as all over the world, counselling has become standard practice in terms of helping people with HIV/AIDS deal with their diagnosis. The techniques of counselling and the manuals used to train counsellors are largely copied from United States sources and emphasise a non-directive approach. The purpose of counselling, as a Ghanaian instructor of counsellors explained to me, is to assist people in making their own decisions, based on adequate information about their condition.

The effects of HIV-related counselling are very much debated. Reports and policy papers that promote counselling for people with HIV/AIDS tend to paint a rather optimistic picture. In case of disappointing results, these are attributed to a lack of political will and the insufficient skills of counsellors, implying that counselling would certainly work if political support and adequate training were present.[1] More neutral sources are more critical and pessimistic about the impact that counselling can make on the prevention of and coping with HIV/AIDS. Meursing and Sibindi (2000) noted that in Zimbabwe, psychological distress due to stigma prevented individuals from disclosing to family and friends and made them refuse professional support, including counselling. The small minority who did attend counselling felt unable to put into practice the lessons learnt, for the same reason (see also Meursing, 1997). Angotti (2010, 2012) shows the contradictions between Western-based counselling rules and local conditions and concludes that counsellors often feel more inhibited than supported by existing counselling guidelines. In-depth anthropological observations of HIV/AIDS counselling are, however, rare, in spite of its contested status; some exceptions are Whyte et al. (2005), Angotti (2010, 2012), Rasmussen (2013), and Vernooij and Hardon (2013).

In this article, I raise the question of whether the act of counselling in Ghana can be linked to the reputed wisdom of older people and their advice giving to younger family members. In other words, is the type of counselling being applied to people with HIV/AIDS indeed a "foreign" practice or does it have roots and can it find inspiration in the traditional wisdom that is so often mentioned in discussions about the blessings of old age?

It is remarkable, to say the least, that on a continent where consultation and deliberation are so much embedded in local cultures, HIV/AIDS counselling has been introduced as a completely new form of communication without any attempt to link it to traditional forms of advice giving.[2]

Ghana has an estimated incidence of 1.3% of people with HIV/AIDS (2013), though exact numbers are difficult to come by due to the strong stigma attached to the disease (Radstake, 2000; Mill, 2003; Ulasi et al., 2009; Dapaah, 2012; Kwansa, 2013).

Research

This paper builds on extensive anthropological research conducted since 1994 among older people and focusing on their relationships with younger generations in the Kwahu area of southern Ghana. Practices of advice giving, notions of respect, and the concept of experience-based wisdom were central themes in the research. Thirty-five older people in the town of Kwahu-Tafo took part in the research. I held numerous conversations with them; some were lengthy discussions, others short chats. I sat with them during the day, accompanied the energetic ones on

their activities such as farming, staking lotto, and attending church. I also talked to their family members and held group discussions with younger people about their older relatives. Students in secondary schools completed questionnaires or wrote essays about older people.

The second study that led to this paper was extremely short, almost the opposite of that which I conducted with older people. In 2009 I spent three days in the Holy Family Hospital at Nkawkaw and had conversations about counselling with five people: three counsellors, one person living with HIV/AIDS, and the manager of the HIV/AIDS programme (the programme is officially called "Social Welfare", to protect its clients from stigmatisation). As counselling is private and confidential, initially I did not ask to attend any counselling sessions.[3] I therefore had – against my methodological principles – to rely entirely on what the people *told* me that they did, without actually observing them during their actions. Two days later, I was given permission to spend three hours with a nurse at the pre-natal service and observed how she counselled pregnant women on HIV/AIDS (see Figure 1). None of these women were HIV positive, however.

In addition, I read several pieces of documentation on counselling that I found in the manager's office, including two training manuals, two counselling checklists (see Appendices), and several reports and sets of instructions. Finally, I also benefited from the research that Jonathan Dapaah (2012) and Benjamin Kwansa (2013) have carried out on approaches to people living with HIV/AIDS in two hospitals and two communities in the Ashanti Region, Ghana.

Local settings

Kwahu-Tafo, where I conducted the majority of my research among older people, is an "ordinary" Kwahu town of about 6 000 inhabitants. It hosts about fifteen Christian churches, a mosque, five junior high schools, one technical school, and one senior high school. The town has piped water, though most inhabitants still rely on wells and rainfall. There is electricity, which also allows for television and loud music until late in the night. There is a clinic for outpatient treatment and a maternity annex for deliveries. From Kwahu-Tafo, roads lead to the Volta Lake, which has rich fishing grounds, and to the Afram Plans, with their high production of yams and other food crops.

Figure 1: Nurse at pre-natal service combining routine tests of pregnant women with HIV/AIDS counselling

The town of Nkawkaw, where the Holy Family Hospital is located, is a busy trading centre on the main road from Accra to Kumasi, Ghana's two largest cities. It counts about 45 000 inhabitants and lies 25 km from Kwahu-Tafo. Inhabitants of Kwahu-Tafo go to Nkawkaw if they want to buy items that are not available (or too expensive) at home. They also pass Nkawkaw if they travel to Accra or Kumasi.

The hospital at Nkawkaw is one of three that people from Kwahu-Tafo can choose from when they need medical care. The other two are the government hospital at Atibie, which is about 15 km away, and the private hospital Agyakwa on the outskirts of Nkawkaw. The Holy Family Hospital was founded and is still run by Catholic religious sisters. In the year 2007, it reported 115 623 outpatients and 8 649 admissions. In that same year, seven doctors, eighty nurses, and 153 paramedical staff worked in the hospital. The number of new HIV/AIDS cases was about one per day.

Counselling procedures at the hospital

The terms "voluntary testing" and "voluntary counselling", which are commonly used in HIV/AIDS circles, are misleading. In about 90% of cases, people do not directly ask for a test. Rather, they report to the hospital due to health problems (cf. Daapaah, 2012; Kwansa, 2013), and if the doctor suspects HIV/AIDS, s/he will refer the patient for a test. In principle, the patient can decline, but in practice this rarely occurs. Testing for all types of diseases is routine in the hospital and patients normally do not have grounds to refuse. After all, they came to the hospital to find out the cause of what is troubling them. This practice is called diagnostic testing. In addition, all pregnant women are offered an HIV test; the overwhelming majority complies.

Before going for an HIV test, a patient is counselled regarding the reason for the doctor's referral and the possibility of a positive test outcome. Strict confidentiality is assured at all times. The patient is given the option not to be tested, though as I have said, this is rarely taken up.

When a patient tests positive, s/he will be counselled for a second time and will receive detailed information on the consequences that the disease will have for his/her personal life. The patient is given ample opportunity to express his/her worries and to ask questions. The counsellor informs the patient about the available treatment and puts him/her into contact with local support and counselling groups. A follow-up appointment for counselling is arranged. This second counselling session – known as post-test counselling – is also given to those who test negative. They receive further information on how to avoid HIV infection, and are also asked to come back for a second – confirmation – test three months later.

In 2009 when I conducted my research at the hospital, of the approximately five or slightly more diagnostic HIV tests conducted per day at the hospital, on average one was positive. This means that five or more pre-test counselling sessions were carried out every day. At the Nkawkaw hospital, there were around twenty counsellors, all volunteers; about five were particularly active. Most were

nurses or other health-related professionals and social workers. One very active counsellor, Yaa Somuah, was herself living with HIV and was not a professional. She was one of the three counsellors that I interviewed.

Before exploring further the counselling practices at the hospital, let us first see what wisdom and advice giving entails in terms of the communication between elders and younger people.

The wisdom of older people

The most outspoken virtue of older people in Kwahu-Tafo is their wisdom – at least, this was strongly impressed upon me during my conversations with elders, as well as with younger people. The older one becomes, the more knowledge one collects. Wisdom, knowledge, life experience, and the ability to foresee what will happen and to offer advice are indeed considered the qualities of older men and women. The fact that one has lived for a long time means that one has seen a lot of things and has begun to see how they connect. Life experience, in other words, teaches one how events follow one another. Wisdom is, by definition, derived from "hindsight": learning from past experiences. Hindsight, however, becomes foresight. The *ɔpanyin* (elder) may, on the basis of his/her understanding of the past, be able to predict the future and advise people on how to act in order to prevent trouble. When I asked an elder to define the term *ɔpanyin*, he said:

> *An* ɔpanyin *is someone who, through his experience in life, has gained a lot of wisdom and can know what is good and what is not good … Wisdom is the ability to think carefully about things before doing them. The young don't have that quality; they just get up and do things.*

The wisdom of the *ɔpanyin* implies power and prestige. That is why they say "*ɔpanyin ano sen suman"* [The *ɔpanyin*'s mouth is more powerful than an amulet]; that is, the words of an older person will tell you what is going to happen. You should listen to him/her, or you will get into trouble. The old therefore tend to regard this period as the most gratifying of their life. Another elder buttressed his claims to wisdom with a quotation from the Bible:

> *I have set my mind on the sayings of St. Paul in the Bible: "When I was a child, I spoke like a child and did things like a child". Because of this age, you realise that most of the activities of the young are useless, and at times I laugh when I see them indulging in them … When you are young, you make a lot of mistakes. Now that I have grown old, I have realised it, and I don't want to become young again … It is a blessing from God to grow old. When you die young, without experiencing a lot of things in life, it is not a blessing.*

In the Twi language, *nyansa* is the most common term used for "wisdom". *Onim nyansa* ("he/she is clever", lit. "he/she knows knowledge/wisdom") is commonly used in everyday situations and can apply to young as well as older people. Another term, which has roughly the same meaning, is *nimdeɛ* (lit. "knowledge thing" or "knowing things").

The respect shown to older people and their wisdom may be mere performance, however. Not all elders are considered wise. In contrast to the good elder (*ɔpanyin pa*), there is also the bad elder (*ɔpanyin bɔne*). Such people are believed to have failed in life due to drinking, laziness, squandering money, etc., growing old without having any property to bequeath to their children. Such people are despised, and no one will approach them for advice. But even those who *are* wise and respected are not often consulted, as I will explain further below.

When I invited school pupils to associate freely about the words "grandmother" and "grandfather", about one third mentioned that grandparents gave advice to people in the house, told them stories, or helped them in other ways (see Van der Geest, 2004b). Older people claim that they put their wisdom at the disposal of younger relatives in the house. They stop travelling and stay at home to take care of family affairs. Several proverbs express this idea using enticing metaphors. One says that the old person stays at home to look after the beans (*Akwakora ntena efie mma asadua mfɔ*). Thus while the other relatives are out, the older person watches the beans drying in the sun, and when it starts to rain, s/he will cover them up. The beans, of course, stand for family affairs. Another favourite saying of the people I talked to was "Unlucky is the house without an elder" (*Wunni panin a, due*), since such a family would miss the advice and experience of older people. Many years ago, Fortes (1950, p. 276) made a similar observation; grandparents, he wrote, are looked upon with reverence because they are "the repositories of ancient wisdom".

One of the most touching lines I recorded during my research was the remark of an older man, that there was no greater happiness for him than a young person coming to him and asking him a question. In speaking to the next generation and giving younger people advice, this older man can reap the joys of growing old. Handing down his wisdom constitutes the most positive experience of old age. Conversely, not being able to share one's life experiences and the accompanying wisdom creates loneliness and depression among older people (Van der Geest, 2004a).

My research has, however, shown that the wisdom and knowledge of older people is far less "tapped" by the younger generation than is generally assumed. One elder complained bitterly about the disinterest of the youth in his knowledge and wisdom:

> *I don't understand why my grandchildren and the young people in my house don't come and greet me and ask me about a lot of things I know. I want them to come and ask questions so that I tell them, but I don't get them. If you don't come, I will die and take it [my wisdom] along (*Mewu a na medekɔ*). My head is full of things, but I will go with them because they don't come.*

Our Lady of Good Council

The Catholic parish church in Kwahu-Tafo is called Our Lady of Good Council. A huge painted relief behind the altar (see Figure 2) shows what the artist and the faithful understand by "good council" or "good counselling". The Holy Mary is sitting on a chair and talking. Her right hand is raised to underline what she is saying. Two persons, a mother sitting on the ground and a child standing, but both lower than Mary, listen attentively to her wise words. Two

more people are arriving to join the sitting audience. Giving advice is here literally represented as "talking down" to people. Wisdom is transported from the head of the senior into the heads of juniors. That is how most of the older people like to see their role as advice givers.

But the artist has added another figure to the scene. A young man is sitting behind Mary. Leaning against her chair, he has fallen asleep. The artist probably wanted to teach the faithful a moral lesson: do not act like this young man. I prefer to read this figure as a realistic presentation of what happens when "wise people" start to give advice. Most young people are not interested, considering the wisdom of older people irrelevant to them, and thus turn away. The church painting illustrates the omnipresence of (the ideal of) giving advice and sharing wisdom in everyday situations. The painting resonates with people's expectations of living a good and prudent life.

The wisdom in counselling people with HIV/AIDS

The approach to counselling people with HIV/AIDS is – at least ideally – very different from the style that older people employ when advising the younger generation. The key element in counselling is listening. The training manual at the hospital reads:

> *In order for a counsellor to provide effective help he or she needs to listen attentively to the client. Listening is a skill that has to be learned and practiced. … Listening involves putting aside one's own self-interests and committing one's self to understand how the client feels and what his needs are from his perspective* (OICI, 2006, p. 84).

The skills required to achieve effective listening include:

- Establishing contact and putting the client at ease
- Building trust
- Attentive body language
- Continuing responses, nodding, probing, etc. to encourage client
- Adding questions for clarification
- Paraphrasing and summarising what client has said to check correct understanding and confront the client with his own information. (OICI, 2006)

The checklist for post-test counselling that the Nkawkaw hospital provides confirms this non-directive approach (see Appendix 2).

These instructions sound very familiar to those given to an anthropologist; they are almost identical to the interview or conversation skills that we teach our students in preparation for their fieldwork. The main difference, of course, is that the counselling should eventually lead to the client making decisions that will help him/her to cope with his/her problems, whereas the anthropologist usually has no other intention than to grasp the other's point of view.

During my conversations with the five people at the Nkawkaw hospital, this "anthropological" approach in counselling was also stressed. The manager told me:

> *Counselling is not giving advice and it is not passing judgement, but you help the person to make an informed decision. You are not to decide for the person but he decides for himself and chooses what will suit him based on the situation he finds himself in.*

And some time later in the interview, the manager added:

> *If you tell them to go and do so and so and it doesn't work they will come back and blame you. So you tell them the options and allow them to make their choice. We tell them the pros and cons and they have to make their decision.*

The nurse-counsellor I talked to emphasised the same point:

> *You don't dictate but you listen to the person and find out whatever the person's problem is. So, together with the person, you solve that problem.*

As I said before, I did not attend any counselling sessions with a person with HIV/AIDS, but I have reason to believe that the listening component in the actual counselling is less prominent than the books and my interviewees suggest. For starters, there is a lot of knowledge about the disease that needs to be transmitted in order to help the client make an *informed* decision about what to do next. I expect that nurses in particular – who bear the brunt of counselling at the Nkawkaw hospital – will be inclined to continue in their conventional role of informing and instructing patients on what to do and what not to do. Furthermore, patients in Ghanaian hospitals are not supposed to ask questions (cf., Andersen, 2004) and have learned to keep a respectful silence before nurses (and doctors in particular). A "good patient" is a quiet patient. It is unlikely that these established "scripts" for nurse-patient communication in the hospitals will be easily reversed during counselling.

Yaa, the only "non-professional" person providing counselling at the hospital, who was herself living with HIV, also gave me the impression that she did most of the talking during counselling. I asked her to explain to me how she counselled a person, and she gave me the following description:

> *I take the example of someone who has just got to know of it [being HIV positive] and is afraid that she*[4] *will die. I take her as my friend. I converse with her, talk to her about the disease and explain that it will not kill her. I tell her that I have had the disease for seven or eight years. I take my case as an example to the person. I also tell her the kind of medicine she has to take, how to eat, keep yourself and your room clean and all you should do not to bring the disease to somebody else.*

She continued by providing concrete examples of what does and does not spread the disease in order to educate the client and correct misconceptions about HIV/AIDS. This rather one-sided mode of counselling seems unavoidable in a situation where the available information about the disease is as fragmented and incomplete as it is in the Kwahu area. Due to stigma, HIV/AIDS is probably the most muted topic in the community, which makes open discussion and public education extremely challenging. Incorrect ideas about the disease abound and are difficult to correct. A counsellor may therefore have no other choice than to "lecture" the client and provide a multitude of facts concerning HIV/AIDS. The checklist on pre-test counselling that the hospital distributes also reflects this need for "educating" the client on the disease. Out of the 16 instructions to the counsellor, six start with "Explain …", three tell the counsellor to "discuss" (which

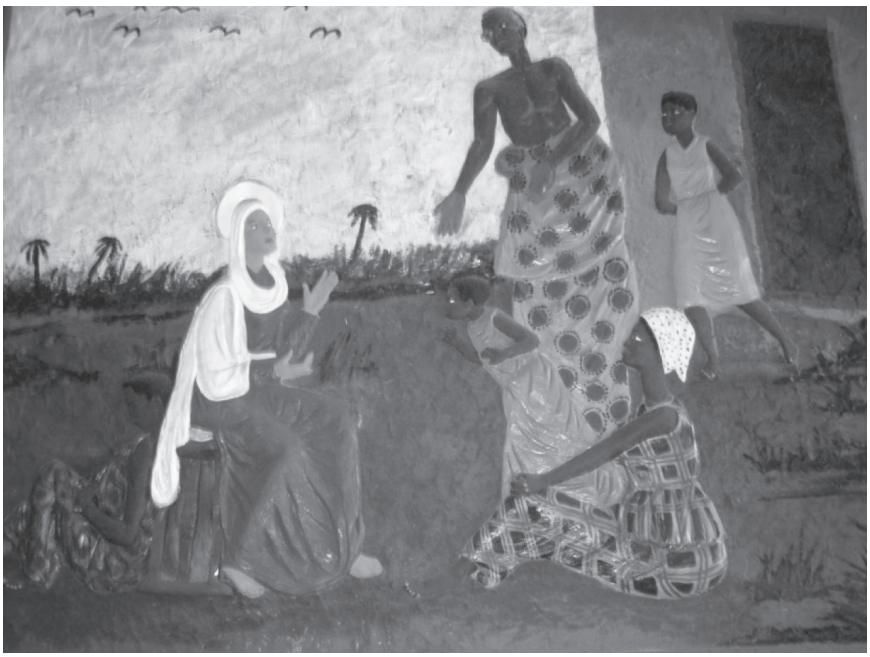

Figure 2: Our Lady of Good Council, Catholic church, Kwahu-Tafo

Figure 3: Yaa Somuah, peer counsellor

proves a synonym for "explain"), and only four instructions refer to "asking" the client something (see Appendix 1)

It is, however, not only the client's need for more information that prompts the counsellor to talk more than to listen. The emotional element of the counselling is also likely to produce "advice" in the traditional sense of the term. When Yaa demonstrated to me her style of counselling, she concluded:

> *The one who is HIV positive has to be comforted. You must encourage her that if she has got the disease, it does not mean that her life has come to an end. You will have to advise her that if she has got the disease, there is hope for her and she has more time to live.*

The conversation with Yaa was in fact a conversation between three people. The third person, Mr X, was a man around sixty who was also HIV-positive but who – in contrast to Yaa – had never revealed his status to anyone in his surroundings. His hiding of the disease prevented him from becoming a counsellor like Yaa. In fact, his decision to keep his status secret was the "normal" thing to do. Yaa was rather the exception; she was the only person in the Nkawkaw area who had publicly revealed her status, and had even spoken about it on the local radio. She even asked me if I could arrange for her to appear on national television and requested that I include her picture in any article that I would write about her work (Figure 3).

Half way during our conversation, I asked Mr X why it was not possible for him to do what Yaa had done, and then invited Yaa – as a kind of role playing exercise – to counsel X on breaking secrecy and overcoming stigma, as she herself had done. What followed was not a counselling session according to the rules of the manual, but a plea by Yaa to convince or "convert" X to adopt a different attitude towards his status, and a counter-plea by X to explain why this was not possible for him. X was very concerned about his reputation and feared that his own children and other relatives and people in his environment would turn their backs on him, and that he would lose his job as a teacher:

> *If they get to know about it, they will no longer respect me. When I call them, they will not mind me. They may not like to come near me. Because of the disease they will call me names and tease [harass] me… But if I don't tell people that I am sick, I am respected and regarded… If I disclose it to people, they may even stop giving me some assistance because they will assume that I will die very soon.*

Yaa made some further attempts to convince X that things would work out much better for him than he feared. After all, she said, she had actually gained respect and elevated her reputation in the town by revealing her HIV positive status. The debate continued and I could not help thinking of what the manager of the HIV/AIDS programme had told me: "If you tell them to do so and so and it does not work, they will come back and blame you" (see above). What would happen if Yaa convinced X to "come out" and his family and friends did indeed "reject" him as a result?

Yaa is a highly motivated and charismatic person, but telling people to do as she does would go entirely against all the rules of counselling. I admit that this was not a "normal" counselling session and my invitation to her was perhaps taken as a challenge to demonstrate her rhetorical skills. Indeed, Yaa's experiences with overcoming both the disease and its stigma are so impressive that it would be difficult for her not to present herself as a model for others. As a matter of fact, this was exactly what she told me she did during counselling. Interestingly, according to the manager, she was the best counsellor they had.[5]

Summarising so far, it seems that the emphasis on listening is less practised than both the manuals and (some)

interviewees suggested. Not surprisingly, similar observations have been made elsewhere; for example, by two studies in Uganda (Rasmussen, 2013; Vernooij & Hardon, 2013) and one in Zambia (Simbaya, 2013). MacGregor (2009, p. 15), who studied HIV/AIDS counselling in South Africa, remarked that the isiXhosa word commonly used for "counselling" is derived from the verb "to give advice". During his fieldwork, it became evident to him that this root did indeed encapsulate the actual practice of counselling. Paradoxically, he observed that this pragmatic choice "… might in fact be closer to meeting the expectations of patients, whilst also dove-tailing with perceived public health imperatives". A striking example of doing the right thing for the wrong reason. Simbaya and Moyer (2013, p. S453), who sketched the historical development of HIV counselling in Zambia, also emphasise that counselling is bound to become "practical" and an attempt to persuade the client to change his/her behaviour on the basis of knowledge passed on during the session:

> *… as knowledge about HIV grew, counselling objectives expanded to include behavioural change, encouraging safer sexual practices, encouraging disclosure, convincing people to test, treatment adherence and shaping HIV-positive people's sexual and reproductive choices.*[6]

Angotti (2010), who followed counsellors in Malawi, describes how they felt constrained by the official rules of counselling. They often knew both the HIV positive client and his/her relatives and felt responsible for them. Keeping a professional distance and not informing relatives when their health was in danger was not acceptable to them. Counsellors therefore adjusted and twisted the rules to suit local values and conditions.

Above, I mentioned three reasons for the reversal of the original concept of counselling. First, substantial medical information about the causes and prevention of HIV is necessary to help clients to assess their situation and make informed decisions (cf. Vernooij & Hardon, 2013). Secondly, the hierarchy between nurse and patient will be difficult to reverse if the two meet during counselling (cf. Rasmussen, 2013, p. S547; Anglotti, 2012, p. 370; Vernooij & Hardon, 2013). Thirdly, encouraging the client not to lose hope is likely to take the form of a pep-talk, which leaves little room for listening by the counsellor.

What is wisdom? Comparing traditional advice giving and counselling

"On paper", the traditional style of giving advice, as practiced by older people, is very different from what is practised during the counselling of people with HIV/AIDS. Traditional advice giving is explicitly based on the fact that the advisor and the advised are different. The former is older, has more life experience, and is therefore "wise"; the latter is younger, has less experience in life, and is therefore less "wise". It is this difference, which is also felt to be a hierarchical one linked to rules of respect, that makes the giving of advice possible and imbues it with authority. The meeting between older and younger people can be largely characterised as the former speaking and the latter listening.

This hierarchical difference is avoided as much as possible in counselling instructions. The key to counselling is trust, which is believed to thrive best when there is equality between both partners. Although there is often an age difference between counsellor and client, this difference is downplayed and equality emphasised. All five people with whom I spoke in the hospital further agreed that peer counselling has a definite advantage: the more equal or similar counsellor and client are, the more effective the counselling will be. By "peer", they thought of three forms: being of the same age, of the same sex, or both being HIV positive. About age, the manager remarked:

> *Children understand each other. If you bring a ten-year-old child and let a fifty-year-old person counsel it, there will be certain facts that the child will not disclose.*

This problem was still stronger with regard to gender, he said:

> *In our culture, it is difficult – but not totally impossible – for a man and a woman to sit and talk about sex. If a woman has an infection or rashes around the vagina, for example, she may find it difficult to speak about this to a man, but she could easily tell a woman about it.*

When I asked him whether people with HIV had an advantage when acting as counsellors, he replied, "I will say emphatically yes", and gave the example of Yaa:

> *Anytime someone is tested positive and is going through the trauma, sadness and denial, and I refer that person to her, she begins to calm down. She [Yaa] is on drugs and doing very well. When they test positive for the first time, they think there is no hope, but then they see someone who is also positive and on drugs and when they see that person is doing well, they regain hope. She may say: "Look at me. I am on drugs and doing very well. You can also be put on drugs and be like me" … If all our counsellors would be people who are positive, it would be very good.*

The nurse-counsellor reacted as follows when I posed the question to her about the advantage of HIV positive peer counsellors:

> *Yes, it is true. I don't have the disease, but I am sharing with you in pain because I know how you are feeling … I can become a patient like you. It can also happen to me today.*

So, while the traditional method of advice giving is rooted in the superiority and seniority of one partner over the other, in counselling the advice is believed to be most effective if the partners have as much as possible in common (cf. Wolf et al., 2000).

Another contrast – at least in theory – as we have seen, is that the traditional advice giver is a speaker, while the counsellor wants to be a listener. Let me quote the nurse-counsellor again:

> *With counselling: when a person has a problem, you have to listen to that person. If you don't listen, how can you help?*

When I asked her to compare her counselling with the advice she received from her grandmother when she was young, however, she said that there was not much

difference. Her grandmother listened patiently to her, she said, before giving her advice. When I prompted further and told her about my own research experience – that the young hardly approached older people for advice and that what the old had to say did not interest the young – she unexpectedly agreed and started to give a far less romantic picture of the wisdom of older people:

> *Yes, going to the old lady to listen to advice is not what is happening at the moment. Their [young people's] life is different. Some will tell you that the old people talk too much and do not want to listen to them … When the old people start to talk, they go away … They have no interest in what they are saying.*

But her grandmother was different, she stressed. We may perhaps conclude that there are two types of elders with two different types of wisdom. There is the exceptional ideal elder who does indeed listen, who tries to "come down" to the level of the younger person, and who is really "wise". And there is the more common elder who merely claims wisdom and life experience and wants to impress the younger generation with it. The latter's "wisdom" is first of all a tool to maintain his/her respected position in the community. It is typically a top-down phenomenon, which does not so much originate from an interest in and concern about the younger generation, but is rather an attempt to convince the young people that they (the elders) know more than them (the younger generation). Unsurprisingly, the young do not flock to hear their stories, but – politely – avoid them.

Conclusion: The wisdom of counselling

The two styles of advice giving and the sharing of wisdom and knowledge discussed above may be more alike than the promoters of counselling would like them to be. That is: the listening component on the part of counsellors may be less than intended, due to the reasons presented earlier. The sharing of common experiences and concerns and the envisaged sense of equality may also be less effectively achieved than is hoped for.[7]

Aside from the similarities in the practice of traditional and HIV-related advising, there are nevertheless vast differences in the wider implications of the two. HIV counselling deals with issues that are extremely relevant to the clients taking part in it. Indeed, in contrast to the advice that older people may want to pass on to the young, the information that counsellors pass on to people who have or may have HIV is of utmost importance to them. Most people who have or suspect that they may have HIV are desperately looking for reliable information, and are seeking emotional and material support. The relevance of counselling therefore lies entirely with the client, who needs information in order to make a decision that will determine his/her life or death. The relevance of traditional advice giving, on the other hand, lies mainly with the older person, who wants to demonstrate his/her knowledge, life experience, and superior position to the younger generation that is about to supplant him/her.

HIV counselling could learn from the ineffectiveness and approaching obsoleteness of present day elderly advice giving (Van der Geest, 2008). Training and monitoring should place even more emphasis on the art of listening and the importance of peer counselling in all three meanings of the term (age, gender, and HIV status), but particularly on counselling given by people with HIV (cf. Kober & Van Damme, 2006; Dapaah, 2012, p. 121–122; Dapaah & Moyer, 2013).[8]

The present stigma around HIV/AIDS is the main obstacle that holds people with HIV back from making themselves known as "living positively" and from turning their misfortune into an asset of wisdom and experience. In this regard, peer counselling can have a twofold impact. Not only can it help new clients to cope with the disease, but it can also contribute to the emancipation of people living with HIV/AIDS who have learned to "cope" with the disease over many years and have gained much wisdom and experience along the way. Up till now, many of these people have felt unable to reveal their status to others and therefore continue to experience social suffering in addition to the physical pains and insecurity of the disease. By becoming effective and respected counsellors, such HIV-positive people will contribute to the destigmatisation of HIV/AIDS. They can demonstrate that not only is living with HIV/AIDS possible – in other words, it is not an automatic death sentence – but they can also endow others with the valuable experiences and skills that they have acquired over time. Their "experiential expertise" can in turn open up new avenues to them and restore the respect that they feared to lose.

Taking this first step requires an enormous amount of courage and moral strength. The discussion between the peer counsellor Yaa and Mr X, to which I referred earlier in this article, vividly shows the dilemmas but also the victories that present themselves when people with HIV consider the step of "coming out". Yaa dearly "enjoys" having taken this step and being admired and respected by others, both her peers in HIV/AIDS and the general public. Her step has given her a new status and a new purpose in life. As to the question of how she was able to take this step against the current of stigma, I am afraid I was unable to find an answer. Firstly, she gave the expected answer that God had given her courage. When I insisted on her own role in the process, she talked about her love for her fellow men and women and the whole country. At some point later, she "admitted" that people are different.

Destigmatisation of the disease will be a long and painful process. It will require people like Yaa to force a breakthrough. If more people with HIV dare to come out of hiding and offer their services to counsel their peers, their experiences will be of immense benefit to those who are newly diagnosed as HIV-positive. Such peer counselling does not need to be the formal counselling that takes place in clinical settings. If peers undergo professional training, they are likely simply to replicate the approach of the nurse/health worker. Peer counselling could also – perhaps preferably – take the form of an informal chat about HIV/AIDS and the pros and cons of going for counselling and testing. Sharing their experiences with others and teaching their lessons in an egalitarian conversational style is, to me, the essence of relevant wisdom. Wisdom that is not relevant is not wisdom.

Notes

[1] See for example UNAIDS (1997), Boswell & Baggaley (2002).

[2] An exception is Whyte et al. (2005), who compared voluntary testing for HIV to advice seeking from a diviner in Uganda. The test technology is referred to as a "truth machine". The style and technique of counselling is, however, hardly discussed. Mpofu (2011) has edited a collection of papers that link counselling in various settings to African traditions to promote community health, well-being, and development. Simbaya and Moyer (2013: S464) emphasise the difference between traditional advice giving and HIV counselling in Zambia "… as people are now counselled by relative strangers in healthcare settings" (emphasis added).

[3] Dapaah (2012) was not allowed to attend counselling sessions in two hospitals in another region of Ghana.

[4] In Twi, the personal noun is gender neutral. By using the female form in the English translation, I follow the transcription/translation of one of my co-researchers.

[5] By contrast, Dapaah observed that although people living with HIV/AIDS are widely regarded as the best people to counsel their peers, many professionals at the clinic where he conducted his study did not properly recognise their contribution (Dapaah & Moyer 2013).

[6] Indeed, as others have observed, "Failure to convince someone to test or "accept" results was perceived as failure on part of the counsellor" (Simbaya 2015), and "…counsellors [in Uganda] are under pressure to produce certain behavioural outcomes, including responsibilised sexuality" (Rasmussen 2013: S538). Rasmussen further argues "that the counsellors' preoccupation with giving instructions, and the wider social and moral context of HIV counselling in Uganda, may limit the clients' abilities to share their intimate thoughts" (S 539).

[7] Whyte et al. (2005), who compare and contrast divination and HIV counselling in Uganda, implicitly confirm that counselling may best fit into traditional forms of advice seeking, with its hierarchical character. "Culturally appropriate counselling" is also the main thrust of Klopper et al. (2014), in their treatise on stigma and HIV disclosure in South Africa.

[8] Related to the effectiveness of peer counselling is the support and friendship that children offer one another in situations of acute distress. Skovdal and Ogutu (2012) describe the "importance of peer social capital" for children in Kenya coping with HIV/AIDS.

Acknowledgements — I thank Evans Osei (HIV/AIDS coordinator), Yaa Somuah, "Sister Kate", and other helpful people at Holy Family Hospital, Nkawkaw. I also thank my friends at Kwahu-Tafo, Anthony Obeng Boamah and Benjamin Boadi for their help. Finally, thanks to Jonathan Mensah Dapaah for his comments on an earlier version of this article and Zoe Goldstein for editing. Parts of this essay draw on an earlier publication (Van der Geest, 2008). Permission for the research in the hospital was given by the hospital direction.

References

Andersen, H. M. (2004). "Villagers": Differential treatment in a Ghanaian hospital. *Social Science & Medicine, 59*(10), 2003-2012. http://dx.doi.org/10.1016/j.socscimed.2004.03.005

Angotti, N. (2010). Working outside of the box: How HIV counsellors in sub-Saharan Africa adapt western HIV testing norms. *Social Science & Medicine, 71*(5), 986-993. http://dx.doi.org/10.1016/j.socscimed.2010.05.020

Angotti, N. (2012). Testing differences: The implementation of Western HIV testing norms in sub-Saharan Africa. *Culture, Health & Sexuality, 14*(4), 365-378. http://dx.doi.org/10.1080/13691058.2011.644810

Boswell, D., & Baggaley, R. (2002). Voluntary counselling and testing (VCT) and young people: A summary overview. http://ocw.mit.edu/courses/special-programs/sp-783-engineering-capacity-in-community-based-healthcare-fall-2005/readings/vct_toolkit_fhi.pdf

Dapaah, J. M. (2012). *HIV/AIDS treatment in two Ghanaian hospitals: Experiences of patients, nurses and doctors*. Leiden: African Studies Centre.

Dapaah, J. M., & Moyer, E. (2013). Dilemmas of patient experience: People living with HIV as peer educators in a Ghanaian hospital. *Ghana Studies, 15/16*, 195–221.

Fortes, M. (1950). Kinship and marriage among the Ashanti. In A.R. Radcliffe-Browne and D. Forde (Eds). *African Systems of Kinship and Marriage*. pp. 252–84. Oxford: Oxford University Press.

Klopper, C., Stellenberg, E., & van der Merwe, A. (2014). Stigma and HIV disclosure in the Cape Metropolitan area, South Africa. *African Journal of AIDS Research, 13*(1), 37–43. http://dx.doi.org/10.2989/16085906.2014.886606

Kober, K., & Van Damme, W. (2006). Expert patients and AIDS care. A literature review on expert patient programmes in high-income countries, and an exploration of their relevance for HIV/AIDS care in low-income countries with severe human resource shortages. http://www.itg.be

Kwansa, B. K. (2013). *Safety in the midst of stigma. Experiencing HIV/AIDS in two Ghanaian communities*. Leiden: African Studies Centre.

MacGregor, H. (2009). What constitutes "counselling"?: Shifting meanings and re-inventing practice in HIV/AIDS treatment programmes in Cape Town, South Africa. Unpublished conference paper, University of Sussex.

Meursing, K. (1997). *A world of silence: Living with HIV in Matabeleland, Zimbabwe*. Amsterdam: Royal Tropical Institute.

Meursing, K., & Sibindi, F. (2000). HIV counselling – a luxury or necessity? *Health Policy and Planning, 15*(1), 17–23. http://dx.doi.org/10.1093/heapol/15.1.17

Mill, J. (2003). Shrouded in secrecy: Breaking the news of HIV infection to Ghanaian women. *Journal of Transcultural Nursing, 14*(1), 6–16. http://dx.doi.org/10.1177/1043659602238345

Mpofu, E. (Ed.). (2011). *Counselling people of African ancestry*. Cambridge: Cambridge University Press. http://dx.doi.org/10.1017/CBO9780511977350

OICI. (2006). *Psychological Counselling Manual*. Accra: Opportunities Industrialisation Centres International.

Radstake, M. (2000). *Secrecy and ambiguity: Home care for people living with HIV/AIDS in Ghana*. Leiden: African Studies Centre.

Rasmussen, L. M. (2013). Counselling clients to follow "the rules" of safe sex and ARV treatment. *Culture, Health & Sexuality, 15*(sup4, Suppl. 4), S537-S552. http://dx.doi.org/10.1080/13691058.2013.809606

Simbaya, J. (2015). Chapter 3. HIV/AIDS care through Counselling – a clinic ethnography. Chapter 3 in his draft dissertation. Amsterdam Institute of Social Science Research (AISSR), University of Amsterdam.

Simbaya, J., & Moyer, E. (2013). The emergence and evolution of HIV counselling in Zambia: A 25-year history. *Culture, Health & Sexuality, 15*(sup4, Suppl. 4), S453–S466. http://dx.doi.org/10.1080/13691058.2013.794477

Skovdal1, M., & Ogutu, V. O. (2012). Coping with hardship through friendship: The importance of peer social capital among children affected by HIV in Kenya. *African Journal of AIDS Research,* 11 (3): 241–250.

Ulasi, C. I., Preko, P. O., Baidoo, J. A., Bayard, B., Ehiri, J. E., Jolly, C. M., & Jolly, P. E. (2009). HIV/AIDS-related stigma in Kumasi, Ghana. *Health & Place, 15*(1), 255-262. http://dx.doi.org/10.1016/j.healthplace.2008.05.006

UNAIDS. (1997). Counselling and HIV/AIDS. http://data.unaids.org/Publications/IRC-pub03/counstu_en.pdf

Van der Geest, S. (2004a). "They don't come to listen." The experience of loneliness among older people in Kwahu, Ghana. *Journal of Cross-Cultural Gerontology, 19*(2), 77–96. http://dx.doi.org/10.1023/B:JCCG.0000027846.67305.f0

Van der Geest, S. (2004b). Grandparents and grandchildren in Kwahu, Ghana: The performance of respect. *Africa, 74*(1), 47–61. http://dx.doi.org/10.3366/afr.2004.74.1.47

Van der Geest, S. (2008). Wisdom, an intergenerational gift? Notes from Kwahu-Tafo, Ghana. In E. Alber, S. van der Geest, & S. R. Whyte (Eds.), *Generations in Africa: Conflicts and connections.* pp. 381–398. Berlin: LIT-Verlag,

Vernooij, E., & Hardon, A. (2013). 'What mother wouldn't want to save her baby?' HIV testing and counselling practices in a rural Ugandan antenatal clinic. *Culture, Health & Sexuality, 15*(sup4, Suppl. 4), S553-S566. http://dx.doi.org/10.1080/13691058.2012.758314

Whyte, S. R., Whyte, M., & Kyaddondo, D. (2005). Unveiling the hidden: AIDS testing and divination compared. Conference paper: 'Unveiling the Hidden: an Interdisciplinary Conference on Divination.' University of Copenhagen, 1–3 August 2005.

Wolf, R. C., Bond, K. C., & Tawfik, L. A. (2000). Peer promotion programs and social networks in Ghana: Methods for monitoring and evaluating AIDS prevention and reproductive health programs among adolescents and young adults. *Journal of Health Communication, 5*(Supplement 1), 61–80. http://dx.doi.org/10.1080/10810730050019564

Appendix 1: Checklist for pre-test counselling

1. Introduce yourself.
2. Explain that the interview is completely confidential.
3. Explain why the doctor has suggested an HIV antibody test, or explore why the client is requesting the test.
4. Ask what the client already knows about HIV transmission and prevention.
5. Explain the medical facts about HIV infection and how it is spread:
6. How HIV affects the immune system
7. How HIV infection is different from AIDS
8. That there is a long incubation period
9. The routes of transmission
10. How HIV does not spread
11. That there is no cure at present
12. There is treatment for opportunistic infections
13. There is symptomatic treatment
14. Give hope that there may be a cure in future.
15. Explain that the HIV antibody test is not a test for AIDS.
16. Explain the 'window period', that is, the time between infection and seroconversion, when the test is negative but the person is infected and infectious – see HIV Slide 12.
17. Explain policies for follow up and for confirmatory tests.
18. Ask about family circumstances.
19. Discuss the personal implications of a positive result: Whom would they tell? How might they cope with a positive result?
20. Identify what support they have from family and friends.
21. Discuss some of the practical issues, e.g. how to use and where to get good condoms and family planning advice.
22. Discuss the importance of a healthy lifestyle (good diet, sleep, exercise, etc.).
23. If clients keep their outpatient cards, tell them what to write on it so that they can protect their confidentiality.
24. Check their understanding.
25. Arrange a follow up appointment.