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Motivation, responsibilities, and experiences of HIV/AIDS counselors in the Volta Region of Ghana: a descriptive phenomenological study

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Abstract

Background The provision of professional counseling services for persons living with human immunodeficiency virus (PLHIV) is crucial in the prevention and treatment continuum of the disease. However, for counselors of people infected with the human immunodeficiency virus (HIV) leading to acquired immune deficiency syndrome (AIDS) to give their best, their motivations to become counselors and the challenges they face in their line of duty need to be contextually understood and addressed. We ascertained the roles, motivations, and experiences of HIV/AIDS counselors in the Volta Region of Ghana to inform HIV/AIDS counseling decision-making in the region and the country.

Methods A phenomenological study conducted among sixteen (16) HIV/AIDS counselors from five HIV/AIDS sentinel sites in the Volta region of Ghana, recruited through a purposive sampling approach and interviewed to ascertain their HIV/AIDS counseling-related experiences. The data were thematically analyzed using the Atlas. ti software, and sub-themes supported with verbatim quotes.

Results Five motives for becoming an HIV/AIDS counselor were found. These include being randomly assigned to the unit, developing interest in the job, because of the status of a relative, witnessing bad attitudes of healthcare providers, and seeing HIV- clients lacking knowledge of the condition. The study found that these counselors performed six core roles: providing nutritional counseling, educating clients on HIV, treatment, and medication provision, conducting testing and comprehensive counseling of clients, providing social support to clients, and offering financial support to clients. The experiences these counselors had were boosting clients' health status, counseling clients back to a normal mental state, cooperation from clients, participants gaining knowledge on HIV through counseling, counseling clients to accept their status, and when a client delivered an HIV-negative baby. Their negative experiences included clients denying their HIV status, clients defaulting on their treatment, uncooperative

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clients, death of clients due to fear of breach of confidentiality, self-stigmatization among clients, and the myths some people hold towards HIV/AIDS.

Conclusion By organizing capacity-building training programs for HIV/AIDS counselors in the Volta region and addressing the negative experiences they encounter, they could be empowered to provide effective counseling, curative, and social services to people living with HIV in the region, leading to improved health outcomes.

Keywords HIV/AIDS, HIV counseling, HIV prevention and treatment, Ghana AIDS Commission, Volta Region

Introduction

Counseling plays a crucial role in the prevention and management of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) [1]. When individuals learn about their HIV status, they often experience significant psychosocial and psychological distress associated with the fear of rejection, social stigma, disease progression, and the uncertainties about future HIV management [2]. HIV/AIDS counselors are responsible for providing the necessary time, attention, and respect to help these individuals live peacefully and resourcefully with the virus [3].

HIV/AIDS counseling seeks to address the biopsychosocial needs of persons living with HIV (PLHIV) for timely management [4]. Counselors assist in preventing HIV transmission and support those affected by the virus to improve their health outcomes [5]. They also promote behavioral changes in affected individuals and collaborate with their families to encourage treatment adherence and sustain behavior changes [6]. Furthermore, HIV/AIDS counselors provide support and education to PLHIV, which is crucial for preventing the spread of the disease [7]. They help patients and families understand their diagnosis, manage their treatment plans, and cope with the social and emotional impacts of living with a chronic illness [8]. Additionally, counselors collaborate with other healthcare professionals to coordinate care for their clients [9].

The demanding role of HIV/AIDS counselors underscores the necessity for motivated counselors, as the quality of the counseling services depends on their performance. It is crucial to have experienced, dedicated, and motivated HIV/AIDS counselors providing counseling services to PLHIV [10]. A lack of motivation among HIV/AIDS counselors can affect the care provided to PLHIV and may even lead some to leave their jobs [11, 12].

Despite the vital role of HIV/AIDS counselors, they face many challenges, many of which are underreported. For example, often face stigma and discrimination due to the nature of their work [13]. Some people believe HIV is contracted through witchcraft and promiscuity, which undermines the efforts of HIV/AIDS counselors in combating the disease [14]. These challenges are context-specific to the African continent. In South Africa, for instance, challenges such as confidentiality, stigma, emotional responses when informing clients of their HIV status, cultural and contextual factors, situational stressors related to the work environment, and inadequate support from their work infrastructure are some of the issues HIV/AIDS counselors encounter [15]. In Nigeria, poor governance, weak institutions, poverty, and cultural norms and practices have been found to negatively affect HIV/AIDS counseling in general [16].

In Kenya, training needs, lack of in-depth understanding of the root causes of risky sexual behaviors among PLHIV, especially among men that sleep with men, and perceived intractability of clients' issues have been reported as some of the challenges facing HIV/AIDS [17].

In Ghana, HIV/AIDs remain a significant public health issue, with an estimated prevalence of 1.8% according to the Ghana AIDS Commission [18]. As of the end of 2022, there were a total number of 354,927 people living with HIV in the country, with an estimated 16,574 new cases in 2023 [19]. The Volta region ranks seventh out of the sixteen regions in terms of HIV burden, with 16,996 HIV/AIDS cases. To reduce the transmission of the virus and improve the health outcomes of those already affected in the region, it is essential to motivate HIV/AIDs counselors and address context-specific challenges they face.

Despite the important contributions of HIV/AIDS counselors in Ghana, the literature on HIV/AIDs in the country has often overlooked their crucial role. While some studies focus solely on the experiences of HIV/AIDs counselors [20–23], most literature emphasizes HIV counseling and testing [24–35]. In the Volta region, research has primarily focused on the epidemiology of the disease, its risk factors, and transmission patterns [36–40]. Therefore, the specific roles, motivations, and experiences of HIV/AIDS counselors have not been comprehensively documented in the country to inform policy on HIV/AIDS counseling. This study aims to contribute to the existing literature on HIV/AIDS by exploring the core roles, motivations, and experiences of HIV/AIDS counselors in the Volta region of Ghana, following the standards for reporting qualitative research (SRQR) as outlined by O'Brien et al. [41].

Methods

Study site description

The study was conducted at five HIV/AIDS sentinel sites in the Volta Region of Ghana. The region has a total of 749 health facilities, including 29 hospitals, 156 health centers, 44 clinics, 4 polyclinics, 14 maternity homes, 452 CHPS compounds, and 50 private health facilities [42]. Among these, the Volta Regional Hospital, the Ho Teaching Hospital, the Bator Catholic Hospital, the Adidome Hospital and the Torgorme Hospital serve as the HIV/AIDS sentinel sites, with certified HIV/AIDS counselors. These five facilities were specifically selected for the study. According to the 2021 population and housing census figures, the region has an estimated population of 1,659,040 [42, 43].

Study design

A qualitative approach, using a descriptive phenomenological design, was employed to explore the motivation, responsibilities, and experiences of HIV/AIDS counselors in the Volta Region of Ghana. Descriptive phenomenology suggests that a phenomenon should be described rather than explained or investigated for its causal relationship [44]. It examines and aims to comprehend the subjective human lived experience concerning a phenomenon as it appears in a natural context [45]. This approach enabled the participants to share a narrative about their lived experiences. Since there is a paucity of research data on the motivation, responsibilities, and experiences of HIV/AIDS counselors in the Volta Region of Ghana, descriptive phenomenology facilitated the elucidation of poorly understood aspects of this human lived experience.

Researchers' characteristics and reflexivity

The research team consisted of an Associate Professor experienced in qualitative research (MD), three Senior Lecturers (EM, JK & VC) and a public health degree holder (FD), all with qualitative research experience. To ensure objectivity, we bracketed our biases by identifying and acknowledging our preconceptions and assumptions and setting them aside during the interview and data analysis processes in order not to misrepresent participants' meanings and experiences, as explained by Chan and colleagues [46].

Study population

The study was conducted among HIV/AIDS counselors at the five (5) HIV/AIDS sentinel sites in the Volta region of Ghana. According to the records of the Volta Regional Health Directorate, there were a total of twenty-five (25) certified HIV/AIDS counselors across these sites at the time of the study. Of these twenty-five (25) certified counselors, eighteen (18) met the inclusion criteria of having at least three (3) years of experience working as HIV/AIDS counselors. However, two of these eligible counselors were on leave during data collection and were thus excluded from the study.

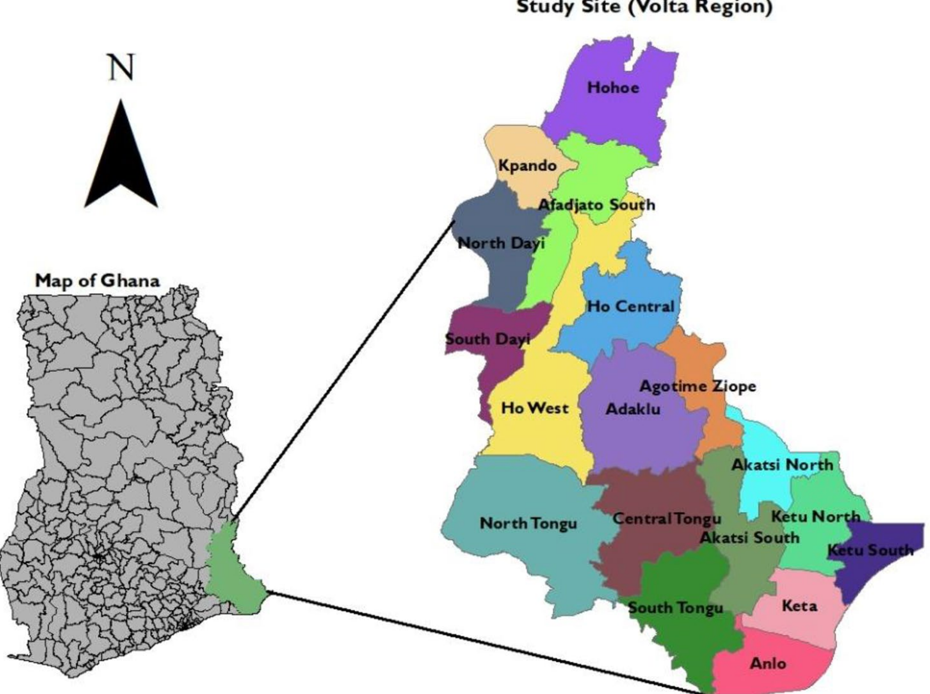

Fig. 1 Map of Ghana indicating the Volta Region

Sample size determination

The sample for the study consisted of sixteen (16) purposely selected certified HIV/AIDS counselors from the five (5) sentinel sites. Although data saturation could have been reached by the 13th interview [47], we decided to interview all the eligible participants (16) since the total available sample was small enough (16 people) to include everyone.

Sampling procedure

At each sentinel site, all potential participants who met the inclusion criteria and were on duty were purposely recruited and interviewed. Therefore, a census approach was followed in recruiting eligible participants at the various sentinel sites for the study.

Data collection tool

A semi-structured interview guide was used to moderate the interviews and gather data for this study. This approach was preferred because it provided structure, focusing on core issues while allowing flexibility for participants to express themselves and for the interviewer to probe for clarity when necessary. The guide was designed to explore four thematic areas: the socio-demographic characteristics of the participants, their motivation to become HIV counselors, their responsibilities, and their experiences as HIV/AIDS counselors.

The guide was pre-tested among two (2) HIV/AIDS counselors from the Oti region, which has similar demographic characteristics to the Volta Region. This pre-testing aimed to identify and clarify any areas of the guide that needed adjustment before the actual data collection.

Data collection procedure

In-depth individual interviews (IDIs) were conducted with participants from June 10, 2023 to July 17, 2023. IDIs were preferred because participants were scattered across the various sentinel sites in the region, making it financially burdensome to converge them at one place for focus group discussion. Additionally, participants may have felt more comfortable expressing themselves in one-on-one interviews compared to group settings, influencing the choice of IDIs [48].

The interviews were moderated by the Principal Investigator (FD), a Bachelor of Public Health Student at the time, along with an experienced team member under the supervision of the team lead (EM). Each interview lasted an average of 45 min and was conducted in English, as all participants had tertiary-level education. To ensure privacy, interviews were held in secluded rooms away from the public. Hand-written notes (with pens and notebooks) and call recorders were used to document the interviews. The notes were taken by a team member (either JK or VC) while the interviews were recorded by the Principal Investigator (FD). The use of both call recorders and handwritten notes was to ensure that interviews were not halted as a result of equipment breakdown during the interview process and also to fall back on the notes as a backup in case of data loss.The handwritten notes also helped to capture nonverbal cues of the participants.

Data analysis

Data collection and analysis were conducted concurrently. Each interview was transcribed and compiled into a Microsoft Word file, from which codes, sub-themes and themes were developed using the Atlas ti. v7.5 software. To reduce subjectivity in the analysis process, the data were analyzed by two research team members [FD and EM]. The data analysis followed the descriptive phenomenological method proposed by Colaizzi [49]. The steps employed included: (1) repeated reading of the transcripts to obtain a general sense of the whole content, (2) extracting and recording significant statements related to the phenomenon under study for each transcript, (3) formulating meanings from these significant statements, (4) sorting the formulated meanings into categories, clusters of themes, and overarching themes, (5) integrating the findings into an exhaustive description of the phenomenon under study, (6) describing the fundamental structure of the phenomenon, and (7) conducting member checking with seven of the participants to validate the descriptive results.

The authors met regularly to discuss and verify the accuracy of the emerging themes and their meanings. In cases of disagreement, an independent coder served as an arbitrator to resolve the issues. A theme was not accepted until an agreement was reached between the two authors. Member checking was utilized to ensure the rigor of the analysis process. The themes that emerged capturing the motivations, responsibilities, and experiences of HIV/AIDS counselors in the Volta Region of Ghana were emailed to all the participants for verification and confirmation of the researchers' interpretation of their experiences. All seven participants confirmed that the results accurately reflected what they said during the interview process. Verbatim quotes from participants were used to support the study findings.

Rigour

Following Lincoln and Guba's criteria [50], the credibility of the study findings was ensured through several measures. First, rapport was developed between the research team and HIV/AIDS counselors before the study commenced, encouraging participants to share sensitive but vital information openly. Additionally, peers with expertise in qualitative research were consulted to assist in the study design. Dependability of the study findings

was guaranteed through the involvement of professional qualitative researchers on the research team and the evaluation of processes, transcripts, and findings by peers with qualitative expertise to minimize bias. Transferability of the findings was ensured by providing a detailed description of the methods, ensuring that they could be replicated in similar settings if needed. Finally, confirmability was ensured by having seven participants review the transcripts and the results for approval, thus validating the accuracy of the researcher's interpretations and ensuring the findings were grounded in the participants' experiences.

Results

Socio-demographic characteristics of participants

The total number of participants in the study was sixteen (16). The majority, 10 (62.5%), were females. Additionally, half, 8 (50%), were aged between 30 and 40 years. most participants, 11 (68.8%) were Ewe. All participants, 16 (100%), were Christians and the majority, 9 (56.2%), were single. All participants had a tertiary educational background, and the majority, 9 (56.3%), had working experience between 3 and 5 years (Table 1).

Table 1 Socio-demographic characteristics of participants

Background Characteristics	Frequency	Percent (%)
Sex		
Male	6	37.5
Female	10	62.5
Age		
< 30	5	31.3
30–40	8	50.0
41 and above	3	18.7
Ethnicity		
Ewe	11	68.8
Ga	1	6.3
Guan	2	12.5
Kassena	1	6.2
Krobo	1	6.2
Religion		
Christian	16	100.0
Marital status		
Divorced	1	6.3
Married	6	37.5
Single	9	56.2
Professionally trained as a counselor		
Yes	10	62.5
No	6	37.5
Working experience		
3–5 years	9	56.3
6–9 years	4	25.0
10 years and above	3	18.7
Highest level of education		
Diploma	8	50.0
Degree	7	43.8
Masters	1	6.2

Thematic findings

From the data, four (4) main themes, along with their accompanying sub-themes, were generated. These themes are: motivation to become HIV/AIDS counselor (random assignment, personal interest, HIV status of a relative, bad attitude of healthcare workers), responsibilities as an HIV/AIDS counselor (nutritional counseling, education, counseling on medication, comprehensive counseling and testing, provision of social support), positive experiences as an HIV/AIDS counselor (boosting client's health status, counseling client back to a normal psychological state, client's acceptance of their HIV/AIDS status, gaining knowledge on HIV/AIDS, and client delivering an HIV negative child) and the negative experiences as an HIV/AIDS counselor (denial of HIV status, treatment default, uncooperative clients, self-stigmatization, death of a client, myths surrounding HIV/AIDS). The themes and their corresponding sub-themes are presented in Table 2.

Motivation to become an HIV/AIDS counsellor

About what motivated participants to become HIV/AIDS counselors, five sub-themes emerged. These include being randomly assigned to the unit, developing an interest in the job, having a relative with HIV status, witnessing the bad attitudes of healthcare providers, and seeing HIV- positive clients lacking knowledge of their condition.

Random assignment as an HIV/AIDS counselor

> *Some of the respondents indicated that they had no specific motivation to become HIV/AIDS counselors. Rather, they were simply assigned to the antiretroviral therapy (ART) unit and began working there as counselors before receiving formal training. This sentiment is exemplified by the following story:*
> *"I am a practitioner in the health system who was assigned to the unit based on my profession as a nurse to work with the HIV unit or the department. The HIV/AIDS unit is part of the healthcare system. So, when I was sent here, I knew it was just a service to humanity and also to facilitate and speed up the work at the department."-(R3, Male, 26 years).*

Developed an interest in the job

Some respondents mentioned that they simply developed an interest in the job. They were intrigued by the HIV/AIDS services and wanted to learn about the disease. One of them explained:

Table 2 Summary of the thematic findings

Themes	Sub-themes
Motivation to become an HIV/AIDS counselor	
	Assigned to the unit
	Developed interest in the job
	HIV status of a relative
	Bad attitude of healthcare providers
Responsibilities as an HIV counselor	
	Nutritional counseling
	Educating clients about HIV
	Counseling clients on their treatment and medication.
	Comprehensive counseling and testing of clients
	Providing social support to clients
	Providing financial support for clients
Positive experiences as HIV/AIDS counselor	
	Improving clients' health status
	Counseling clients to return to a normal psychological state.
	Clients' cooperation and acceptance of their status.
	Gaining knowledge on HIV as a counselor
	Achieving the delivery of HIV-negative babies by clients
Negative experiences as HIV/AIDS counselor	
	Denial of HIV- status by clients
	Clients defaulting on their treatment
	Uncooperative clients
	Self-stigmatization by clients
	A client died due to a breach of confidentiality.
	Myths surrounding HIV transmission

> *"There is no particular thing that motivated me, I will say. I just developed an interest in the job and volunteered. I can't point out something in particular that motivated me."-(R14, Female, 30 years).*

HIV status of a relative

Participants said they decided to become HIV/AIDS counselors as a result of a relative contracting the disease. One of them explained:

> *"What motivated me is that I have a family member who has been exposed to HIV and through the interactions we had, I felt that the information they passed on to the family member was not enough, and that this nearly contributed to a lot of things that nearly led to them making a certain decision which was out of context." - (R4, Male, 42 years).*

As a Result of the poor attitudes of healthcare providers towards HIV/AIDS

One of the participants said they were motivated due to the poor attitudes of healthcare providers towards HIV/AIDS clients. He had experienced a situation where a friend was mistreated by healthcare providers and decided to become a counselor himself. The quotation below summarizes what the participant had to say:

> *"I have a friend who has been in the hospital and was tested. So, during that time, anytime I went to the hospital, the way the healthcare providers handled the patient or talked to the patient was not nice at all, so I was touched to become a counselor who would sympathize with the client and calm them down".-(R1, Male, 36 years).*

Primary responsibilities of an HIV/AIDS Counselor

We also identified the primary responsibilities of HIV/AIDS counselors in the Volta region of Ghana. Some of the responses that emerged include nutritional counseling, educating clients about HIV, providing treatment and medication to clients, conducting testing and comprehensive counseling, offering social support to clients, and providing financial support to clients.

Counseling clients on their nutritional needs

Most participants emphasized that their primary responsibility as an HIV/AIDS counselor was to provide nutritional counseling to clients. This is crucial because the medication the clients take increases their calorie demands, necessitating a balanced diet for effective

treatment. This sentiment was expressed in narratives such as:

"When the patients arrive, you talk to them about their medication, the type of food they are supposed to eat, and what they are supposed to do and what they are not supposed to do." -(R1, Male, 36 years).

Educating clients about the disease (HIV/AIDS)

Some participants indicated that their primary responsibility is to educate clients about HIV/AIDS. They emphasized the importance of ensuring that clients have comprehensive information about the disease to guide them in managing their health effectively. One participant explained:

"My primary responsibilities as an HIV/AIDS counselor are to pass on relevant information about the disease condition to anybody who has come for counseling and testing. Also, I must ensure the person receives adequate information so that, regardless of the testing outcome, they can accept the result and move forward." -(R4, Male, 42 years).

Providing counseling to clients on medication and adherence

Participants mentioned that their primary responsibility as an HIV/AIDS counselor was to provide counseling related to clients' treatment and medication. They emphasized the importance of guiding clients through their treatment plans and ensuring adherence to medications. This is elaborated below:

"Yes, I do play a role in their treatments and medications. We call it adherence counseling for those who are receiving treatment. So, we give them information on how the medication works, how they should take it, and the duration that they should take it". (R4, Male, 42 years).

Comprehensive HIV counseling and testing of clients

Participants highlighted that their primary responsibility as HIV/AIDS counselors was to provide comprehensive counseling and testing for clients. They stressed the need for conducting thorough counseling sessions to ensure clients understand their HIV status, the implications of the disease, and the necessary steps for managing their health. This is illustrated by the explanation provided by a participant:

"Okay, the first one is counseling and testing, and the other ones are educating the client on viral loads, EID (Early Infant Diagnosis) and other services, but providing enough and adequate information to the client is the major responsibility. So, for the counseling, it depends on the client you have with you".-(R10, Female, 29 years).

Providing social support to clients

Some participants mentioned that they offer social support to clients, particularly those who face discrimination from their families. They aim to provide a sense of community and understanding to help clients cope with these challenges. The quotation below summarizes what a participant said:

"We also provide them with social support. It is done in a way like caring for them as if they were our family members, attending to their day-to-day needs." -(R3, Male, 26 years).

Provision of financial support for some clients

Some participants mentioned that they provide financial support to clients. Although it is not supposed to be one of their core roles, the dire financial situation of some clients often compels counselors to help them financially. One of them explained:

"For financial support, some of them come and will be like 'I do not have money to buy food to take the drug' and we do our best to assist them. We also advise them to eat well because the drug that they are on needs a whole lot of balanced diet". -(R3, Male, 26 years).

Positive experiences of HIV/AIDS counselors

The study explored the experiences of HIV/AIDS counselors in the Volta region of Ghana. Responses that emerged under this theme include: boosting clients' health status, counseling clients back to a normal psychological state, cooperating with clients, gaining knowledge on the disease through counseling, counseling clients to accept their HIV/AIDS status, and clients delivering HIV-negative babies.

Improving clients' health status

When participants were asked to share their experiences as an HIV/AIDS counselor, some mentioned that they cherished the aspect of being able to restore a client's health to normalcy through counseling. One of them mentioned:

"The experience is that I have counseled people who are and not close to me, and the outcome is that they are doing very well. Initially, when some of them come, it looks like there is no hope but with time, as they listen to us, they improve greatly." -(R4, Male 42 years).

Counsel clients to return to a normal psychological state

Some participants mentioned that they found fulfillment in counseling a client back to their normal psychological state after receiving the shocking results. The quote below sums up their views.

"Okay, so when it comes to the experiences, the people who are living with HIV at first, when you break the news to them, they break down and are in denial. Some even want to hurt themselves, but if you can counsel them to get back to their normal state, it is such an experience." -(R1, Male, 36 years).

Cooperation from clients

Few of the participants mentioned that cooperation from clients was a significant experience they often encountered, as many clients are unruly and in denial after receiving HIV- positive results. Therefore, when a client cooperates and accepts their status immediately after testing, it becomes a notable experience for them. They recounted:

"Some clients are a bit enlightened on the condition because there is some literature among them. The disease is not only for the illiterate. Some have heard of the condition, and they accept it in good faith that it has come and there is nothing they can do, and they stick to treatment, and they see improvement." -(R14, Female, 30 years).

Gaining knowledge of the disease through counseling

Some participants reported that their experience as an HIV/AIDS counselor involved gaining knowledge about the disease. They explained that prior to becoming counselors, they had limited knowledge about HIV/AIDS. However, their involvement in counseling and testing exposed them to a wealth of information about the disease, thereby enhancing their understanding over time. They explained:

"When I came here first, I had a different perception of HIV and how to deal with the clients, but after some time, I got used to the system and was very comfortable. I can boldly say that I have gained much knowledge of the disease." -(R10, Female, 29 years).

Client giving birth to an HIV-negative baby

One participant expressed that witnessing a client deliver an HIV-negative baby brings him great joy, knowing that his counseling efforts contributed to this positive outcome. He narrated:

"The experiences as an HIV/AIDS counselor are rewarding when you witness mothers who are HIV-positive, provide care for them, and by the end of the day, their babies test negative and are doing well and healthy is a significant motivation. " -(R7, Male, 37 years).

Negative experiences of HIV/AIDS counselors

Another theme that emerged from the study was the negative experiences of HIV/AIDS counselors in the Volta region of Ghana. Again, six (6) sub-themes were identified under this theme. These include clients denying their HIV status, clients defaulting on their treatment, clients being uncooperative, the death of some clients due to fear of breach of confidentiality, self-stigmatization, and the myths surrounding HIV/AIDS.

Denial of HIV- status by clients

Three participants mentioned that one of their negative experiences as HIV/AIDS counselors was clients' denial of their status after testing positive for HIV. This hindered effective counseling and treatment, as the clients did not accept the reality that they were infected with the virus. One of them explained:

"One of the negative experiences as an HIV/AIDS counselor is when I had a mother who initially came here saying she was coming to fight me. She was tested, took medication once, and then never returned. So, I used to call her intermittently, but one day I called her, and she got crazy on the phone saying that she does not have HIV". -(R15, Female, 40 years).

Client defaulting on their treatment

Additionally, a few participants mentioned that clients defaulting on treatment and medication was a negative experience they encountered as HIV/AIDS counselors. This is particularly challenging because the counselors put in a lot of effort to enroll the clients on ART to control their viral load, only for them to default on treatment and disrupt the entire treatment course. They shared:

"Clients discontinuing treatment after all the counseling and reassurance given to them is both frustrating and sad at the same time. It poses a big challenge to us because it looks like we are not doing our work very well." -(R3, Male. 26 years).

Uncooperative clients

Some participants complained that uncooperative clients pose a significant challenge to HIV/AIDS counselors. Despite the efforts they put in, some clients still see them as the problem and refuse to listen, making their efforts seem in vain. A male participant summarized this, stating:

"The negative experience was when a pregnant woman who had been diagnosed with HIV. Despite the counseling and empowering I had provided, she did not cooperate or adhere to the treatment. After giving birth, the child became infected, which deeply saddened me." - (R7, Male, 37 years).

Self-stigmatization by clients

A few participants explained that clients sometimes stigmatize themselves (self-stigmatization), feeling worthless and becoming shy or afraid to engage with healthcare providers. One of them explained:

"There is still some form of stigmatization. The clients themselves have self –stigma, so society also plays a certain part. That's why they still have that self-stigma because they see themselves as worthless as they are infected with some sort of extraordinary or dangerous disease, which I think is not true." -(R14, Female, 30 years).

Client committing suicide due to breach of confidentiality

A participant recounted that a client committed suicide due to a breach of confidentiality, which was a negative experience he faced as an HIV/AIDS counselor. He narrated that one of his clients took her own life when a nurse in the community disclosed her status to the community members, leaving a lasting impression on his mind. He explained:

"One of the negative experiences I have encountered as an HIV/AIDS counselor is that after counseling someone I know who had tested positive, later on, she passed on information to another health staff working here that because of me, she is not comfortable with it, so she wants to transfer to another facility." - (R4, Male, 42 years).

Myths surrounding the transmission of HIV/AIDS

Furthermore, another participant was concerned about the myths and beliefs people hold towards HIV/AIDS. For example, some clients still believe that HIV is a curse and only affects those who live promiscuous lives. Therefore, these beliefs make the counseling process difficult as people do not readily accept their status or commence treatment. She explained:

"Some people still feel that HIV/AIDS is a curse done on them, so they prefer visiting herbalists, prayer camps, and the like. So, talking to them, you get to know what they believe in some myths and superstitions, as they remain in denial." -(R9, Female, 28 years).

Discussion

This study aimed to understand the motivations, responsibilities, and experiences of HIV/AIDS counselors in the Volta Region of Ghana to guide HIV/AIDS counseling policy in the area. Four (4) main themes were generated. These themes are: motivation to become HIV/AIDS counselor, responsibilities as an HIV/AIDS counselor, positive experiences as an HIV/AIDS counselor, and the negative experiences as an HIV/AIDS counselor.

The motivation of participants to become HIV/AIDS counselors was influenced by many factors. Some were randomly assigned to the HIV counseling unit, others developed an interest in the job, some were motivated by a relative's status with HIV, while others were driven by witnessing poor attitudes of healthcare providers towards HIV clients. Additionally, some participants were inspired to become counselors after encountering HIV clients who lacked knowledge about HIV/AIDS and wanted to help educate and support them.

The practice of randomly assigning healthcare workers as HIV/AIDS counselors is prevalent in some African countries like Eswatini [11]. The reason for such random assignment in these settings is to fill the gap left by the lack of professionally trained HIV/AIDS counselors in providing counseling services to clients [12]. In the long run, nevertheless, this could be counterproductive since the personnel were not motivated to work as HIV/AIDS counselors, which could compromise commitment and the quality of services delivered to clients [51].

Conversely, some participants were self-motivated to become HIV/AIDS counselors by developing an interest in the job. This could have been due to curiosity to get a better understanding of the nature of the disease or to make a potential impact on the lives of people living with HIV [52]. On the African continent, the interest in helping others and a desire to make a difference in the lives of HIV clients are common motivations for becoming

an HIV/AIDS counselor [53]. This is because the concept of "Ubuntu" transcends the African continent [54]. Recruiting individuals with the passion and motivation to become HIV/AIDS counselors could thus help improve the quality of care given to HIV/AIDS clients in the Volta region and Ghana in general, helping curb the transmission, morbidity, and mortality associated with HIV/AIDS.

Another reason why some participants chose to become HIV/AIDS counselors was due to a family member being diagnosed with the disease. Having a close relative or friend who is living with HIV/AIDS can inspire one to pursue a career in counseling to make a difference in the lives of others affected by HIV/AIDS and gain a better understanding of the challenges they face [55]. Similar reasons have been cited by some HIV/AIDS counselors in South Africa, where the HIV status of a family member or friend motivated them to become involved in HIV/AIDS counseling [56, 57]. In some African communities, supporting and embracing the HIV status of family members often inspires individuals to become HIV/AIDS counselors to provide quality HIV/AIDS counseling services to family members suffering from the disease [58].

Witnessing the bad attitude of some healthcare providers towards people living with HIV/AIDS also served as motivation for some participants to become HIV/AIDS counselors. Bad attitudes of healthcare providers can have a significant impact on the quality of care that patients receive [59]. In Ghana, the narrative has often been that health workers are harsh and frequently treat patients without respect, ordering them around or yelling at them [60]. While this could be the case for some healthcare workers, others who detest such behavior see it as motivation to get involved and offer quality and humane healthcare services, as found in the present study.

As HIV/AIDS counselors, participants had responsibilities that included counseling in six thematic areas: nutritional counseling, educating clients about HIV/AIDS, providing treatment and medication, testing and offering comprehensive counseling, as well as providing social and financial support to clients.

HIV/AIDS treatment goes hand in hand with nutrition. Research has shown that malnutrition is a major complication of HIV infection that accelerates disease progression, increases morbidity, and reduces survival outcomes [61]. This is often exacerbated by the fact that antiretroviral drugs place much more energy demands on patients and thus require them to eat nutritious meals [62]. Providing nutritional counseling to HIV/AIDS clients to eat healthy food in the appropriate amounts regularly can help them better tolerate HIV drugs, maintain a healthy weight, and improve their health outcomes. This is a primary focus of HIV/AIDS counseling in Ghana [63].

The provision of comprehensive knowledge on HIV/IDS is another important role of HIV/AIDS counselors in the Volta region. This aligns with the World Health Organization's recommendation that HIV/AIDS counselors provide a range of services, including educating clients on the prevention and modes of transmission of the disease [64]. In some jurisdictions, HIV/AIDS counselors are encouraged to patiently educate clients on the disease by communicating at the client's level of understanding to ensure they gain substantial insight and knowledge about the condition [1]. Providing accurate information about the disease, its transmission, and treatment options can help dispel myths and misconceptions, thereby reducing discrimination and promoting acceptance within communities [65].

Participants also mentioned the provision of medication/treatment, counseling, testing, and educating persons living with HIV/AIDS about the disease as their responsibilities. The practice of HIV/AIDS counselors also acting as treatment providers is common in HIV/AIDS care across Africa. In Botswana for instance, HIV counselors are responsible for treatment and medication services for persons living with HIV [66]. As previously explained, the diverse roles fulfilled by HIV/AIDS counselors on the continent stem from the insufficient number of healthcare providers. Thus, HIV/AIDS counselors in the Volta region of Ghana are responsible for monitoring persons living with HIV/IDS regarding treatment adherence and managing medication side effects [67]. Comprehensive education of clients on HIV/AIDS through counseling is essential to raising awareness about the disease, improving treatment accessibility, and reducing stigma among people living with HIV [68]. This ensures that clients receive thorough and holistic guidance and support pre- and post-testing [69]. To offer comprehensive counseling services, HIV/AIDS counselors must be empowered. In this context, empowerment involves promoting the emotional well-being of clients and educating them on managing HIV/AIDS [70].

Moreover, providing social and financial support to clients was another responsibility undertaken by the HIV/AIDS counselors in the Volta region of Ghana, according to findings. Social support involves emotional, esteem, companionship, and informational support that HIV/AIDS counselors give to clients, while financial support involves providing monetary assistance or resources to persons living with HIV/AIDS [71]. Effective HIV/AIDS care encompasses not only medication management but also addressing the psychological, social, and economic aspects of an individual's life [11]. Similar roles have been reported among South African HIV/AIDS counselors [72]. Although it is not their mandate to provide financial

support, HIV/AIDS counselors, out of empathy, share their own money with some clients as they struggle with medication costs, transportation, and access to nutritious foods. This finding was also reported as a negative experience of HIV/AIDS counselors, where PLHIV lacked financial and social support, hampering their treatment process and outcomes. Therefore, stakeholders in the fight against HIV/AIDS could consider channeling funding through HIV/AIDS counselors who readily identify clients in financial need of assistance to improve treatment adherence and outcomes. Additionally, efforts should be made to strengthen support networks for PLHIV in the Volta region of Ghana.

Participants' experiences as HIV/AIDS counselors included both positive and negative aspects in working with persons living with HIV. Positive experiences revealed by the study include the improvement in clients' health status, counseling clients back to a normal psychological state, cooperation from clients, gaining knowledge on HIV/AIDS, and clients delivering HIV-negative babies. One of the most significant achievements for HIV/AIDS counselors is experiencing both losses and successes, with the restoration of clients' health to normalcy [14]. This was identified as one of the cherished experiences among participants. According to Okal et al., counselors experience both losses and successes, with the restoration of clients' health being a major source of happiness for them [73]. The joy stems from the fact that their counseling and educational efforts resulted in positive outcomes [74].

Another positive experience mentioned by participants was gaining knowledge on the disease and being able to calm a client down after testing positive for the first time. They highlighted the importance of gaining knowledge and experience in HIV counseling, which assists counselors in calming difficult clients. It is reported that it takes at least three years of working experience for counselors to gain the expertise needed to handle clients who test positive for HIV for the first time [75]. Given that all the study participants had practiced as HIV/AIDS counselors for no less than three years, this finding is well-supported. Thus, as a form of incentive, HIV/AIDS counselors in the Volta region should be provided with ongoing capacity-building training programs to optimize their operations [76].

With regard to the negative experiences, participants recounted clients denying their HIV status, treatment default, lack of cooperation from some clients, self-stigmatization, clients committing suicide due to a breach of confidentiality, and the myths that some clients hold about HIV/AIDS. Clients defaulting on their treatment was a significant concern for most participants, as it leads to negative health outcomes. Treatment default among HIV/AIDS clients is a major global challenge. For instance, in Nigeria, clients defaulting on treatment and medication have been one of the greatest challenges faced by HIV/AIDS counselors [77]. Unfortunately, some PLHIV often stop taking medication under the mistaken belief that they have been healed or remain in denial about the disease [78, 79]. Even long-term HIV clients on ART often misinterpret undetectable test results, leading to noncompliance with the therapeutic regimen [53]. Therefore, client education programs could be established as an effective intervention strategy to improve treatment adherence and minimize treatment default [80].

Participants also raised concerns about self-stigma among people living with HIV. They mentioned that one of their biggest challenges was counseling clients out of self-stigma. Upon receiving an HIV- positive diagnosis, clients often experience self-pity, low self-esteem and social isolation. This hinders their treatment and recovery, as they may default on treatment or not receive the support they need. This challenge is also prominent among HIV/AIDS counselors in Nigeria [81]. Persons living with HIV often face rejection and stigmatization upon disclosure of their status [82], leading them to isolate themselves from society, loved ones, and healthcare providers.

Additionally, a client committing suicide due to a breach of confidentiality was identified as a negative experience. Confidentiality in HIV/AIDS treatment is crucial for the progress and success of treatment [83]. When clients do not trust healthcare providers to keep their HIV status private, they may change health facilities, opting for ones further from where they live, which can lead to financial strain and health complications [84]. To address this, healthcare providers should assure clients that their status will not be disclosed to a third party to maintain their trust and sustain them on treatment.

Finally, participants were concerned about the myths and misconceptions that some clients hold about the disease. Some clients believe that HIV is contracted through a charm or only affects those who lead promiscuous lives. According to Agyeman and colleagues, this is a long-held perception in Ghana [85]. Similar misconceptions are found in South Africa, where some believe that HIV can be transmitted through mosquito bites [86]. These may be attributed to the lack of education on the disease in Sub-Saharan African countries [87]. HIV/AIDS-related myths and misconceptions, if not addressed, could hamper HIV prevention and treatment efforts in the Volta region and across the country. Extensive education on the disease is essential to dispel these misconceptions and promote effective HIV/AIDS care.

Strengths and limitations of the study

The robustness of the methods, such as allowing both the participants and independent qualitative research experts to thoroughly review the transcripts and results before and after data analysis, coupled with the detailed description of the methods, strengthens the scientific and credible nature of the findings. However, the study sample was female-dominated, which could have skewed the responses obtained. Therefore, interpretation of the findings should be done with caution.

Conclusion

In this study, we ascertained the varied motives, responsibilities, and experiences of HIV/AIDS counselors in the Volta region of Ghana. Based on our findings, we conclude that by organizing capacity-building training programs for HIV/AIDS counselors in the Volta region and addressing the negative experiences they encounter, they could be empowered to provide effective counseling, curative, and social services to PLHIV in the region, leading to improved health outcomes for PLHIV.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CHPS	Community-Based Health Planning Services
HIV	Human Immunodeficiency Virus
IdIs	In-depth Interviews
PLHIV	Persons Living with HIV
SRQR	Standards for Reporting Qualitative Research

Supplementary Information

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Supplementary Material 1

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Author contributions

F.D., E.M., and M.D conceptualized the study. F.D., V.C., and J.K. collected the data. F.D., and E.M. analysed the data and drafted the manuscript. All authors reviewed and approved the manuscript.

Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was sought from the University of Health and Allied Sciences Research Ethics Committee (UHAS-REC A.10[041]22–23). Permission was also sought from all the health facilities where the study was conducted with a letter of introduction from the University of Health and Allied Sciences before the commencement of the study. Signed informed consent was obtained from the participants. All participants were informed of their right to withdraw from the study at any time. Participants' anonymity and confidentiality were ensured by assigning them alpha-numeric codes.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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