

# **CHAPTER**

## **1**

### **INTRODUCTION**

### **AND**

### **REVIEW OF LITERATURE**

## **Chapter 1**

### **Introduction and Review of Literature**

#### **An Overview**

The Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome (HIV/AIDS) is a disease of the human immune system caused by infection with human immunodeficiency virus – HIV (Sepkowitz, 2001). The HIV/AIDS remains one of the world's most serious health challenges. Globally, approximately 34.0 million people were living with HIV at the end of 2011 including almost 5 million people living with HIV in South, South-East and East Asia combined (Joint United Nations AIDS-UNAIDS, 2012). India has the third largest number of people living with HIV/AIDS (National AIDS Control Organization-NACO, 2011).

The HIV outbreak in India is a dual epidemic driven by the sexual route and injecting drug use. According to NACO's 2011 Annual Report, India continues to be in the category of concentrated epidemic because the HIV prevalence among the most-at-risk populations (MARPs) that is, Female Sex Workers – FSW (4.94%), Injecting Drug Users – IDUs (9.19%), and Men who have Sex with Men –MSM (7.3%) is about 20 times higher than the general population attending Sexually Transmitted Infections (STIs) clinic (2.46%), and low prevalence among Ante-Natal Clinic (ANC) attendees (0.48%).

The Government of India established NACO in the year 1998 to prevent and control HIV epidemic in India. The NACO designed National AIDS Control Program Phase I to III (NACP phase I to III) to respond to the HIV epidemic. In 2006, NACO

redesigned NACP-phase III (2007–12), which focused on behavior change, decentralized response, through integration of prevention, care, support and treatment services, and increasing involvement of NGOs as well as People living with HIV/AIDS (PLWHA). Interventions under NACP include targeted interventions (TIs) for MARPs namely MSM, FSWs, IDUs, Truck drivers and Single Male Migrants (SMM); Integrated HIV Counseling and Testing Centers (ICTCs), STI centers, anti-retroviral therapy (ART) centers, HIV-TB program and Information-Education and Communication (IEC) program. As a result of various interventions under the NACP and scaled-up prevention strategies in NACP III, the recent HIV estimations highlight an overall reduction in adult HIV prevalence. Adult HIV prevalence reduced from 0.39 in 2004 to 0.31 in 2009. Further, NACO recorded decline in annual new HIV infections by more than 50 percent –as new HIV infections reduced to 1.2 lakhs in 2009 from 2.7 lakhs in 2000 (NACO,2011). While declining trends in adult HIV prevalence and new HIV incidence are evident at the national level, some states have shown rising trends in HIV epidemic especially among MARPs such as FSW, MSM and IDU. The situation thus warrants focus on prevention efforts and needs for strengthening targeted interventions (TIs) in the country.

### **Targeted Interventions for HIV Prevention**

The purpose of the Targeted Intervention (TI) project is to reduce transmission of STIs and HIV among MARPs through peer educators –member from MARP are engaged in outreach activities (NACO, 2012). TI comprises six components namely; condom promotion (CP), services related to sexually transmitted infections (STI services), enabling environment (EE), community mobilization (CM), behavior

change communication (BCC) & referral and linkages (NACO, 2007). The TI has provision of human resources such as program manager (in Gujarat State, this post is named as project officer), monitoring and evaluation officer cum data entry operator, accountant, counselor, outreach workers-ORW (1 ORW per 200 MARPs) and peer educators (1 PE per 60 MARPs). As on March 2011, total 1785 TIs were functional to prevent HIV among at-risk populations in 32 States including four Union Territories (NACO, 2011).

With an objective to reach to NACP III goal, halt and reverse the epidemic, the TIs are engaged in establishing referral and linkages with HIV related as well as services needed for the community (such as de-addiction service, rehabilitation services for IDUs and FSWs, mental health services etc.), reaching out to MARP every day and encourage them to access preventive (condoms, HIV test, regular medical check-up for STI screening, STI treatment etc.) as well as care and support services (registering HIV positive clients at ART center, screening for TB etc.), tracking clients who have accessed and not accessed any of the project services and plan outreach accordingly. Nationally, total 81 per cent (6.78/8.68 lakhs) FSWs, 80 per cent (1.42/1.77 lakhs) IDUs, and 64 per cent (2.74/4.27 lakhs) MSM populations were covered through TIs and were linked to prevention as well as care and support services (NACO, 2011). In order to facilitate effective implementation of TIs through proper planning and monitoring, NACO has set up total 15 technical support units (TSU) in the country.

### **Counseling as a Preventive Strategy in Targeted Interventions**

Counseling is one of the strategies of BCC within TI. Counseling emerged as a

preventive strategy that aims to act in the individual sphere. It works with the identification of the risk per se and stimulates a reflection about viable preventive measures for individuals who are at-risk of contracting and transmitting STIs including HIV and those who are willing to undergo an HIV test. More recent studies have evidently shown the importance and efficacy of counseling as a preventive mechanism, because it helps to reduce STIs including HIV (Dhadwal, Bhardwaj, Gupta, Sharma, Parashar, Thakur, Mahajan, Chander, & Sood, 2009; Kanekar, 2011; Miranda & Barroso, 2007; Nutty & Edward, 2005; Schreibman & Friedland, 2003). Burnard (1992) stated that HIV/AIDS counselors have become an integral part of a patient's health care and serve as the most appropriate individual to help with emotional life crises. These include not only matters of life and death but also emotionally charged issues such as sex and relationships (Grinstead & Van Der Straten, 2000). Moyo, Chirenje, Mandel, Schwarcz, Klausner, Rutherford & McFarland (2002) considered counseling as a powerful tool in the HIV/AIDS education, prevention and care processes. It is established fact that counseling is an important component in targeted intervention to reduce the epidemic.

The NACO also recognizes the importance of counseling and affirms its commitment with particular focus on building the capacities of counselors through various capacity building initiatives (Kumar & Parashar, 2012). The NACO has developed training module specifically for counselors working with TIs and established 18 State Training and Resource Centre (STRC) to build capacity of TI team. The STRC has conducted 1300 trainings of counselors during the year 2011 to 2012 in the country based on NACO's TI counselors' training module (NACO, 2012). The training module broadly covers five themes, namely, (1) overview of the TI

program which includes objectives of the TI, its components, role of counselors, and ANM in TI and recording keeping mechanism; (2) overview of sexuality which includes understanding social and sexual networks, sexuality and gender, characteristics of MARP, societal attitude toward sexuality and MARP; (3) Basics of counseling includes counseling, WHO's definition of HIV counseling, risk assessment and risk reduction strategies; counseling skills which include active listening, paraphrasing, , questioning, reflection of feelings and interpretation; (4) special counseling situations such as crisis intervention, dealing with HIV positive clients; and (5) ethical and legal issues in counseling which talks about confidentiality, professional relationship (respect for clients, fair treatment to clients, taking care of physical safety, work within the limits of competence), and strive to promote clients' control over their lives. Various participatory methods such as role plays, case studies, and group discussions are used to deliver training. The counseling training module is not based on specific behavior change theory or counseling approach but principles of person-centered and solution-focused approach reflected in some aspect of the training module. For example, definition of counseling reflected the promotion client's control over their lives and taking informed decisions. Further, the module discusses goal-oriented strategies (encouraging clients for HIV test, regular medical check-up, teaching prevention alternatives etc.) and dedicates a section on problem-solving approach. It refers to sexual networks and sexuality issues in general, but does not address about counseling principles such as privacy, culture specific counseling messages, skills and techniques. Also, it does not consider existing counseling practices that the counselors are using in their everyday work.

Kumar and Parashar (2012) conducted a study (the only study the researcher could find on counseling in TI context) to understand challenges of HIV counseling in TI

context. The study reported that counselors lack requisite qualification and adequate capacity building on counseling. The authors conclude that counseling has not been given adequate attention and priority, and that counseling practices in TIs remain unexplored in the global as well as the Indian context. The following section describes theories of counseling and behavior change in the context of HIV prevention.

### **Behavior Change Theories, Counseling Theories and Their Applications in HIV Prevention**

Behavior change models and counseling theories have the potential to enhance efforts to lower the substantial health risk behaviors and foster self-protective action. Several behavior change models and counseling theories have been developed. These can be classified into three major categories: (1) theories focusing on individuals, (2) theories focusing on community or social groups, and (3) theories focusing on structural and environmental aspects. The Table 1 provides a bird's eye view of existing behavior change models and counseling theories that are widely used for HIV prevention.

Table 1

*A Bird's Eyeview of the Behavior Change Models and Counseling Approaches*

Sr. No.	Name of the model/theory	Author	Key features
<b>Theories focusing on individuals</b>			
<b>1</b>	<b>Health Belief Model (HBM)</b>	Group of Social Psychologists 1950	The HBM addresses the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy).
<b>2</b>	<b>Theory of Reasoned Action (TRA)</b>	Fishbein and Ajzen, 1980	The theory is based on the assumptions that human beings are usually quite rational and makes systematic use of the information available to them and that people consider the implications of their actions in a given context before they decide to engage in a given behavior. The theory specifically focuses on the role of personal intention, attitude (toward the behavior), subjective norms, i.e., social influence and perceived control.
<b>3</b>	<b>The AIDS risk reduction model (ARRM)</b>	J.A. Catania, 1995	The ARRM points out that change are a process, and individuals move from one step to the next as a result of a given stimulus. In the ARRM, an individual must pass through three stages: (1) behavior labeling, (2) commitment to change, and (3) taking action.

<b>4</b>	<b>The stages of change or transtheoretical model (SoC or TM)</b>	James Prochaska, Carlo DiClemente, 1990	The theory describes individuals' motivation and readiness to change a behavior. This model has proposed six stages that individuals pass through when changing behavior: pre-contemplation, contemplation, preparation, action, maintenance and relapse. In order for an intervention to be successful it must target the appropriate stage of the individual or group and support them in moving from one stage to another. Groups and individuals pass through all stages, but do not necessarily move in a linear fashion.
<b>5</b>	<b>The theory of planned behavior (TPB)</b>	Icel Ajzen, 1991	The theory of planned behavior examines the relations between an individual's beliefs, attitudes, intentions, behavior, and perceived control over that behavior. Behavioral intention and perceived likelihood of change is influenced by individual's personal beliefs, attitudes, social influences (how important the change is to family, friends, co-workers, etc), and perceived control over outcomes (I am sure I can quit smoking). The concept of perceived behavioral control came from Bandura's concept of self-efficacy.
<b>6</b>	<b>The precaution adoption process model (PAPM)</b>	Weinstein and Sandman, 1992	The PAPM identifies seven stages in an individual's journey from awareness to action. It begins with lack of awareness (stage 1) and advances through subsequent stages of becoming aware but not engaged by it (stage 2), deciding whether or not to take decision about their health condition (stage 3). They may decide to take no action (Stage 4), or move to the next stage about taking action (stage 5). For those who decide to adopt the precaution, the next step is to initiate the behavior (Stage 6). A seventh stage, if relevant, indicates that the behavior has been maintained overtime (Stage 7)

<b>7</b>	<b>Social learning theory or Social cognitive theory (SLT or SCT)</b>	Albert Bandura, 1985	The social learning theory asserts that providing information alone is not sufficient to change behavior, rather sustained behavior change requires the skills to engage in the behavior and the ability to use these skills consistently and under difficult circumstances. According to SCT, three main factors affect the likelihood that a person will change a health behavior: (1) self-efficacy, (2) goals, and (3) outcome expectancies. If individuals have a self-efficacy, they can change behaviors even when faced with obstacles.
<b>8</b>	<b>The information-motivation-behavioral skills model (IMBS)</b>	Fisher & Fisher, 1992	The IMBS model demonstrates that information is a prerequisite for changing behavior, but in itself is insufficient to achieve this change. It suggests that at present, most persons at risk possess inadequate information about preventive behaviors, insufficient personal and social motivation for preventive behavior and skills for practicing preventive behaviors. This model proposes that information that is directly relevant to the preventive behavior, motivation to practice, and behavioral skills for practicing are the fundamental determinants of behavior change.
<b>9</b>	<b>Person centered therapy (PCT)</b>	Carl Rogers, 1951	The PCT is a therapeutic approach rather than a theory. It views that the client is fully capable of fulfilling their own potential for growth. It purports three core conditions that provide a conducive climate to clients for growth and therapeutic change. They are: (1) congruence, (2) unconditional positive regards, (3) empathic understanding. These conditions provide the freedom and space to make positive and constructive choices by taking responsibility for themselves.

<b>10</b>	<b>Cognitive behavior therapy (CBT)</b>	Aron Beck, 1960	The CBT is a short-term, goal-oriented psychotherapeutic approach to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel. There have been various revisions of the CBT; however core principles remain the same. Modern CBT emphasize changes in one's relationship to maladaptive thinking rather than changes in thinking itself (Hayes, Villatte, Levin and Hildebrandt, 2011). The CBT includes 6 processes, assessment, Reconceptualization, skill acquisition, skills consolidation and application training, maintenance, and post-treatment assessment follow-up.
<b>Theories focusing on community or social groups</b>			
<b>11</b>	<b>Diffusion of Innovation theory (DIT)</b>	Everett Rogers, 1962	The DIT addresses how new ideas, products, and social practices spread within an organization, community, or society, or from one society to another. It is based on four essential elements: the innovation, the communication channel, the social system, and time. People's exposure to a new idea, which takes place within a social network or through the media, will determine the rate at which various people adopt a new behavior. The theory posits that people are most likely to adopt new behaviors based on favorable evaluations of the idea communicated to them by other members whom they respect (Kegeles, 1996).
<b>12</b>	<b>Social influence theory (SIT)</b>	Berkman, 2000	Social influence is the effect others have on individual and group attitudes and behavior. The theory of social influence states that behavior is intentionally or unintentionally influenced by others. By understanding social influence, you might be able to ignore peer pressure and manipulation.

<b>13</b>	<b>The social network theory (SNT)</b>	Barnes, 1954, Granovetter, 1982	The theory proposed that the social structure of relationships around a person, group, or organization affects beliefs or behaviors. This theory looks at social behavior through relationships, and appreciates that HIV risk behavior directly involves two people.
<b>14</b>	<b>The theory of gender and power (TGP)</b>	R.W. Connell, 1987	The theory has outlined three major structures that characterize the gendered relationships between men and women: the sexual division of labor (gain economic independence), power (to negotiate), and the structure of cathexis (affective relationship). Both the sexual division of labor and power explain gender relations, which put less powerful individual at high risk and the structure of cathexis explain the affective component of the relationship that regular risk behaviors.
<b>Theories focusing on economic and structural issues</b>			
<b>15</b>	<b>Theory for individual and social change or empowerment model (TISC or EM)</b>	Backer, 2001	The theory asserts that social change happens through dialogue to build up a critical perception of the social, cultural, political, and economic forces that structure reality, and by taking action against forces that are oppressive. In other words, empowerment increases problem solving in a participatory fashion that enables participants to understand the various forces in their lives to take action to improve their situations.
<b>16</b>	<b>Social ecological model for health promotion (SEM)</b>	McLeroy, 1988	According to this model, behavior is determined by various levels of influences such as the intrapersonal factors (like knowledge, attitudes, behaviors and skills), interpersonal processes, (social support systems like family, work group, peer etc), institutional factors (organizational rules, regulations etc.), community factors (community organizations, informal networks), and public policy (local, state, and national policies).

*Theories focusing on individuals.* As HIV transmission is propelled by behavioral factors, theories about how individuals change their behavior have provided the foundation for most HIV prevention efforts worldwide. These theories have been formulated using cognitive-attitudinal and affective-motivational constructs (Kalichman, 2007; Cain, Weinhardt, Benolsch, Presser, Zweben, Bjodstrup, & Swain, 2005), which focus on predicting risk behaviors, behavioral changes, and maintenance of safe sexual behaviors. The brief description of behavior change theories are as follow:

*The Health Belief Model (HBM).* The model was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs. The underlying concept of the original HBM is that health behavior is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958; Becker, 1974). In 1997, Stretcher and Rosenstock have revised the model. The Figure 1 illustrates the health belief model.

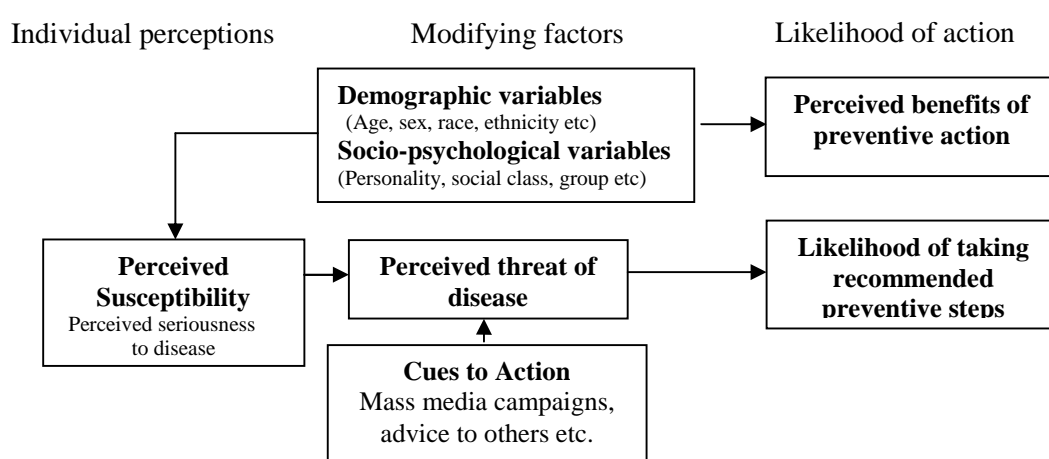


Figure 1. The health belief model.

Source: Becker, 1974

According to this model, health behavior is a function of individual's socio-demographic characteristics, perceived susceptibility of the disease, and perceived seriousness. Individuals receive cues to action through various sources and they weigh the benefits against the perceived costs and barriers to change. With respect to HIV, interventions often target perception of risk, beliefs in severity of HIV/AIDS ("there is no cure"), beliefs in effectiveness of condom use, and benefits of condom use or delaying onset of sexual relations.

*The Theory of Reasoned Action (TRA)*. The TRA advanced in 1980 by Ajzen and Fishbein. The theory is conceptually similar to the health belief model but adds the construct of behavioral intention as a determinant of health behavior. The following Figure 2 illustrates the process of theory of reasoned action.

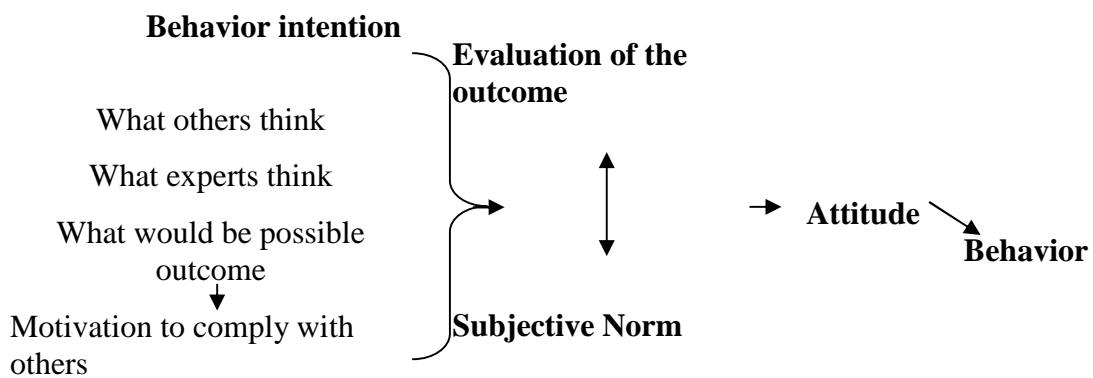


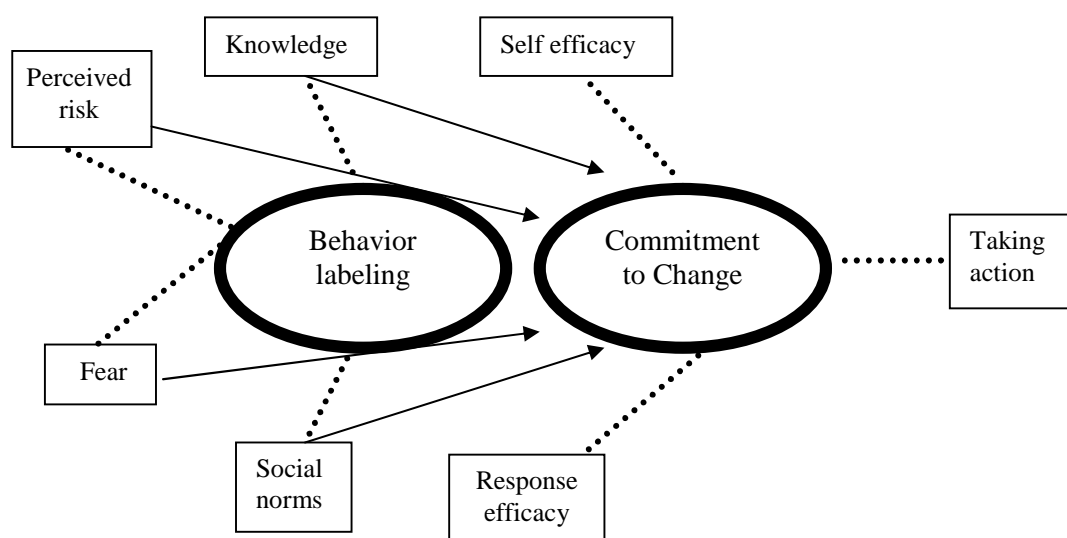
Figure 2. The theory of reasoned action.

Source: Ajzen & Fishbain, 1980

The theory discusses behavioral intention, evaluation of the outcome, social norm, attitude that change the behavior. Behavior intention is characterized by what others' think, what experts' think, possible outcomes and motivation to comply with

others. Individual evaluation of outcome is influenced by social norm. If the outcome seems beneficial to the individual, he or she may then intend to or actually participate in a particular behavior. Also included in one's attitude toward a behavior is their concept of the subjective norm.

*The AIDS Risk Reduction Model (ARRM).* The ARRM was proposed by Catania, Kegeles and Coates in 1990. This model suggests that change is a process, and individuals move from one step to the next as a result of a given stimulus. The Figure 3 describes stages of the AIDS risk reduction model.



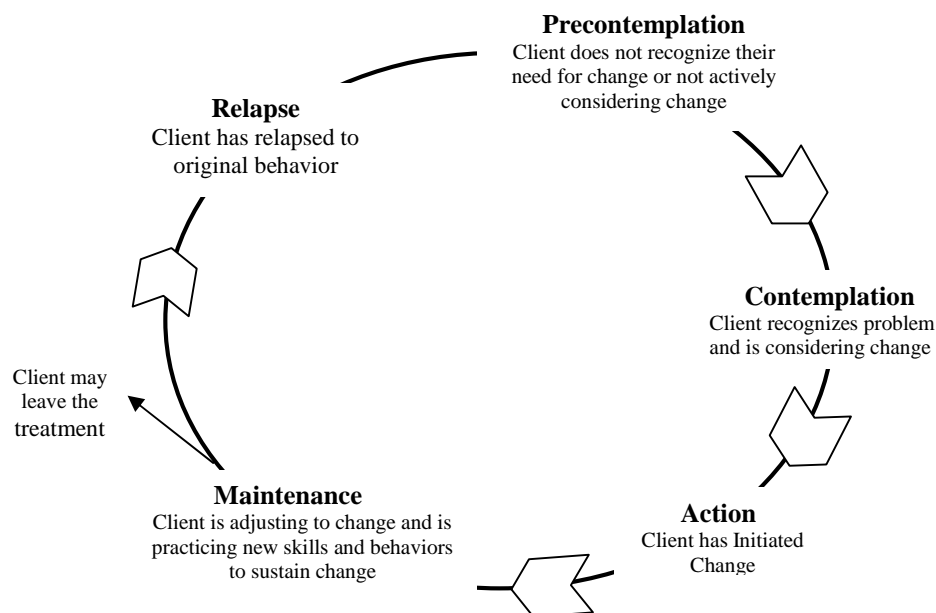
*Figure 3.* The AIDS risk reduction model.

Source: Schneider, Dandona, Pasupneti, Lakshmi, Liao, Yeldandi, & Mayer, 2010

The ARRM combines aspects of the health belief model, the diffusion of innovation model, and social cognitive theory. According to this model, individuals pass through three stages: (1) behavior labeling, (2) commitment to change, and (3) taking action. Programs that use this model focus on clients' risk assessment; influence the decision to reduce risk through perceptions of enjoyment or self-

efficacy, and clients' support to enact the change, for example, access to condoms, social support.

*The Stages of Change Model.* This model, also known as the transtheoretical model, developed by Prochaska and DiClemente in 1982 as psychotherapy. This theory views behaviour change as a dynamic process that occurs continuously and gradually. The Figure 4 describes client's movement from through five stages; precontemplation, contemplation, action, maintenance and relapse.



*Figure 4.* The stages of change model.

Source: Prochaska & DiClemente, 1982

It attempts to explain why some people respond quickly to problems while others resist. People experience change differently. Some move quickly through the stages, while others move more slowly and may remain “stuck” in one stage. Other individuals may skip or repeat stages. Relapse after behavior change is possible, and

a person may therefore cycle through the stages more than once. Therefore, prevention interventions should be targeted to the stage of behavior change that a person is actually within during that given period.

*Theory of Planned Behavior.* The concept was introduced by Ajzen in 1991 to improve on the predictive power of the theory of reasoned action by including perceived behavioral control. Like the stages of change theory, this theory acknowledges that a person may not be ready for a desired behavior. The Figure 5 illustrates the process of behavior change.

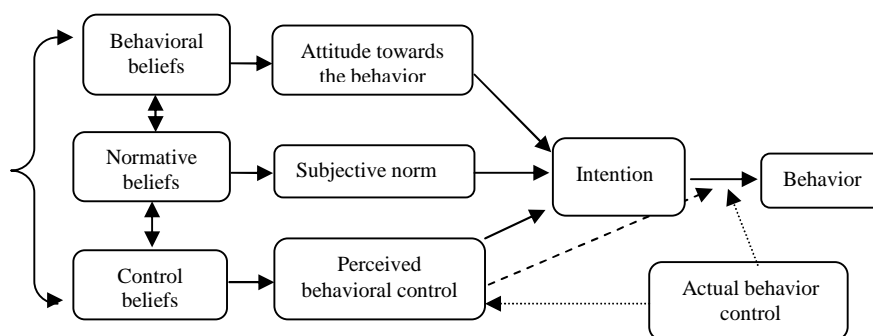


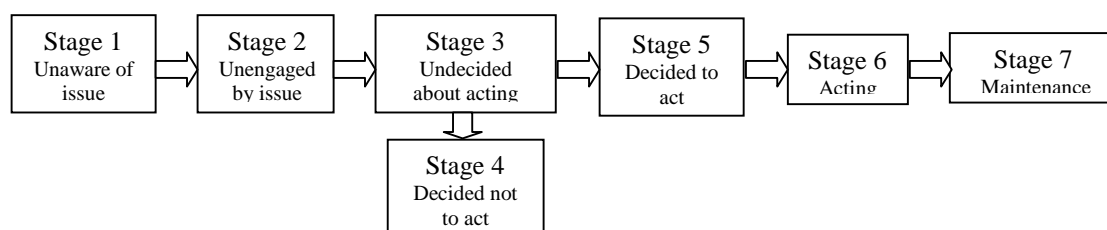
Figure 5. The theory of planned behavior.

Source: Ajzen, 1991

As shown in the Figure 5, behavior is a function of compatible intentions and perceptions of behavioral control that moderate the effect of intention (person's readiness to perform a given behavior) on behavior. Intention is influenced by his/her personal beliefs, attitude toward a behavior (the degree to which performance of the behavior is positively or negatively valued), normative beliefs (the perceived behavioral expectations of such important referent individuals or groups as the person's spouse, family, or friends), subjective norm (the perceived social pressure to

engage or not to engage in a behavior), control beliefs (the perceived presence of factors that may facilitate or impede performance of a behavior), perceived behavioral control (refers to people's perceptions of their ability to perform a given behavior). Interventions based on this theory focus on providing instructional strategies to encourage positive attitudes towards change, develop a positive social support system, and to demonstrate that changed behavior can result in positive outcomes, which are supported by the community or the organization.

*The Precaution Adoption Process Model (PAPM).* The PAPM discusses seven stages in an individual's journey from awareness to action. Weinsten, Sandman and Blalock (2008) mentioned that an individual's journey to change begins with lack of awareness and advances through subsequent stages of becoming aware, deciding whether or not to act, acting, and maintaining. The Figure 6 illustrates the seven stages behavior change.



*Figure 6.* The stages of the precaution adoption process model.

Source: Weinsten, Sandman, & Blalock, 2008

The PAPM identifies seven stages along the path from lack of awareness to action. At some initial point in time, people are unaware of the health issue (Stage1). When they first learn something about the issue, they are no longer unaware, but they are not yet engaged by it either (Stage 2). People who reach the decision-making stage (Stage 3) have become engaged by the health issue and are considering their response.

This decision-making process can result in one of three outcomes: They may suspend judgment, remaining in Stage 3 for the moment. They may decide to take no action, moving to Stage 4, halting the precaution adoption process, at least for the time being or, they may decide to take (action) precaution and move to the Stage 5. For those who decide to adopt the (action) precaution, the next step is to initiate the behavior (Stage 6). A seventh stage indicates that the behavior has been maintained overtime (Stage 7). Informing the individual about the desired behavior and motivating him/her to view it positively becomes important intervention strategy. Once the individual decides to act, instructional strategies can be similar to those identified for the stages of change theory. If the individual decides not to act, then intervention should consider what's influencing his or her behavioral intentions and use design motivational strategies.

*Social Learning Theory*. This theory, also known as social cognitive theory, was developed by Bandura in 1977. The Figure 7 describes cognitive, behavioral and environmental factors that determine human behaviors.

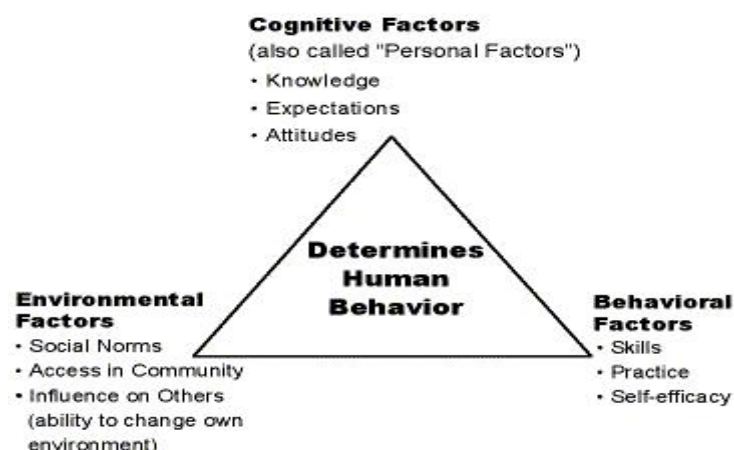


Figure 7. The social learning theory.

Source: Bandura, 1989

According to Bandura (1989) behavior change is affected by environmental factors, cognitive or personal factors and behavioral factors. A central tenet of social cognitive theory is the concept of self-efficacy. Self-efficacy is a person's belief in his or her capability to perform the behavior. The theory classifies expected outcomes as having immediate benefits (e.g., feeling energized following physical activity) or long-term benefits (e.g., experiencing improvements in cardiovascular health as a result of physical activity). These expected outcomes are filtered through self-efficacy, a person's expectations or perceptions of being able to perform the behavior. In 1994, Bandura suggested three main factors that affect the likelihood of the desired health behavior. These factors are (1) self-efficacy, (2) goals, and (3) outcome expectancies. If individuals have self-efficacy, they can change behaviors even when faced with obstacles.

*The Information-Motivation-Behavioral Skills Model (IMBS).* The IMBS model postulates that motivation and behavioral skills are important to bring change. The Figure 8 illustrates the information, motivation and behavioral skills that bring desires behavior change.

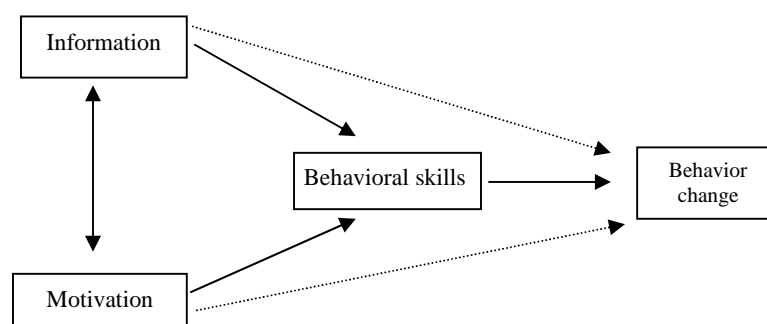
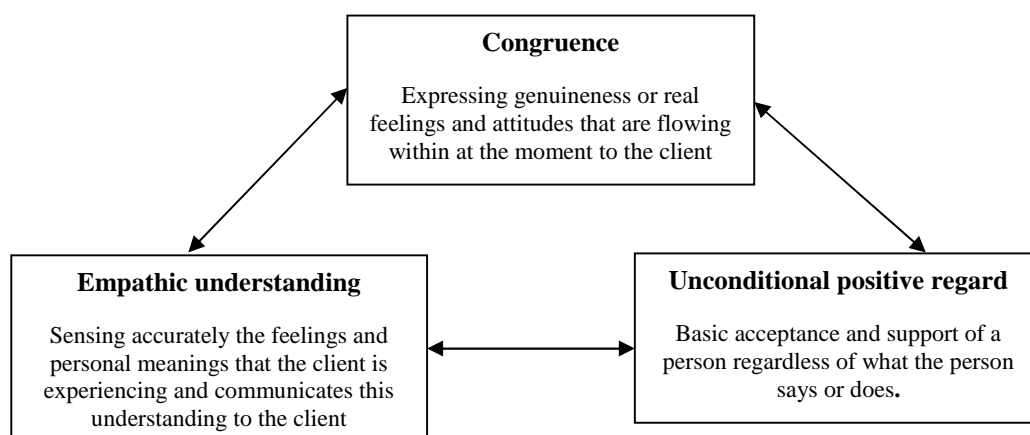


Figure 8. The Information motivation behavioral skills model.

Source: DiClemente & Velasquez, 2002

The model demonstrates that information is a prerequisite for changing behavior, but in itself is insufficient to achieve this change. Information and motivation work largely through behavioral skills to affect behavior; however, when the behavioral skills are familiar or uncomplicated, information and motivation can have direct effects on behavior. DiClemente and Velasquez (2002) proposes that information that is directly relevant to the personal practice of preventive behavior, motivation to practice prevention, and behavioral skills for practicing prevention effectively, are the fundamental determinants behavior change. The theory suggests that most persons at risk possess inadequate information about the personal practice of preventive behavior, insufficient personal and social motivation to practice prevention, and inadequate behavioral skills for practicing prevention effectively. The theory designates information, motivation, and behavioral skills as critical factors to target for change in intervention efforts to promote preventive behavior.

*Person Centered Therapy (PCT)*. It is therapeutic approach rather than a theory. This was developed by Carl Rogers in 1951. The goal of PCT is to provide clients with an opportunity to develop a sense of self wherein they can realize how their attitudes, feelings and behavior are being negatively affected. This therapeutic approach maintains three interrelated core conditions that provide a climate conducive to growth and therapeutic change. The Figure 9 depicts core essential conditions for counseling and therapy.



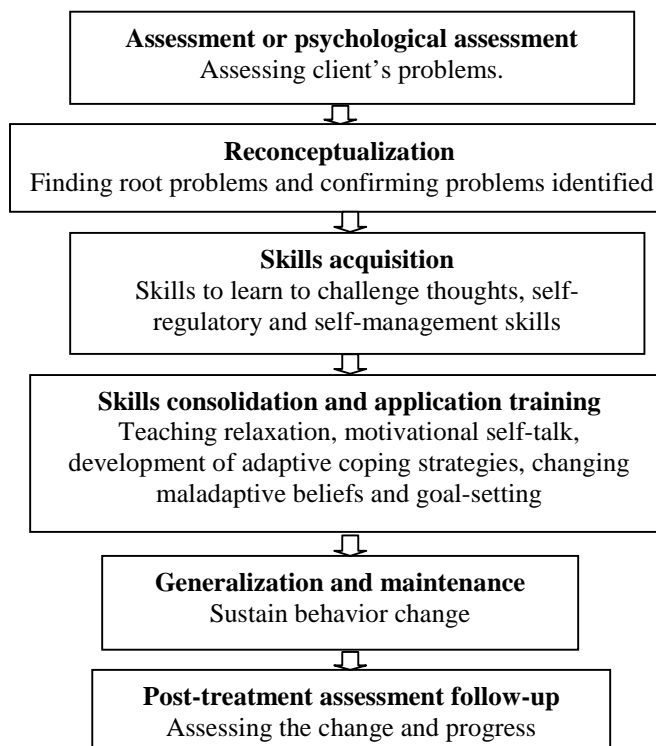
*Figure 9.* Core conditions of person-centered therapeutic process.

Source: Rogers, 1951

The first condition, congruence, means that the counselor is real and genuine. The counselor is transparent to the client. There is no air of authority. The second, empathic understanding means that the counselor accurately understands the client's thoughts, feelings, and meanings from the client's own perspective. When the counselor perceives what the world is like from the client's point of view, it demonstrates not only that that view has value, but also that the client is being accepted. The third, unconditional positive regard means that the counselor accepts the client unconditionally and non-judgmentally. These conditions promote clients' experience of being understood and valued, which gives client the freedom to grow and space to make positive and constructive choices by taking responsibility for themselves and their lives. Most HIV counseling interventions incorporate person-centered approach.

*Cognitive Behavior Therapy (CBT).* The CBT is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes

and contents through a number of goal-oriented, explicit systematic procedures. There have been various revisions of CBT. The Figure 10 illustrates six steps of CBT that are widely applied in public health context.



*Figure 10.* Phases of cognitive behavior therapy.

Source: Hofmann, 2011

The six stages of the CBT are: assessment, reconceptualization, skill acquisition, skills consolidation and application training, maintenance, and post-treatment assessment follow-up (Hofmann 2011; Gatchel, & Rollings, 2008). The modern CBT emphasize changes in one's relationship to maladaptive thinking rather than changes in thinking itself (Hayes, Villatte, Levin, & Hildebrandt, 2011). The CBT is widely applied in HIV prevention. HIV intervention based on CBT teaches clients coping skills to handle high-risk behaviors.

*Theories focusing on community or social groups.* Overemphasis on individual behavioral change with a focus on the cognitive level has undermined the interactive relationship of behavior in its social, cultural, and economic dimension. Aggleton (1996) points out that, in many cases, motivations for sex are complicated, unclear and may not be thought through in advance. Societal norms, religious criteria, and gender-power relations infuse meaning into behavior and enable positive or negative changes. The following theories describe environment and community as change agents.

*The Diffusion of Innovation Theory.* The theory was developed by Rogers in 1962. It describes the process of how an idea is disseminated throughout a community. The Figure 11 explains the diffusion of innovation theory. According to the theory, there are four essential elements: the innovation, its communication, the social system and time.

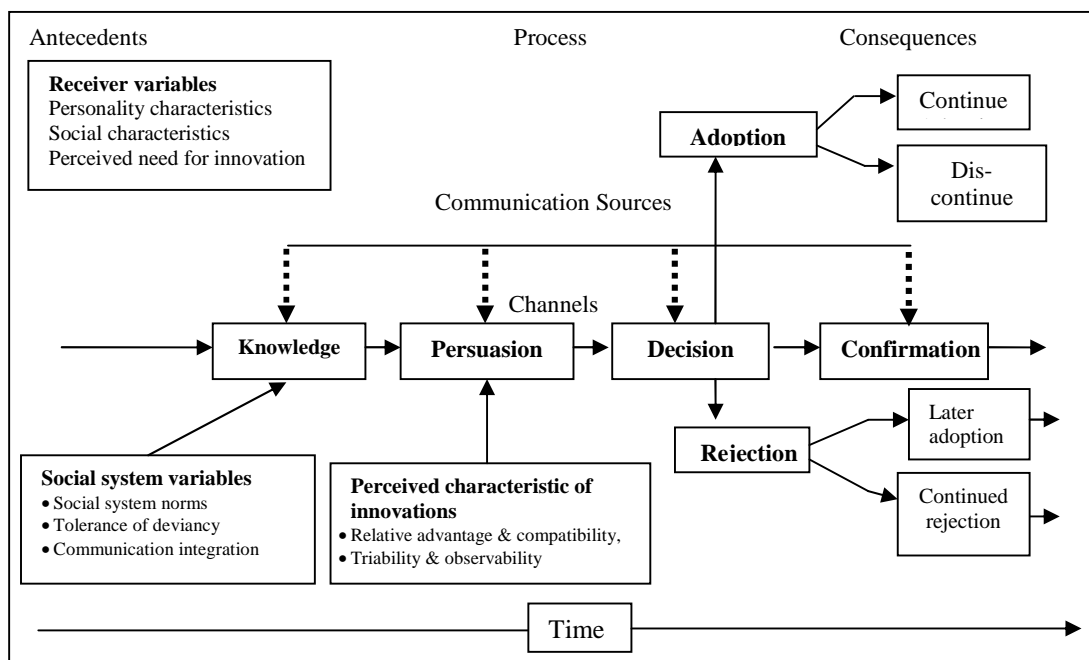


Figure 11. The diffusion of innovation theory.

Source: Rogers, 1995

People's exposure to a new idea, which takes place within a social network or through the media, determines the rate at which various people adopt a new behavior. The theory suggests that people are most likely to adopt new behaviors based on favorable evaluations of the idea communicated to them by other members whom they respect (Kegeles, 1996). Kelly explains that when the diffusion theory is applied to HIV risk reduction, normative and risk behavioral changes can be initiated when enough key opinion leaders adopt and endorse behavioral changes, influence others to do the same and eventually diffuse the new norm widely within peer networks. (Kelly, 1995). When individuals perceive benefits of prevention along with similar beliefs among one's immediate social network, individuals' behavior is more likely change.

*Social influence theory.* Social influence is the effect others have on individual and group attitudes and behavior (Berkman, 2000). The Figure 12 explains how individual's behavior is influenced in given in social context by social norms and social pressures.

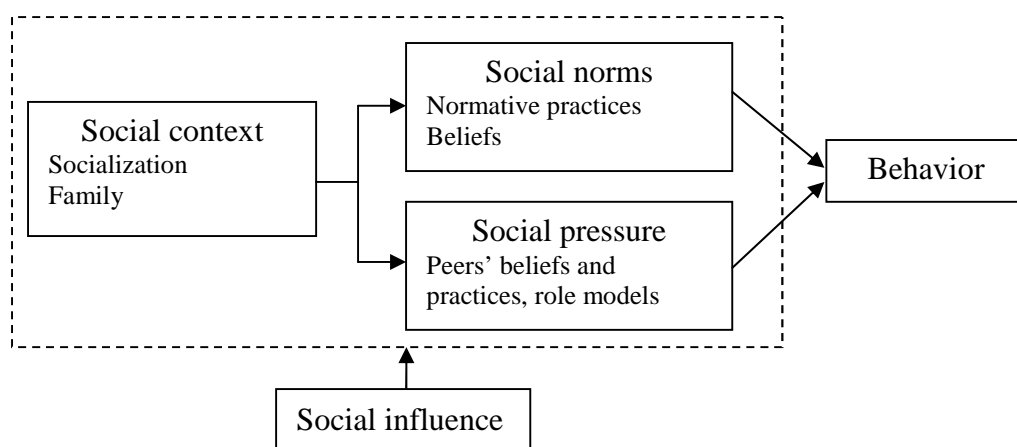


Figure 12. The model of social influence on behavior.

Source: Howard, 1990

The theory of social influence states that behavior is intentionally or unintentionally influenced by others. By understanding social influence, you might be able to ignore peer pressure and manipulation. People engage in behaviors including early sexual activity partly because of general societal influences, but more specifically from their peers (Howard, 1990). The model suggests role models to present factual information, identify pressures, role-plays, strategies to deal with pressures, teach assertiveness skills and discuss problem situations to bring desired change in behavior (Howard, 1990).

*The Social Network Theory.* Barnes (1954) coined the notion of social networks. The Figure 13 describes networks connecting individuals, groups, organizations and societies.

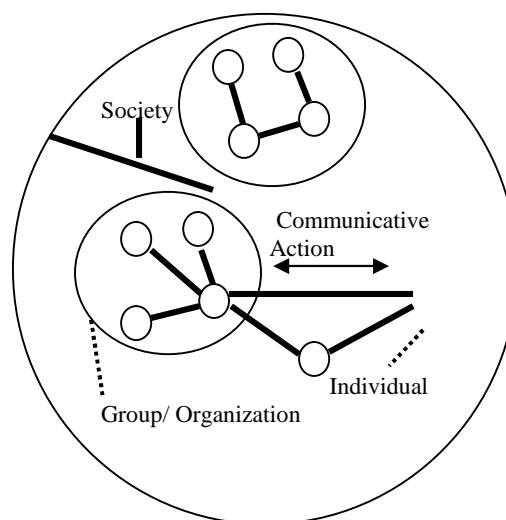


Figure 13. Networks connecting individuals, groups, organizations and societies.

Kadushin, 2012

Kadushin (2012) mentioned that the social structure of relationships around a person, group, or organization affects beliefs or behaviors. Causal pressures are inherent in social structure and these pressures are detected through reviewing

relationships between social units. The social units are individuals, groups/ organizations and societies. This theory looks at social behavior not as an individual phenomenon but through relationships, and appreciates that HIV risk behavior, unlike many other health behaviors, directly involves two people (Morris, 1997). With respect to sexual relationships, social networks focus on both the impact of selective mixing (i.e. how different people choose who they mix with), and the variations in partnership patterns (length of partnership and overlap). Relations and communication within the couple, the smallest unit of the social network, is critical to the understanding of HIV transmission in this model. Those who serve as reference people, and who sanction behavior, are key to comprehending individual risk behavior (Auerbach, 1994). In other words, social norms are best understood at the level of social networks

*The Theory of Gender and Power.* In 1987, Connell developed an integrative theory of gender and power. According to Connell, three major structures characterize the gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis. Both the sexual division of labor and the sexual division of power had been identified as two fundamental structures that partially explain gender relations and the third structure, the structure of cathexis, introduced to address the affective component of relationships. These three overlapping but distinct structures serve to explain the cultural bound gender roles assumed by men and women. Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices (DiClemente & Wingood, 1995). Programmes using the theory of

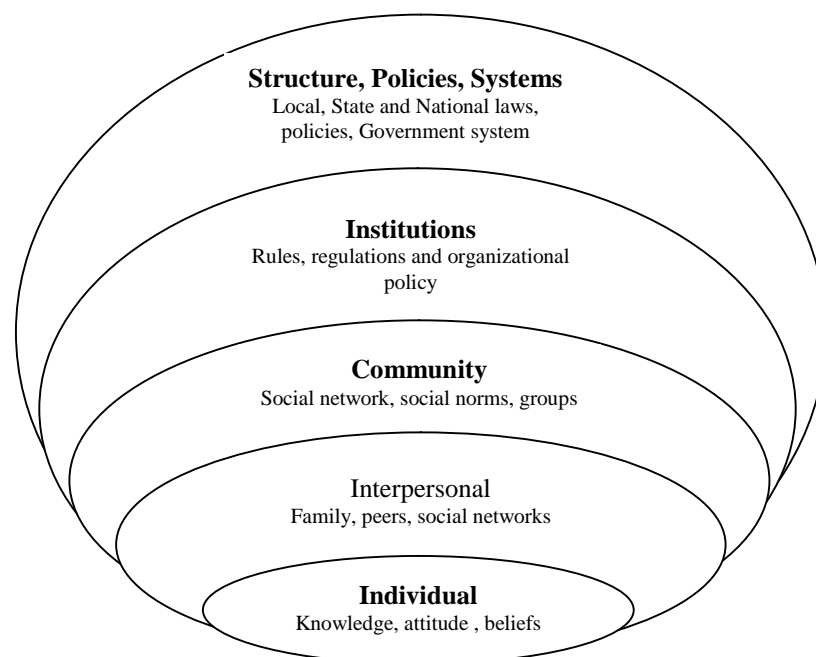
gender and power assess the impact of structurally determined gender differences on interpersonal homosexual as well as heterosexual relationships (perceptions of socially prescribed gender relations).

**Theories focusing on economic and structural issues.** All above theories focus on individual, social and community determinants of health behavior, and largely ignore the influence of economic and structural factors on behavior. Sexual behavior is not only regulated by individual and social factors but also by structural and environmental factors (Carael, 1997; Sweat, 1995; Tawil, 1995). Human behavior is influenced by individual's immediate social relationships which are governed by community, organization, the political and economic environment. Theories focusing on economic and structural issues are multidimensional with an emphasis on linking the individual to the surrounding larger environmental systems. Interventions using this approach, thus, target organizations, communities and policy.

*Theory for Individual and Social Change or Empowerment Model.* This theory asserts that social change happens through dialogue to build up a critical perception of the social, cultural, political and economic forces that structure reality and by taking action against forces that are oppressive (Parker, 1996). In other words, empowerment should increase problem solving in a participatory fashion, and should enable participants to understand the personal, social, economic and political forces in their lives in order to take action to improve their situations (Israel, 1994). Interventions using empowerment approaches consider key concepts such as beliefs and practices that are linked to interpersonal, organizational and community change. Intervention activities address issues at the community and organizational level such as central

needs the community identifies, and any history community organizing among community members.

*Social Ecological Model for Health Promotion.* According to this model, behavior is the outcome of interest and behavior is determined by various factors as shown in the Figure 14. The Figure 14 provides an overview of levels of influence on individual.



*Figure 14.* Levels of influence in the social ecological model.

Source : McLeroy, Bibeau, Steckler & Glanz, 1988

McLeroy, Bibeau, Steckler and Glanz (1988) discussed various levels of influences that include, the intrapersonal factors (characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills), interpersonal processes, (formal and informal social network and social support systems, including the family, work group, and friendships), institutional factors (social institutions with

organizational characteristics and formal and informal rules and regulations for operation), community factors (relationships among organizations, institutions, and informal networks within defined boundaries), and public policy (local, state, and national laws and policies). Intervention strategies range from skills development at the intra-personal level to mass media and regulatory changes at other levels (Laver, 1998). This theory focuses the interplay between the individual and the environment, and considers multi-level influences on unhealthy behavior. The next section discusses the critical reflections on the theories.

### **Critical Reflections on Existing Behavior Change Models and Counseling Theories**

Existing behavior change models and counseling theories reflect similarities and differences in their approach and focus of strategies to bring about behavior change. The core difference between these theories is the different drivers of behavior change and different routes that people travel in the process of changing their behavior. The theories can be classified as follows:

- Theories that see information about the health threats as the main driver of the behavioral change.
- Theories that conceive the motivation and learning behavioral and interpersonal skills as the main driver of the behavioral change.
- Theories that postulate gender norms, social pressures, community norms and personal self-efficacy as the main driver of the behavioral change.

- Theories that see economy (poverty), environment and policy as the most influencing driver for risk behaviors.

Although there are many differences in the details of each of these models, there are also important overlaps. As we move from the theoretical and research arena into the real world of intervention for HIV prevention, it will be increasingly important to emphasize the commonalities between these models. Five commonalities are identified from review of key behavior change models and theories: First, all theories and models emphasize the critical importance of engaging the client into the intervention and are in that sense client centered. This is accomplished by individualizing risk assessment, targeting behaviors the client is willing to change and developing a risk reduction plan with the client that he or she considers feasible and achievable. The second commonality, more or less explicitly stated in each of these models, is that change is a dynamic process in which stages may be recognized and in which small steps will ultimately lead to the desired outcome. Third, it is recognized that the progression through these stages is influenced by factors that must be specific for each stage and need to be tailored to the client's capabilities and circumstances. Fourth, these theories and models emphasize more on psychological processes and do not pay much attention to sexuality issues, situational, and unique cultural factors that may influence the behavior change process and may be of particular importance in counseling for HIV prevention. Finally, these theories and models do not discuss culturally appropriate behavior change strategies, counseling skills and techniques. To understand applicability of these theories in Indian context, we need to understand status of HIV counseling in India. The following section discusses HIV counseling in India.

***Research on HIV counseling in India.*** Empirical research carried out in India suggests that interventions guided by behavior change models are effective in bringing about desired change among targeted populations to prevent HIV. Most these theories were used to develop HIV prevention behavioral interventions with MARPs and counseling interventions in hospital settings (voluntary counseling and testing centers-VCTCs, prevention of parents to child transmission centers-PPTCTs, STI clinics, ART centers etc.) and community settings in Western and African countries. In reference to this, Solomon (2002) noted that the above mentioned behavior change models and theories have been experimented for efficacy and effectiveness in HIV prevention programs primarily in western and African countries and have been blindly replicated in developing countries without rigorous attention to the longstanding critique concerning the necessity for cultural appropriateness in counseling. Most available literature on effectiveness of behavior change models and counseling comprises studies that are primarily conducted from the perspectives of pre and post HIV test, treatment of STIs and adherence to ART in hospital settings. Few researchers have addressed the counselors' experiences and their perspectives of HIV counseling in hospital settings (Grinstead & Van der Straten, 2000; Liechty, 2005; Solomon, 2002).

In the same vein, international literature shows scarcity of empirical research on counselors' experiences of HIV counseling and their perspectives on HIV counseling practices in the context of TIs. Since TI is recognized as a crucial strategy for prevention of HIV among MARPs, it is essential to examine HIV counseling practices, HIV counseling process and behavior change process among clients, and

counselors' experience of providing HIV counseling. Generating a culturally grounded theoretical framework around these themes would add to knowledge about culturally contextualized HIV counseling practice in the TIs. For this it is imperative to understand the Indian culture and how sexuality governed is by apparent and invisible cultural structures.

### **Sexuality and Counseling in Indian Culture**

Culture is the set of ideas, behaviors, attitudes, and traditions that exist within large groups of people, which are passed on from one generation to the next. Culture is commonly defined as a set of shared values, mentalities and beliefs that characterize national, ethnic, moral and other group behavior (Craig & Douglas 2006; Faure & Sjostedt 1993; Shweder, 2003; Valsiner, 2009).

**Sexuality in Indian culture.** India is a country with a wide social, religious, cultural and sexual variation. The Indian culture, often labeled as an amalgamation of several cultures, spans across the Indian subcontinent and has been influenced by a history that is several millennia old (Keay, 2011; Malika, 2007). The Indian concept of sexuality has evolved over time and has been immensely influenced by various rulers and religions. Sex and sexuality is regularized by laws and customs. In India, a sexual relationship within marriage is the only socially acceptable sexual expression. Although homosexuality and sex work existed even in ancient India, they are never attained social as well as legal approval in the Indian society. The constitution of India prohibits sex outside marriage, homosexuality, and sex work. As a result, various forms of sex such as premarital, extra-marital, prostitution, and homosexual

acts are considered a sin and immoral. Sex and sexuality is rarely discussed openly in the society. Conversely, it is important to note that few forms of sexualities are culturally accepted in tribal Indian societies.

No quantitative estimate of the sexual practice is available for any rural or tribal community of India, but casual reports indicate that it is not uncommon (Verma & Schensul, 2004). In many tribes premarital sex is found in youth. Few Indian tribes in central India during the 1930s and 1940s give detailed descriptions of institutionalized premarital relationships (Elwin, 1964 as cited in Verma, Pelto, Schensul & Joshi, 2004). Another tribe known as the Santal living mostly in Bihar and Orissa have a permissive attitude towards premarital sex (Biswas 1956 as cited in Nag, 1995; Mukherjee, 1962 as cited in Nag, 1996). Sex work is age old tradition in India. The devadasi system –dedicating unmarried young girls to gods in temples, which often made them objects of sexual pleasure of temple priests and pilgrims) was an established custom in Southern India since 300 AD (Basham, 1959). Sex work was evident in Dhayanti tradition among Jaunsar tribe of Uttaranchal and Khelwadi tradition among Bachhed tribe of Madhya Pradesh where eldest daughter is made a sex worker with the intention of supporting the family (Chantia, 2009). Further, Sausi and Bedia tribes of Gujarat and Rajasthan states are popular for their sex work (Chantia, 2009; Nag, 2006). In certain rural and tribal areas, women are sold for example, Mondapatti tribes in Gangam district of Orissa sell women for money (Madavi, 1999). Men mortgage their wives in difficult times and bring them back when they repay the loan.

Apart from these facts, polyandry, polygamy, and sequence marriage are prevalent in many tribal and rural settings in India (Chantia, 2009). Various researches, primarily conducted in the context of HIV with low income groups, have reported that many girls, women, men, transgender and hijra engage into sex work as a survival strategy to earn (Chakrapani, Mehta, Buggineni, & Barr, 2008; Nag, 1995, 1996; Humsafar Trust, 2000; Lakshya Trust, 2005; Pandya, 2011). The National AIDS Control Organization has described various types of sex work, namely, brothel based sex workers, street based, home based, hotel or lodge based, dhaba (roadside restaurants at highways) based sex workers, beauty parlor/massage parlor based sex workers, call girls, and home based (operate sex work secretly from home) sex workers (NACO, 2011). The Humsafar Trust describes the circle of men who have sex with men which includes koti identified men, double-decker, panthi, transgenders, hijra, hotel boys, taxi drivers, and masseurs. Many of them engage in sex work with other men and women for money (Chakrapani, Mhaprolkar, Basu, & Kavi, 2007; Joseph, 2005; Khan, 2004; Pandya, 2011; Ramanathan, Chakrapani, Ramakrishnan, Goswami, Yadav, Subramaniam, George, & Paranjape, 2013).

Past researches conducted in Delhi, Madras, Kolkata, Maharashtra reveal that extra marital relationships exist in India and comparatively married men were more engaged in extramarital relationships than married women (Basu, 1994; Savara & Sridhar 1994). Married women are expected to remain loyal to the husband under all circumstances. Premarital sex and marital infidelity is more punishable for women than for men. Women often are bound by their helpless situation to accept their husbands' deviations from marital fidelity in order to stay in a married state (Nag,

1996). The cultural familial and gender roles are thus well-entrenched in the Indian society. Culturally, men are expected to accept responsibility for meeting the needs of others, support the old, take care of widows, never-married adults and the disabled; assist members during periods of unemployment and illness; and provide security to women and children while women are expected to accept a position subservient to men, and to subordinate their personal preferences to the needs of other (Sethi, 1989). Sexuality is expressed within the boundaries of the cultural division of family and gender roles. Hence sexualities that are apparently prohibited must be expressed within a private sphere without violating family and gender roles. Consequently, both men and women maintain publicly acceptable (heterosexual) relationship (within marriage) while keeping their other sexual relationships (extra marital, homosexual relationships and sex work) confined to clearly articulated spatial context within which they are socially safe (Hirsch, 2003; Hirsch, Wardlow, Smith, Phinney, Parikh, & Nathanson, 2009; Pandya, Pandya, Patil & Merchant, 2012). Men and women strive to perform socially-sanctioned sexuality in one context, and express homosexuality, infidelity or nurture specific kinds of sexual relations in another (Hirsch et al., 2009; Pandya, Pandya, Patil & Merchant, 2012), thereby creating HIV risk context for both men and women.

*Sexuality and HIV risks.* Sexuality as reflected by more number of sexual partners, sex with sex workers, being in sex work and receptive anal sex, has been reported to be strongly associated with HIV infection (Bollinger, Brookmeyer, Mehendale, Paranjape, Shepherd, Gadkari, & Quinn, 1997; Godbole & Mehendale, 2005; Solomon, Kumarasamy, Ganesh, & Amalraj, 1998; NACO, 2011). Male and female sex workers, their customers; homosexually oriented men, transgenders and

hijras are at high risk for transmission of HIV (Nag, 1995). Higher risk of HIV infection has been associated with poor educational backgrounds (Mehendale, Shepherd, Dovekie, Gangakhedkar, Kamble, Menon, Yadav, Risbud, Paranjape, Gadkari, Quinn, Bollinger, & Rodrigues, 1996; Shepherd, Gangakhedkar, Sahay, Reynolds, Ghate, Risbud, Paranjape, Bollinger, & Mehendale, 2003), low, inconsistent condom use and sexually transmitted infections (Rodrigues, Mehendale, Shepherd, Divekar, Gangakhedkar, Quinn, Paranjape, Risbud, Brookmeyer, & Gadkari, 1995). Avoidance of multi-partner sexual relationships and use of condoms are usually advocated for prevention of spread of HIV and other sexually transmitted diseases. In this context, counseling is crucial. The next section provides an overview of counseling in the Indian cultural context.

**Counseling in Indian culture.** Cultural beliefs, values and norms influence counseling which involves close interactions between the counselor and client. Counseling in a formal context is a culturally less important and much misunderstood concept because in Indian culture, younger people often seek advice and guidance from parents, elderly, teachers, and gurus (spiritual master) with expectation of prompt compliance. According to the Indian scriptures a salient quality of elders and teachers (spiritual master) is to provide direction and guidance to the individual in all significant domains of life. Indian family is interdependent and collective in nature (Panda & Gupta, 2004); therefore, seeking help, guidance and advice from family members is culturally desired. India is a hierarchical society where roles are well-defined, so Indians are socialized to take advice from elders, and major life decisions are often collective in nature (Kakar & Kakar, 2007, Ruth, 1998; Sinha, Sinha, Verma, & Sinha, 2001). Unlike the individualistic self that is predominant in many

Western societies (Markus & Kitayama, 1991), for Indians the family collective and its approval is important. This tendency plays out in most hierarchical relationships (e.g., teacher-student, boss-employee). Hence even in counseling situations the client looks upon the counselor as the one who knows more and is there to guide and give advice about the right path or solution to a problem (Kakar, 1996). This cultural context raises questions about the applicability of Western counseling theories and principles in India.

Indian people hold cultural values that promote respect toward authority figures and tend not to question or challenge authority. Counseling as practiced in the West, however, requires the client to be independent, self-sufficient and sharing experiences and emotions with counselors (Arulmani, 2009; Chong & Liu, 2002; Smoczynski, 2012). Therefore, during counseling the expectation that the client should be led to find his or her own answers and the counselor should refrain from giving advice, can be quite foreign to Indian clients. With emphasis on pragmatism, seeking and expecting advice or solutions is rather common in the everyday life of an Indian individual. Further, indigenous models of healing such as Ayurveda, Astrology, Yoga, Gurus (Priests), Bhava/Shamans (traditional healer) are prevalent in India (Kakar, 1982; Raney & Cinarbas, 2005) and people often consult these when they face any social or family, or personal problems. Hence, multiple approaches and sources are often consulted simultaneously to seek a way out of problems. Counseling in India thus needs to be viewed in this context.

In 2007, Kalichman noted that most counseling theories and models are privileged by Western-cultural orientation. Many scholars have expressed concerns related to the usefulness of Western counseling philosophies to non-Western cultures (Arulmani, 2009; McGuiness, Alfred, Cohen, Hunt, & Robson, 2001; Chong & Liu, 2002; Smoczynski, 2012). Therefore, blind adaption of Western counseling without considering Indian cultural factors and Indian psyche may be harmful to the client and hinder the development of counseling psychology. For example, Indian people are family oriented and decisions are often influenced by opinions and approval from family members (Kakar, 1981, 1996). Therefore, a client may not be able to take a decision on his/her own without consulting the family. By not considering this cultural orientation, Western counseling orientation may create more internal conflicts in clients which may be counterproductive in the long term.

What is necessary is to integrate effective processes from Western counseling theories and principles, modified to suit the Indian context, and simultaneously evolve strategies that fit well with the Indian psychological, philosophical and cultural orientations to evolve a culturally sensitive counseling framework. A crucial step in such an endeavor is to understand HIV counseling practices in the local context, the challenges that the counselors experience in everyday counseling, and the cultural adaptations of strategies to render counseling more effective on the field.

## **Significance and Rationale of the Study**

Counseling is one of the components of TIs. In the context of HIV, counseling has become an important strategy to bring change in high-risk sexual behaviors of MARPs. Various behavior change theories and models primarily developed in West have been applied to the Indian context without rigorous attention to the longstanding critique concerning the necessity for cultural appropriateness in counseling and concern for contextual factors. Several scholars have directed attention to the Western bias that exists in science, and emphasized the need for cultural adaptation of methods and approaches in counseling (Gerstein, Leung, & Norsworthy, 2009; Laungani, 2009).

Inadequate experimentation of counseling theories or behavior change models with the Indian population may lead to ignorance of cultural nuances and make programs ineffective in yielding behavior change among at-risk populations. Further, most of the researches on effectiveness of behavior change models were conducted almost a decade ago, and that too mainly from perspectives of pre-post HIV test counseling and STI counseling in hospital settings or in STI clinic settings. In fact, the body of research that exists on this topic is from the clients' perspectives in hospital setting; however, the experiences of counselors' providing HIV counseling to most-at-risk populations, the challenges that they face, the unique counseling practices that they adopt on the field, and counselors' own perspectives on their experiences and the HIV prevention program have not been addressed. TI is a very crucial strategy for prevention of HIV among MARPs. Lot has been written in the area of sexuality,

sexual health issues of MARPs, counseling pertaining to HIV test, STI treatment, and people living with HIV, however, HIV counseling practices in TI context, behavior change processes among clients, counselors' experiences and perspectives of HIV counseling is largely ignored.

The present study is thus important for several reasons. India has continued to be in the category of concentrated epidemic characterized by unprotected paid sex, anal sex, and injecting drug use with contaminated injecting equipments (NACO, 2011, 2012). According to 2011 NACO's annual report, HIV incidence among MARPs on increase; therefore, prevention of HIV among MARP becomes crucial. There is a felt need to strengthen HIV counseling services by understanding existing counseling practices, counseling and behavior change processes. There exist few Indian studies on HIV test and ART counseling in hospital settings. The present research is thus, a contribution to advancement of in the knowledge about HIV counseling practices, HIV counseling processes, behavior change processes and counselors' experiences of providing HIV counseling in TI context, with emphasis on culturally sensitive approaches. Importantly, it presents a culturally adapted HIV counseling process model that could be used in TIs.

At a broader level, the present research contributes to the goal of NACP phase-III to halt and reverse the epidemic in general and in particular, objectives of TIs to prevent and control HIV among most-at-risk populations. It also contributes to three goals of the Centres for Disease Control and Prevention: 1) health protection goal for healthy people in a healthy world through global health promotion; 2) global

health objectives to promote safer, healthier, and longer lives through the prevention and control of infectious diseases; and 3) priority populations including low-income groups and women. Finally, the research advances the United Nations Millennium Development goal to prevent HIV/AIDS globally.

### Conceptual Framework of the Study

Based on preliminary literature review, a conceptual framework was developed.

Figure 1 depicts the conceptual framework of the study.

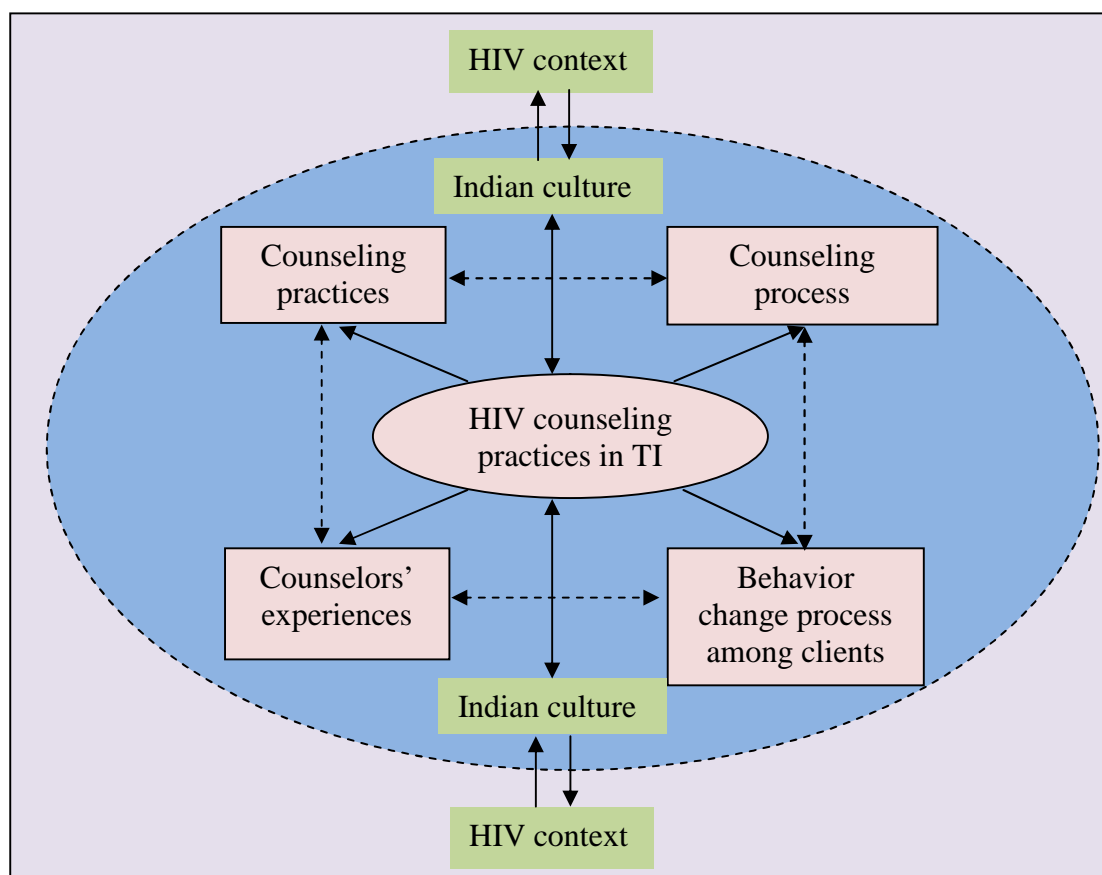


Figure 1. Conceptual framework of the study.

The study is conceptualized in the macro context of HIV/AIDS, with reference to the Indian cultural context. The fundamental assumption in this conceptual construct is that counseling take place in given cultural context where counselors and clients are culturally prepared in a similar way (Arulmani, 2009). This means that certain phenomenon within a culture, prepares its inhabitants to think, feel, behave in certain culturally bound ways, share similar vocabulary, life orientation, values and so on (Smoczynski, 2012). Counseling process and methods need to be culturally relevant and should address individual's needs. In this context, with experience counselors may develop culturally informed theory and use methods or techniques which are culturally relevant that help clients. Keeping Indian cultural context in mind, HIV counseling practices, HIV counseling process, behavior change process among clients were areas of inquiry. See single arrows that demonstrate key domains of the study in the Figure 1. Further this study also focuses on understanding various factors that influence counselors' experiences. Counselors' experiences of providing HIV counseling may influence counseling practices, process, and behavior change in clients or vice versa. Broken lines in the Figure 1 depict reciprocal relationships of key domains. Based on the conceptual framework, objective of the study was determined.

### **Objective of the Research**

The objective of this research was to examine existing HIV counseling practices, HIV counseling process, behavior change processes among the clients and counselors' experiences of providing HIV counseling services to the most at-risk population (MARPs) through targeted interventions (TIs) in Gujarat State.

## Research Questions

1. What are the existing HIV counseling practices in Targeted Intervention (TI)?
2. What are the key HIV counseling processes that emerge during counselor-client interactions in Targeted Intervention (TI) context?
3. What are the key behavior change processes that emerge during counselor-client interactions in Targeted Intervention (TI) context?
4. What are the counselors' experiences of providing HIV counseling services within Targeted Interventions (TI) context?

## Summary

The chapter has provided an overview of the HIV scenario and status of HIV counseling in India. The researcher has reviewed behavior change models and counseling theories which are extensively used in HIV prevention. It also discussed Indian culture, sexuality norms and the concept of counseling in Indian concept. The chapter explained the existing gaps in the areas and rationale and the significance of the present study to address some of these gaps were discussed. Research objectives, research questions, and conceptual framework of the research were presented.

The next chapter is devoted to methodology. It discusses intent of the research, research design, and the process of adapted constructivist grounded theory methodology, right from the conceptualization of the research to its synthesis is discussed in detail.