CHAPTER

3

RESULTS

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An Overview

The purpose of the present research was to explore counselors' experiences and perspectives of providing HIV counseling services to most at-risk population (MARPs) namely men who have sex with men (MSM), female sex workers (FSW) and injecting drug users (IDU) under targeted intervention (TI) setting in Gujarat. The data were gathered through in-depth interviews, review of counselors' documents and participant observations of counseling sessions.

In order to organize the vast data collected from the research, the chapter is organized into five sections to present the data as per the analytic process followed in the study. Section I describes the characteristics of the research participants, which presents participants' socio-demographic profile such as gender, age, education, training, typology of TI and the region they represented. Section II presents results based on the four key domains, namely HIV counseling practices, HIV counseling process, behavior change process and counselors' experiences. In each domain, data is presented as per the data collection sequence and method including in-depth interviews, review of counseling documents, and participants' observations. Section III discusses triangulation of the data presented in the previous section II including researcher's observation notes and memos. Next, the emerging theoretical frameworks are presented based on the triangulation. Section IV presents a tentative constructivist grounded theory of HIV counseling practice in TI context. Section V

summarizes the chapter. Participants were assigned codes, P1 to P14 while the counselors included in the participant observations were assigned codes from C1 to C5 and clients were assigned the code from CL1 to CL5. The excerpts of participants and counselor-client interactions are presented using these codes.

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Section I

Participants' Background

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Characteristics of Participants

This section describes the socio-demographic background of the participants and the experience and training that they received. The Table 6 provides socio-demographic information of the study participants.

Table 6

Sociodemographic Characteristics of Study Participants (N=14)

Type of counselors	Gender			Age					Education level					Experience					Training					Typology of TI					Region				
	Men	Women	Total	24-28	29-33	34-38	39-43	Total	Upto High School	Graduate	Post graduates (psychology)	Post graduates (Other)	Total	1 year	1 to 2 years	2-3 years	More than 3 years	Total	2 trainings	2-4 trainings	5-7 trainings	More than 7 trainings	Total	FSW	MSM	IDU	Core Composite	Total	Central	South	North	West	Total
Community Counselors	1	1	**2**	2	-	-	-	**2**	2	-	-	-	**2**	-	-	1	1	**2**	-	-	1	1	**2**	1	1	-	-	**2**	1	1	-	-	**2**
Auxiliary Nurse Midwives	-	2	**2**	2	-	-	-	**2**	-	2	-	-	**2**	1	1	-	-	**2**	1	1	-	-	**2**	1	-	1	-	**2**	1	1	-	-	**2**
Qualified counselors (psychology post-graduates)	1	2	**3**	1	2	0	0	**3**	-	-	3	-	**3**	1	2	-	-	**3**	1	1	1	-	**3**	1	1	-	1	**3**	1	-	1	1	**3**
Other counselors (graduate and post-graduate other than psychology)	5	2	**7**	2	3	1	1	**7**	-	1	-	6	**7**	-	-	1	6	**7**	1	1	2	3	**7**	1	3	-	3	**7**	-	1	3	3	**7**
Total	7	7	**14**	7	5	1	1	**14**	2	3	3	6	**14**	2	3	2	7	**14**	3	3	4	4	**14**	4	5	1	4	**14**	3	3	4	4	**14**

Two counselors were from the community were educated up to high school and two were ANM who completed graduation with diploma in nursing. Only three counselors were qualified counselors who completed post-graduation in psychology, whereas the rest seven counselors were graduates and post-graduates in other fields. Half of the participants (7) had more than 3 years of experience as TI counselors. Total eight participants had attended more than 5 trainings. Total five participants were working with MSM TI followed by FSW (4), CC TI (4) and IDU TI (1). One participant was recruited from IDU TI because at the time of data collection, Gujarat was implementing only one IDU TI. Participants were recruited from four geographical regions of the Gujarat, central region (4), south region (2), west region (4) and north region (4).

Socio-demographic characteristics. The study participants were diverse in their education qualification, which ranged from high school education, graduation (arts, commerce, science stream and diploma in nursing) to post graduation in various subjects (such as social work, labor laws and psychology). Majority of the participants were in the age group of 24-33 years. Most participants had more than 3 years of experience working with TI and had more than 2 years of experience. All of them received training at-least twice.

Participant groups. Participants were divided into two groups. Group I included 14 participants with whom in-depth interviews were conducted. First interviews were held at their work place, which lasted from 60 to 90 minutes, and subsequent interviews (up to three times) were conducted telephonically for 15 to 20 minutes each. Group II comprised 5 counselors (from total 14 participants who were previously interviewed), two community counselors, one ANM, a qualified counselor (working with core-composite TIs) and other counselor (working with FSW TI). Duration of the first counseling session was ranged from 20 to 75 minutes while follow-up counseling sessions were lasted between 10 to 20 minutes. In total 23 counseling sessions were observed.

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Section II

Data Analysis based on Method of Data Collection

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Section II presents analysis of the data obtained from in-depth interviews, review of counselors' documents, participant observation data, field observations, and researcher's notes. Data in each core domain is characterized by categories, sub-categories and elements. In a few instances, elements are further explained by sub-

elements. The objective was to break down the data until saturation of information was achieved for each category of the domain. Each domain is described in detail.

HIV Counseling Practices

The data on counseling practices were gathered through in-depth interviews, review of counseling documents, participants' observations, and field observations.

Analysis of In-depth Interviews

The domain, HIV counseling practice, was characterized by six main categories such as (1) counselors' routine, (2) time-management, (3) documentation, (4) types of counseling, (5) counseling skills and techniques, and (6) counselors' challenges.

The first main category was counselors' routine. The participants shared activities that they engaged in daily as part of their job profile. In order to help participants identify routine tasks, the researcher used diurnal map by plotting significant activities they engaged in throughout the day, and the approximate time slots. An analysis of the diurnal maps of the participants (Figures 24 to 27) helped identifying counselors' routine tasks, allocation of time to counseling task and other activities.
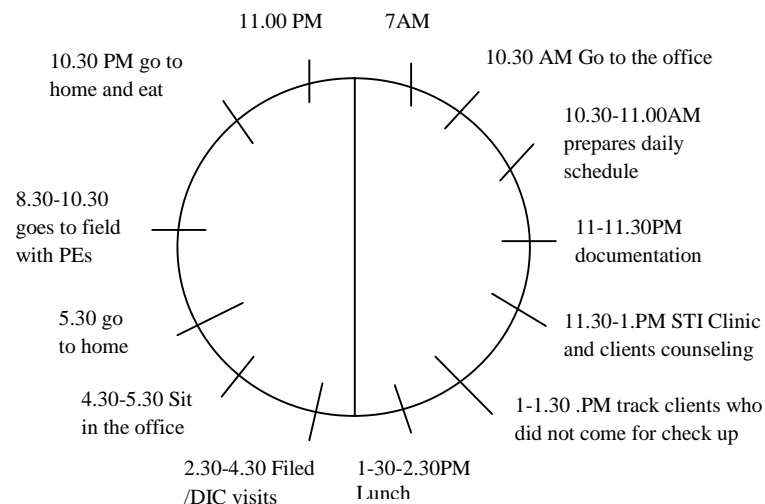
11.00 PM 7AM

10.30 PM go to home and eat

10.30 AM Go to the office

10.30-11.00AM prepares daily schedule

8.30-10.30 goes to field with PEs

11-11.30PM documentation

5.30 go to home

11.30-1.PM STI Clinic and clients counseling

4.30-5.30 Sit in the office

1-1.30 .PM track clients who did not come for check up

2.30-4.30 Filed /DIC visits

1-30-2.30PM Lunch

Figure 24. Diurnal map of community counselors working with MSM TIs.

10.00 PM go to sleep

7AM wakes up and complete household work

10.00 Go to office and checks diary

5.00-10.00 Household work and spends time with family

10.00-11.00 Documenta tion

5.00 Go home

11.00-1.00PM STI Clinics

2.00-5.00PM sits at office or manage evening clinic

1.00-2.00PM Lunch Break
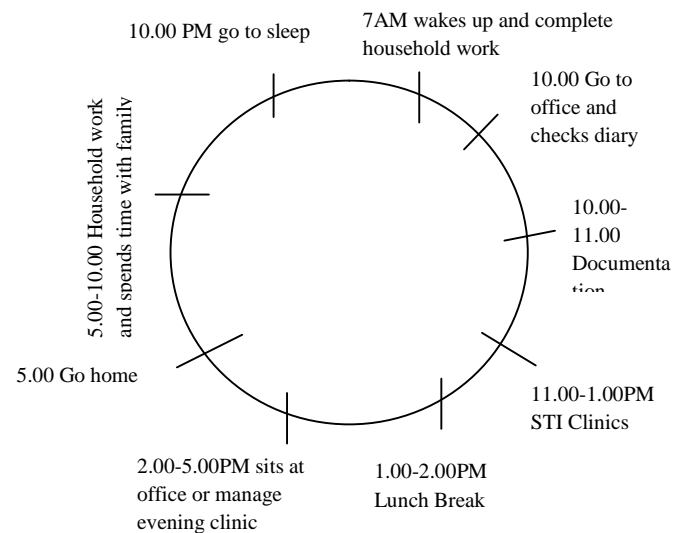
Figure 25. Diurnal map of ANM working with IDU and FSW TIs.

09.00 PM go to sleep

6.00 AM wake up and completes household work

05.00 PM go to home

10.00 AM go to office

10.00 -11.00 AM checks tracking sheet and make plan

03.00-5.00 PM go to the field

11.00-01.00 PM STI clinic

2.00-3.00 PM DIC visit or any meetings or meeting ICTC counselor

01.00-02.00 PM Lunch Break
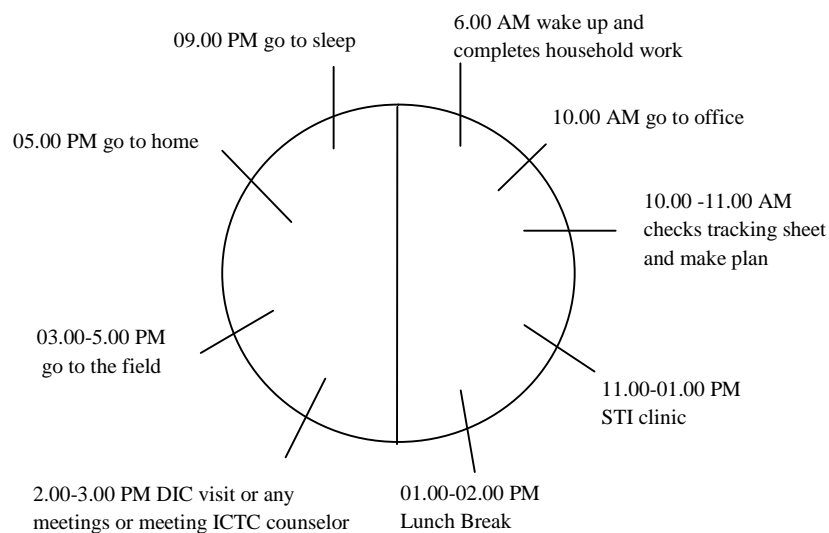
Figure 26. Diurnal map of female counselors working with FSW and MSM TIs.

10.00-11 PM go to sleep

08.00 AM wake up

10.00-10.30 AM checks tracking sheet and make plan

09.00-10.00 AM go to office via field

8.00-10.00 field visit if required

10.30-1.00 PM go to STI Clinic

5.00PM Go to home

01.00 -2.00 PM Lunch Break

03.00-5.00 PM evening clinic or DIC or meeting ICTC counselor

2.00-3.00PM documentation and field visit plan
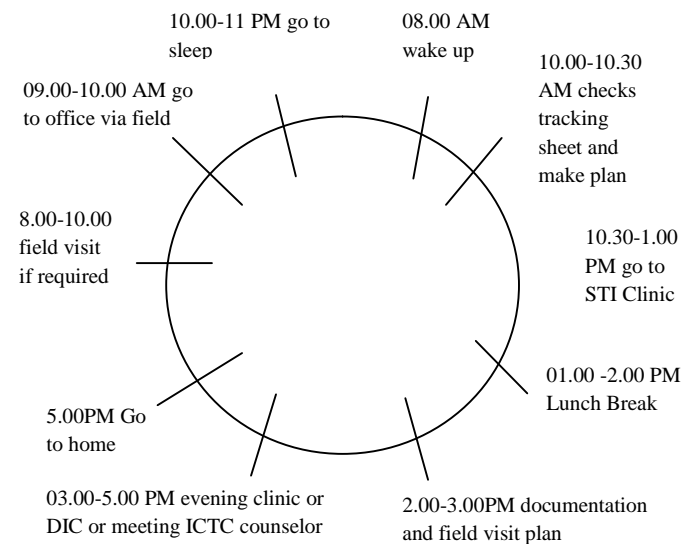
Figure 27. Diurnal map of male counselors working with MSM and FSW TIs.

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Based on the diurnal map, six sub-categories of counselors' routine activities were emerged, namely, (a) diary writing, (b) update counseling documents, (c) STI clinic management, (d) counseling clients, (e) field visits, and (f) other activities. Each sub-category was further explained by elements. Figure 28 illustrates the sub-categories and elements of the counselors' routine.

Diary writing essentially included checking the previous day's work, planning the day's work based on tracking sheet and recording the day's work. In addition to diary writing, participants were engaged in updating counseling documents daily. Many participants perceived documentation as tedious. In the words of one participant,

> P09 …TI [targeted intervention] has very lengthy and rigorous documentation. I update previous days' activities. After I write daily diary, next routine is to update documents in prescribed formats.

Another key routine activity was STI clinic management, which included multiple activities such as checking STI examination tools for cleanliness; disposal of biomedical waste such as hand gloves, expired STI drugs and condoms as per the guideline; coordination with doctors to collect daily clinic data, arrange clinic timings as per clients' preferred timings, calculating doctors' payment; checking STI drugs stock, and ensuring STI treatment as per the protocol. Such multiple activities affected quality of STI counseling. One participant (P13) shared, "*In so much of STI clinic related work, counseling clients for STI is sidelined.*"
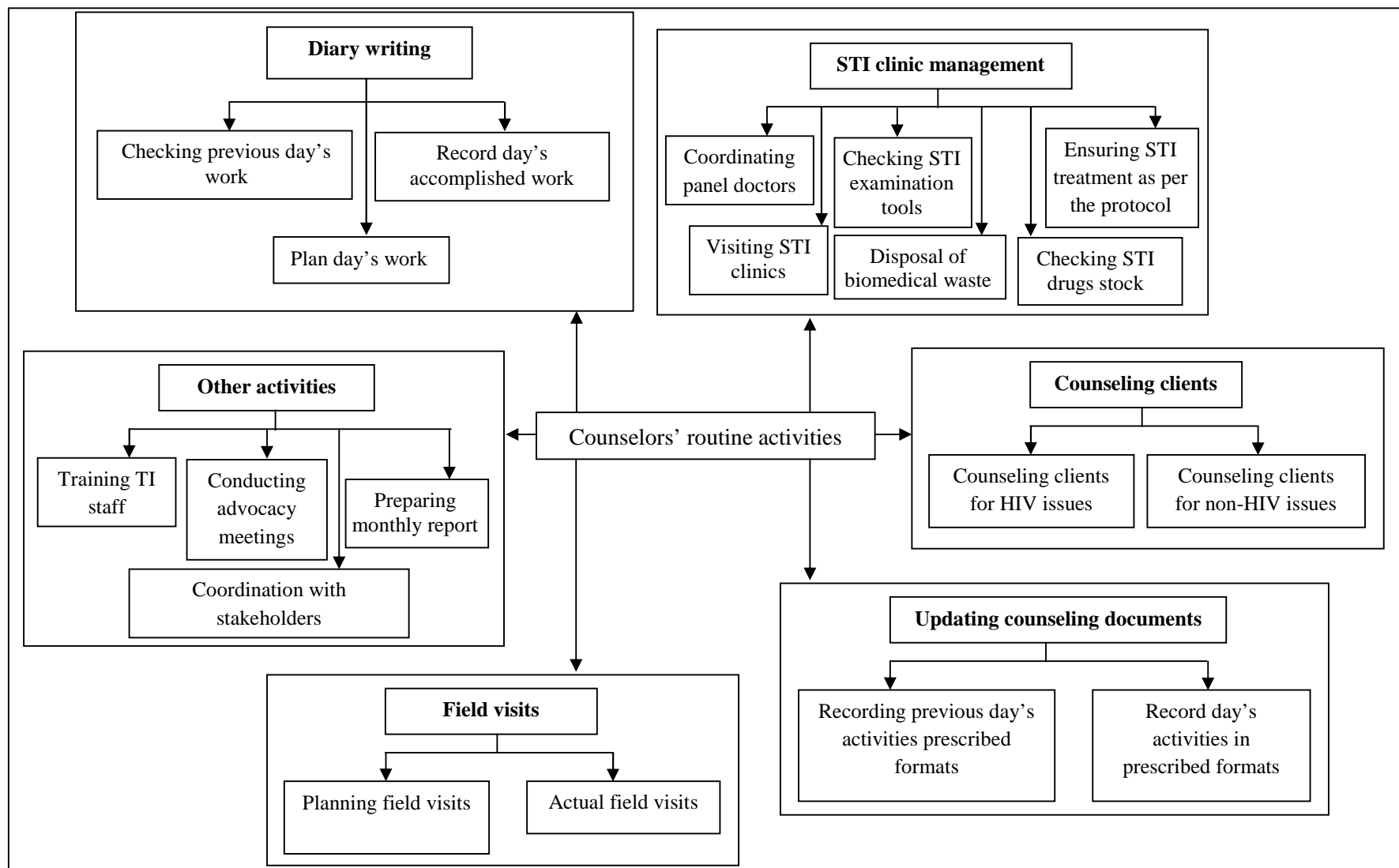
Figure 28. Sub-categories and elements of the counselors' routine activities: In-depth interview

Field visits and other activities comprised conducting trainings for the staff, advocacy meetings with police and local leaders and coordinating with stakeholders such as integrated counseling and testing centers – ICTCs, anti-retroviral treatment centers – ARTCs. The following statements reflect field level activities:

> P3 I make field visits during hotspot meeting with MARP organized by peer educators (PEs), meeting with PEs organized by outreach workers (ORWs).
>
> P7. …also visits to ICTCs, STI clinics, ART centers, TB-DOT centre for coordination and cross-check number of clients referred to these services availed services.

In addition to the above activities, the counselors offered counseling services to clients. Counseling essentially comprised HIV and non-HIV specific counseling services. HIV specific counseling referred to counseling related to HIV prevention, and HIV related services. Non-HIV specific counseling covered client's personal issues. As P7 said,

> "...in order to encourage clients to bring change in risky sexual practices, it is important to help clients deal with non-HIV problems, such as relationship issues, sexual and gender identity issues, helping clients getting election card or ration card etc…"

In summary, the participants had a very busy routine, from maintaining daily diaries, documenting activities, making field visits, other activities to counseling the clients.

The second main category, time management, emerged as an important part of

the counseling practice. Counselors' routine activities clearly reflected participants'

priorities and allocation of time to counseling and non-counseling activities. The

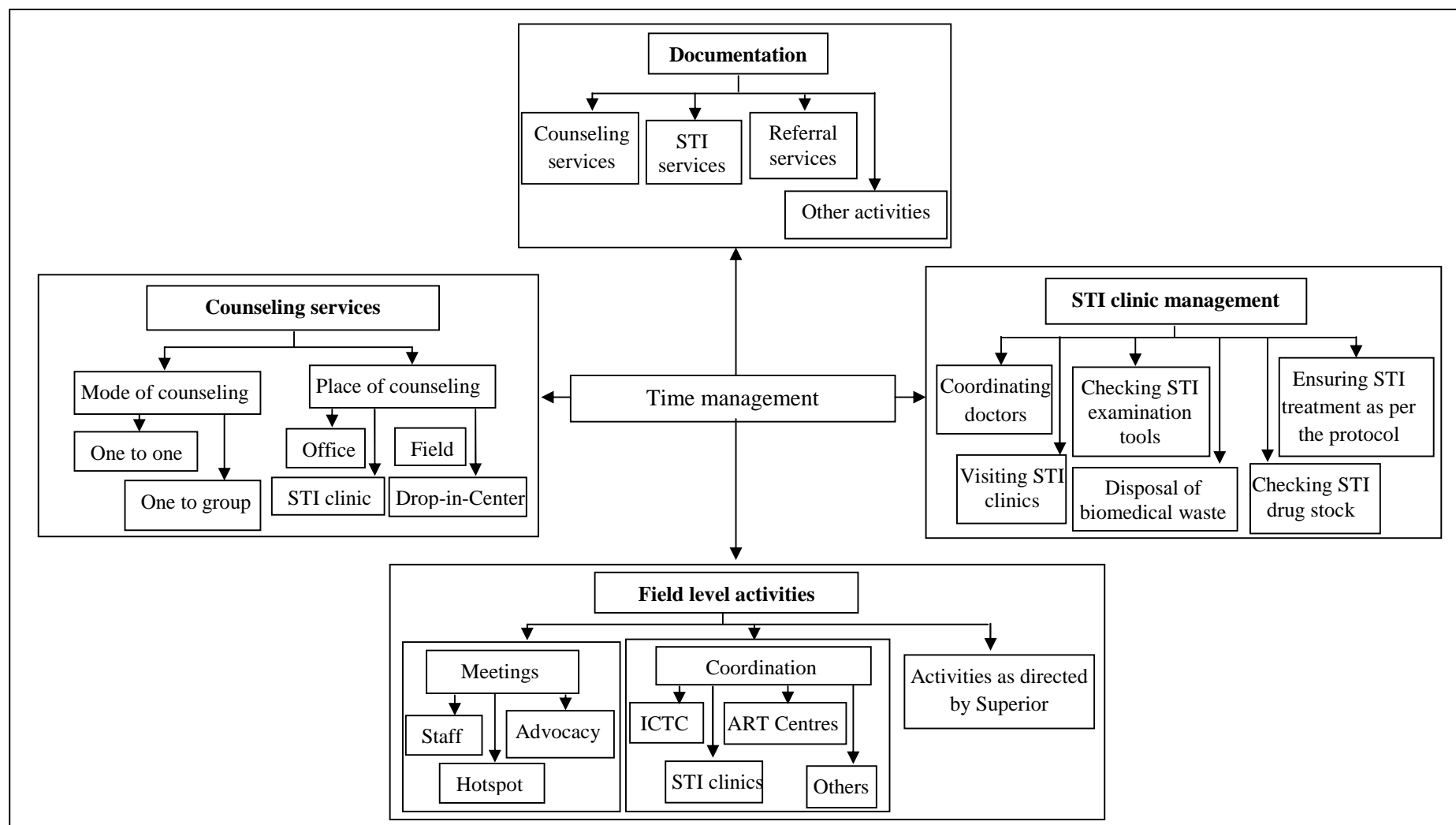Figure 29 illustrates the categories, sub-categories and elements of time management.

Figure 29. Sub-categories and elements of the time management: In-depth interview.

As shown in the diurnal map (Figure 24 to 27) and Figure 29, participants managed their time across four activities, namely, (a) documentation, (b) STI clinic management, (c) field related activities, and (d) counseling related activities. Participants primarily spared more time for documentation activities. It included documentation of counseling services, STI services, referral services and other activities. Detailed description of the documentation with examples is provided in the description of the documentation. Participants expressed that documentation consumed considerable time and therefore they were unable to spare adequate time for other activities specifically counseling related activities. This is reflected from the following statement:

> P05…most of my time is consumed by documentation activities…TI project's focus is on documentation so all counselors' mainly focus on documentation. Due to lengthy documentation we are not able to focus on counseling activities.

Second most prioritized and time consuming activities were STI clinic management and field level activities. Participants had prioritized the work based on their professional competency. For example, ANMs, spared more time in STI clinic management as ANMs are trained to assist doctors. Non-community counselors (those who were post-graduates) engaged in training TI project team, conducting meetings, coordinating with stakeholders and compiling project's monthly data. Community counselors were more engaged in interacting with clients, frequent field visits to reach

out hard to reach clients, and conducting group sessions, focused group discussions and group counseling sessions. As reflected from the diurnal map, participants had different priorities and have allocated more time to the activities they felt comfortable with. Most participants except community counselors remained more occupied with non-counseling activities.

The third main category, types of counseling comprised six sub-categories, namely, (a) preventive counseling, (b) STI counseling, (c) HIV test counseling, (d) supportive counseling, (e) crisis counseling, and (f) psychological counseling. The Figure 30 illustrates sub-categories, elements and sub-elements of the types of counseling.
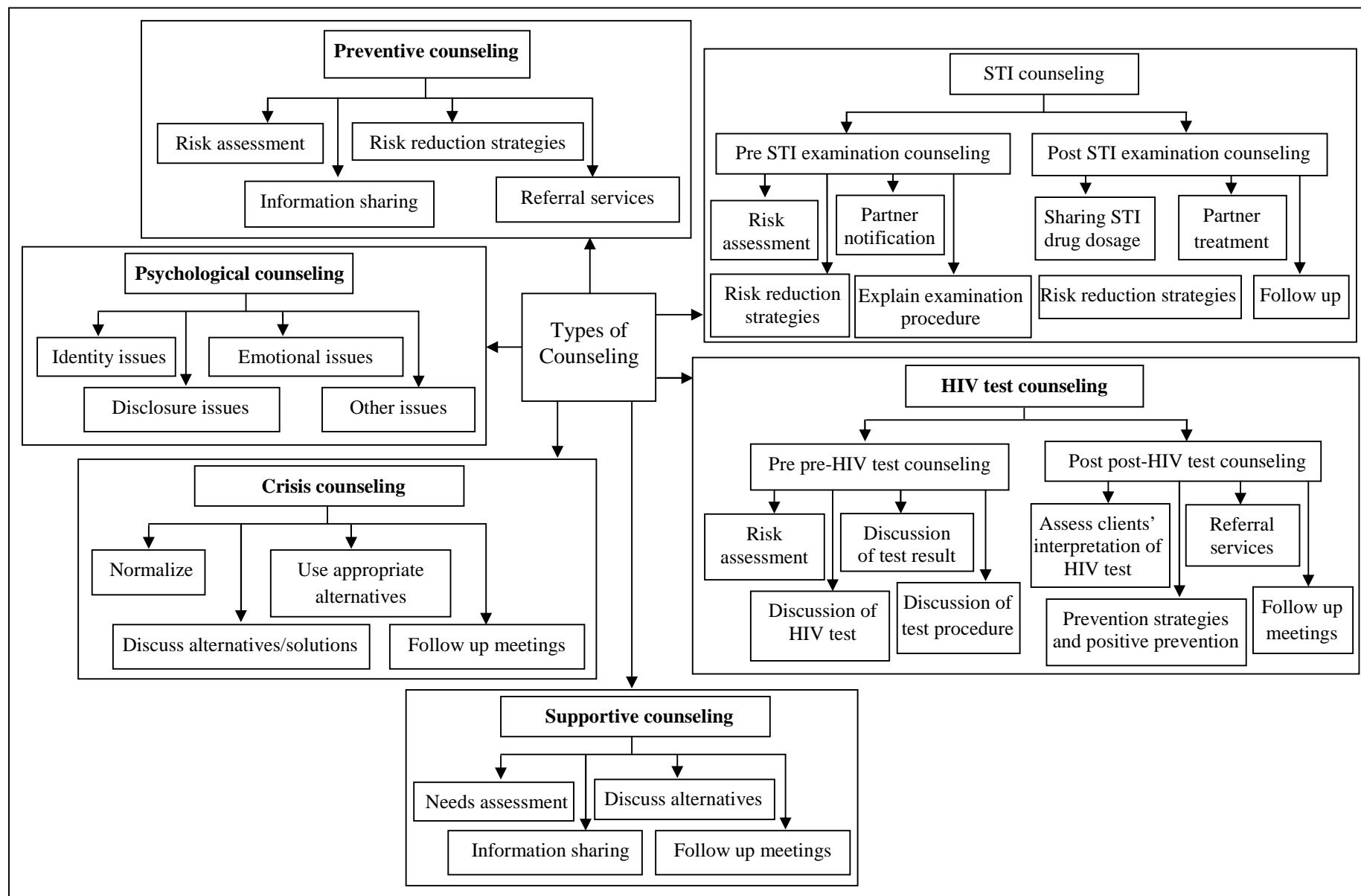
Figure 30. Sub-categories and elements of the category, types of counseling: In-depth interview

Preventive counseling referred to counseling newly identified clients. Preventive counseling essentially focused on prevention of HIV transmission. One participant shared,

> P01 Preventive counseling includes assessing client's risks, provide information on HIV…take sexual history and assess client's risk of HIV, provide HIV related information to clients and discuss risk-reduction alternatives such as condom use...tell clients about HIV test and encourage client to go to ICTC and STI clinic.

HIV test counseling was referred as counseling before referring clients to the Integrated Counseling and Testing Centre (ICTC) for HIV test and after clients have received HIV test report from the ICTC. HIV test counseling was comprised pre pre-HIV test counseling and post post-HIV test counseling. Pre pre-HIV test counseling was referred to counseling a client before referring them to the ICTC. As per the norm, pre HIV test counseling is offered at ICTC, therefore, participants called counseling related to HIV test in TI as pre pre-HIV test counseling. The post post-HIV test counseling was conducted after clients' have received HIV test result from ICTC. Supportive counseling was offered to HIV positive clients to equip them to deal with everyday challenges and provide practical help such as getting food and free bus pass to travel to ART center. It covered primarily two key areas, living with HIV positive status, which focused on healthy life style, prevention of opportunistic infections, and prevention of transmission of HIV to others; and adherence to ART, which included sharing the importance of ART adherence and strategies to adhere to it. These characteristics were reflected in following excerpts.

P10 …I provide information about healthy lifestyle and positive prevention to those who are diagnosed as HIV positive. As per client's need, I help HIV+ clients, [for example], I helped one client to get bus pass to travel from home to ART centre, helped one client to get job and helped poor clients get food from builder.

Crisis counseling was referred as counseling clients who have faced any critical events or incidents in their life (for example, cheating or blackmailing by clients or sexual partners, beating by spouse or lover, harassment from police and so). As illustrated in the Figure 30, key characteristics of crisis counseling were normalizing clients' intense feelings and helping them regain strengths to cope with the crisis situation and discussing alternatives by sharing various options to deal with the situation, for example, taking legal action, help from police, and/or linking clients with other service providers. Psychological counseling addressed issues related to sexual and gender identities such as coming in terms with sexual and/or gender identities, forced sex work, difficulties accepting self and low self-esteem; self-disclosure issues such as disclosure of sexual or gender identity, engagement in the sex with multiple partners or sex work, and HIV positive status to others; issues related emotional disturbances such as feelings of being worthless, disturbances due to blackmailing from lovers or pimps, or forced sex and; other issues such as substance abuse, suicidal tendencies, and anxiety related to HIV test. Participants stated that psychological counseling is important in TI. P12 said,

"…my client [female sex worker], was disturbed with personal matter. While counseling I found out that she had forced anal sex by her pimp. At this time, providing psychological support was most important than just assessing HIV risk and discussing risk reduction strategies."

Not all participants engaged in all types of counseling described above. Commonly, preventive counseling, pre/post STI counseling and supportive counseling were offered by counselors. Very few participants (4) provided psychological counseling and crisis counseling.

The fourth main category was documentation which included documenting four types of activities such as: (a) counseling, (b) STI, (c) referral, and (d) other activities. The Figure 31 illustrates sub-categories, elements and sub-elements of the documentation.
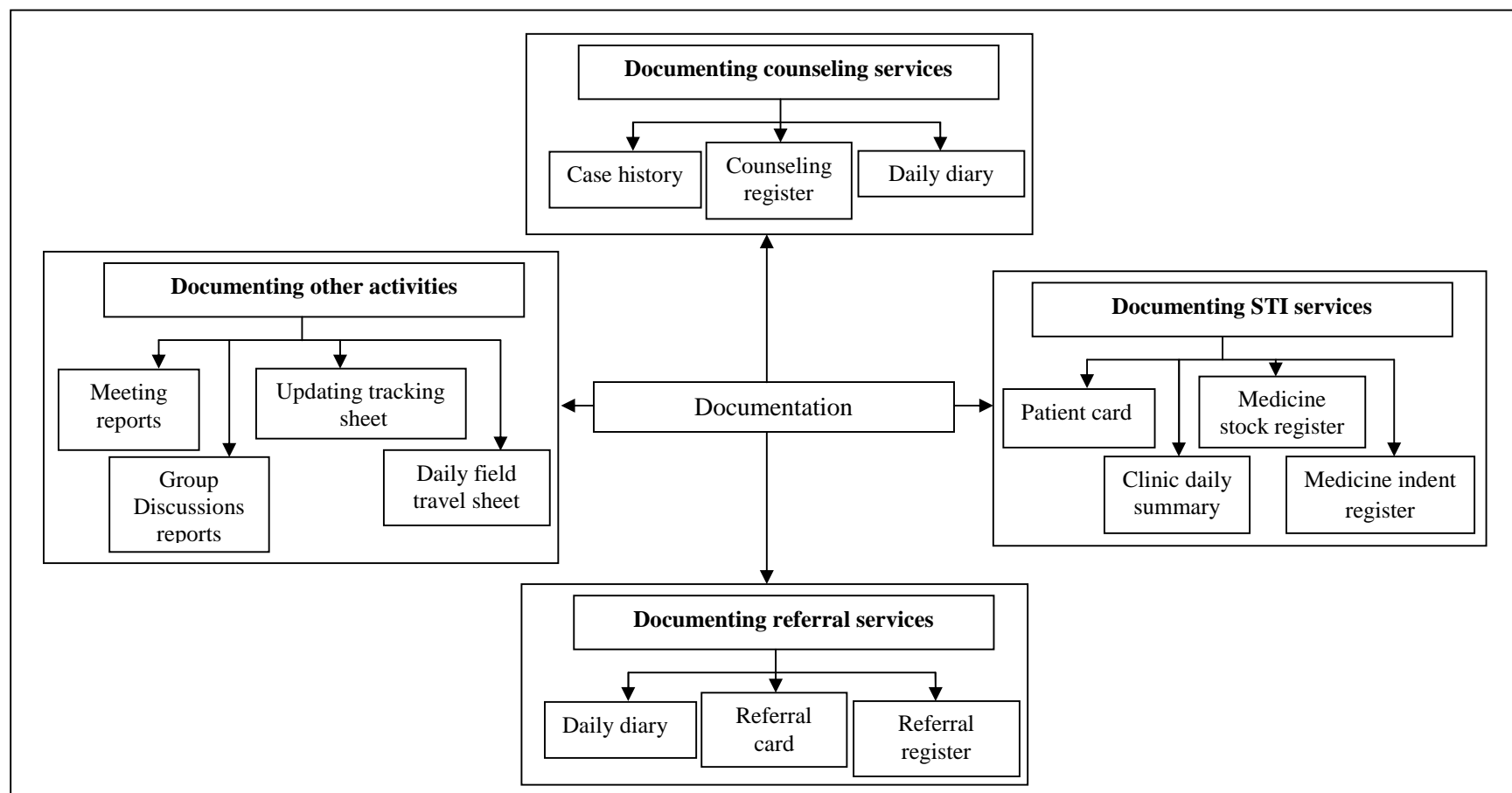
Figure 31. Sub-categories and elements of the category, documentation: In-depth interview.

Total 13 registers/formats were used for documenting above activities: (i) case history format, (ii) counseling register, (iii) daily diary, (iv) patient card, (v) clinic daily summary, (vi) daily and monthly medicine stock registers), and (vii) medicine indent register,(vii) referral card, and (ix) referral register. In addition to recording of these regular services, participants were engaged in recording of other activities, which primarily included documentation of (x) meeting reports, (xi) focus group discussion reports, (xii) daily field travel sheet, and (xiii) updating tracking sheet.

The fifth main category, counseling skills and techniques was characterized by (a) listening, (b) paying attention, (c) questioning, (d) summarizing, (e) being non-judgmental (f) information sharing, (g) explanation, (h) risk assessment, and (i) sharing alternatives. Figure 32 illustrates the sub-categories and elements of counseling skills and techniques.
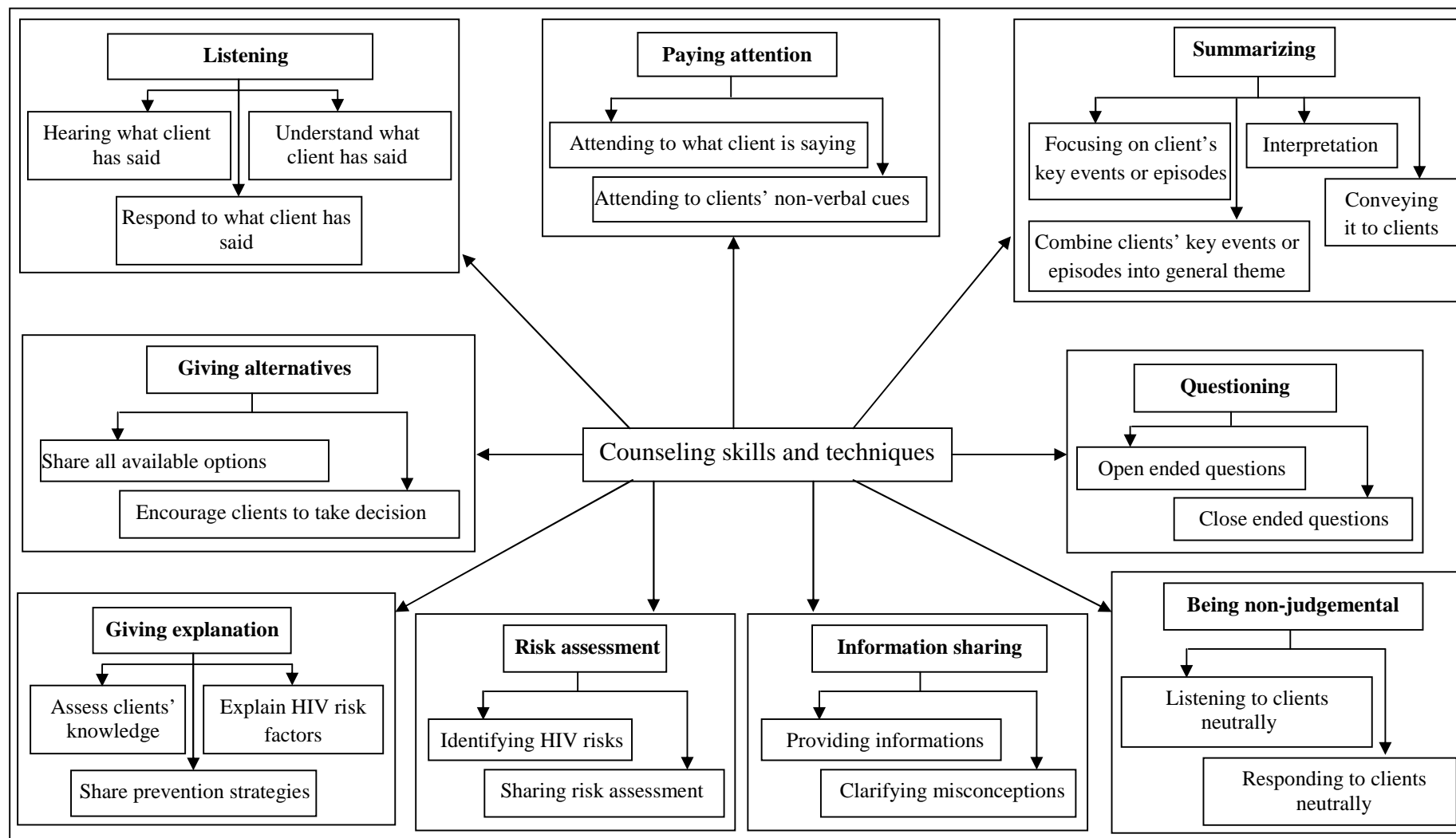
Figure 32. The sub-categories and elements of the counseling skills and techniques: In-depth interview..

Listening essentially included hearing clients' problems, understand clients' problems and respond to it by questioning to clarify or agreeing to it. The following excerpts demonstrate the same.

P10 Listening is hearing clients' problems and risky sexual practices, understand client's problem by interpreting what clients have said, and respond to it by questioning to clarify or agree to it by facial expressions or short words like "hmmm," "right".

Paying attention was characterized by attending to what client has said and attending client's non-verbal cues. Participants shared that paying attention to clients is an important skill to build trust between client-counselor, encourage personal sharing, and boost client's self-confidence in counselors. One participant stated,

P12 Paying attention to client boosts client's self-confidence as well as builds client's confidence on counselors and counseling process. Talking about personal matters such as sex, sexual practices with someone else is difficult. Clients fear that information might be provided to police...when we pay attention to what client is saying and responding them through our body language, we create comfortable environment for client to share. It reduces clients' anxiety to share their personal matter.

While questioning during counseling, participants reported asking open-ended questions to explore clients' problems, assess clients' knowledge and misconceptions related to HIV, sexual practices and preventive strategies, and assess clients' risk for HIV transmission. Close-ended questions were asked to clarify what clients' have

said, and terminate the session. Giving alternatives was another approach

characterized by sharing all available options, and encouraging clients to take a

decision. In summary, participants used various counseling skills and techniques to

deal with clients.

The last main category, counselors' challenges was defined as challenges that

participants have faced in everyday counseling practices. The Figure 33 illustrates
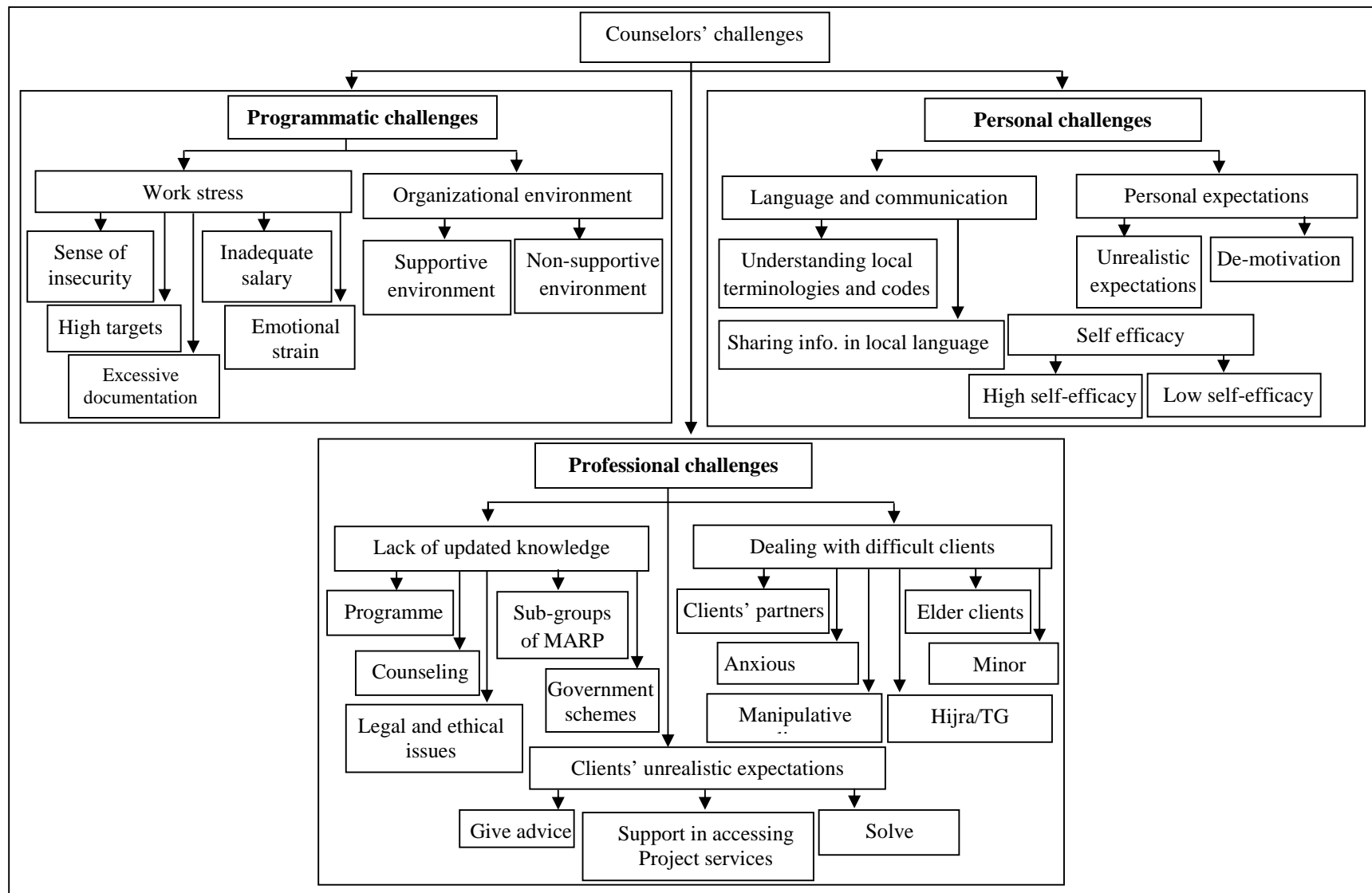
sub-categories, elements and sub-elements of this category.

Figure 33. Sub-categories, elements and sub-elements of the category, counseling challenges: In-depth interview.

Participants had shared three challenges, namely, (a) programmatic challenges, (b) professional challenges, and (c) personal challenges. The programmatic challenges were explained by two elements, namely, work stress, and organizational environment. Work stress included sense of insecurity due to temporary project, high work load, excessive documentation, inadequate salary, and emotional strain due to emotionally demanding nature of the counseling profession. Organizational environment was classified as supportive and non-supportive.

> P11 My organization is very supportive to my work. Trustee and program manager conducts monthly review meetings where the whole team presents their work, progress and share next month's plan. The team always support and encourage us for our good work.

> P12 …organization is not supportive…there is no review meetings at all. Organization's trustees and program manager were not interested in the program, they were just interested in continuing the program to receive funds from the GSACS and hence they pressurized us to achieve project targets.

Personal challenges, was characterized by language and communication, personal expectations and self-efficacy. Language and communication challenge included difficulties in understanding local terminologies and code language used by clients, and sharing information about HIV/AIDS in local language that clients understand.

P05 In Chotaudepur, HIV/AIDS is defined as "*Moti Bimari*" (big disease). If

a counselor uses the term HIV/AIDS, they won't understand, but they

will understand "Moti Bimari." "Moti Bimari" is AIDS. Further, "Koti"

use coded language; they call *"farsi language."* For example, *"dhamni"*

means anal sex, *"nikam"* means penis, *"adiyal ghadiyo"* means

handsome man, *"program ma chhe"* means having sex. Counselors

need to know these terminologies and code language.

Participants had unrealistic expectations to remember everything, do everything

correctly and experienced guilt for not being able to bring the desired change in clients'

risk behaviors.

Self-efficacy was characterized by participant's belief in their capabilities as a

counselor. High self-efficacy included participant's ability to provide counseling

services, confidence, and satisfaction with their job. While low self-efficacy was

characterized by feelings of discomfort, insecurity for working with most-at-risk

population, and feelings of powerlessness due to participants' inability to help and

support clients. A participant shared his experience of being powerless as follows:

P11 I feel I have no power to help HRGs [MARPs]…I had HIV positive

client who needed money to buy food and shelter since he was disowned

by family due to his HIV positive status. I tried my best to mobilize

resources from my own organization and others but I could not arrange

shelter and money for him

Professional challenges were characterized by lack of updated knowledge, difficulties in dealing with difficult clients, and clients' unrealistic expectations from counselors. Participants shared lack of updated knowledge on the national and local HIV/ STI prevalence, effects of ART on the body, information about hijra, transgender populations and injecting drug users, counseling skills and counseling tools such as case history format, suicide risk assessment. They expressed concern to know more about hijra and TGs issues and counseling skills in order to deal with them better. Following statements reflect the need to know more about hijra and TGs as well as legal issues.

06 I need to know more about hijra and TG population, their typologies, castration practices. Many Koti and Hijra asked me about techniques of breast-augmentation, about sex change operation (sex re-assignment surgery), hormone therapy…

P02 I found myself helpless, when clients ask about legal issues of sex change operation [sex reassignment surgery] and when client share that he is going to kill himself. What am I suppose to do in such situations? What are the legal provisions? What should I do if minor clients ask me to provide condoms? Should I give condoms to minors? What is client's partner ask to know about client who is coming for counseling?

Participants reported six types of difficult clients, namely client's regular partner or lover, anxious clients, manipulative clients, elder clients, minor clients, hijra/transgender

(TG) clients. The following statements provide a glimpse of clients' regular partner/lover, anxious clients and manipulative clients:

> P01 Clients come to us in pair [with partner or lover]. Many times I ask client if you would like to discuss alone but they refuse. Coming with partner or lover is one way to express their trust in partner. In such situations, clients do not share high risk sexual practices…sometime clients tell us [counselors] to share their HIV positive status or sexual identity to their partners. If don't understand their requests, they disappears and doesn't allow others to access counseling services.

> P05 Some clients were "anxious" – overly concerned about HIV. I had few clients [4] who felt that they were infected with HIV and underwent HIV testing multiple times at different government HIV test centres and private laboratories in Vadodara. I then met him in the field and counseled. …dealing with anxious clients is difficult as they just do not understand the situation. They frequently come for counseling.

> P07 IDU are most manipulative…they ask for pocket money if I want him to undergo HIV test…during every counseling, they promise to leave injecting practices, undergo HIV test every six months. But the moment they leave counseling room, they become they forget everything.

Participants emphasized that dealing with elder and minor clients (below 18 years) was difficult. Elder clients were those who were more than 45 years of age. They were

unwilling to know about prevention strategies, did not accept their risky sexual practices and were resistant to change their risky sexual practices. A P8 shared his difficulties dealing with minor clients:

"It is illegal to provide counseling and HIV services from the project to minors but I know many minors who are into risky sexual practices. Isn't it counselor's ethical responsibility to prevent them from HIV infection?"

Unrealistic client's expectations from counselors were defined as follows:

P09 Client expects advice from us. Some clients directly ask us to "give your advice…" Many clients' expect that counselors' job is to solve client's problems and help them to access project services. One client asked money to reach to the ICTC for HIV test. He [client] said, "you should accompany me and give me money to reach to the ICTC."

In summary, in-depth interview data revealed six main categories of HIV counseling practices, namely, counselors' routine, documentation, types of counseling, time-management, counseling skills, techniques and counselors' challenges.

Review of Counseling Documents

The review of counseling documents consisted of (1) types of documentation format/registers, (2) content of documentation, and (3) usage of documentation. It revealed 10 different formats/ registers to record their activities as shown in the Figure 34. The Figure 34 illustrates sub-categories and elements of documentation.
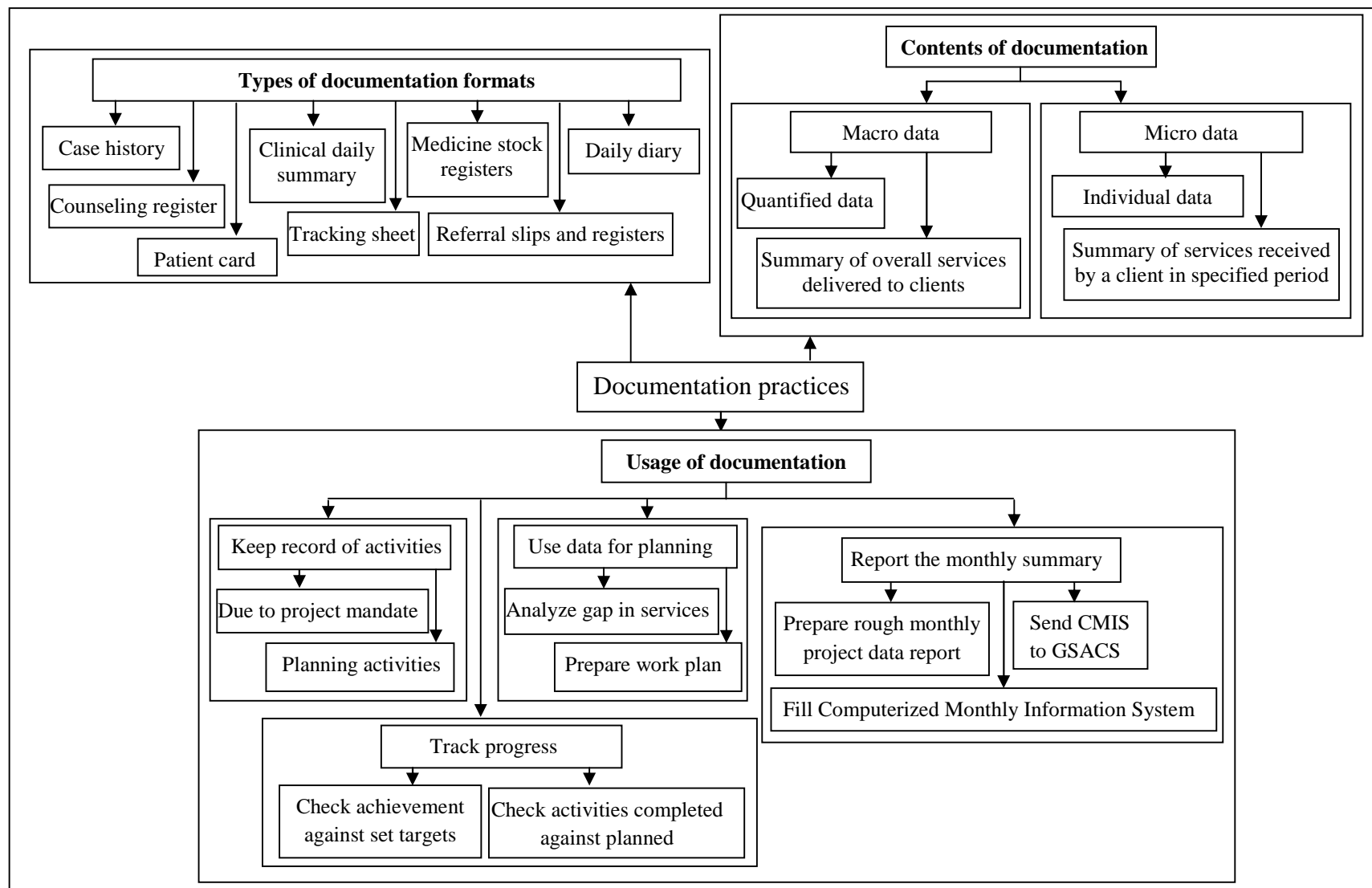
Figure 34. Sub-categories and elements of documentation practices: Review of counseling documents.

The content of documents included two levels, (a) macro and (b) micro level contents. The macro level content was quantified data of overall project, for example, total number of clients referred to HIV test versus number of clients reached to ICTC, number clients' counseled and so. Micro level data characterized by recording of each client's data for example, types of services provided to each client, frequency of one client availing counseling services, date and time of providing service and so. Macro data was calculated based on micro level data. For example, daily counseling data calculated at the end of the month to prepare monthly data. Use of document was to keep record of counselors' activities as key requirement of the project, track the counselors' progress and utilize the data to analyze gaps in the services and strategize outreach plan. In summary, review of documents revealed that various types of documentation format/registers, content of documentation and its usage.

Analysis of Participant Observations

The participant observations comprised observations of the interactions between counselors and clients. During observations, counseling set-up emerged as an important factor influencing counseling practices. Three aspects were observed (1) counseling set-up, (2) counseling context, and (3) counseling skills and techniques. Figure 35 describes the counseling set up and counseling context.
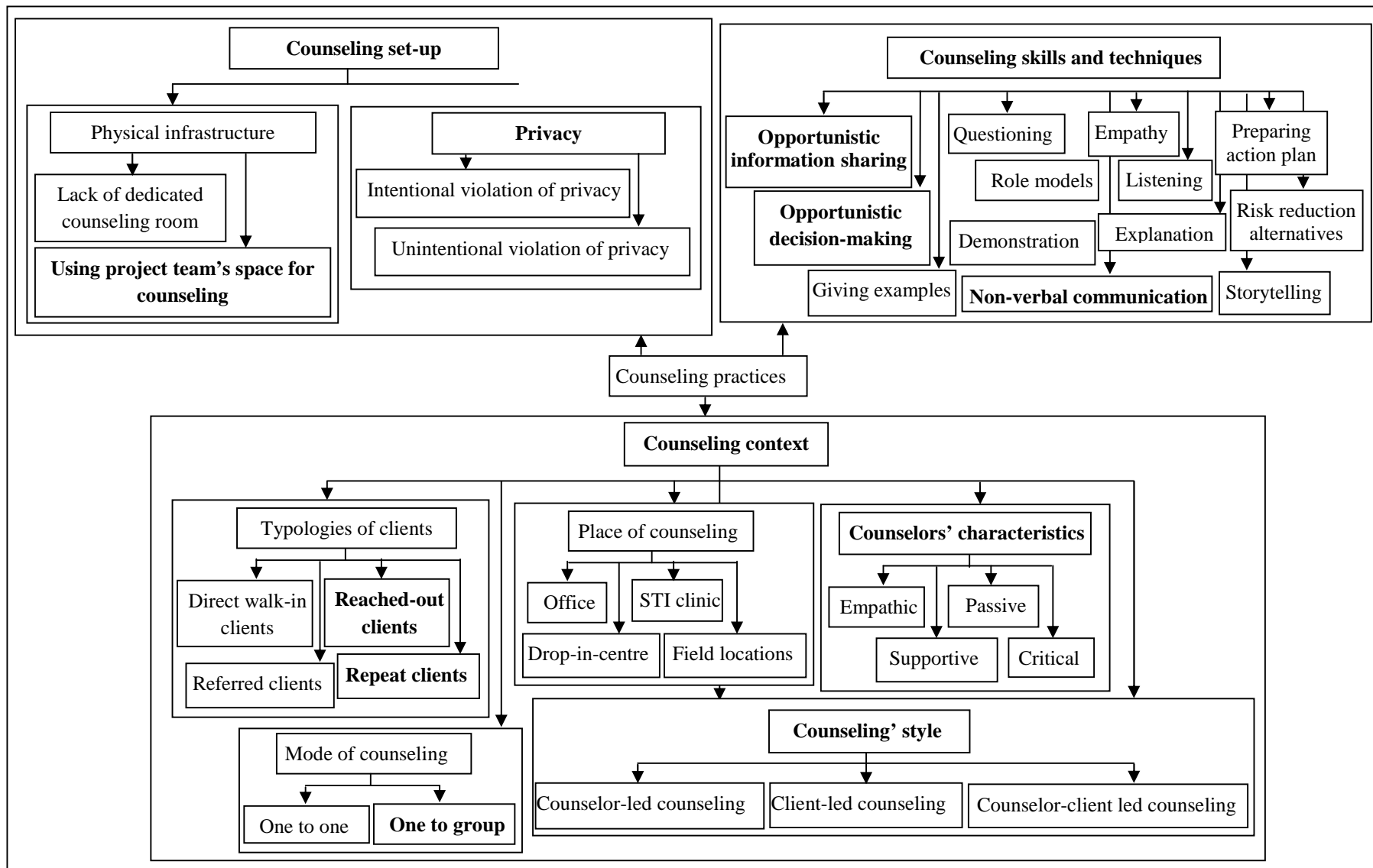
Figure 35. Categories, sub-categories and elements of counseling practices: Participant observation.

The counseling setup consisted of (a) physical infrastructure and (b) privacy. The TI project office lacked appropriate physical infrastructure for counseling such as lack of dedicated counseling room due to budgetary constraint to have exclusive room for counseling and lack of technical knowledge to set-up (appropriate) physical infrastructure for counseling. Therefore counselors were using project team's space for counseling. In the study, only one TI has dedicated counseling room while rest of the TIs were sharing project team's rooms for counseling. In Figure 36, photographs (1 to 4) provide glimpses of the physical structure available for counseling.

Photo 1. Outreach workers' room used for counseling.

Photo 2. Pantry room used for counseling.

Photo 3. Project officer's room used for counseling

Photo 4. Doctor's room used for counseling.

Figure 36. Photographs of counseling set up: Field observation

In addition, it was observed that most TIs were not able to maintain complete audio-visual privacy. Infrastructural constraint and lack of intentions to arrange alternate infrastructure was observed, which was considered by the researcher as intentional violation of privacy. Privacy was also violated unintentionally by frequent movements of other clients and project team during counseling and noise from the outside that required clients to talk loudly, as a result of which their voices could be heard by others. Nevertheless, the clients and counselors appeared to be least affected by these factors, and in fact considered this as a normal situation.

The counseling context included the following aspects: (a) typologies of clients, (b) mode of counseling, (c) place of counseling, (d) counselors' characteristics, and (e) counseling style. Typologies of clients were explained in terms of the way in which clients had approached counselors to access counseling services. It contained direct 'walk-in' clients, 'referred' clients, 'reached-out' clients, and 'repeat' clients. 'Reached-out' clients were defined as those clients whom counselors had reached to in the field. These clients were ones who were not accessing HIV services, and were unwilling to practice prevention alternatives. 'Repeat' clients were defined as those clients who already availed counseling services and were availing follow-up counseling services.

Counseling services were provided using two modes: One to one and one to group. One to group counseling focused on specific concerns of the group, for example, use of condoms with lovers, correct use of condoms in specific context (public places such as public toilets, gardens) where sex is completed in hurry without using condoms due to fear of being caught by police,

dealing with rejection by lovers, in case of MSM – heterosexual marriage of lovers etc. Other group activities included group educational sessions and focused group discussions (FGDs). Two participants adopted the practice of group activities to reach out to more clients. Group educational sessions on STIs, HIV/AIDS, and condom use were also regularly conducted based on the analysis of risk behaviors, misconceptions about sexuality, STIs, HIV/AIDS, and condom use by MARP in specific area. For example, a participant analyzed monthly counseling data and found that many clients have been identified with STIs from one area. Therefore, the counselor had planned group educational sessions and FGDs on STIs and its prevention.

Counselors' characteristics included empathic counselor, supportive counselor, critical counselor, and passive counselor. Empathic counselors were those who demonstrated empathy by expressing feelings and emotions that clients' have shared, showed concern and respect to clients, empowered clients to realize their personal risks and problems, helped client to adopt appropriate preventive strategies among others. The supportive counselors have demonstrated sympathy by understanding clients' problems (not expressing feelings and emotions clients have shared), encouraged clients to share, educated clients on HIV/AIDS/ STIs and its prevention strategies, provided open and direct advice to avail project services, and provided practical help (such as helping clients to access other services like HIV test, STI treatment, ART, medical treatment etc., receiving social entitlements like election card, ration card, other Government schemes, and arranging food for HIV positive people). Critical counselors judged clients' risk behaviors, sexual orientation or drug use practices and imposed personal values by reiterating clients' behaviors as "bad," assessed clients' risks, and forced clients to access project services.

Passive counselors provided HIV/AIDS information to clients without assessing clients' risks for HIV, did not pay attention to clients' concerns, and advised clients to access project services.

The counseling style was defined as counselor's approach that shaped the counseling process. Counselor-led counseling was defined as counselor's active role in directing counseling process where in counselors began inquiring about clients' problems and HIV risks with leading questions and provided relevant information to clients. In this counseling approach, major control of the counseling process was retained with the counselor and client had limited choice and space for exploration. Client-led counseling was characterized by client's leading and active role in directing the counseling process where in clients clarified their doubts by asking questions, sought assistance in terms of advice and support from counselors. With clients' dominant nature of seeking assistance, counseling process was controlled by the client. In counselor-client led counseling, counselors actively initiated the counseling process and gradually engaged clients actively in the counseling process. This counseling style was participatory and counselor acted as facilitator.

Counseling skills and techniques shared during in-depth interviews were validated and few skills were expanded from participants' observation data. Following Figure 37 illustrates the counseling skills and techniques in detail.
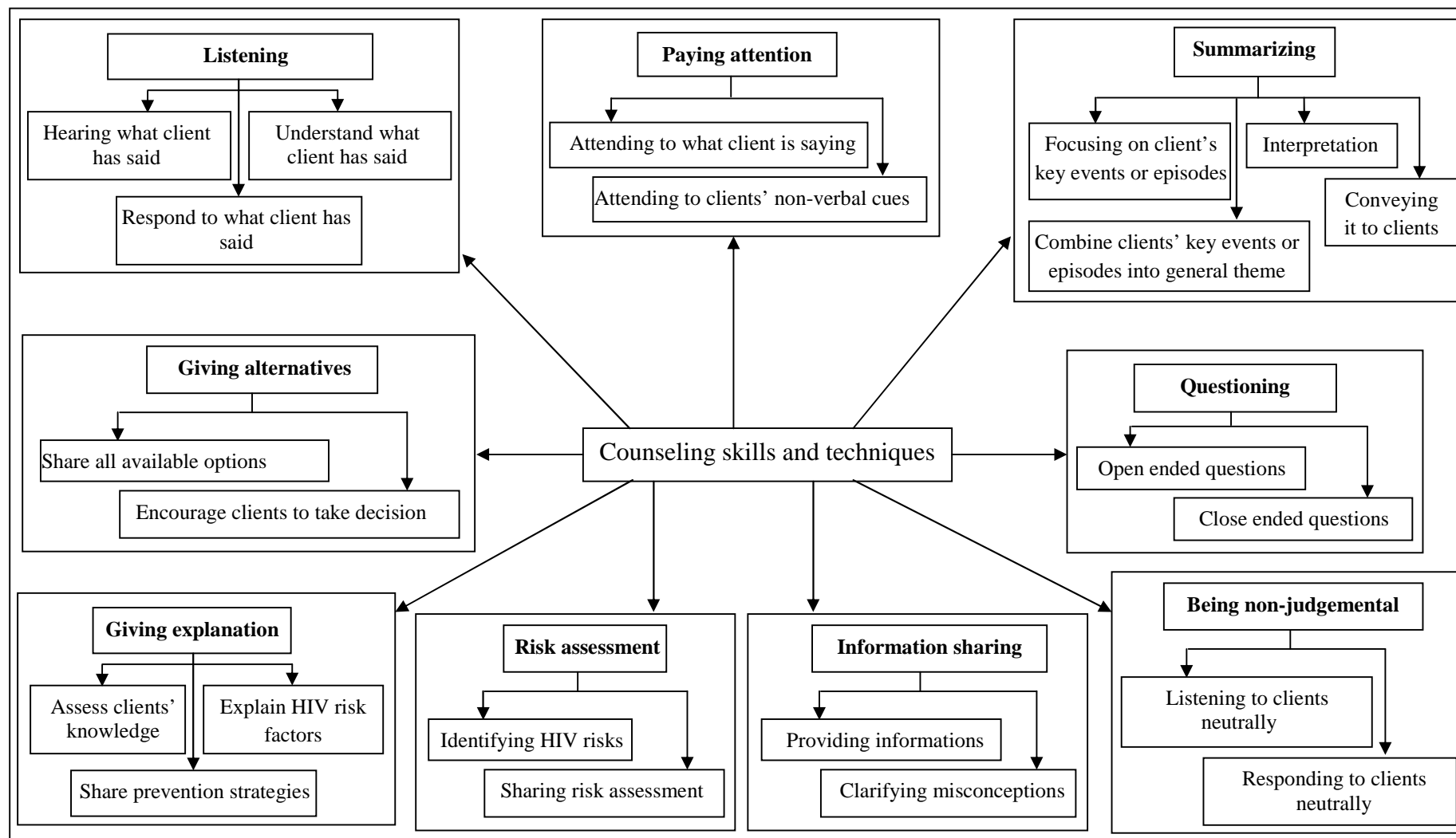
Figure 37. The sub-categories and elements of the counseling skills and techniques: Participant observation.

Many practical counseling techniques have emerged from observations of counseling sessions such as (a) opportunistic information sharing, (b) explanation, (c) giving example, (d) opportunistic decision-making, (e) role models (f) storytelling, (g) demonstration, (h) questioning, (i) listening (j) non-verbal communication, (k) empathy, (l) resource mapping, (m) goal setting (n) risk reduction alternative, and (o) preparing action plan. Opportunistic information sharing was characterized by identifying an opportunity by assessing clients' knowledge, risks and sharing specific information on HIV/STIs. The following conversation between counselor and client illustrates how the counselor has provided specific information based on assessment of client's misconceptions related to HIV/AIDS:

Counselor: What have you heard about HIV/AIDS?

Client: People die if infected with AIDS.

Counselor: hmmm…many people think like that. In your opinion, how

do you think HIV virus contracted?

Client: AIDS can be contracted through sex with prostitutes.

Counselor: Many misconceptions regarding HIV/AIDS existing in the community. One can prevent from being contracted with HIV. Due to lack of knowledge about HIV/AIDS, it's become widespread. HIV is a virus that enters in body through four routes. While AIDS is a collection of diseases due to suppression of immunity. After HIV infection, there are no symptoms appear in the body for around 10-12 years. This condition of the body is considered AIDS. Person dies of AIDS due to HIV infection.

Opportunistic decision making was characterized by conveying decisions related to prevention alternatives and imposing decision to clients as indicated in the following example.

Counselor: How many partners you have in last week?

Client: Four

Counselor: Did you use condoms?

Client: No.

Counselor: What were some reasons for not using protection?

Clients: Partners don't like using condoms.

Counselor: I earlier told about HIV/AISDS and STIs. Do you

remember them?

Client: Yes. You told me how HIV and STIs spread.

[Counselor assess client's knowledge about prevention

Alternatives which were discussed in previous session]

Counselor: So now do you find yourself at risks?

Client: Hmmm

Counselor: Since you are involved in risk behaviors, you need to go for HIV

test and STI screening. It's free for you…okay? Visit STI clinic

today and ICTC tomorrow without fail. I am waiting for you.

demonstration techniques were used to explain transmission of HIV/STIs from one person to another and importance of prevention, one of which is described in the following example.

Counselor used penis model and two magnet balls. [GSACS has given penis models to all NGOs implementing TI implementing organizations]. Counselor has put metal nail on the tip of penis. Counselor showed client penis model and magnet. When he took penis near color marked magnet ball, magnets ball attracted to the penis, which marked it with color. Counselor asked client, "What do you understand by this?" Client answered, "Magnet attracted to penis and colored the penis tip." "Now look," Counselor said. He showed condom demonstration using penis. He put up condom on penis and took it near magnet. Magnet attracted and colored the condom. He then, removed the condom and asked, "What have you seen?" "What do you understand by this?" Client said, "Magnet attracted to the penis, but penis was not colored." Counselor said, "Similarly to this, STIs are transmitted from one person to another through sex without condoms (unprotected sex). If one wear condom then STIs cannot be transmitted to another person. Condom prevents HIV/STI infections."

The next section presents the counseling process.

Counseling Process

The data on counseling process was gathered through in-depth interviews and participants' observations.

Analysis of In-depth Interviews

The counseling process comprised four categories. (1) building rapport, (2) exploring problems and risks, (3) discussing alternatives, and (4) follow up plan. The Figure 38 illustrate the sub-categories and elements of counseling process that emerged from the data.
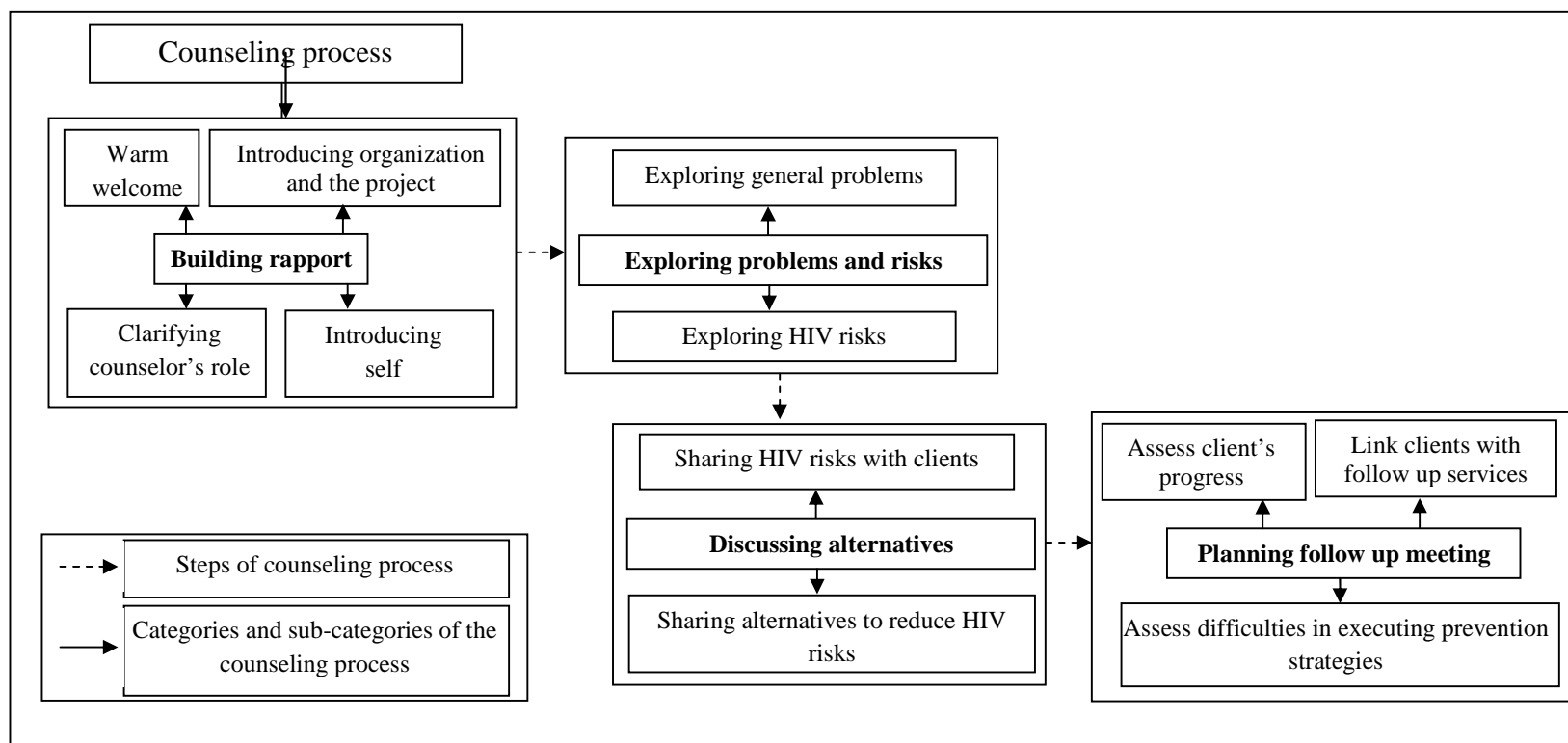
Figure 38. Sub-categories and elements of HIV counseling process: In-depth interview.

During the in-depth interviews, the participants stated that they began counseling with rapport building process to build the context for the counseling. P8 and P4 referred the process of exploring problems and risks as follow:

P8 I assess client's expectations from counseling. Clients' share their general problems such as problems related to their job, child's education, relationship issues etc. This prepares clients to talk about sexual experiences…

P4 …before exploring their risks, I explain what is HIV/AIDS and STIs, how HIV/AIDS, STIs transmit? Then I take sexual history by asking specific questions related to (risky) sexual activities and assess client's risk….

Participants shared that they discuss alternatives with clients by sharing HIV risks with clients and sharing clients' vulnerabilities for STI/HIV infection such as sex work, injecting drug use, multiple same-sex partners etc. Next they talked about risk reduction alternatives such as condom use, monogamous relationship, reducing multiple partners, use of sterile needles, use of HIV tested blood, identification of STI symptoms and its treatment. After discussing the alternatives, follow-up meetings were planned. P04 has described the process of follow-up meetings:

P4 After discussing plan for use of prevention strategies, I discuss follow up
date, time and place for next meeting…in follow up meeting I assess use
of alternatives, reasons for not using alternatives. I discuss strategies to
use alternatives and refer them to a project services which client has not
availed.

Participants reported that counseling process was characterized by building rapport
with clients, exploring problems and risks, discussing risk reduction alternatives and
planning follow-up meetings.

Analysis of Participant Observations

The data on counseling process emerged from the interview was validated and expanded
through participant observations. The Figure 39 illustrates the counseling process.
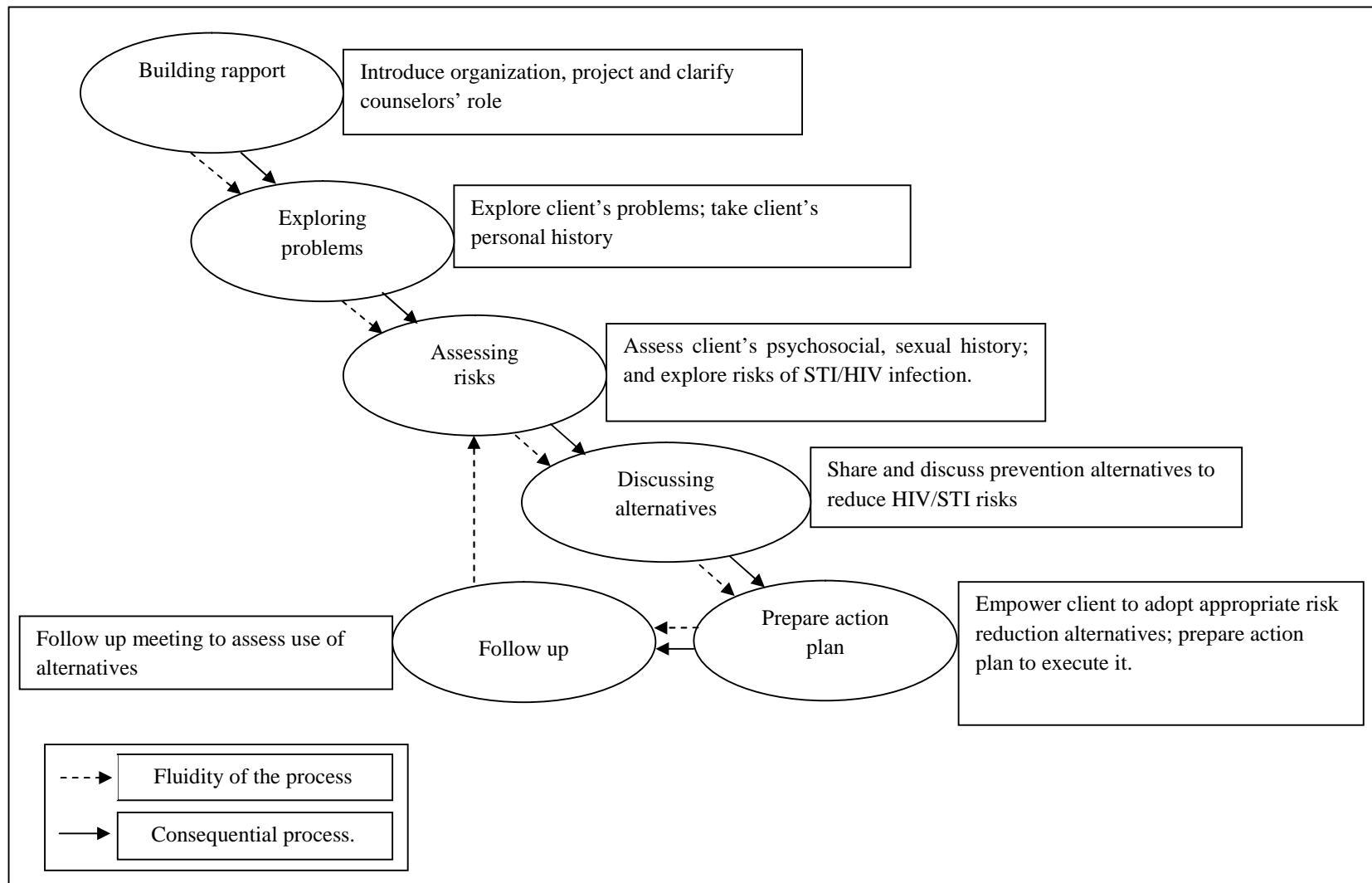
Building rapport

Introduce organization, project and clarify counselors' role

Exploring problems

Explore client's problems; take client's personal history

Assessing risks

Assess client's psychosocial, sexual history; and explore risks of STI/HIV infection.

Discussing alternatives

Share and discuss prevention alternatives to reduce HIV/STI risks

Prepare action plan

Empower client to adopt appropriate risk reduction alternatives; prepare action plan to execute it.

Follow up

Follow up meeting to assess use of alternatives

- - - ▶ Fluidity of the process

──────▶ Consequential process.

Figure 39. Sub- categories of HIV counseling process: Participant observation.

Commonly followed processes were characterized by (a) building rapport, (b) exploring problems, (c) assessing risks, (d) discussing alternatives, (e) preparing action plan, and (f) follow up meeting plan. It was observed that each counselor was individualistic in the process adopted for counseling clients. Counseling process did not emerge as a linear process wherein one step takes place after another; rather it was horizontal and fluid. The broken line in the Figure 39 reflects fluidity of the process while the straight line suggests the consequential process. Rapport building process can be stretched up to next counseling sessions and during that period other processes such as exploring problems and risk assessment may take place. Further, counseling processes such as exploring problems, assessing risks, discussing alternatives, and preparing action plan could overlap. It was also noted that each follow up counseling session was started with brief rapport building to set the stage, assess knowledge and safe practices, and review action plan. The following script illustrates the counseling process.

Counselor: Come in, how are you?

Client: Fine

Counselor: Your name please?

Client: Jayesh (pseudonym)

Counselor: Where are you from?

Client: Bapu Nagar (name of the place is changed)

Counselor: Bapu Nagar? I often come there to meet people and talk about
                   HIV/AIDS and its prevention. I am happy to meet you. I am a
                   counselor, provide information about HIV and help others to

prevent themselves from HIV and live healthy life. [Stops for a while and look into client's eye] Whatever we talk and share, I will not tell it to anyone. Do you know anything about HIV/AIDS and this organization's work?

Client: I heard that AIDS is killing disease.

Counselor: From where did you hear?

Client: Rajesh (pseudonym of the Peer Educator) told me. He also told me about the organization.

Counselor: Great. How do you know Rajesh?

Client: I know him through my friend.

Counselor: Hmmm. Rajesh [pseudonym] works as a Peer Educator. His area includes……

[Counselor talked about areas where Rajesh works, asked about what Rajesh shared about HIV/AIDS and project services]

Counselor: When did you last have sex?

Client: About a week ago with a lady in my neighborhood. I had sex with many [partners].

Counselor: You said you have had sex with many women. Have you ever had sex with men?

Client: (Pauses)….It was about six months ago..

Counselor: Do you have oral sex with men (and women), meaning "mouth on penis/mouth in vagina"?

Client: No

Counselor: When having anal sex, do you insert your penis into your

partner or does he insert his penis into you? or both?

Client: Both

Counselor: Have you used condom?

Client: No.

Counselor: Sex without condom with men or women increases risk of

STI including HIV. Do you think that you are at risk of HIV

and STI Transmission?

Client: As you mentioned four routes of HIV, I am at the risk of HIV/

STIs.

Counselor: Good that you listen to me very clearly. You correctly

evaluated yourself. Can you tell me how you can prevent

yourself from HIV/STIs?

Client: Condom use.

Counselor: Yes. Is there anything else, do you think can prevent you from

HIV/STIs?

Client: No.

Counselor: In order to know whether you contracted any STIs or HIV, you

need to go for STI screening and HIV test. Also, you should

decrease number of sexual partners and frequency of sexual

activities. Always use condom while having sex. [Counselor

then demonstrated correct use of condom].

Counselor: Great. Now what else would you do after talking with me?

Client: I will go to the STI clinic for body check-up and ICTC for

       HIV test. I need condoms so will collect from Harish

       [a pseudonym of the peer educator].

Counselor: Good. So you already met peer educator. He will take you to

       the STI clinic. I will meet you at STI clinic and go to the

       ICTC. Meet me after you get test report.

[Counselor-client interaction during Follow-up meeting]

      Counselor: How are you doing, Jayesh?

      Client: I am fine Sir. What about you?

 Counselor: Thanks. I am doing well. Happy to see you here again. How was

       your experience using condom?

Client: Good

Counselor: Have you encountered any difficulties using condoms?

Client: …condoms are small. I require big condom so that I can use

       Comfortably. Once condom was leaked, so I used two

       condoms…it dried so I used oil on condoms.

[Counselor explained other condoms such as Durex, Kamasutra etc. available in the market.. He clarified not to use two condoms and oil. Counselor demonstrated correct use of condom and suggested to use Jelly (water based lubricant)]

Counselor…have you undergone HIV testing?

Client: No. I could not get time.

Counselor: Go right now if outreach worker accompany you?

Behavior Change Process among Clients

During participant observations of counseling sessions including at least four follow up

sessions, behavior change indicators were noticed and recorded. Behavior change

processes were characterized by seven main categories, namely, (a) sensitization, (b)

personalization, (c) experimentation, (d) evaluation, (e) modification, (f) maintenance,

and (g) relapse. The Figure 40 summarizes the process of behavior change among
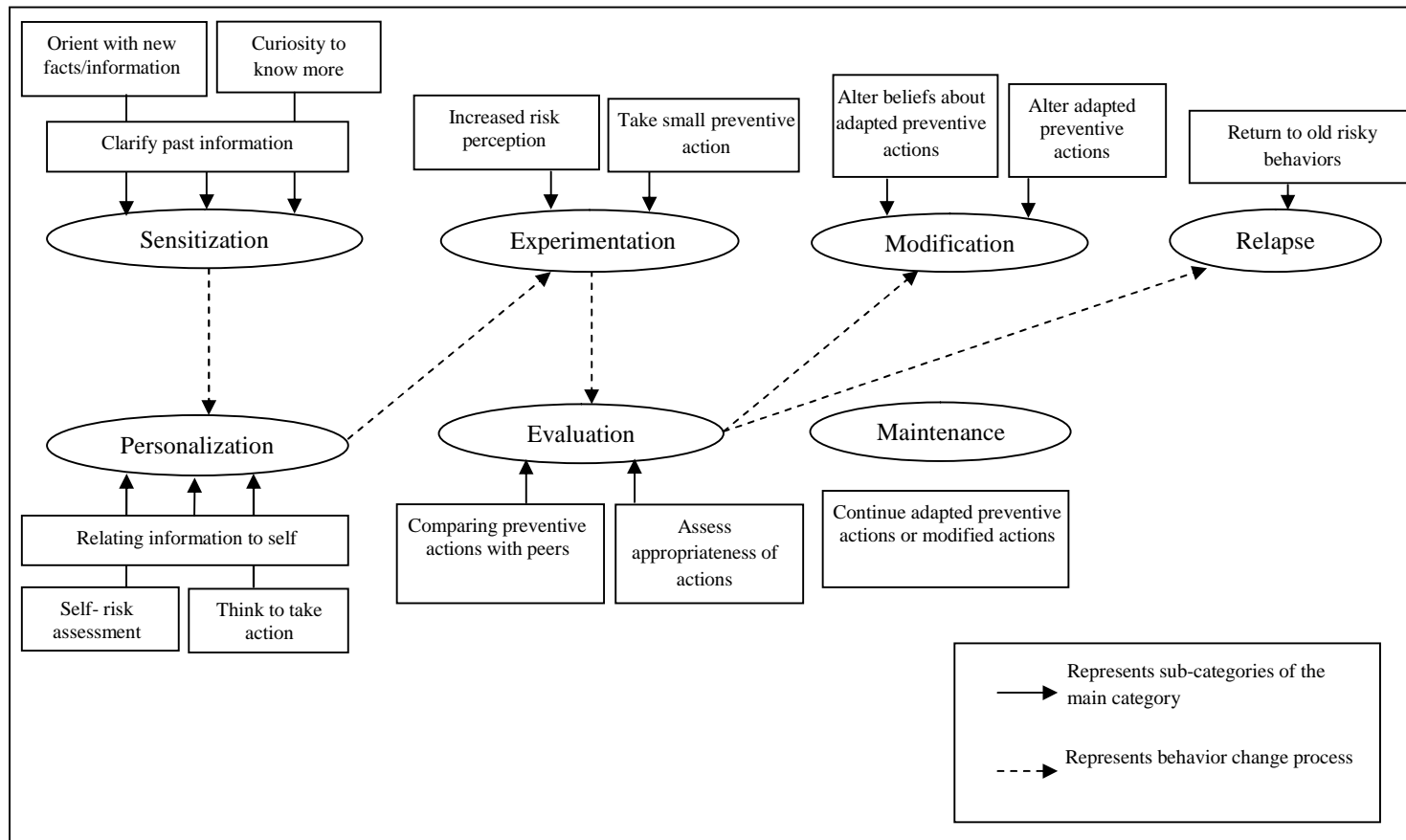
clients.

Figure 40. Sub- categories and elements of the process of behavior change among clients: Participant observation.

First, clients' thoughts and perspectives about HIV/AIDS/STIs, and sexual practices were influenced through information shared during the counseling process. This was a process of sensitization where clients were oriented and sensitized about HIV/AIDS issues. With sensitization, clients were able to personalize HIV risks with their knowledge about risks and their risky sexual behaviors. In personalization, clients were encouraged to know more about it. With an assessment of personal risks and possibilities of avoiding risks, clients began with taking small preventive steps and experimented with preventive methods. Clients evaluated their sexual practices by comparing their practices (for example, condom use) with peers and adopt sexual practice which is culturally approved. For example, not using condom with wife was the norm and considered culturally appropriate. One client shared during counseling,

"All my friends don't use condom with wife. Women don't go out [for sex] and don't have extramarital affairs, so there is no need to use condom."

In other situation, two clients brought in the issues of counseling about difficulties in negotiating safe sex practices with the spouse.

"Two years back my wife underwent tubectomy [surgical excision of a fallopian tube, a permanent method to avoid pregnancy). Now there is no need to use condom with wife...I cannot talk about condom use with my wife. She will ask many questions for using condoms. She will give examples that her married [female] friends don't use condom after tubectomy. What will I answer? She would start doubting?"

"My husband underwent vasectomy (surgical procedure for male sterilization) so he says condom is not required. I know he has multiple sexual affairs but I can't say anything. In our society, women are advised to keep mouth shut. If I say something, he may leave me. Where will I go? In my case use of condom is risky."

Up on self- evaluation of preventive technique/s and comparing peers' sexual practices, clients modified present preventive method (for example, after knowing HIV risks from unsafe sex with regular partners, clients start using condom with them), or maintained a preventive practice (for example, continue condom with all) or continued old risky practices (for example, do not use condom with spouse) depending upon the context and counseling intervention. In the process of behavior change, relapse may occur. Clients may go back to earlier risky practice, for example, clients use condom with regular partner a few times but do not enjoy it so begin to practice unprotected sex. If clients had modified preventive practices, gradually clients either maintained those practices or relapsed to risky practices based on personal experiences and contextual factors. The following script provides a glimpse of the behavior change process.

(Example of sensitization, personalization and evaluation)

Client: What are the chances of getting infection from HIV positive woman to a man? Since men always penetrate, penis never receives rather leaves sperm in vagina, how HIV is transmitted from women to men?

Counselor: Hmmm. Good question. I don't know the right

answer right now. I need to ask my senior and tell

you the correct answer next week when we meet

again. Can you meet

me next week? Do you have any other questions?

Client: How HIV came in existence?

[Counselor explains how HIV came in existence.]

Client: I had few sexual incidents without condom. I think

I should undergo HIV test first and from now

onwards I will use condom.

[Counselor discussed prevention strategies, how client can undergo HIV test and STI screening. Following excerpt from follow-up meeting of the same client]

Counselor: Have you followed what we discussed last week?

Client: Immediately after counseling, I underwent STI screening

from STI clinic at project office. On the same day I

underwent HIV test. Till date I never had sex without

condom.

Counselor: Does anyone from your friend circle use condoms and

underwent HIV test?

Client: All friends use condoms and underwent HIV test

and STI screening. We two friends went to ICTC

and STI clinic together. I feel I am not alone to use

condom and underwent HIV test, and STI screening.

(Example of Modification)

Client: Last time when I had sex, condom torn while having sex. It is too short. I and my partner did not enjoy use of condom and hence did not use last time.

Counselor: It may happen when condom is not used correctly. In fact, condom adds to pleasure and extend time of climax. Try to use K Y Jelly (water based lubricant) with dotted condoms (Counselor provide dotted condoms and K Y Jelly sachet and asked client to share experience of using condoms)

(Example of Maintenance)

Counselor: Have you used condom?

Client: Yes.

Counselor: Good. How many sexual encounters you had in last month?

Client: Three. I have used condom in every sexual act. Now I don't keep any sexual relationship without condom.

(Example of Relapse)

Counselor: As we discussed last time about condom use with Jelly?

Have you used condom? How was your experience?

Client: No. I did not enjoy condom use with my partner.

Counselor: Have you used condom with your wife?

Client: I have not used condom even with wife. There is no need

to use condom Sir because I am safe and she had already

have operated for tubectomy after our second child to

avoid pregnancy. I cannot use condom with wife.

Counselor: You said you are safe. What made you think that you are

safe?

Client   I am safe because keep sexual relationship with healthy

and people from good family background.

Counselors' Experiences

The data on the domain, counselors' experiences, was gathered primarily through in-depth interviews. Counselors' experiences were characterized by factors that influenced their counseling practices and its perceptions. Figure 41 illustrates five main categories namely, (1) training influences, (2) peer influences, (3) program influences, (4) organizational influences and (5) counseling practice influences.
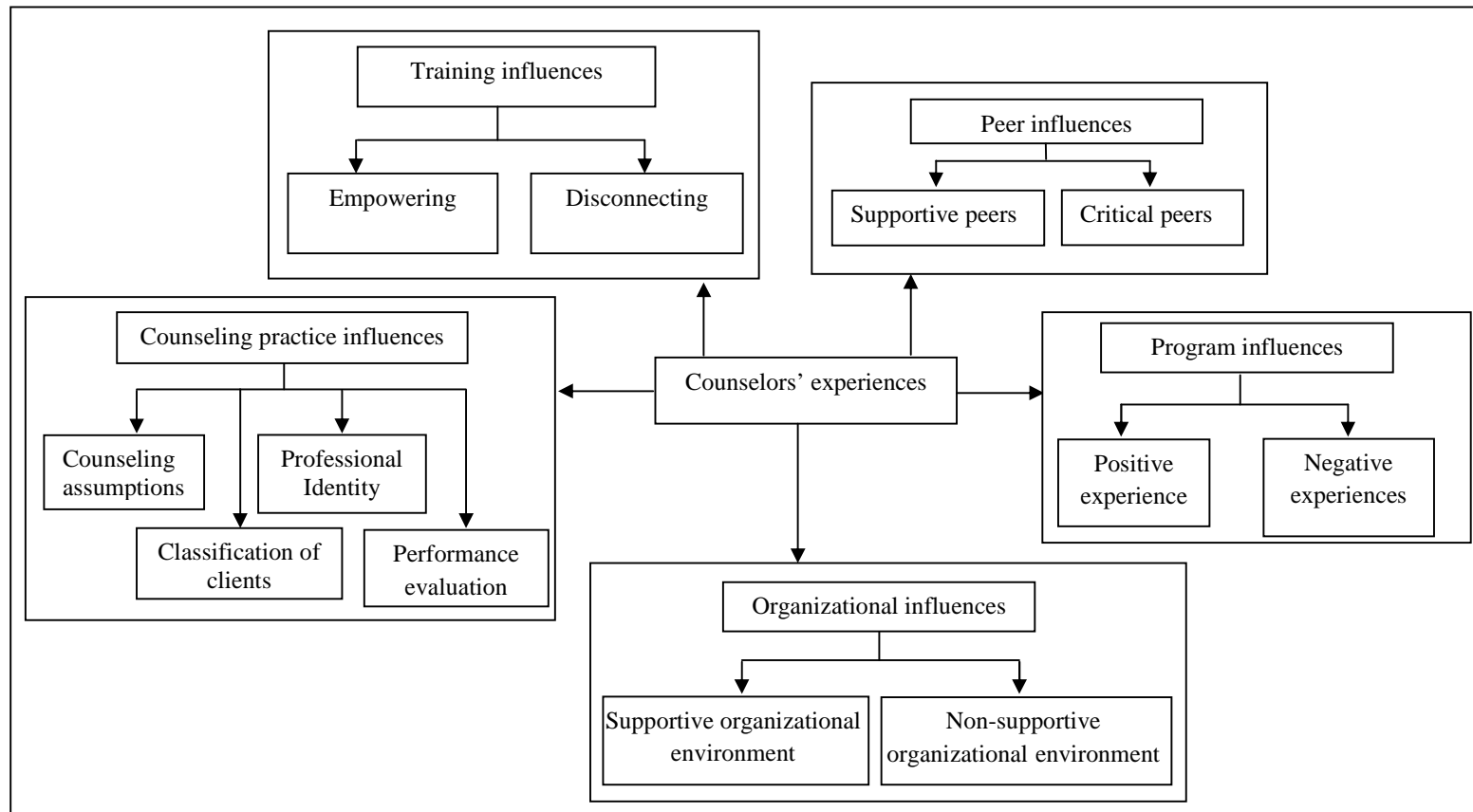
Figure 41. Sub-categories and elements of counselors' experiences: In-depth interview.

The main category, training influences, was defined as participants' experience of trainings and a variety of ways in which trainings were influential to them and their counseling practices. The training influences were characterized as (a) empowering, and (b) disconnecting. Many participants expressed empowering nature of trainings they received. They felt empowered by improved knowledge, counseling skills and confidence that they gained from the training. However, few participants did not find the training relevant to the field realities due to insufficient coverage of the training content relevant to field reality and sharing of irrelevant examples that failed to connect the learning from the training to the field practice. P1 and P7 shared their experiences of the training influences.

P1 There is this one trainer who is actually worked as a TI counselor. He gave examples from real counseling practices with the community. It has really helped me understand counseling in TI setting. I feel I am prepared, have skills that I can apply in the field. I feel empowered.

P07 I am not able to understand examples and role plays practiced in the training. Need examples from the field. I need to learn writing case study, taking sexual history and counseling IDUs, Hijras and TG. We were taught in the training to maintain confidentiality and privacy. How to maintain them at the field? People come in pair for counseling then how to maintain confidentiality norm? Whatever they teach, we are not able to connect with field realities.

Peer influences, the second main category, was characterized as the support participants received from counselors working with other TIs. Few participants stated that some peers criticized them for their good work without getting enough salary from TI and tried to de-motivate them.   Program influences and organizational influences have discussed earlier in the section on counseling challenges. The last main category, counseling practice influences was defined as the experiences of counseling practice that influenced participants. It comprised four sub-categories, namely, (a) counseling assumptions, (b) classification of clients, (c) professional identity and (d) performance evaluation. Counseling assumptions contained counselors' definition of counseling, counselors' values, and counselors' role. Participants defined HIV counseling as, *"a process of interaction with clients, providing correct information on HIV/AIDS and STIs, remove misconceptions, identify their risks factors, discuss strategies to reduce risks and empower clients to take appropriate decisions."*

Counselors' values included being non-judgemental, open and accepting clients as they were. Participants defined counselors' role in TI as educator, teacher, supporter and advocate. Participants stated that the first important role of a counselor was to educate clients about STI/HIV risks and clarify misconceptions related to HIV/AIDS and sexual practices; the second role was to teach preventive strategies to clients, correct and consistent use of prevention strategies; the third role was to provide support to access preventive services and support to get other social entitlements, and the fourth role was to advocate for the client's rights/needs and for creating conducive environment so that client can access project services. Participants reported classifying clients based on their

motivation to seek counseling and project services. They classified clients as (i) just curious clients, (ii) curious clients, (iii) shy clients, (iv) anxious clients, (v) manipulative clients, and (vi) indifferent clients. The just curious clients were mostly referred by PEs or ORWs to avail HIV services who shared selective information pertaining to their identity, name, address and sexual activities in the first two sessions. They were unlikely to return for follow-up meetings on their own. Curious clients were characterized by clients who come to the project office or DIC on their own, shared honestly about their life (such as name, address family details), their risk behaviors to counselors, and sought follow up services such as counseling sessions and other project's services on their own. Shy clients had a fear of being judged for their HIV positive status, sexual practices or drug use, reluctant to share their sexual or drug use practices to counselor s and did not avail follow-up services alone. Indifferent clients were those clients who were unwilling to know about HIV/AIDS and its prevention and access to HIV project services. Anxious clients and manipulative clients were described earlier in professional challenges, namely dealing with difficult clients. Professional identity was defined as participants' ways to relate themselves as a professional counselor. It comprised positive professional identity, and negative professional identity.

Participants expressed professionalism and their positive as well as negative beliefs related to professional identity as counselors. They explained that they felt positive about themselves as professional counselors when they were respected and were able to help clients. Participants were motivated to enhance knowledge on counseling and improve counseling skills. The negative professional identity was characterized by

feelings of incompetent for not being able to help clients, lack of counseling skills, and discomfort working with most-at-risk population. Participants have evaluated their performance as satisfactory and unsatisfactory performance. Satisfactory performance was characterized by achieving counseling targets such as number of clients counseled, referred and followed-up etc.; accomplishing other project activities such as meetings, focused group discussions etc., and bringing change in client's risky sexual practices such as correct and consistent use of condoms, and accessing project services. Non-achievement of counseling targets, incomplete project activities, and not bringing desirable change in clients' risky sexual practices were evaluated by participants as unsatisfactory performance. The following examples support the above description of performance evaluation:

P5 I am satisfied with my work. I contacted each community member and counseled them in last two years. Now I focus on tracking clients for follow-up services. Most clients access follow-up services that were reflected in lower HIV incidents this year compared to last year.

P4 I am not satisfied from my work. I am not able to bring desired behavior change in clients. There are increasing number of STIs and HIV cases. It means that clients do not adopt safe sex practices and avail project services regularly.

In summary, counselors' experiences were influenced by five key factors, namely trainings, peers, program, organizations, and counseling practice.

Researcher's Field Observations

Field observation is an integral part of data in grounded theory research. Field observations were categorized into two major themes, namely (1) local context of TI, and (2) local counseling practice context.

    (1) Local context of the TI. Targeted Interventions –a part of the National AIDS Control Program-III (NACP-III) of the National AIDS Control Organization, New Delhi were implemented in each state by State AIDS Control Societies (SACS) – an autonomous body established under Department of Health and Family Welfare, State Government. At the time of the research, Gujarat SACS was implementing 95 targeted interventions through non-governmental organizations and community based organizations. TI was designed as a peer based outreach focusing on HIV/STIs risk reduction through six key components such as condom promotion, STI management, behavior change communication, referral and linkage services, enabling environment through police sensitization, advocacy with stakeholders, crisis management, and community mobilization. The TI components were similar across MSM TI and FSW TIs. IDU TI included additional three components, Needle Syringe Exchange Programs (NSEP), Abscess and STI management and Oral Substitute Therapy (OST). Gujarat has no Technical Support Unit (TSU) – a unit sponsored by NACO to provide technical support to TIs in each SACS. In order to provide technical support to TIs in Gujarat, 25 mentors were empanelled and 6 TI supervisors were appointed to monitor activities of TIs and strengthen implementation of TIs through their regular visits to TI sites. Within TI program framework, counseling was reduced to providing information, referring clients to ICTC and STI services and documentation. Achieving huge targets was

important rather than quality counseling. Most of the follow-up visits were with regard to completing targets of counseling clients. Behavior change in counseling was not emphasized programmatically. The program lacks the mechanism to measure and evaluate delivery of counseling services and indicators to strengthen counseling components of the TI.

Counselors were not able to take detailed case history. Counselors' assumed each client to be at equal risk, therefore similar information about HIV prevention and project services was provided to all clients. Counseling primarily focused on issues related HIV. Psychosocial and mental health issues were hardly addressed in counseling. None of the documents reflected qualitative information of counseling process. Documents largely contained quantitative information. Client's case history was not maintained by most counselors. Clients were tracked and linked to services, however, follow up counseling of all clients were not ensured. Quality counseling sessions were not ensured because counselors were pressurized to achieve counseling targets. It was also observed that there were no definite steps followed by participants for documenting their activities. The recording formats were same, but were filled and used as per the participants' convenience. For example, most participants maintained client's history in daily diary, while two participants were using case history formats developed by them. Some participants documented the services that they provided immediately after service delivery, while most participants filled the relevant documents the next day or after a week. This characteristic is represented as a process rather than definite steps of documentation. It is hence named it as documentation process. Documentation process

included 8 steps namely, (a) planning day's activities, (b) providing counseling services, (c) management of STI clinic/s, (d) tracking of clients, (e) Preparing personal file of each client, (f) daily data entry, (g) weekly and monthly data compilation, and (h) filling up computerized management information system format.

(2) Local counseling practice. Local counseling practice was categorized as (i) counselors' involvement in TI, (ii) values and judgements, (iii) privacy, (iv) advice giving, and (v) best practices.

Counselors' professional involvement in TI. As per the TI team hierarchy, counselors were considered the second most senior person after project officer. As per the roles and responsibilities of TI staff shared by GSACS with all TIs, the counselor's role was defined as one who delivers counseling services and supports project officer in team building, advocacy and capacity building of the TI staff. The researcher reviewed the TI guidelines developed by NACO and the resource pack developed by GSACS to understand counselors' role. The key tasks of the counselors were as follows:

➢ Ensure that all the high risk groups – HRGs (most-at risk populations-MARPs) visiting the project clinics are counseled.

➢ Ensure that the HRGs [MARPs] visiting the clinics also visit the referrals centers such as ICTC, TB centre, ART centre.

➢ Maintaining a list of the HRGs [MARPs] who have been referred to referral centers and reached there.

➢ Ensure that all the relevant counseling registers are maintained on day to day basis and put in safe custody.

> ➢ Ensure field visits, 8 days in a month (at least twice in week), for conducting
>
> counseling sessions as per the plan.

Considering the local context of TI project, most counselors had spent more time on non-counseling activities such as arranging advocacy meeting, training TI staff, conducting FGDs, documentation, coordinating with referral services and the like. Very few counselors equally focused on all aspects as per their job's terms of reference (ToR). In most instances, counseling was reduced to information sharing process. The counselor used to track all most-at-risk populations (MARP) registered with TI. Those MARPs who did not avail any project services were listed and counselors shared the list with ORWs to reach out these MARP to avail counseling and other project services. It was observed, in many instances, that clients were directly referred to referral services such as ICTC, STI clinics etc. without counseling. ORWs used to provide list of clients referred to services and were entered into counseling register.

Labeling and judgments. Counselors were aware of the importance of being neutral and listening to clients without prejudice and said repeatedly that their job was not to judge clients. Although there was no indication that counselors used judgemental language in the counseling sessions, their language in the research interviews reflected derogatory judgements of clients' behavior. Sexual risk behavior was described with statements such as *'bad behavior is what generally causes them to get infected.'* Sex work was labeled *'bad thing'* to earn money. MSM were generally cast as a 'sexual maniac' and labeled as being 'naturally promiscuous', 'immoral by nature', or 'person anyone needs to be careful of.' In contrast, women were described as 'victims', 'passive

in nature' and 'submissive.' Injecting drug users (IDUs) were described as criminals as

most IDUs were involved in petty crimes such as pick pocketing, chain snatching etc.

Further, participants categorized clients in six different typologies such as just curious,

curious, shy, anxious, manipulative and indifferent clients. Although such labeling or

classification was not verbally shared with clients, however, counselors inherently used

them as a tool to plan strategies to deal with them. The question that arises is the ethical

implications of such a practice. Is labeling a client appropriate, even if it may help to

the counselors to remember the background and situation of the client better?

Privacy. The researcher observed and witnessed counseling sessions at STI

clinics, field, DICs and project office where counseling room was not available. While

counseling STI clients, in most cases, counseling was performed in the clinic's waiting

room. Clients were not provided privacy or conducive environment in many instances.

Due to the lack of privacy, counseling, in many instances, was reduced to a quick process

of information exchange. However, the clients seemed to be okay with existing

counseling services without being concerned about the privacy issues. For instance,

when clients were asked whether they were satisfied with privacy norms after the

counseling session, all agreed to be satisfied with privacy norms. The reason for having

no concern could be attributed to the lack of knowledge about counseling process.

Counseling is still a foreign concept for many clients. When questioned about past

counseling experience or whether they had heard the term "counseling" many clients

responded not to have had any past experience of availing counseling services and had

heard the term "counseling" for the first the time. Those who heard the term, they

referred counseling with the equivalent local word "salah" –advice. The translation of

counseling in Gujarati is, "Paramarsh." Therefore, culturally counseling has been referred as "salah." As a result, clients have considered a counselor similar to a health advisor. Many clients regarded a counselor as a doctor who gives advice on HIV. This may also be based on their experiences of availing general public medical services where privacy norms are not met due to various reasons such as long queue of waiting clients inside and outside doctor's room. Clients may have linked counseling to what doctors' offer at Government hospitals/dispensaries.

It was observed that the counselor had to reach out to clients in the field through peer educators and out-reach workers where maintaining privacy would be a challenge. In some instances, clients brought a friend, partner or lover in the counseling. This was also a breach of privacy from professional standards. There could be various reasons for this behavior. One such reason may be the personal dynamics between friends/lovers or partners. Another reason could be an opportunity for the client to demonstrate trust to the partner. In order to prove their faithfulness, clients bring their partners/lovers or spouse along with them and discuss certain socially prohibited sexual incidents of their life while hiding the actual risk taking behaviors. Also in addition to this, clients use counselor during the counseling process to communicate about their faithfulness towards their partners/lovers/spouses.

Advice giving. Advice giving is considered inappropriate conduct in professional counseling. Participants mentioned that they were instructed not to give advice during counseling training and believed that advice should be avoided. However, during the actual counseling practice, clients expected advice and sometimes clients explicitly sought advice from counselors. In such situations, participants straight away provided

advice but did not recognize it as such. After the counseling session when clients were asked what they expect from counseling, most clients expressed that they expected to get "good advice" from counselors. Nonetheless, most clients did not express their expectations to the counselors; they assumed that 'advice giving' was an inherent part of the counseling process. On the other hand, it was also noted that some counselors provided advice to clients believing that giving suggestive information shall help clients to act on it. Although counselors knew the importance of refraining from advice giving, it continues to occur. As illustrated in the following example, in the Indian culture, seeking advice and giving advice is regarded an integral part of showing respect and concern for others.

> Client: I am very disturbed. I don't understand my partner's behavior. Sometimes he speaks to me very nicely and at other times he ignores me completely…it has been over a month I spoke to him. I got the news that he is going to get married and did not inform me. I want to break this relationship. Tell me what should I tell him? Since you helped me earlier in my relationship, you are the best person to seek advice from.
>
> Counselor: Well, it sad to know that you are not going steady in your relationship. I think the best way is to meet your partner and discuss with him about this issue.

In the researcher's informal conversation with counselors, they expressed, "advice giving is helpful for maintaining trustworthy relationship with client; however, we are

expected to avoid advice giving." This raises an important point about cultural

perspectives in formulating ethical standards rather than imposing western professional

standards which may not work in the Indian context.

Best practices. A few counselors were doing an excellent job and demonstrated

best counseling practices and, innovative counseling strategies. In a few instances,

counselors adopted a systematic mechanism to track clients, counseled each one of them

and recommended to allied referral services. When clients were not able to come to the

TI office or DIC or STI clinics, the counselor would go and meet those clients in the

field. Counselors regularly plan field meetings and participated in the field meetings

arranged by Peer Educators every month. Group educational sessions emerged as an

innovative way to encourage clients to avail services and appreciate those who are

availing services regularly. This was an effective strategy to use peer pressure for

behavior change to adopt safer sex practices and avail project services regularly. Thus,

group counseling sessions, though rare, emerged as an effective strategy to deal with

clients with similar problems. Use of counseling techniques such as demonstration, role

models, and storytelling in the cultural context were effective because most clients were

less educated, were able to comprehend HIV risk and HIV prevention strategies though

stories and demonstration techniques.

Section III

Theoretical frameworks: Triangulation of the data

Data from four sources, in-depth interviews, participant observations, counseling documents and researcher's field observations, were triangulated; analyzed and theoretical frameworks were developed. This section presents the integration of the overall results of the research.

Research Question 1

What are the Existing HIV Counseling Practices?

The data on HIV counseling practice was gathered through four different sources. The data was then organized into categories, sub-categories and elements and were compared with each other. The data presenting similar concepts were merged. With triangulation, six main categories of the domain HIV counseling practice were developed, validated, and confirmed. These included counselors' professional involvement, counseling context, counselors' characteristics, types of counseling, counseling skills and counseling techniques.

Professional involvement. Counselors' routine activities, time-management, and documentation practices were merged into new a category, professional involvement as they reflected counselors' engagement in TI's activities. As Figure 42 illustrates, counselors' routine activities were writing diary, updating counseling documents, STI clinic management, counseling clients, and other activities.
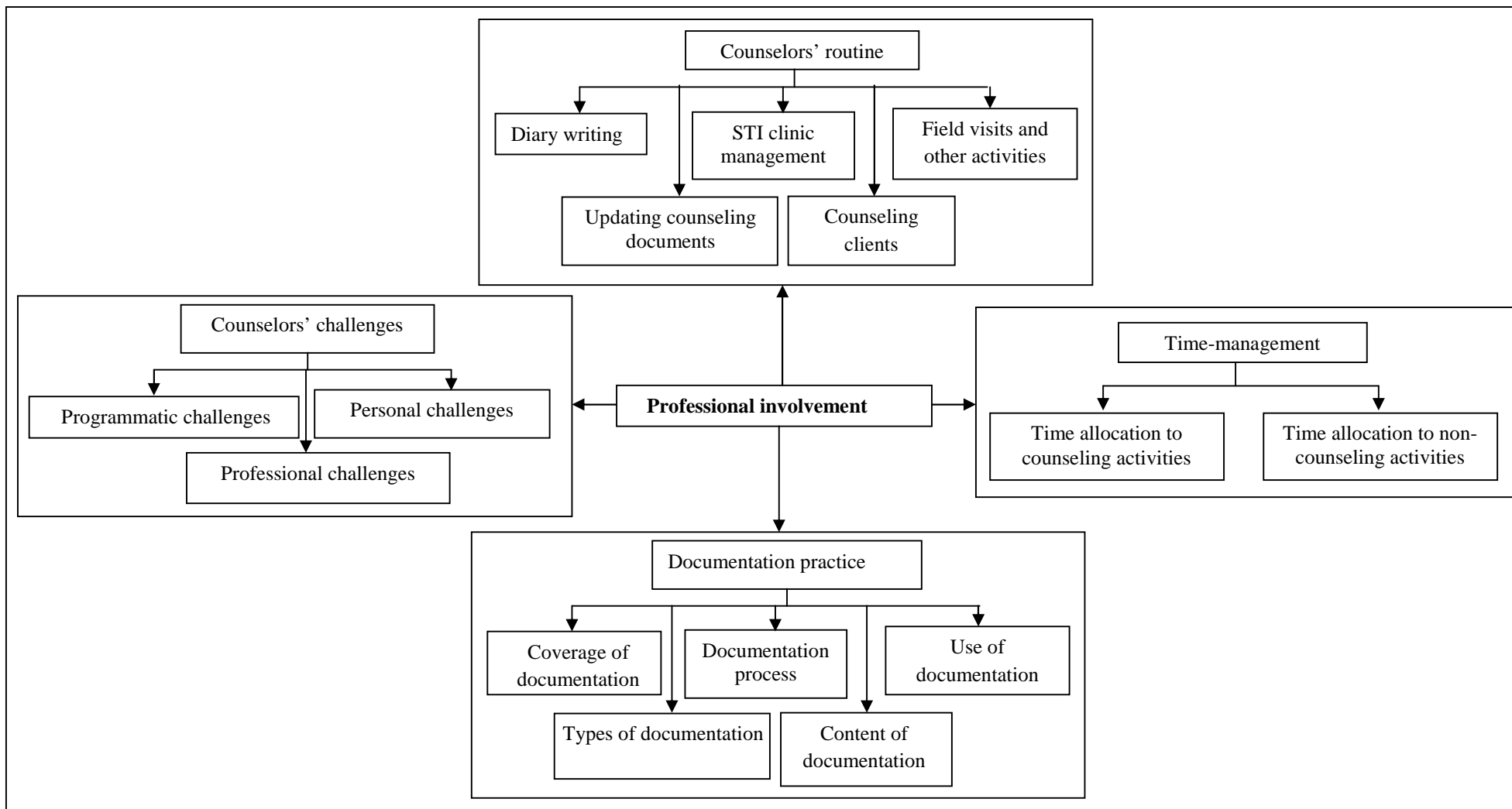
Figure 42. Final sub-categories and elements of the counselors' professional involvement: Triangulation of the data

The detailed description of this category is provided in Figures 24 to 28. Counselors' time in routine activities was primarily allocated to counseling activities and non-counseling activities. Counseling activities were counseling clients at project office, STI clinic, DIC and in the field and rest activities that did not involve counseling clients such as documentation, STI clinic management, staff meeting and activities required by the project were conceptualized as non-counseling activities. Most counselors were unable to allocate adequate time for counseling related activities. ANMs, in particular, were primarily engaged in non-counseling activities such as assisting doctors, documentation, and also engaged themselves in counseling related activities either at office or STI clinic. Even with programmatic challenges, few counselors, particularly community counselors and counselors working with MSM and FSW TI projects were more engaged in face to face as well as in group counseling activities as compared to the ANMs.

Gender difference was captured in terms of allocation of time to field visits and counseling clients in the field. Male counselors' as well as community counselors (MSM/FSW) had frequent field visits, extended working hours in the field to reach out the clients and documentation of their activities. The professional involvement of counselors was also reflected in types of documents maintained by counselors, areas covered in documentation (such as counseling, STI services, and other activities such as field visits, meetings etc.), major content of the documentation and using documentation for data analysis and preparing project's outreach strategies. Counselors followed specific process for documenting activities. It included planning day's activities, tracking of

clients, preparing personal file of each client, daily data entry, weekly and monthly data compilation, and filling up computerized management information system (CMIS) format. Participants shared their concerns related to lengthy and tedious documentation, which prevented them from providing adequate time to counseling activities and other activities to promote behavior change among clients such as field visits, group discussions, health camps and community advocacy meetings. Counselors reported facing challenges in everyday counseling. Counselors' challenges were in programmatic, personal and professional areas. For more details, see the section on counseling challenges.

Counseling context. The counseling context was described as the local context in which counseling services were offered. Figure 43 illustrates the counseling context, particularly place of the counseling, mode of counseling, typologies of clients and counseling styles.
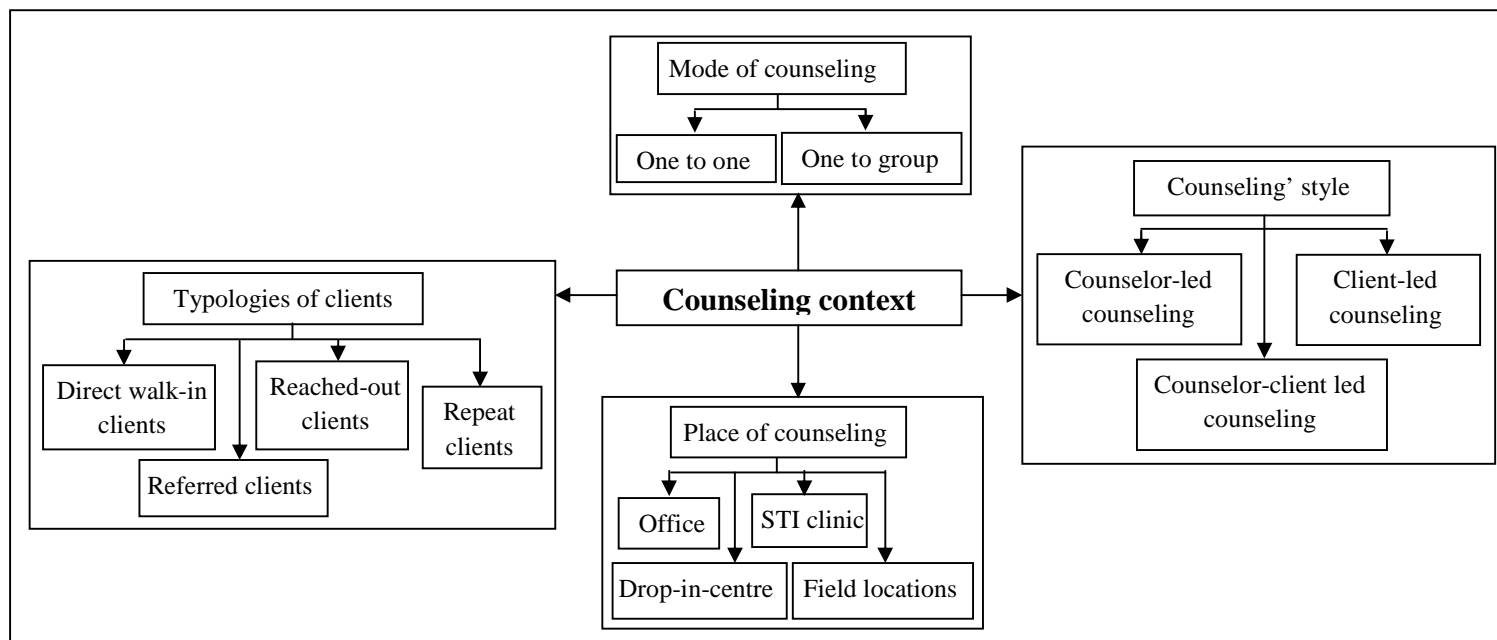
Figure *43*. Sub-categories and elements of the counseling context: Triangulation of the data.

Counseling services were offered either via one to one interactions or through group interactions at project office, DIC, STI clinics, and in the field. HIV test counseling and STI counseling were provided at office or DIC or STI clinic. Preventive counseling was usually provided in the field either at client's home, hotspot (a place where MARP usually congregate) or in the "barren" open place. Counselors classified clients received counseling services into four typologies, direct walk-in clients, referred clients, reached-out clients and repeat clients. These typologies helped counselors to assess levels of motivation to change their risky behaviors. Clients who accessed counseling services on their own (direct walk-ins) were self-motivated to learn preventive alternatives and access project services. Counselors had to track those clients in the field who had not accessed any project services such as counseling, STI and referral services to the STI clinics ICTCs. Many clients were repeat clients who availed counseling and other project's follow-up services regularly. Based on the counseling place, mode and typologies of clients, counseling styles were emerged.

Counseling styles were an approach to help clients bring change in their risky behaviors by making them realize their risky sexual behaviors and adopting preventive alternatives. In most instances, counselor-led counseling style was observed where counselor took the lead and played an active role in directing the counseling process. Sometimes clients had taken a leading role and controlled counseling process where counselors had furnished specific information or referrals asked by clients. In few instances, counseling process was shaped by the counselor and later increased client's engagement in the counseling process, which was described as counselor-client led counseling style.

Counselors' characteristics. The counseling process was characterized by qualities displayed by counselors' toward the client. Figure 44 illustrates counselors' characteristics emerged from triangulation of the data.
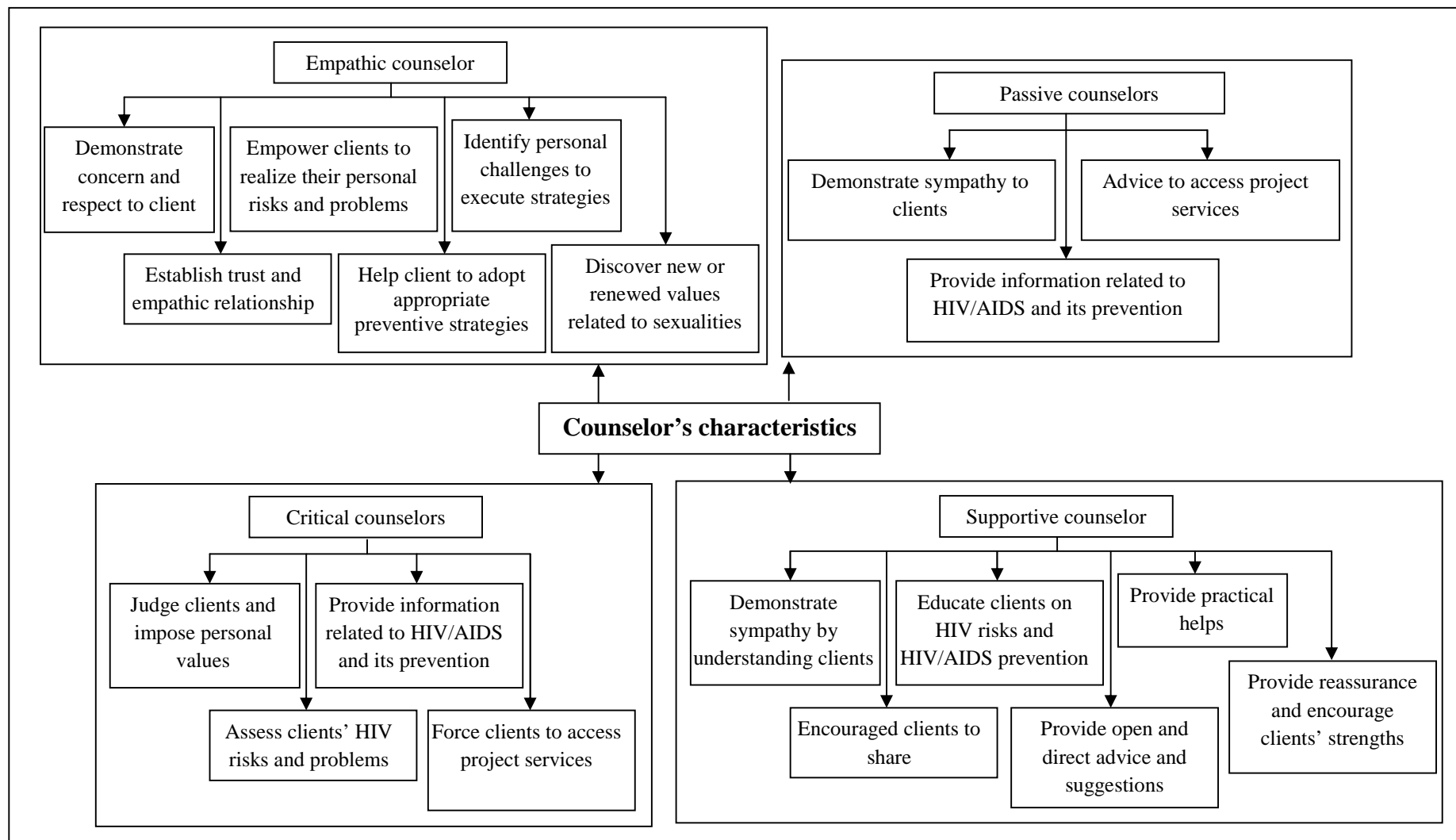
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│  │         └───────────────────────┘                    │   │      └─────────────────────────┘              │  │
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│  │  │Demonstrate│ │Empower clients│ │Identify       │     │   │ │Demonstrate sympathy│  │Advice to access  │   │  │
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│  │  │client     │ │and problems   │ │execute        │     │   │                                               │  │
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│  │                                 └───────────────┘     │   │        │Provide information related │          │  │
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│  │  │Establish trust│ │Help client│ │Discover new or│      │   │        │prevention                  │          │  │
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Figure 44. Final sub-categories and elements of the counselors' characteristics: Triangulation of the data.

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Types of counseling. Counselors were offering six types of counseling services to clients. As Figure 45 illustrates, six counseling services were preventive counseling, STI counseling, HIV test counseling, crisis counseling, supportive counseling, and psychological counseling.
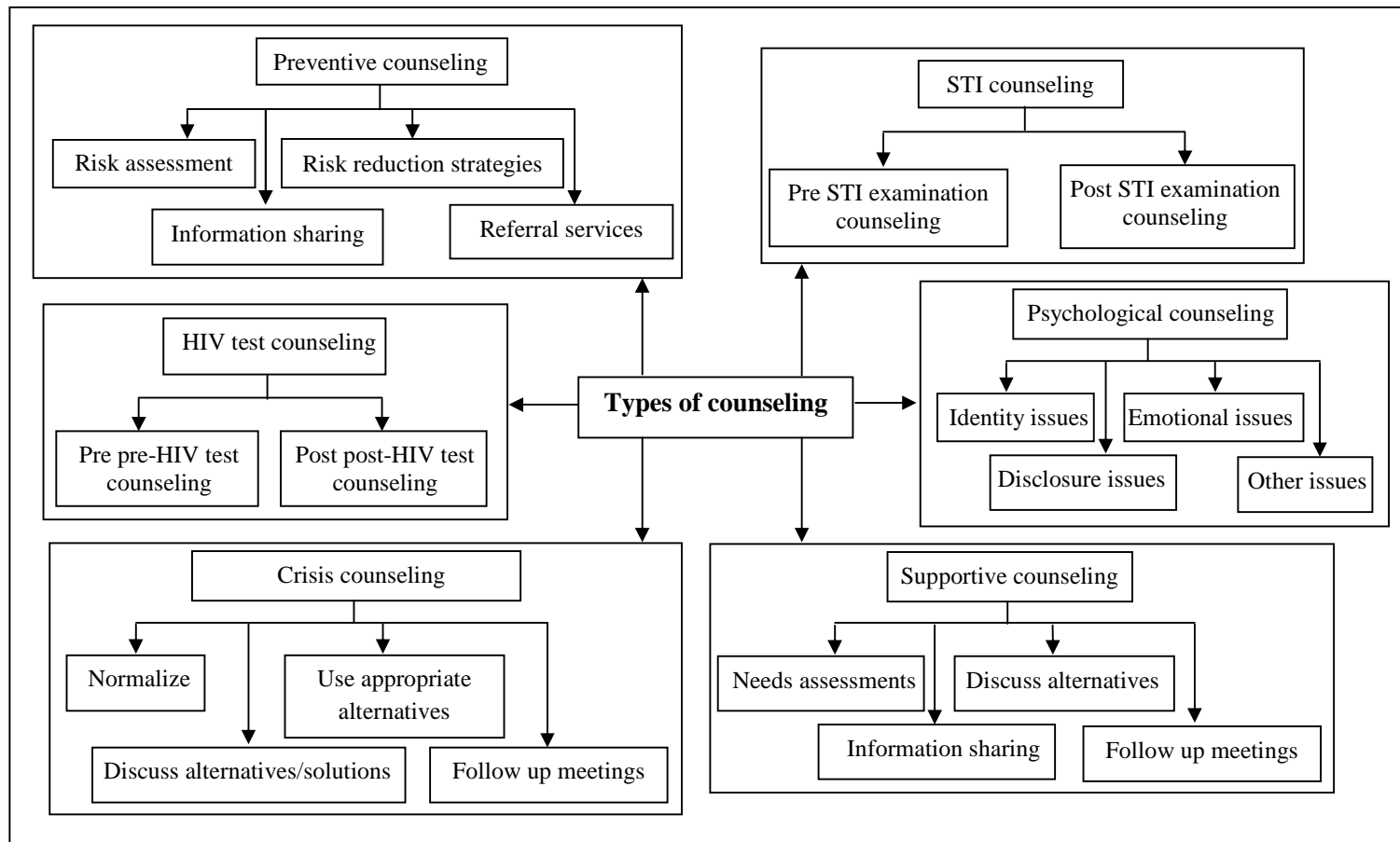
Figure 45 . Sub-categories and elements of the types of counseling: Triangulation of the data

Preventive counseling, STI counseling and crisis counseling were mandatory part of the TI. Other counseling services such as HIV test counseling (pre pre-HIV test and post post-HIV test counseling), supportive counseling and psychological counseling services were indicative and largely emerged out of the need at the field levels. Counselors' were using these added services to establish faithful relationship with clients and bring clients to access HIV prevention services. Various education group sessions, and counseling in group settings were practiced by counselors.

Counseling skills. With triangulation, the previous category, counseling skills and techniques" was expanded and separated into two separate categories namely, counseling skills and counseling techniques. Counseling skills practiced by counselors were categorized into four skills namely questioning skills, listening skills, non-verbal skills and empathy skills. The Figure 46 illustrates sub-categories and elements of counseling skills.
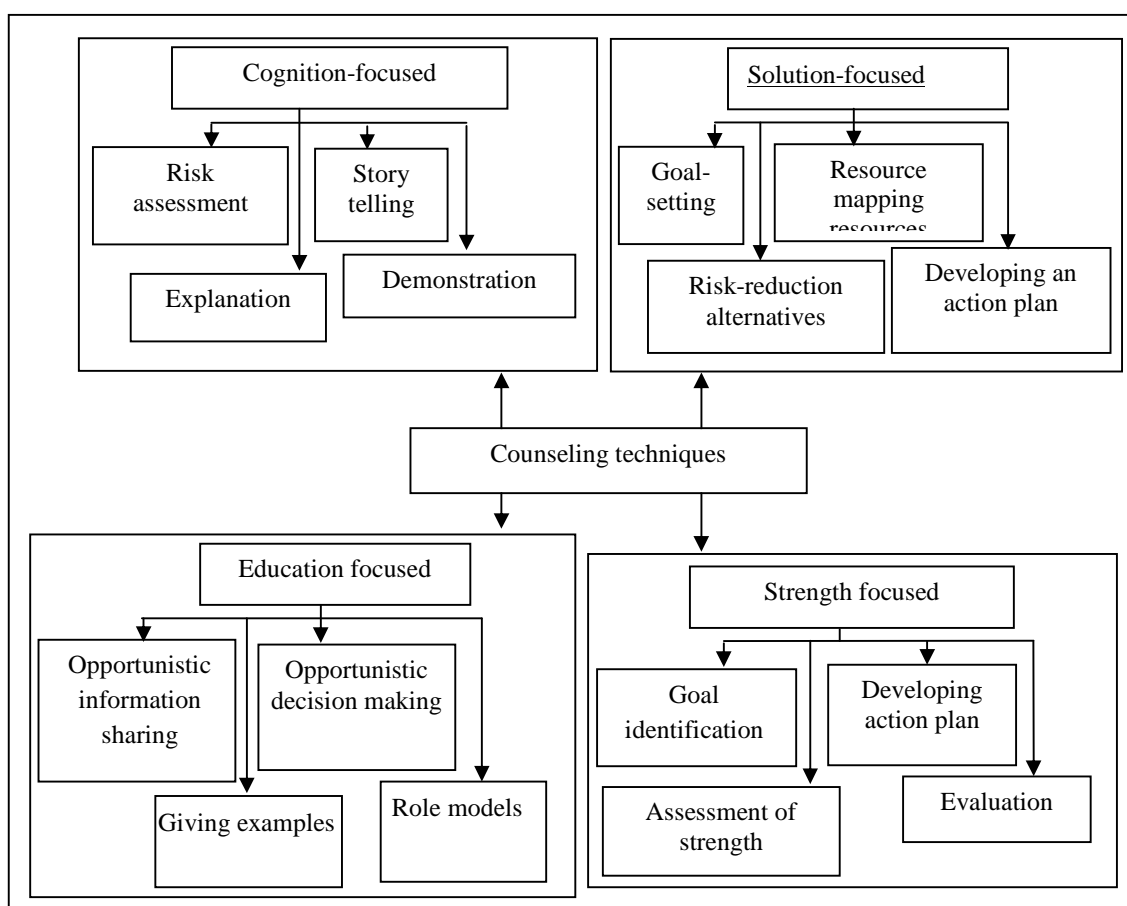
Figure 47. Sub-categories and elements of the counseling skills: Triangulation of the data.

Questioning helped the counselors to guide the counseling conversation and assisted in enriching the client's story. Questioning skills were used during the entire counseling process when information or clarifications were required from the clients. It comprised open-ended, close-ended and clarifying questions. Open-ended questions were used during the middle of the counseling process while assessing and exploring clients' problems. Close-ended questions were used to gain very specific information that can be given in short or exact answers, such as yes, no, or a word.

Counseling techniques. Counseling techniques used by counselors were categorized as cognition-focused, solution-focused, and strength-focused. The Figure 47 illustrates sub-categories and elements of counseling technques.
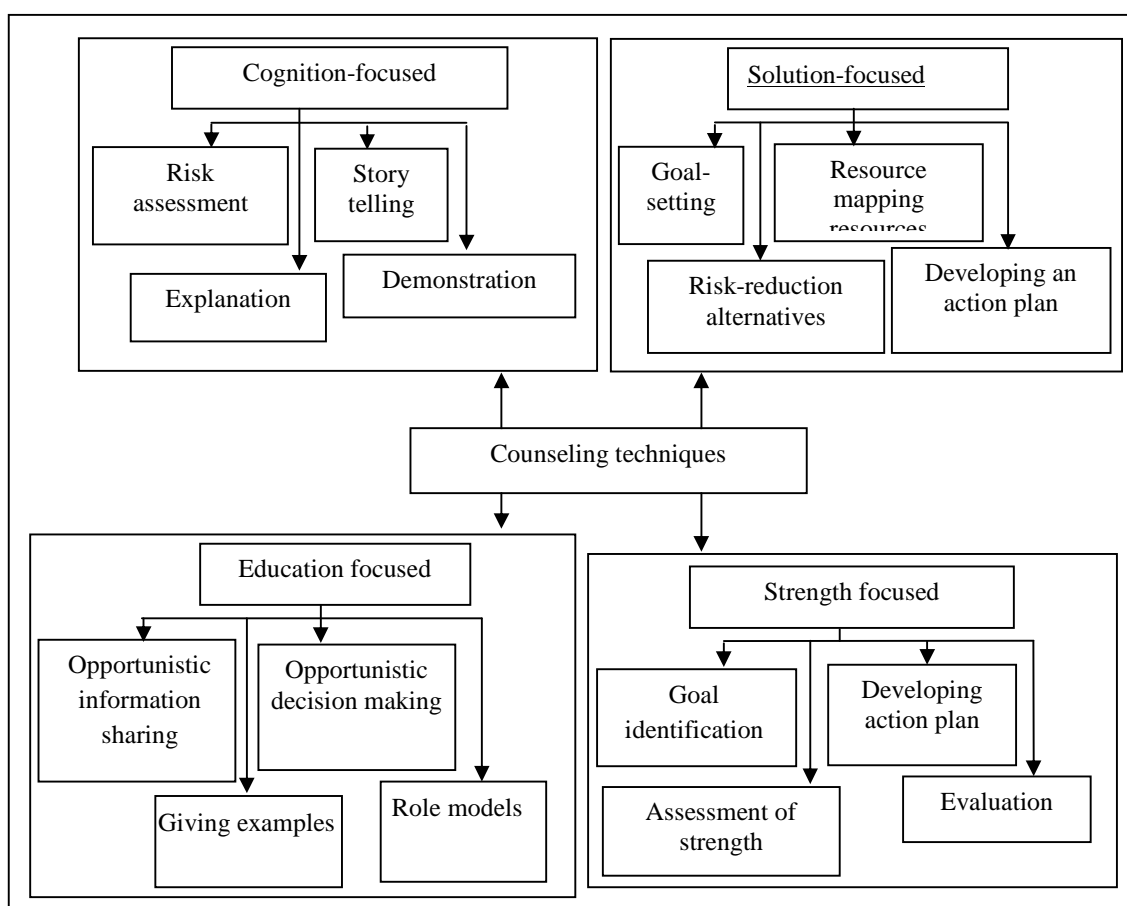
Figure 47 . Sub-categories and elements of the counseling skills: Triangulation of the data

Cognition-focused techniques were used to understand clients' beliefs, misconceptions regarding HIV and sexual practices and explain risk context to the clients. It included risk assessment, demonstration, explanation, and storytelling. Solution-focused techniques were used to provide solutions to minimize clients' sexual health risks. It included goal-setting, risk-reduction alternatives, mapping resources and sharing them with clients, and developing an action plan. Strength-focused techniques were used to understand clients in terms of their strengths. It included goal identification, assessment of strengths, plan of action and evaluation. Education-focused techniques included opportunistic information sharing – sharing specific information based on its requirement, opportunistic decision-making –conveying decisions related to reducing HIV risks, giving examples related to HIV/AIDS and STIs risk factors, and use of role models – sharing preventive strategies used by few community members and how change in risk behaviors changed their life during counseling.

Theoretical Framework of Counseling Practices in the TI Context

With this procedure, categories, sub-categories were revised, confirmed and put into theoretical framework. The Figure 48 illustrates theoretical framework of HIV counseling practice in TI context.
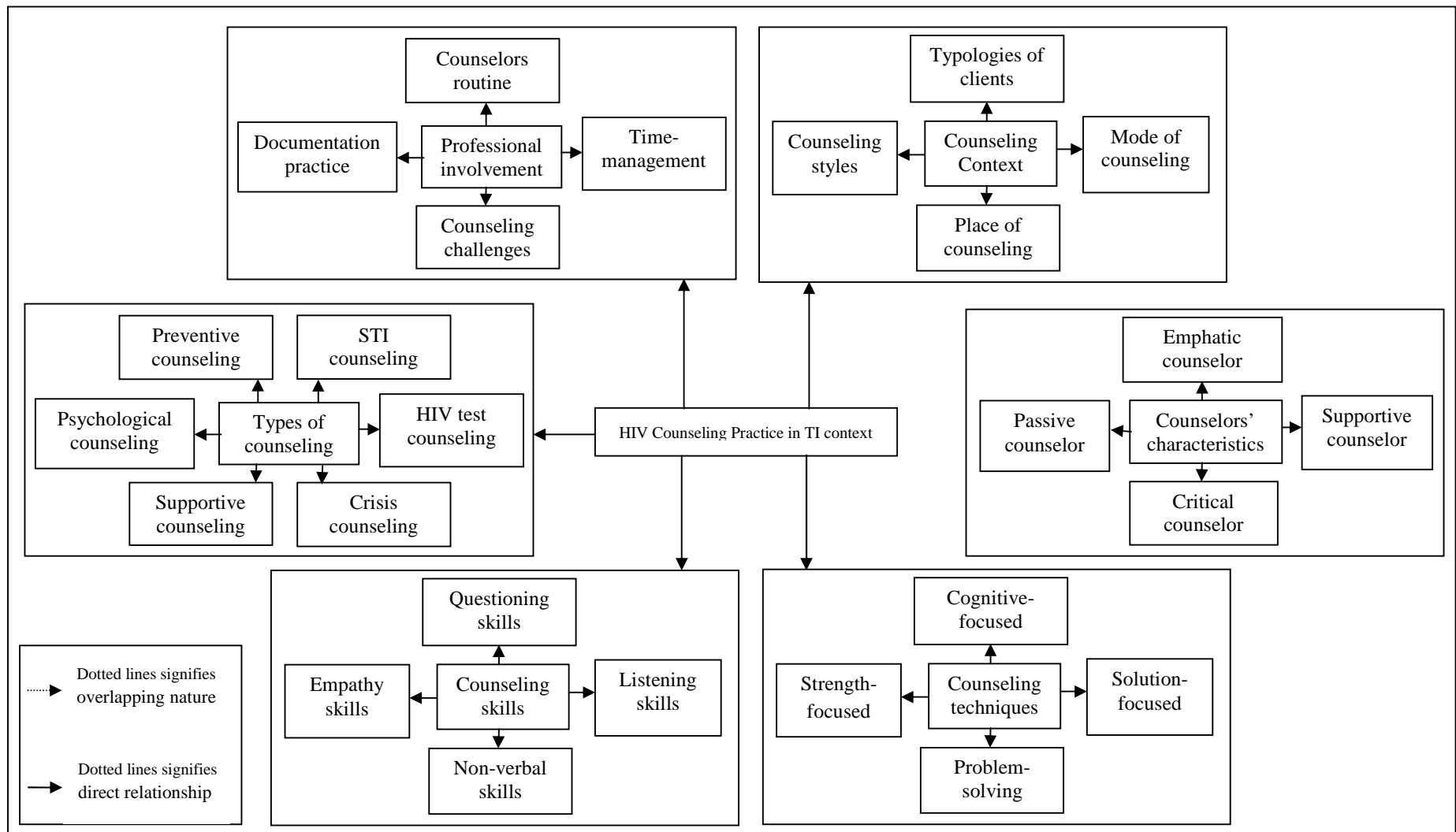
Figure 48. Theoretical framework of the HIV counseling practice in the TI context.

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The HIV counseling practice in TI context included five main categories, counselors' professional involvement (in the counseling activities), counseling context, types of counseling, counseling skills and counseling techniques. Counseling context revealed the local context in which counselors had conceptualized clients' based on clients' approach to access counseling services. This reflected counselors' pragmatic approach to compartmentalize clients. Counseling context also reflected counseling style – counselors' approach of counseling that guided the counseling process about which counselors were not explicitly aware of. Three styles were emerged from the data, counselor-led counseling, client-led counseling and counselor-client led counseling. Counselors used combination of these styles. There was an overlap of counseling styles in the counseling practice.

Counselors' demonstrated different characteristics such as empathic, supportive, critical and passive nature in counseling process. Mostly these characteristics were overlapping. One counselor had demonstrated more than one characteristic, for example, empathic counselor was supportive to clients at one point of time during counseling and become critical and passive at other point of time during entire counseling process. Counselors had used different counseling skills and techniques to facilitate the counseling process. Counselors did not stick to fixed cognitive focused or solution focused skills, rather adapted different skills with different clients at different time of counseling process. It reflected eclectic or integrative approach of counselors.

Research Question 2

What are the Key HIV Counseling Processes That Emerge During Counselor-Client Interactions in TI context?

Based on the first round of analysis, new categories emerged and were saturated through the second round of interviews and participant observation of follow-up counseling sessions. While re-analyzing data and re-coding of the data, the HIV counseling process was revisited. Each counselor was individualistic in shaping the counseling process. There was no uniform counseling process followed by all counselors. However, certain common steps of the counseling process emerged were (i) building rapport, (ii) exploring problems, (iii) assessing risks, (iv) discussing alternatives, (v) preparing an action plan, and (vii) follow up meeting plan. Figure 49 summarizes the counseling process.
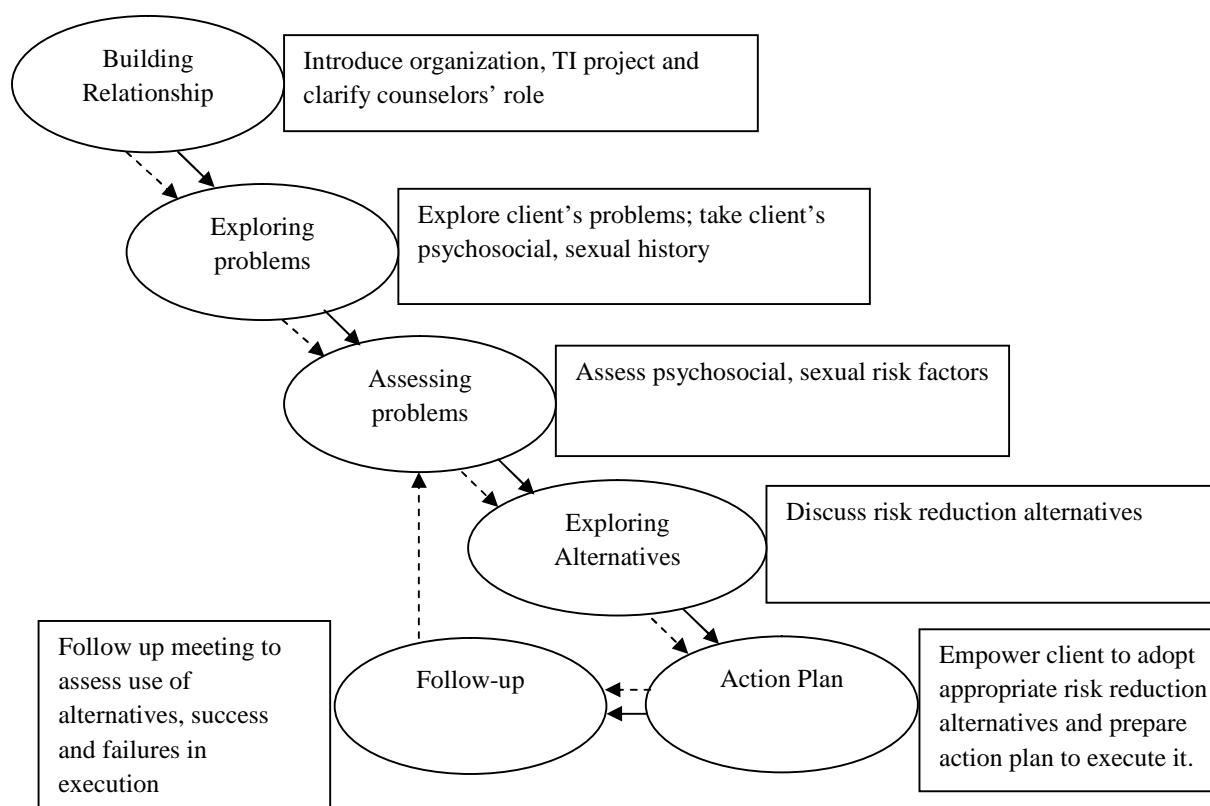
Figure 49. Sub-categories of the HIV counseling process: Triangulation of the data.

The dotted lines reflected the fluidity of the process while straight lines suggest the consequential nature of the process. Rapport building process can be stretched up to the next counseling sessions and during that period other processes such as exploring problems, risk assessment may take place. Further, assessment of problems and risk assessment as well as discussing alternatives and action plan could overlap. It was also noted that each follow-up session began with brief rapport building to set the stage, assess knowledge and safer practices, and review the action plan.

Theoretical Framework of HIV Counseling Process in the TI Context

HIV counseling processes (i.e., building rapport, exploring problems, assessing risks, discussing alternatives, preparing an action plan and follow up plan) in TI context was characterized by five cognitive processes, namely (i) exploring, (ii) clarifying, (iii) normalizing, (iv) reconstructing, and (v) taking action. Figure 50 illustrates theoretical framework of HIV counseling process in TI context.
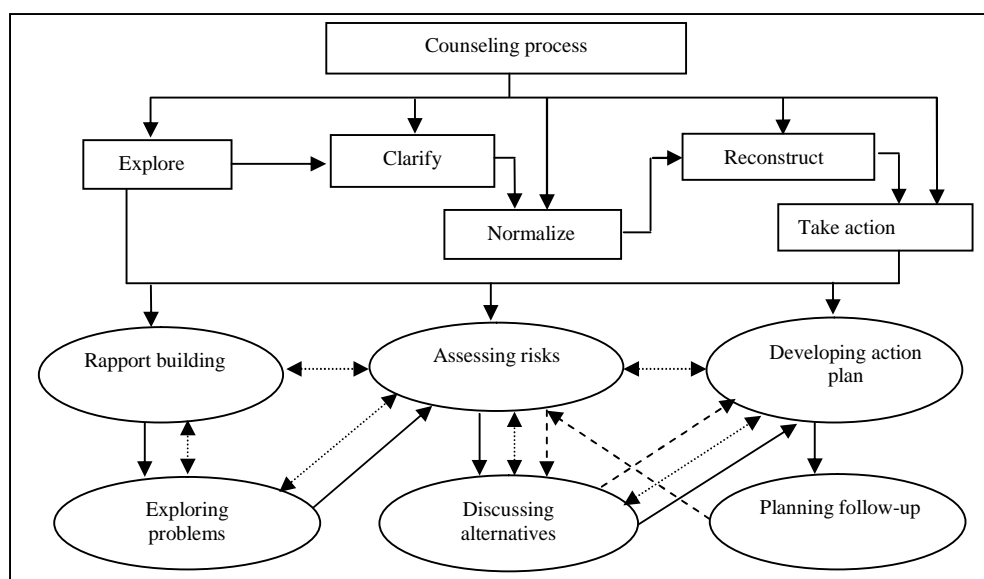

Figure 50. Theoretical framework of HIV counseling process in the TI context.

Interviews as well as participant observations revealed exploration as a dominant feature for initiating counseling process. While observing counseling sessions, it was challenging to draw a line between the process of rapport building and exploring clients' problems. Rapport building and the process of exploring problems were reciprocal and the priority of each process was dependent on the counselor as well as the client's response to counselor's initiation and management of the counseling process. During the

risk assessment of clients, clarifying and normalizing emerged as dominant themes. Counselors assessed risks and knowledge related to HIV/AIDS and risk behaviors followed by informing risks to clients and clarifying misconceptions. With these processes, the counselor tried to normalize clients' risk behaviors and sharing strategies to keep themselves away from HIV /STI transmission.

It was validated that the counseling process does not constitute water tight steps. It is fluid and reciprocal, influenced by both counselor as well as clients. The dotted lines reflected fluidity of the process meaning that these processes were reciprocal and were always sequential, for example, in some counseling sessions, it was observed that the process of rapport building was stretched in the process of exploring problems. There existed no line of demarcation between building rapport and exploring problems. Few counselors began the session with exploring clients' problems. The rapport building process was imbibed in the process of exploring problems (Figure 50). Straight lines suggest consequential process while dotted lines demonstrate the reciprocal process, and the breaking lines reveal a process of follow-up counseling. Follow-up counseling began with assessing risks, knowledge and practices followed by discussion of alternatives that were discussed in the previous session, actions taken by clients and strategies to adhere towards preventive behaviors.

Research Question 3

What are the Key Behavior Change Processes That Emerge During Counselor-client

Interactions in TI Context?

During participant observations of the counseling sessions, behavior change indicators

were noticed and recorded. The following Figure 51 summarizes behavior change
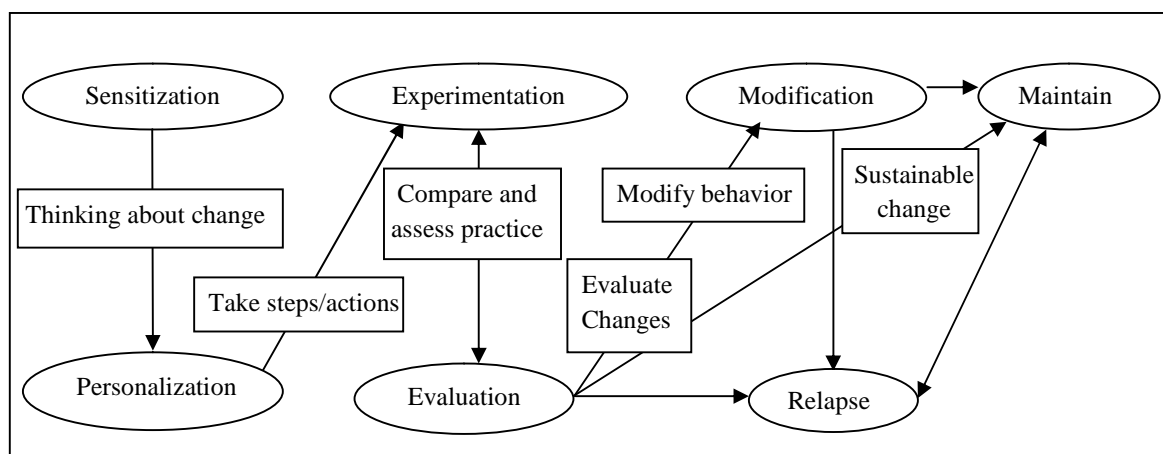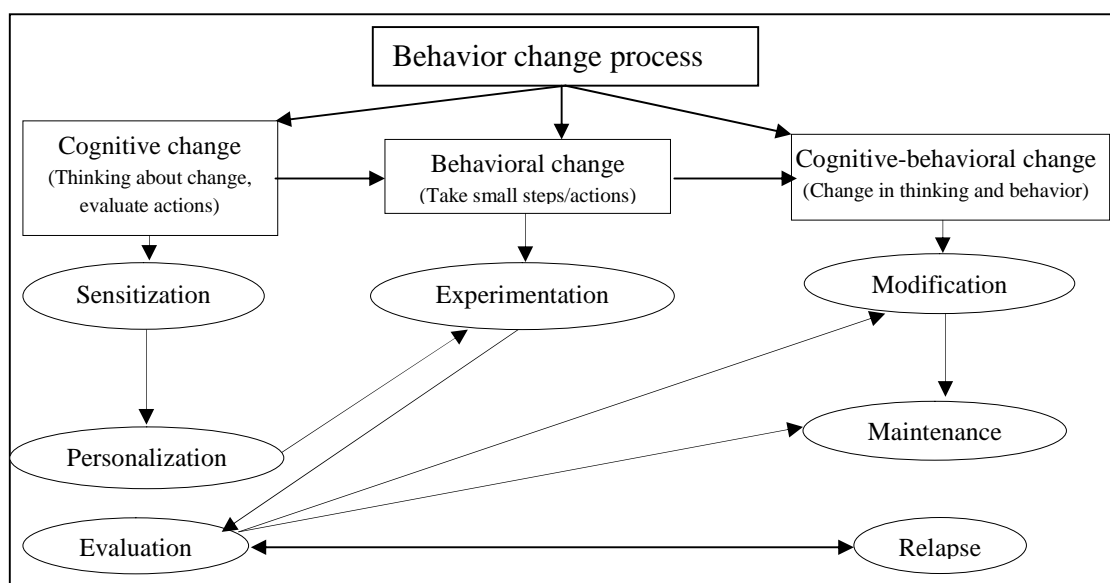
processes among clients.

Figure 51. Sub-categories of the behavior change process among clients.

The behavior change process was characterized by sensitization, personalization,

experimentation, evaluation, modification, maintenance, and relapse. First, clients'

thoughts and perspectives about HIV/AIDS/STIs sexual practices were influenced

through information shared during the counseling process. This process was a process of

sensitization where clients were oriented and sensitized about the HIV/AIDS issues. With

sensitization, clients were able to personalize HIV risks with their knowledge about risks

and their risky sexual behaviors. In personalization, clients were encouraged to know more about it. With an assessment of personal risks and possibilities of avoiding risks, clients began with taking small preventive steps and experimented with preventive methods. Clients evaluated their sexual practices by comparing with others and what is culturally appropriate. Upon self-evaluation of preventive techniques and comparing peers' sexual practices, clients modified their present preventive method, or maintained a preventive practice or continued old risky practices depending upon the context and counseling intervention. If clients had modified preventive practices, they either maintained those practices or relapsed to risky practices based on personal experiences and contextual factors.

Theoretical Framework of Behavior Change Process among Clients in the TI Context

Categories relating to behavior change processes were revisited for in-depth exploration of the properties of each category. Figure 52 illustrate the theoretical framework of behavior change among clients.

Figure 52. Theoretical framework of behavior change process among clients in the TI

context.

In-depth exploration reflected three broad functions namely cognitive, behavioral and

cognitive-behavioral. The categories namely sensitization, personalization and

evaluation emerged as cognitive functions while experiment emerged as behavioral

function. Modification, maintenance or relapse constituted cognitive-behavioral

functions.

Research Question 4

What are the Counselors' Experiences of Providing HIV Counseling Services

within Targeted Interventions (TI) context?

The main categories of the domain, counselors' experiences comprised various influences such as training, peers, programs, organization's environment, and counseling practice influences. The Figure 53 illustrates categories and sub-categories of counselors' experiences.
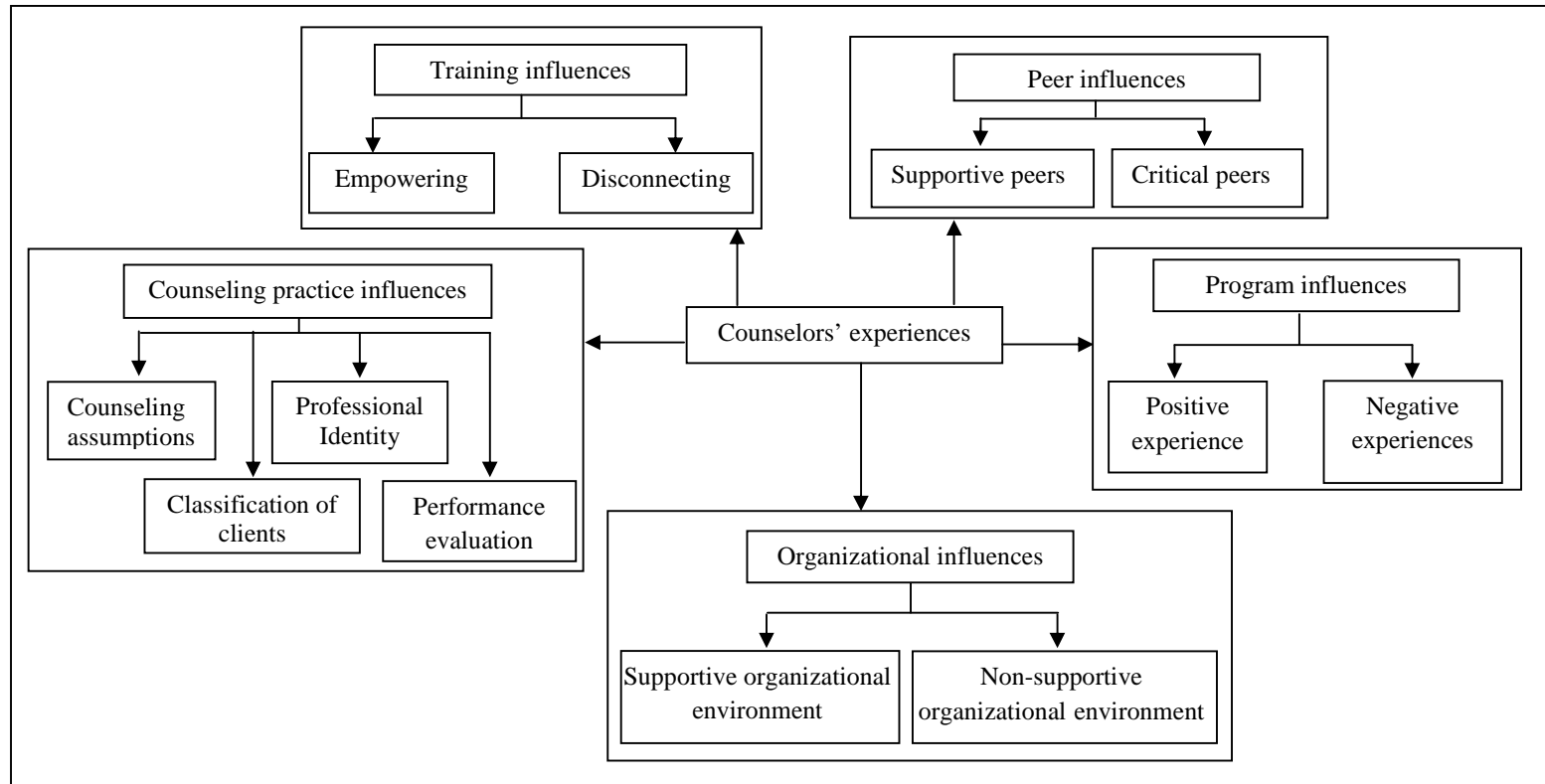
Figure 53. Sub-categories of the counselors' experiences.

Training influences were characterized as empowering and disconnecting. These trainings provided avenues to interact with peers (other counselors), which influenced their experiences. Peer influences were characterized as supportive and critical peers. The TI program had positive as well as negative influences on counselors. Participants expressed positive feelings when program targets were achieved, observed change in their clients' risk behaviors and their work was appreciated by their seniors. Negative influences were characterized by negative feelings when targets were not achieved and their work was criticized during regional review meeting in front of team members of other TI projects.

Counseling practices influenced participants in defining counseling, demonstrating values, and classifying clients into different categories based on clients' motivation to access counseling and other project services. Counseling practices also facilitated participants to identify clients positively or negatively as professional counselors. Participants evaluated their performance as satisfactory or non-satisfactory based on achievement of their work targets and completeness of other activities as per the TI guideline and their job profile.

Theoretical Framework of Counselors' Experiences in the TI Context

Based on triangulation of the data, all categories, sub-categories, and elements were saturated. re-analyzing data and re-coding of the data, counselors' experiences were revisited and repositioned. Figure 54 illustrates the theoretical framework of counselors' experiences in the TI context.
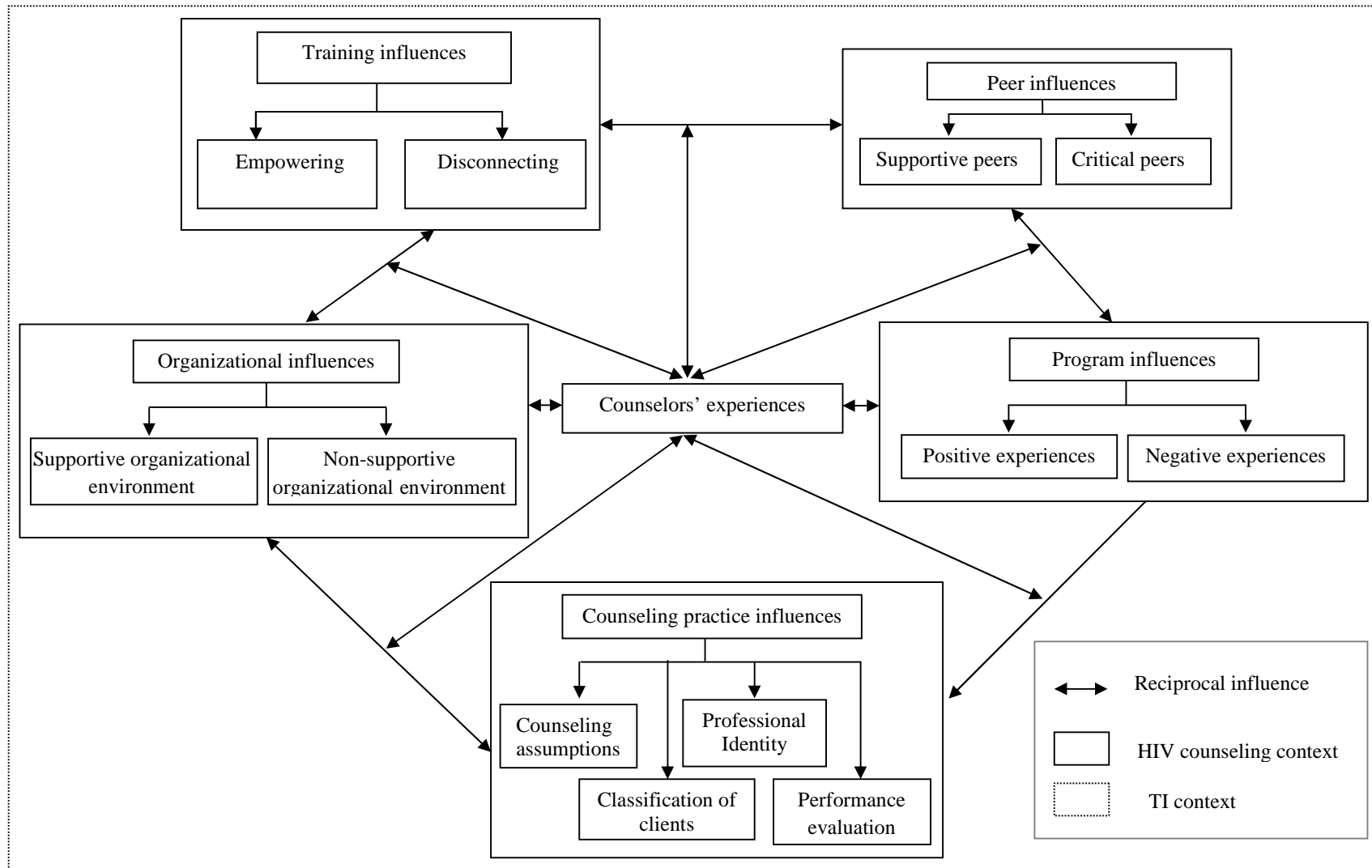
Figure 54. Theoretical framework of counselor's experiences in the TI context.

Within this context, the researcher, selectively, looked into specific HIV counseling context.   The straight lined box represents HIV counseling context while dotted box represents TI context. Each sub-category was influenced by the other and complementary to each other. For example, training influences and peer influences influenced each other and complementary to each other. Participation in training enhanced interactions with counselors from other organizations implementing TIs, which contributed to their learning. Interactions with peers after training also contributed to their learning. To demonstrate reciprocal influences, double are arrows used in the Figure 54. Counselors' overall experience as a TI counselor was influenced by the trainings they received, interactions with peers, existing TI project, organizations they were working with, and their counseling practice.

These factors influenced counselors to create meaning out of their experience from the HIV counseling context situated within the broad TI context. The present research identified the HIV counseling context and the broad TI context and reciprocal interactions between them facilitated the process of 'making sense' from their experiences.

Section IV

Emerging grounded theory

The present research has generated theoretical frameworks on HIV counseling process and behavior change process among clients and counselors' experiences in the given socio-cultural context of TI. Based on these theoretical frameworks, the present study theorized constructivists' grounded theory of HIV counseling in TI. The theory is characterized by four core categories, namely, counselors' experiences, counseling

practices, counseling process, and behavior change process. These four domains represent the constructive process of making sense out of experiences and professional practices.

Constructivists Grounded Theory of HIV Counseling Practices

Participants' thick descriptions and researcher's observations described the process of constructing meaning of their experiences. The process revealed different ways in which TI context and HIV counseling context influenced participants' experiences as TI counselors and their counseling practices. The Figure 55 illustrates the constructivist grounded theory of HIV counseling in TI context.
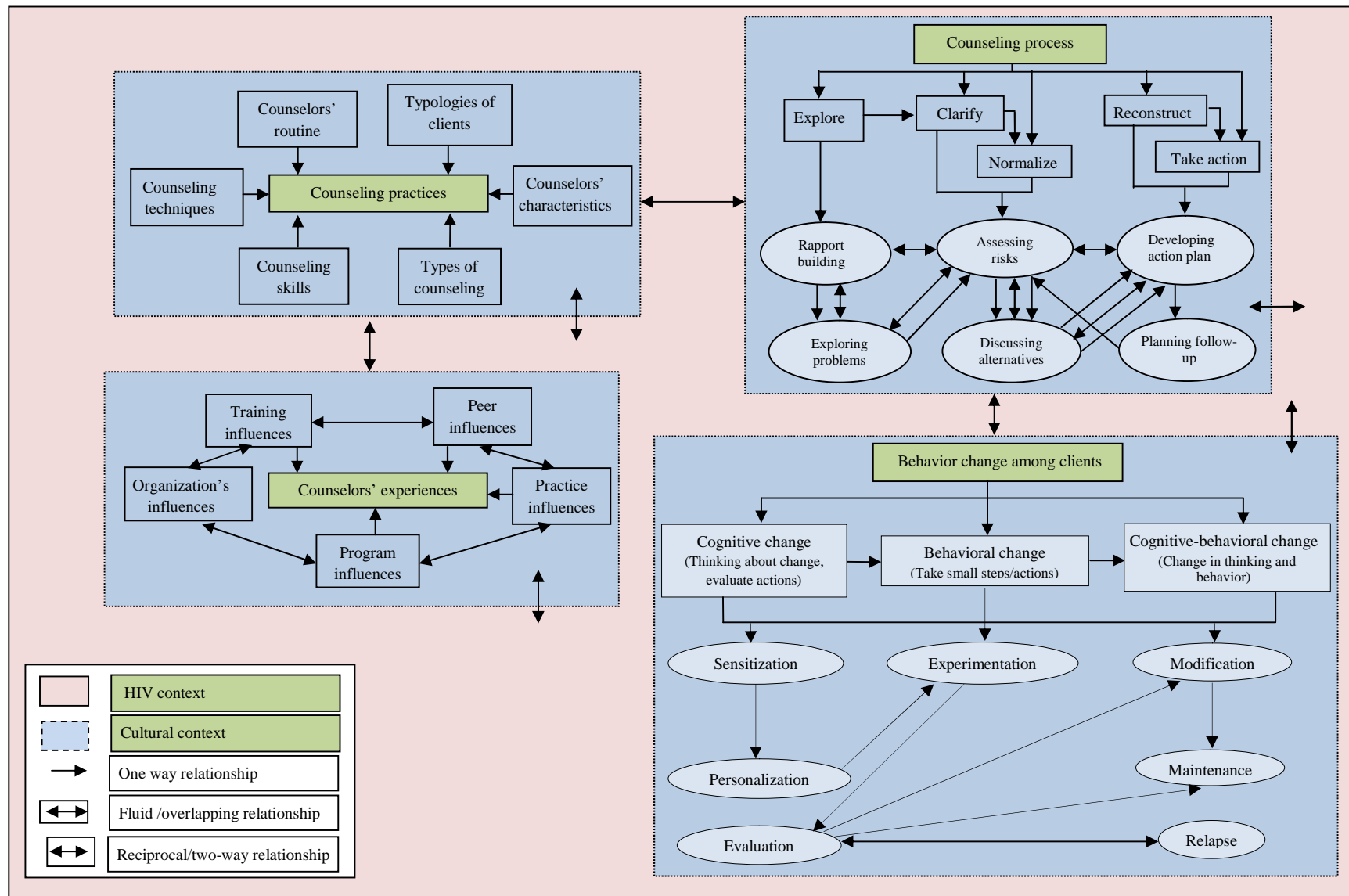
Figure 55. Constructivists' grounded theory of HIV counseling practices in Targeted Interventions.

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Constructivists' grounded theory of HIV counseling in TI context emerged as the contextual category in which all of the main categories were conceptualized and organized. The counselors' experiences were considered as the first main category. Counselors' experiences create a platform for counselors to explore counseling practices. The first main category, counselors' experiences result from various influences such as trainings, peers, conditions of TI project, organization's environment, and counseling practice in broader TI context. These factors provide context to counselors to construct meaningful experience as TI counselor. Counselors' experiences influence their counseling practices which in turn facilitated the process of constructing meaning of their experiences. Both, counselors' experiences and HIV counseling practices directly influenced each other. Further, the study revealed the reciprocal relationship between HIV counseling practices and counseling process. Some elements are common to any counseling process and would remain so.

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counseling process and would remain so. The HIV counseling process in the TI context is common to any counseling process and strategies described in the Western Psychology, but they are transacted differently in the TI context. Five counseling processes, namely, exploring, clarifying, normalizing, reconstructing, and taking actions emerged from the data. Counseling steps or strategies such as rapport building, exploring problems, assessing risks, discussing alternatives, developing action plan, and planning follow-up meeting facilitates behavior change (cognitive change, behavioral change or cognitive-behavioral change) among clients. The level of behavior change among clients was indicated by six processes, namely, sensitization, personalization, experimentation, modification, maintenance and relapse. Behavior change at a particular level guided the counselors to facilitate specific counseling process, which demonstrates overall counseling practice. The primary counseling process may be the same but the way it is carried out is culture-specific. In a nutshell, counseling practices, counseling process and behavior change process were found to be interrelated.

HIV counseling in Indian Cultural Context: Key Features

The present research reveals key Indian cultural features in the HIV counseling, which are explained as below:

Many clients sought counseling in pair; clients brought their friend, spouse, or lover in the counseling process. The study revealed that clients' sexual behaviors were also regulated by religious notions. Many counselors' mentioned that clients refrained from sexual activities in certain religious festivals such as Ramzan id, Christmas and during fasting in the month such as Ekadasi or Purnima. Conversely, sexual activities

were more frequent during festivals such as Navratri and Diwali. Counselors' mentioned that in many religions, use of condom is prohibited and clients often denied the use of condoms. To deal with this situation, counselors had interwoven religious reference, indirectly, in group educational sessions. One participant (P11) stated how he used to convince clients for condom use in given religious context:

> "…condom use during (secret) sexual activities not only saves the person
>
> from HIV and other STI infections but also help you hide your secrets."

Further, clients had different interpretation safe sex. The meaning of safe sex for many clients was the sex that can be safely hidden, rather than sex that carries no risk of an infection (STIs/HIV). They perceived disclosure of secret sexual activities to be dangerous, as it could cause social risks to themselves as well as their families.

As shown in the socio-demographic profile of participants, most counselors in TI were not qualified. Many were graduates or post-graduates in social work, commerce or other field while few were from the community who had up to high-school educated. Amongst all, community counselors had allocated more time for reaching out to clients, had very good rapport with clients, and were accepted from the clients. It was noted that the TI lacked adequate counseling set up due to lack of budgetary provision for setting up counseling room with audio-visual privacy. As a consequence, the counseling sessions were conducted primarily at STI Clinic, DIC, and office and in the field (under the tree, client's home, open ground etc.), where ideal audio-visual privacy were not maintained. Many counselors expressed the need for counseling room and minimal requirements such as a round table and three similar chairs (one for counselor and two for counselee) for

informal sitting arrangements, table and chair for counselors to do everyday documentation, cup-board for keeping general counseling documents, and lock and key cabinet to keep confidential documents).

In the TI, project services including counseling is free for clients; however, most clients often do not seek the service. Thus counselors had to reach them out in the field. Relationship between counselors and clients was (hierarchical) provider-receiver relationship where counselors were perceived as the authority, and more knowledgeable person. Most clients were not familiar with the concept of counseling often counselors were considered as health advisors and expected immediate solutions or advice to their problems from counselors. Even after termination of counseling, clients' often carry forwarded relationship by inviting counselors to their social functions.

Counseling approach that emerged from the study was solution-focused and client-centered. Solution focused orientation is reflected by their focus on providing workable solutions and alternatives to clients at the same time, emphasized clients' need and need based risk assessment, which reflected client-centered orientation. Many counseling strategies used in Indian cultural context were similar to Western counseling process and methods, but are applied culturally.

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Section V

Summary

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The research has generated constructivist theory of HIV counseling practice in the context of targeted intervention (TI). The constructivist processes have been filtered through all of the other categories, sub-categories, elements and sub-elements of

counseling. For example, the main category counselors' experiences contained various influences such as trainings, peers, TI projects, organizations and counseling practices. Each of these influences was characterized by key elements (such as training influences were characterized by empowering and disconnecting), which were further explained by sub-elements (for instance, positive and negative experiences of the trainings). Each main category was further compressed, scrutinized and created theoretical frameworks. The results chapter discussed theoretical frameworks of counselors' experiences, HIV counseling practices, HIV counseling process and behavior change process among clients. An integration of these theoretical frameworks generated constructivist grounded theory of HIV counseling practices in Targeted Interventions, which was explained in the results section.

The theoretical framework of counselors' experience has been explained through various influences, such as trainings, peers, organization's environment, TI project, and counseling practices, created a context to construct meaningful experiences as TI counselors in HIV counseling context within the broader TI context. The theoretical framework of HIV counseling practice has explained counselors' professional involvement in counseling activities, counselors' conceptualization of typologies of clients based on clients' motivation to access counseling and other services, various types of counseling services offered to clients, characteristics demonstrated by counselors, skills and techniques used in the counseling process. It revealed nuanced HIV counseling practice in Indian socio-cultural context. The theoretical framework of counseling process has explained five cognitive processes, namely, exploring problems, clarifying clients' beliefs and misconceptions, normalizing feelings, reactions to the situation,

reconstructing alternatives and taking actions on decisions clients have taken. Each of these processes were facilitated by counseling strategies such as rapport building, exploring problems, assessing risks, discussing alternatives, developing action plan and planning follow-up meeting. The framework has revealed that HIV counseling process was characterized as fluid and reciprocal – influenced by both counselor as well as clients. In the TI context, counseling process was emerged as horizontal and fluid, not comprising of any fixed step one after the other. For example, assessment of problems and risk assessment as well as risk assessment and action plan were overlapping. There was no fixed direction of the process and counseling strategies. The theoretical framework of behavior change among clients has explained progression of behavioral change from cognitive change to behavioral change to cognitive-behavioral change. The framework has revealed six indicators of behavior change process, namely, sensitization, personalization, experimentation, evaluation, modification, maintenance, and relapse. The behavior change process did not follow strict steps rather it emerged as cyclical process. Clients moved back and forth from one process indicator to another.

With these four theoretical frameworks, the research has generated constructivist grounded theory of HIV counseling practices in the context of Targeted Interventions. At the end, key features of Indian culture in HIV counseling were presented.

The next chapter discusses the results and link findings with relevant literature.