CHAPTER 1

INTRODUCTION
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AIDS is a medical diagnosis for a combination of symptoms which results from a breakdown of the immune system. AIDS stands for Acquired Immune Deficiency Syndrome. The immune system defends the body against infections and diseases. The immune deficiency is caused by infection with a virus. ‘A’ stands for Acquired which means that it is obtained or received by a person and is something which does not ordinarily exist within one’s body. ‘ID’ stands for Immune Deficiency which means there is deficiency in the immune system or that the immune system is weakened. ‘S’ stand for Syndrome which means AIDS is not one particular isolated disease but one which has a variety of symptoms leading to various disorders and a set of diseases. It is not a curse or a punishment.

AIDS is a caused by a virus, It’s name is HIV (Human Immuno-deficiency Virus). This process is slow and usually takes years after the infection for a person to notice that he/she has been infected, when the effects of the weakened immune system manifest themselves. When a person’s blood has tested positive for the presence of HIV, we say that she or he is HIV positive.
HIV is not a single virus. So far, two viruses have been identified to cause AIDS-HIV 1 and HIV2. HIV belongs to a family of viruses called Retroviruses. HIV is tiny, a thousand times smaller than the thickness of a hair, it looks like a rolled up porcupine, and it contains two snake-like single strands of Ribose Nucleic Acid (RNA) along with a reverse transcriptase which lies firmly wrapped up in a core which resembles a cone with a dimple at its base. This cone is protected by an envelope which has a knob-like protein sticking out its surface, giving HIV its characteristics appearance.

In healthy individuals, infections are kept at a distance by virtue of an array of defenders of the body which constitute the immune system. The most important components are the White Blood Cells present in the blood and lymphatic system including the lymph glands. Unknown to us these defenders are at work day and night, recognizing foreign invaders in the body and fighting them by producing an army of cells which attack the infection directly and produce antibodies which neutralize/kill the invaders.

How exactly HIV weakens the immune system is still being researched. According to the most accepted theory, HIV directly attacks the white blood cells. HIV zeroes in on white blood cells called CD4 cells which play a vital role in controlling the immune system. These cells have
an ability to communicate to each other. In this case, HIV enters the white blood cell. Upon entry it hijacks the genetic constitution and partly replaces it by its own sensitive information and then multiplies. These cells now attack other white blood cells. Slowly the number of white blood cells in the body is reduced and the immune system is paralyzed. HIV remains practically immune to counter attacks, since it hides inside the attacked cells which are also the cells that are supposed to attack HIV. Eventually, AIDS develops when killed CD4 cells can no longer be replaced. About 10 billion viruses are produced daily in AIDS patient.

HIV +ive means person is infected with HIV. He/she does not show any external signs of infection until the progression to AIDS, which may take up to 10 years or even more.

When a person is infected with HIV nothing is visible on the exterior but it is possible for the person to still infect others.

A person with HIV may initially be perfectly healthy but will eventually develop AIDS. In the meantime he/she may continue to appear healthy like others. A person with HIV is called “having AIDS” when his immune system is totally broken down and killed CD4 cells no longer be replaced in the desired numbers.
AIDS has to be acquired. It has to be passed on from one person to the other either by sex or blood transfusion, or from infected parents to child either inside the womb or during delivery or after delivery through mother’s milk. Hence one has to take the necessary precaution. AIDS does not discriminate a person by sex, religion or caste.

No, it is not possible to identify a person by looking at his/her face. Being clean or dressed properly does not mean that the person cannot have HIV.

No one knows where AIDS came from. It is however important to note that it is now present in the country and spreading at a higher rate. One has to learn to protect oneself.

The transmission is by infected blood, blood products, infected needles and syringes or sexual secretions (semen, vaginal or cervical secretions). Thus, there are only four known ways or routes of transmission of the HIV:

i) Having unprotected sexual intercourse with an infected person.

ii) Transfusion of infected blood or blood product.

iii) By infected blood in syringes and needles and body piercing instruments.
iv) By an infected mother to her unborn child or through the breast milk after the child is born.

It is, but unlike most other STIs it is not curable. Having other STIs increases the risk of getting or transmitting HIV.

Infection with HIV through sexual relations is possible by the following direct contacts:

i) Contact between the penis and vagina in heterosexual intercourse.

ii) Contact between penis and the rectum in anal intercourse between man and woman (heterosexual) or man and man (homosexual).

iii) Contact between seminal fluid (possibly also vaginal secretions including menstrual blood) and the mucous membranes of the mouth in oral (mouth to genital organs) intercourse (heterosexual and homosexual).

iv) A woman has a greater chance of being infected by an HIV infected male than man being infected by an HIV infected woman. This is because the contact period between the seminal secretions and the female’s body is longer than the contact between the vaginal secretions and the male organ.
Mucosal surface area of women exposed to secretions is also larger compared to the males.

Used needles and syringes are always soiled with minute amounts of left over blood. Infected blood will directly transfer HIV into the blood stream.

HIV may be transmitted during pregnancy or childbirth if the mother is HIV +ve. Children born of HIV +ve mothers are likely to be infected with the virus. There is 30% chance that the virus will be passed on to the unborn child. Some children can be infected by taking infected mother's breast milk.

Transfusion of infected blood from one person to another would directly transmit HIV into the blood stream of the recipient. The chances of passing on the virus in such a situation are close to 90%. Blood donation has no risk of acquiring HIV infection, one should donate blood regularly. It is safe to donate once in 3 to 4 months and increase the pool of uninfected blood and thus ensure safe blood for yourself, your relatives and others in your area. Donating blood voluntarily by youth who are not infected and who are healthy is a safe practice which should be encouraged.
The most common route of HIV is through heterosexual intercourse. It accounts for nearly 80% of the world’s AIDS cases. The next important route is injecting of drugs.

A major route of transmission being through sexual contact:

♦ The youth would need to abstain from penetrative sexual contact. This may be done by adopting other safer intimacy option which includes hugging, cuddling, massage, mutual masturbation, kissing etc. Penetrative sex of various kinds including vaginal, oral or anal sex should be avoided.

♦ Have sexual intercourse only with one faithful uninfected partner.

♦ Practice safe sex when there is more than one sexual partner. Use a condom in all types of penetrative sex.

♦ Reduce the number of sexual partners.

♦ Avoid sex with people who have many partners.

♦ If you use needles, syringes or other instruments that pierce the skin, make sure they are sterile.

♦ Never share needles and syringes.

♦ Make sure blood is tested before transfusion. Use blood that is certified HIV free.

♦ Avoid pregnancy if infected with HIV.
The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. These tests detect antibodies to HIV and not HIV itself. Antibodies are produced by our body's defence system to fight against intruders like viruses and germs. These antibodies detect attack and destroy unwanted intruders. There are antibodies against HIV too but these are powerless to destroy the virus.

There has been a rapid evolution in diagnostic technology since the first HIV antibody tests became commercially available in 1985. Today a wide range of different HIV antibody tests are available, including Western Blot test, ELISA tests based on different principles, and many newer Simple and Rapid HIV tests. Most tests detect antibodies to HIV in serum or plasma, but tests are also available that use whole blood, dried bloodspots, saliva and urine.

i) It takes about 6 weeks to 6 months to reveal the presence of HIV in the body.

ii) The patient may remain symptom free upto 8-10 years. Patient may remain unaware of infection, although antibodies are detectable. S(he) is able to transmit the infection to others.

iii) Without anti-retroviral treatment 30% will develop in 3 years. 90% will develop AIDS within 10 years.
iv) The test may indicate false negative from time to time because of the window period in which the presence of the antibodies is not detected.

It has been estimated that in India, nearly 52.06 lakhs people in the age group of 15-49 years are infected with HIV. Out of this, 38.4% are women and 57% of these infections are in rural areas. An overall prevalence of HIV infection among adult population is observed to be 0.91% during 2005. 98.89% of HIV positive patients are among adult population and 1.11% among newly born children. Every day approximately 1500 people become infected with HIV and of them young people below 25 years account for over 50% infections and the predominant mode (85%) of contracting the virus are through unprotected heterosexual contact. Consequently, young people are at the centre of the epidemic and if unchecked it would engulf the major and most vibrant human resource of young people, as the behaviour they adopt now, and they maintain throughout their sexual lives would determine the course of the epidemic for decades to come. It also depends upon the information, education, skills and services they receive; the extent to which they are involved in the process of addressing the HIV & AIDS epidemic and their rights are protected; and the care and support the HIV positive people get from their families, communities and government set-up at different levels.
But the redeeming feature is that the youth if properly educated, motivated and provided opportunities then they can not only protect themselves from HIV & AIDS but can also take a lead role in shaping the behaviour of their peers and educate communities to fight against HIV infection.

Twenty four years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV & AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer.

At the end of 2005, an estimated 36.7-45.3 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women more vulnerable. About one-third of those currently living with HIV & AIDS are aged 15-24. Most of them do not know they carry the virus. Millions more know nothing or too little about HIV to protect themselves against it.

**Evolution of HIV Epidemic in India**

In India the HIV & AIDS epidemic is now 20 years old. Within this short period it has emerged as one of the most serious public health problem in the country. The initial cases of HIV & AIDS were reported
among commercial sex workers in Mumbai and Chennai and injecting drug users in the North-Eastern State of Manipur. The disease spread rapidly in the areas adjoining these epicenters and by 1996 Maharashtra, Tamil Nadu and Manipur together accounted for 77% of the total AIDS cases with Maharashtra reporting almost half the number of cases in the country. The overall prevalence of HIV & AIDS in the country is 0.75%.

In India, the States are categorized as high, moderate or low, based on following definition:

**High prevalent States** – where HIV prevalence in antenatal women is 1% or more.

**Moderate prevalent State** – where the HIV prevalence in antenatal women is less than 1% and prevalence in STD and other high risk groups is 5% or more.

**Low prevalent States** – where the HIV prevalence in antenatal women is less than 1% and HIV prevalence among STD and other high-risk group is less than 5%.

**HIV & AIDS – Indian Scenario**

- Estimate number of adults (15-49 year) living with HIV in 52.06 lakhs. This gives an adult prevalence of 0.91% in the country, which is comparable to the previous year.
Out of the estimated adults living with HIV, 38.4% are females, 57% are of rural background.

On an average, 0.88 of antenatal mothers, 5.66% of STD patients, 8.44% of female sex workers and 10.16% of injecting drug user are infected with HIV. There are, however, considerable differences in the prevalence rates from state to state.

Median HIV prevalence among STD patients increased significantly over the previous years in Delhi, Rajasthan and Orrisa.

Median ANC prevalence fell below 1% in Tamil Nadu.

HIV prevalence in more than 1% among antenatal mothers in 95 districts, including 9 districts in low prevalence states. Similarly, HIV prevalence is more than 10% in 34 STD sites across the country, indicating multiple heterogeneous epidemics.

HIV prevalence in Nagaland and Manipur showed an increase indicating an IDU and heterosexual interface.

The major opportunistic infection in AIDS patients is tuberculosis (about 60%).
Age and Sex wise Distribution of AIDS cases in India

The slide shows age and sex wise distribution of AIDS cases in India. (15-29 years) age groups contribute to the number of AIDS cases to a great extent to the next higher age group of 30-44 years. This is primarily because of long incubation period of HIV and its manifestation into AIDS. It indicates that due to high risk behaviour of younger people they are more vulnerable to HIV infection. Further, for every HIV positive woman there are three men infected with HIV.

Source of HIV Transmission in India

The slide below shows that despite the lowest efficiency (0.1-1.0%) for transmission of HIV infection through sexual inter-course, it is the major route for spreading the virus in Indian population. However, in the states like Manipur and Nagaland it is the injecting drug use leading to vulnerability to HIV infection.

To estimate the total burden of HIV infections in the country some efforts had been made in the past by WHO / UNAIDS by using the data generated by NACO and other publications from various Research Institutes in India. The different estimates of disease burden in the country reported by these organizations since 1990 are as follows:
Street Children & HIV:

Street children describe children who live or work on the streets. Some of these children live with their families (who are also living on the streets). Other street children live and work on the streets but do not live with their families. The term can also include child labourers, sexually-exploited children, and war-affected children, who may also be forced to live or work on the street. The children's relationship to the street varies. Some live and work with their parents on the streets. Some return home at night, but work independently during the day. Others maintain their family contacts, but are forced to spend most of their time on the streets and return home once in a while to spend a night with their family. Still others sleep and live entirely on the streets of the big cities without any family contact at all: often they have left home due to abuse. They sleep in abandoned buildings, under bridges, in doorways, or in public parks. The global figure for children living and working on the world's city streets is likely well over 100 million children. And that number rises every day. About 40 percent of them are homeless. These children may support only themselves or their homeless families. The other 60 percent work on the streets to support their families, but have a home to return to. These young people range in age from three to eighteen. Most of them are in developing countries. Street children are mainly boys, but the number of girls is increasing.
Children and youth may take to the streets for a number of reasons including war, poverty, urbanization, political instability, natural disasters, family breakdown, AIDS, rebellion against their parents, insufficient income, and violence including physical, emotional, and sexual abuse. Children who live and work on the streets are often the victims of violence, sexual exploitation, neglect, chemical addiction, and human rights violations. For example, street children throughout the world are abused—and sometimes murdered—by police, other authorities, and individuals who are supposed to protect them. Those with some family links spend their lives on the streets selling trinkets, shining shoes, begging, working with their families, or washing cars to supplement their families' income. Most never go beyond the fourth grade. Those without direct family contact often create family and security by living in groups with other children. They may also sell small items, or undertake manual labour. When there are no other means of survival, street children with and without formal family contacts may resort to petty theft and prostitution for survival. Street kids may prostitute themselves because they need the money, because they are looking for praise they can't get anywhere else, or because their families, or family contacts, force them into this activity. They are extremely vulnerable to sexually transmitted diseases, including HIV/AIDS. Child prostitutes can be boys or girls, but are more often girls. Up to 90 percent of street children use psychoactive substances, including
medicines, alcohol, cigarettes, heroin, cannabis, and readily available industrial products such as shoe or cobbler's glue and paint thinner. The potent fumes of these cheap and easily available inhalants hit a part of the child's brain that suppresses feelings of hunger, cold, and loneliness. Solvent-based narcotics offer them an escape from reality. But they must exchange their temporary highs for physical and psychological problems—hallucinations, pulmonary edema (fluid accumulation and swelling in the lungs), kidney failure, irreversible brain damage and, in some cases, sudden death.

Origins of HIV/AIDS

When asked about the origins of HIV/AIDS, some informants considered AIDS as a disease sent to black people by ferengi (foreigners—particularly Americans). One informant said that AIDS was the result of the restless hands of the white man. There wasn't anything close to AIDS in our country. It was a certain white man (ferengi) who wanted to do some sexual research with the apes that first got AIDS when he had sex with some ape. But then he didn't know he had contracted any such disease and went on to have sex with some females who got the virus from him and who in turn transmitted it to others. That way it even came to this country through the ferengi.
Another explanation is that AIDS may have been in existence since time immemorial, but under a different name. One of the informants said that there was a disease in the old days, which the people then called amenmin (that makes skinny); it is that same disease, which the scientists now have named, AIDS. Another informant objected to the above line of reasoning by claiming that the people then called any disease that severely wastes body weight before eventual death amenmin, it could be TB or it may have been AIDS or any other disease that was called under the same name amenmin. There is no clear evidence that amenmin was just only AIDS although AIDS might have been one of these diseases that used to be called amenmin.

Some perceive HIV/AIDS as wrath or punishment sent from God for undesirable behaviour. Look at all that is happening, look at the women, they are supposed to wear long dresses but they go around with tight trousers that seem to have been fitted on their skin. That is what has triggered God's wrath. This is only a little punishment compared to all the sins of people. This participant dismissed the view that HIV came from apes by pointing out that if that was the case, it would have also occurred in them. He reasons that because AIDS only occurs in human beings, that rules out any claims of its origins in the animal kingdom. But proponents of a primate origin argued that God would not destroy his own creation.
Why would God want to kill his own people? God's thoughts for us are kind thoughts and He doesn't want us to die. Despite such debates, religious discourse about the origin of HIV/AIDS was an important part of the informants' debate.

**Reactions to Being HIV Positive**

It is a custom in Ethiopia (particularly in rural areas) that women should wash their vagina twice a day (in the morning and evening). This custom is waning in urban areas.

During the course of our interviews we asked participants what they would do if they were diagnosed as HIV positive. With the exception of very few, strongly negative feelings were expressed at the thought of themselves being infected. Some said that they would commit suicide rather than slowly succumb to the disease. Legese said that *I would commit suicide because I see no other choice and wouldn't face the grim possibility of lying down sick one day along a sidewalk without anyone to take care of me. It will be better to die that way than wait for the disease to take root and lead to a pitiful death*. Some of them expressed that they would not reveal their HIV-positive status to others for fear of disrupting existing social relationships, resulting in embarrassment, isolation and discrimination. In this regard, Andualem said that *I would live*
anonymously without disclosing the fact to any one, and would be more
careful and take care not to get any other diseases, which would take me
hurting down to the grave.

A common reaction to this question was a concern not to pass the
virus on to other people by abstaining from sex. Some of the participants
said that they would teach the public not to end up like them by speaking
publicly about their infection. One of these informants, when probed
further if he won’t feel any anger if the virus infected him at such a young
age, said that why should I be angry, death is something that awaits me
anyway.

Still others reported that they would appeal to God for healing. They
said that they would frequent the church, cleanse themselves by holy water
solicit God and confess their situation in the church. These informants
argued that they would turn their attention to God so that having lost their
life in this world; they wouldn’t loose their chances of good life in the
world to come.

Others’ reactions are contingent upon the government’s response to
their situation. Terefe expressed his rage against the government as
follows: I would go and seek assistance from the government. If I am
assisted I would have no problem in exposing myself and teaching the
public to be aware of the disease. But if I am neglected, I wouldn’t feel any
guilt in taking my revenge on as many people as I could by passing the virus onto them by any means I found suitable. Asked why he decided to take vengeance on people, he said that he does not see any difference between the government and the people, for the people make the government. Another informant, Teka, displayed an unshakeable fatalism by stating that his days were numbered and the day and hour of his death was a thing already decided by God, and that he will die at that hour with or without AIDS. The hour will not come any sooner because he has HIV nor will it be delayed if he doesn’t. Therefore, if he discovered he is carrying the HIV virus, he would just continue living until his last day and hour came. However, most of the informants preferred not to have their HIV status confirmed, as sero-positivity was believed to be a most horrifying thing.

**Dynamics of HIV/AIDS Among Different Groups**

Throughout human history, many epidemic diseases have been blamed on the others, on outsiders. Epidemic diseases have also been considered as the problems of marginal members of affected societies (Kane, 1993; Setel, 1999). Similarly, AIDS is considered as the problem of ‘the others’ throughout its history, and has been a metaphor for human differentiation by race, class, sexual identity and gender (Murray and Robinson, 1996). Poverty and other socio-political predicaments have
created favourable conditions for the HIV/AIDS epidemic and prevented an effective response. In line with this argument, Farmer (1992:242) noted that “AIDS is indeed a disorder of poor people, and becoming more so...”. Schoepf’s study also demonstrates the link between poverty and the HIV/AIDS epidemic in Zaire. “Research in Zaire linking macro-level political economy to micro-level socio-cultural analysis shows how poverty and hopelessness born of prolonged crisis and increasing disparities in wealth contributed to a burgeoning HIV/epidemic” (1995:30). In view of the poverty discourse in HIV infection, informants were asked if they thought the rich or the poor were more exposed to AIDS. Most of them argued that the rich people are more exposed because they have the money to do what they want and entertain and win whatever girl they like. The poor have no more thoughts (of sex) than how they can earn for their lunches and dinner and cannot afford to go out with women often. The students (non-street children) involved in the study also shared the same opinion.

Interestingly enough, the participants all agreed that ordinary girls or home girls as they put it, particularly students, are more exposed to HIV than prostitutes are. They all remarked that it is safer to have sex with prostitutes than ordinary girls because the former are more careful and make sure condoms are worn before consenting for sex while the were
described as messy. It is, however, my impression that impoverished
prostitutes may not refuse sex without a condom for fear of losing clients.
Such prostitutes have to succumb to clients' demands for sex without a
condom in order to make money and to remain alive. It is obvious that the
street children cannot afford to visit high-class prostitutes who consistently
insist that their clients use a condom.

Perceptions of Condoms and Condom Use

Since most of the street children involved in the study reported using
condoms, they were asked if they liked using condoms or if they only used
them out of sheer necessity and whether they felt condoms made a
difference to the sexual experience for either partner. There was a general
consensus that sex with condoms is not as enjoyable as sex without, and
that sex is more 'natural' without a condom. Abebe (a street boy) said that
he only uses condoms because there is HIV and there is nothing he can do
to protect himself other than wearing condoms. It would be much more
pleasant if he had sex without condoms. This 'impolite' disease [AIDS]
forced me to use it; otherwise sex would have been more enjoyable
without it. He made these statements with a lot of disgust on his face, and
he latter added that using a condom is 'messy' while putting it on and
taking it off. He added that even using condoms might not be safe, only
God knows if they can really protect one from AIDS. We can only use them
place. Others, however, expressed that many such problems come from not knowing the proper way of wearing condoms. Some wear it inside out, which causes a lot of friction during sex because the lubrication is on the inside.

Asked if they have friends who do not use condoms and what reasons they give for their non-use, they replied that there are people who naturally dislike condoms and are heard saying *who will struggle with condom, I will do it without it!* Some people don’t use condoms because they do not believe that they can protect them, some for fear that their girlfriends will consider them unfaithful or untrusting and some because they think condoms reduce pleasure. One of the informants said that he had friends who do not use condoms. They said that flesh-to-flesh sex is very enjoyable. *Sex with condoms is like ‘childhood sex, and it is also messy.*

All of the informants agreed that they did not have complete confidence in condoms, but used them with the belief that it is better than ‘going-in-bare’. Bekele equates sex with fire, and a condom with a pair of shoes. *It is much safer to step on fire with your shoes on than with bare feet. Same with condoms*, he said, *much safer to put them on than to have sex without them.*

Some said that they use them only because they are used to thinking condom use and sex is associated without any deliberate thoughts of
protection. Teka added that he personally sees condoms as equivalent to AIDS and only uses them because the prostitutes do not consent to sex if he doesn’t wear one.

**Substance Abuse and Unsafe Sexual Behaviour**

Most of the informants admitted that they use chat, alcohol and smoke cigarettes. Even during the focus group discussions, we saw one informant trying to sneak some chat leaves into his mouth without being seen. We told him it was okay with us if he wanted to use it there. He smiled and brought out a very small bundle of leaves from his pocket. Another participant followed his lead, and then many started chewing. We objected when they lit cigarettes. However, they countered that we had to allow them to smoke if we wanted them to keep talking. We were not left with any choices and let them smoke.

Intravenous drug use is something they neither engaged in nor even heard about. Asked if they used hashish or any other drugs (other than chat) they all broke into fits of sarcastic laughter and one of them put it on to words saying that *one only does that when he has money enough to eat well and get satisfied and still has some more left to spend*. The implication was that they don’t even have enough money to feed themselves properly, let alone use hashish, which they perceived as a luxury. Life on the street is very stressful, and they explained that they
usually take chat to overcome their loneliness and escape the harsh realities of their lives.

The participants were asked if they felt that the use of alcohol or other drugs might influence a person’s decision and/or ability to use condoms, or their sexuality in general. Strong associations were discussed between alcohol, chat, cigarettes and unrestrained sex. Seyoum said that I have to drink first and I also have to have money in my pocket to pay for her (the prostitute). I then go to her and we bargain and when we agree I take her to a room in a hotel. Another street boy stated that he only thinks of sex after he has taken chat and has had a few drinks. Asked about how often they engage in sex, they replied that it all depends on how often they drink and chew chat. If they chew chat and drink, sex would necessarily follow.

Furthermore, the informants felt that alcohol, chat and smoking made them careless about using condoms and gave them more confidence, such that they would be more likely to have sex.

Some boys said that when they are drunk they forget to wear a condom or do not use it properly. Some of the informants even suggested that the government should ban all drinking places and ban the production and distribution of alcohol regardless of the effects on the economy, as men are usually lured into having unprotected sex under the influences of
alcohol. Terefe narrated as follows: *You go to a certain hotel just to have a drink or two and then you see those pretty girls in those clothes that leave half their body naked for you to see. When they come and arouse you with all their sex looks and touches, what you knew about AIDS just leaves your mind and you end up in an albergo bed with one of them. I am sure if alcohol was banned, AIDS would cease to be a problem.* Overall, it appears that the informants denied agency, and associated unsafe as an outcome of taking alcohol or chewing chat.

**Prevention Works**

There are success stories for effective prevention and control of HIV infection among CSW as experienced in sex worker intervention programme at Sonagachi, Calcutta where condom use has increased from 0% in 1992 to more than 70% in 1993-94 and sustained over more than 70% till 1998. The VDRL positively has also reduced from more than 20% in 1992 to 5% in 1998. These interventions have been able to prevent the HIV infection from spreading among CSW as evident from HIV prevalence data from 1992 to 1998, which suggest that the infection is still below 5% among CSW in 1998. The Sonagachi experience has provided an opportunity to learn that prevention works in the highest risk groups of population provided effective intervention programmes are implemented with high coverage of risk group population.
Elements of Strategy:

♦ Provide access to information, education and awareness (within the cultural context) necessary to develop life skills required to adopt safe behaviour to reduce vulnerability to HIV infection among young people;

♦ Support youth organizations & structures and enhance their communicational, networking, planning, management, organizational, MIS, operational research and implementation skills for a broad based sustainable social movement to fight the epidemic;

♦ Empower youth to become peer educators, assume local community leadership and act as catalytic agents to help others to prevent HIV infection;

♦ Build capacities of youth to advocate and mobilize community, political leadership and service providers support to fight stigma, discrimination and denial and provide support and care to people living with AIDS.

♦ Promote young peoples’ including PLWA participation and partnership in the strategic planning exercises, programming
process and implementation of activities so as to ensure a true expanding national response to HIV & AIDS;

♦ Mobilize and sensitize parents, teachers, policy-makers, media, political leadership and religious organizations to exhibit commitment and willingness, influence public opinion and policies with regard to HIV & AIDS prevention and young people;

♦ Access to sexual and reproductive health, HIV/STIs prevention counseling and youth friendly services including confidential voluntary counseling and testing of HIV and referral services.

♦ Introduce and or improve the quality and coverage of school, college and university programmes and extra curricular activities that include HIV & AIDS education and information.
KEY ELEMENTS: STRATEGIC PROGRAMMING FOR HIV PREVENTION*
(Create A Supportive And Enabling Environment)

Awareness about HIV Prevention
- HIV/AIDS
  - a serious threat
  - multi-sectoral nature
- Recognize poverty/deprivation spread
- Young people especially Women Girls more vulnerable to HIV

Prevention Package
- Information
- Education**
- Counseling – VCT
- Commodities (Test kits, condoms, drug for STIs) Safe blood transfusion &

Trained Service Providers (Health, Education, other sectors)
- Technical Protocols Manuals, Guidelines

Adoption of Safer & Responsible Sexual Behaviour

* Prevention, care, and support is a continuum to support HIV/AIDS issues.

** Information and Education support of responsible sexual behaviour includes abstinence, delayed age of sexual activity, and Condoms.
Self-Concept:

There are nearly as many different definitions of the self-concept as there are individuals who have studied it. Self was simply an object, like any other. In this sense the self is an object, like any other. In this sense the self is whatever the individual feels belongs to the self is including the material self and the social self. The social self was concerned with the views the individual felt others held about him. There was also an affective component associated with self, the positive or negative views the individual holds about himself.

Others (Golden and Cherry) define the self as that which is meant by the pronouns I, me, mine and so forth. From this perspective, the self is all those feelings the individual has about himself. These feelings arise and develop from social interactions with others and from the individual’s concern about how others react to him. By learning to view the self as others do, the individual is able to predict how others will react to him. From this perspective, then, the self-concept comes to regulate the individual’s many behaviours, particularly his social behaviours.

Leary (1995) defines the self-concept in terms of personality structures. For these researches the self-concept is the nucleus of the personality, an individual’s constellation of traits and values. The self-concept, then, is viewed as basically stable, changing only somewhat when the individual’s personality traits and structures change.
In his extensive discussion of the self-concept, the Maehr. (1984) identified three components of the self-concept: structure, function and quality. The structure of the self-concept is described by such terms as rigid or flexible, simple or complex, broad or narrow, accurate or inaccurate. The accuracy of any one person's self-concept can be measured by the degree to which the individual's view of the self is consistent with the views of others.

The self-concept serves a number of functions, including: self-evaluation self-actualization (the striving to reach one's highest potential); determining whether behaviour will be inner-or outer-directed; and predicting the activities in which one will engage. As Maehr's views it, the self-concept has a motivational function and as a result steers most people into choosing life-styles and behaviours that combine maximum chances of success with maximum reward values. A de-emphasis is placed on activities in which the individual is less likely to achieve success or to receive satisfying rewards. A second aspect of this motivational component of the self-concept is that it directs behaviour. In other words, we are likely to seek out social situations and deal with conflicts in ways that are consistent and deal with conflicts in ways that are consistent with our self-concept.
The final aspect of the self-concept is its quality. Closely related to the concept of quality is self-esteem, which refers to the approving or disapproving nature of the individual’s view of the self. Self-acceptance versus self-rejection, another aspect of the quality of the self-concept, refers to whether or not the individual can live with and be happy with the self, generally speaking, the notion involved here is one of self-evaluation, an affective reaction to the self. Self-esteem is discussed in detail below.

As you can readily surmise from our description of Maehr’s views a self-concept is learned and is therefore, subject to environmental rewards and punishments as well as cognitive evaluation. As positive reinforcements to the individual are increased, the self-concept grows in esteem. The converse is also true. A self-concept is learned from experiences with success and failure; these experiences help the individual become aware of the limits of his competencies.

Singer (1966) identified four basic self-concepts. First, there is the self-concept that includes the individual’s perception of his abilities, roles and self-worth. Second, there is a transitory self-concept that fluctuates from moment to moment or from experience to experience, failure at a given task, for example, may cause the individual’s temporary self-concept to become negative, with a correlated (but only short-term) lowering of self-worth and self-esteem.
Third, there is the social self-concept, by which means the individual’s perception of how others view him and his social competences, the views of others determine, to some degree, the views the individual has of the self. Hence, the social self-concept becomes critical to understanding the more general self-concept of the Peron. If the individual thinks that others believe he is bright and energetic, it is more likely that the permanent self-concept of the individual will include those characteristics. Of course, the converse is also true. The social self-concept also refers how the individual views the self within the social system of society.

Finally, there is the ideal self-concept, which represents the individual’s views of his ideal self. It may be realistic concept, in which case it will be similar to the individual’s basic self-concept, or it may be unrealistic, with aspirations and ideals that are either too high or too low for the individual’s competencies. Too high an ideal self-concept may lead to frustration because competencies don’t measure up and too low an ideal self-concept may lead to self-denigration and unwillingness to attempt to obtain goals that would otherwise be within the individual’s reach. What is desirable is an appropriate match between the ideal and real self-concept, so that the individual has a positive and appropriate views of the self.
Reviewing the multitude of definitions of the self-concept, Douvan, (1970) detailed the characteristics various theorists have attributed to the self-concept. From these characteristics we can build our definition of the self-concept as a system of concepts about the self, including body self, social self, and values. Self-concept has an affective component, which we call self-esteem. Self-concept also organizes our experiences so that they can be used to predict and guide our behaviour in ways that will satisfy basic needs and avoid potential failures. This conceptualization of the self-concept suggests that it is in reality a theory each individual formulates about himself Douvan (1970). Scientists who study self-concepts, then, are seeking to build a theory of self-theory. That is, they describe how one forms a theory of one’s relationships with other people, with nature, with the parts of the self and of other people’s relationships with each other (Brown and Smart (1989).

We have already noted that the self-concept is learned, a process that takes place partly through learning principles and partly through cognitive evaluation. In other words, social forces are important determinants of the self-concept. In addition, cognitive development plays an important role in the development of self-theory. Both Brown and Douvan also discussed the body self as it relates to the self-concept. Hence, the individual’s physical and physiological development also feeds into the development of the self-concept, or self-theory.
It is really no wonder, then, that psychologists who study adolescents development look very closely at the development of self-concept. The body changes, cognitive changes and social changes that occur during the adolescent period of development lead one to suspect that there should be important changes in the nature of the self-concept at this time. The search for identity that occurs at adolescence also suggests sweeping changes in the self-concept, Erikson (1968), as well as others, have talked about the hopelessness of the adolescent stage of development. Erikson’s identity versus identity diffusion conflict is the most obvious expression of adolescence as a period of reorganization of the self. This reorganization is particularly required in cultures that regard adolescence as transition stage; it will not occur (or occur to a much lesser degree) in cultures where there is relative continuity between childhood and adulthood (Harter, 1993). The study of self-concept during adolescence allows us to see how the many cultural, intellectual and biological changes that we have previously discussed relate to the development of the individual’s view of the self and the developing personality.

Self-Concept Development

It is clear from the above discussion that in order to measure the self-concept, we must obtain measurements of the degree to which the individual views himself as a worthwhile person. We might also measure
the ideal self-concept, as noted by Parsons, J. (1982). And we might assess the degree to which the individual’s ideal self-concept and characteristic self-concept match. There is, then, a multitude of ways to measure the self-concept, some of course better than others.

Wells (1976) reviewed various methods of measuring the self-concept and assessed their reliability, validity and utility for research on self-concept development. We shall describe some of the more commonly used methods in order to help you better understand the research discussed below

**Stability of Self-Concept**

Studies on the stability of adolescents’ self concept attempts to assess the hypothesis that adolescence is a period of restructuring the views of the self. It should be expected, then, that the self-concept of a preadolescent will be more structured than that of an adolescent. Increased stability should be seen in adulthood. The rationale for this hypothesis is quite simply that the adolescent’s search for identity leads to a breakdown in the self-concept; the self-concept is restructured when the adolescent enters early adulthood with a new self-identity formed by the resolution of the identity versus identity diffusion crisis. Longitudinal studies are the
only adequate way to test this notion. Unfortunately, there is a paucity of such research in the area of self-concept development.

Gairola (2001) conducted a longitudinal study of self-concept in 172 eighth and tenth grade students, retesting the students two years later, using the Q-sort technique. The self-concept was stable over the two-year period, with a correlation between the first and second testing of 0.78. The students who had a negative self-concept during the course of the two-year period, tended to show poor adjustments on the Minnesota Multiphasic Personality Inventory and were more negative in terms of peer ratings than the students with a more positive self-concept. Engel reported that there were no IQ, sex, or age differences in self-concept development in her sample.

Campbell et al. (1991) studied 49 students, 15 males and 33 females, in the sixth grade and then again in the senior year of high school. Girls showed an increase in social orientation and boys showed an increase in personal orientation toward life; these differences probably reflect cultural personality variables, but there were no significant sex differences in stability of self-concept. The size of the sample, however, precludes any definitive statements.

Crossby (1982) conducted a longitudinal study of adolescent self-concept with a sample of 952 college students. Her major interest was
studying self-concept with reference to Erikson's psychosocial crises. However, part of the study involved a six-week test-retest of self-concept on 150 of the subjects, using the Q-sort technique. The stability correlations ranged from .45 on the identity diffusion scale to .81 on the intimacy scale, with the median correlation of .70 on all scales for the sample of 150 students. These correlations indicate a degree of stability, but are not particularly impressive because of the relatively short time span between tests. Over the extended three-year period of the longitudinal study, few changes in resolution in Erkson's psychosocial crises were reported. This is not surprising given the stability coefficients of the tests. A test can only detect significant and important changes if it is highly reliable and the test used by Constantinople was apparently not sufficiently reliable to detect adjustment changes if they were present.

The author is currently conducting a longitudinal study of self-concept development with a somatic differential scale. Four hundred and thirty adolescents who were in grades five through eleven in 1975 were retested in 1976. Analyses of four aspects of the self-concept derived from the semantic differential instrument indicated no changes in the self-concept for any of the grade levels or for either sex.

There are several problems with these longitudinal studies that limit to some degree the importance of their findings. First, the lowest grade
level studied was the fifth, with children of 10 and 11 years. Since girls mature somewhat earlier than boys, it may be necessary to test younger adolescents in order to obtain a better assessment of change in self-concept. Nevertheless, the data from these longitudinal studies do indicate a certain degree of stability in adolescent self-concept and suggest that to the extent there is a restructuring of adolescent self-concept, it does not completely disrupt the personality. Constantinople's test of Erikson's theory did report differences as a function of the identity versus identity diffusion stage of Erikson's theory, but her subjects were all college students from the middle- and upper-middle classes. Hence, it is questionable that her results can be generalized to the adolescent population in general. For the present, then it remains to be seen whether or not the adolescent self-concept does change substantially.

There are a number of cross-sectional studies of self-concept development in which the investigators have attempted to relate self-concept to other aspects of personality or social development or in which they have attempted to study the structure and nature of self-concept at different age levels. Although, we cannot discuss age changes in self-concept on the basis of these data, we can look at age differences in the self-concept and see whether or not the self-concept becomes more diffuse during the adolescent stage of development.
Horner (1972) hypothesized that the self-concept measures of brighter or older adolescents should evidence a greater discrepancy between ideal self and real self than similar measures of younger or less bright adolescents because the more mature individual is capable of making finer distinctions about the self than the less bright or younger individual. In order to test their hypothesis, 120 children, 40 each from the fifth, eighth, and eleventh grades of a middle-class school. Half the students in each grade level were boys and half were girls the average IQ of half was in the middle 120s, and the average IQ of the other half was in the low 90s. The Dweelc (1974) self-esteem inventory was administered to the students along with an adjective checklist of socially desirable and undesirable qualities to which the students were asked to respond as either descriptive or not descriptive of them. The students responded to each instrument under standard self-concept instructions, ideal self-concept instructions and social self-concept instructions (the way you think others perceive you).

Both scales yielded similar findings. Several sex differences emerged, with fifth-grade boys feeling that they are evaluated more negatively than fifth-grade girls. The opposite was true of the eight-grade students, but there were no sex differences on these dimensions in the eleventh grade. More directly relevant to the major hypothesis was the fact
that the brighter and the older children did indeed show a greater discrepancy between the ideal and real self-concept than the less bright or younger children. The older children and the brighter children apparently had higher standards for their own behaviour and were more self-critical than the others. It appears that with an increase in age adolescents set higher standards for their behaviours. In turn, they become capable of feeling disappointed in not reaching these high standards, and this apparently increases the discrepancy between what they feel they are and what they would like to be.

With respect to IQ differences, several additional findings of interest emerged. Brighter students felt more positively about themselves at the fifth-grade level, but more negatively about themselves at the eleventh-grade level. They also suggest that this is because brighter older students are more aware of possibilities for self-actualization. In this study, then the investigators demonstrated the relationship between cognitive and self-concept development during adolescence. Unfortunately, as Wells (1976) has pointed out, the uses of discrepancy scores of this sort is highly questionable because of interpersonal problems. Nevertheless, Shah and Sinha (1971) data indicate that there may be structural differences in the nature of the self-concept as adolescents mature.
Brown (1989) studied age and sex differences in self-concept in fourth-sixth-eighth, and tenth grade students with the Coppersmith self-esteem inventory. The tenth-grade girls showed a lower self-concept score. Nor, other age sex comparisons produced significant differences. Brown suggested that this sex difference at the tenth-grade level may be the result of the girls new awareness of their role as females, which has traditionally involved feelings of relatively low self-esteem. It is possible that as sex stereotypes change the sex difference reported for the tenth-grade girls would dissipate or even disappear. Although Brown's study is a cross-sectional study, it indicates no particular differences in self-concept across the adolescent years.

Hinshaw et al (1997) conducted an interesting study in which masculinity and femininity ratings were related to self-esteem. The data indicate that androgyny, possession of a high degree of masculine and feminine traits, relates to self-esteem. Androgynous male and female subjects had the highest self-esteem.

An extensive study of adolescent self-concept structure was conducted by Olsen N. and Williansen (1978). A total of 2062 subjects in grades six through twelve rated they on a seven-point semantic differential self-concept scale. The self-concept ratings were factor-analyzed and four factors emerged: (1) achievement-leadership, (2) congeniality-sociability,
(3) adjustment and (4) sex-appropriateness of the self-concept.
Achievement-leadership was defined by the items “smart”, “success”,
“leader”, “sharp”, “superior”, “valuable”, and “confident”. As mange
notes, achievement-leadership conveys the notion of an individual who
feel competent, intelligent and a leader. Congeniality-sociability was
defined by the positive poles “kind”, “friendly”, “good”, “nice”, and
“happy”. It describes an individual as someone stimulated by social
interactions and comfortable in social settings. Adjustment was defined by
“relaxed”, “steady”, “refreshed”, “satisfied”, and “stable”; It describes one
who is adjusted and in harmony with the environment. The factors sex
appropriateness of the self-concept is defined for males as “rugged,”
“hard,” “strong” and “healthy” and for female by “delicate”, “soft”,
“weak” and “sick”. It should be pointed out here that the scores of the
girls have been adjusted, so that high scores reflect a high degree of the
female sex-role component. In fact, both boys and girls received high
scores for viewing themselves as possessing traditionally defined sex-role
personality characteristics.

Both sexes showed a decline in adjustment from sixth to the tenth
grade with the girls continuing to drop off until the eleventh grade. At
every grade level boys rated themselves higher on the adjustment factor
than did girls. The drop in adjustment for the eleventh-grade girls is
reminiscent of Brown's (1989) findings for tenth-grade girls namely, that there was a drop in self-esteem at this grade level. He suggests that the adolescent finds increasingly more difficult to live with the social system and therefore, there is a decrease in adjustment during mid-to late adolescence. He explains the drop in the female's adjustment at the eleventh grade in much the same manners as Brown, indicating that girl's self-esteem drops as they confront the realities of their female sex-role stereotypes. Finally, males seem to solidify their sex role from grades six through nine and maintain the stereotype of the male through grade twelve; the girls seem to react in the opposite way. Perhaps this is because the female sex role is not as clearly defined as the male sex role (Maccoby & Martin, 1983).

Their data, then, indicate clear structural aspects to adolescent self-concept. In addition, his data demonstrate age and sex differences in the manner in which adolescents view themselves. In contrast to the longitudinal data reported above, their scores-sectional data indicate some dramatic differences in the self-concept of adolescents of different ages. However, these data do not indicate that adolescence is a time of broad upheavals in the self-concept; there is only a modest restructuring. It must be remembered, however, that this is a cross-sectional study and that there is a six- or seven-year age difference in the cohorts composing the sixth
and twelfth grades. Until data similar to these are collected to a longitudinal study, it will be difficult to tell the degree to which the age differences reported by them are confounded with cohort differences.

It is of considerable interest that the author, in his ongoing investigation of changes in self-concept, found the same four factors of adolescent self-concept. Approximately 100 students each in grades five through twelve completed the bipolar adjective checklist used by them. Virtually, identical factors were found in the analysis of the data from the total sample of subjects, as well as in analyses done separately by sex. However, when the data were factor-analyzed separately for each grade level, a somewhat different picture emerged. There were 7 factors in grade seven, 6 in grades five and eight, 5 in grades six, nine, and ten and 4 in grades eleven and twelve, indicating that different structures underlie the self-concept at different grade levels. These data suggests that at about the seventh grade, the self-concept is maximally differentiated and that it slowly becomes solidified over the reminder of the adolescent years. Although structural differences are evidence, they indicate that changes in the self-concept are rather gradual.

In a more recent study, Gyanani (1999) extended this technique for the study of self-concept to the adulthood years. It is generally believed that the self-concept remains relatively stale throughout the adulthood
years. Therefore, it is of interest to note here that Gyanani found some age 
and sex difference in the self-concept of the adults he studied. Again, 
however, evidence of dramatic or sweeping in self-concept was absent, in 
accordance with the expectations. Hence, changes in self-concept are 
minimal following adolescence.

The age-difference and age-change data presented in the above 
research, then, do not support the notion of a widespread reorganization of 
the self-concept during adolescence. Nor do they suggest that adolescence 
is a period of Straumann and Higgins (1998). Rather, these data indicate; 
as we have noted above, gradual changes in the structure of the self-
concept.

Indeed, there are a number of reasons to suspect that the self-concept 
will remain stable across the adolescent years. We tend to ignore 
experiences that are in consistent with our self-concept and may 
cognitively distort others so that they become consistent with what we 
believe and think about ourselves. Hence, many social interaction 
situations that might cause us to change our self-concepts are not capable 
of doing so. If the individual can function well within reality, that is, if the 
self-concept stands up to the test of reality, there is little reason for change 
to occur. In situations where a change in the self-concept may occur, it is 
often the result of the individual feeling there is a real to change in order to
exist in the world. In such instances, the changes may not be drastic or
dramatic, for changes of this sort are often resisted by the person. The
majority of the data reviewed above is consistent with this interpretation.

Psychological Intervention Strategies

Given the high levels of psychological distress experienced by
individuals with HIV disease, we need to consider ways of minimizing the
effects of stressors. In this section I shall explore a cognitive-behavioural
model, describe some intervention studies, and consider some common
issues and dilemmas which can lead to distress.

Cognitive-behavioural model

There is a substantial body of evidence which suggests that therapy
based on Beck’s cognitive-behavioural model of treatment (Beck, 1976)
can benefit those with psychological symptomatology. This model rests
on three assumptions:

♦ thoughts determine emotions and behaviour

♦ unrealistic and negative thoughts lead to emotional disorder

♦ decreasing unrealistic and negative thoughts, and increasing
  realistic positive thoughts reduce emotional symptomatology.
A common misapprehension is that cognitive behaviour therapy is simply the encouragement of positive thinking. In fact it comprises a number of techniques which address dysfunctional cognitions and behaviours within a structured therapy session. For example, because many realities for those with HIV infection are negative, the technique of ‘decatastrophization’ is used. This is a process which attempts to separate the reality from the accompanying global negative feelings, and allow the person to explore coping alternatives, through ‘positive reframing’. A though such as ‘I’ll never be well enough to return to work may be realistic when expressed by an individual with HIV disease. If the corollary is ‘so I’ll never be happy again’, then thought depressive could result, whereas the follow-up thought ‘so I’ll have plenty of time for reading’ can be part of a positive reframing can play a major role in preventing a severe depressive or anxiety response.

Cognitive-behavioural Intervention

♦ Relaxation training and breathing exercises
♦ Activity scheduling
♦ Though stopping
♦ Reality testing
♦ Decatastrophization
♦ Positive reframing
♦ Problem solving
♦ Development of long-term and intermediate goals.

The problem solving approach aims to support individuals in making informed decisions about their present difficulties, and to equip them with the general skills and strategies necessary for dealing with future problems.

Counseling:
From the very primitive ages counseling was the part of human society in one form or the other. Counseling is nothing, but the mutual interchange of opinions or ideas or deliberating together in order to relieve stress.

In a society where time pressure and their attended stressful qualities are paramount; recreational outlets have also changed dramatically and many are new pressurized in nature relaxing, restorative pursuits such as craft work, walking or reading are replaced by competitive sports or on the other extreme by passive television viewing. The need for relaxation technique through counseling on a wide scale is beginning to energy as society develops in this vein.

Rollo may state that the neurotic fatigue develops when an individual is unable to deal with normal fatigue at a time of stress and crisis in his growth as a person. Fatigue occurs when a threat to personal values occur. Counseling herein seems to be essential to develop personal
values into mature one, which transcend the immediate situation. Fatigue
occurs when we are diverted from our goals because we lack a favourable
nurturing environment in which we grow and develop. But counseling at
these times develops back a quest for the true self and the modern
psychological therapy based on Roger’s client centered counseling
approach really work out.

The term counseling includes all type of two person situations in
which one person is helped to adjust more effectively to himself and to his
environment (Robinson, 1950). It is a relationship, which allows the client
to gain an understanding to himself to a degree, which enables time take
positive steps it is the application, which enables an organism to use the
personnel resources to the solution of this problem.

Counseling basically involves understanding and working with the
individual or a group to discover his or their unique needs, motivations and
potentialities to help to appreciate them to overcome the problems and
stress. In counseling the counselor and the counselee sit together facing
each other and the counselor who is trained listens to the stress evoking
problems of the counselor and tires to help to find out the solutions to his
problems.

As counseling is a service with the aim to provide people assistance
with various typical problems, which they may face at different stages of
life. Counseling thus described, can be defined as a process which takes place in a one to one relationship between an individual who is troubled by problems and a professional person whose training and experience have qualified him to help others reach solution to various types of difficulties and stresses.

**Goals of Counseling:**

As counseling plays a very important role in the changes scenario of our society. It becomes important to discuss the goals of counseling widely. Some counseling psychologists have presented their statement and according to them both counseling and psychotherapy is the synonymous terms. Therefore, where there is counseling and counselor, psychotherapy is also included with it. According to Robert (1948), “When a person acts in the capacity of the therapist, his goal is not to dominate or persuade, but simply to restore a state of good health. A therapist has nothing to sell and nothing to prescribe”. It is clear by this statement that the main goal of the counselor is to improve the mental health of the counselee by relieving his stress and not by imposing his thoughts forcefully upon him.

While discussing on the client centered counseling, Boy and Pine stated that the aim of the counseling should be “to help the counselee feel better, i.e. to help the counselee accept himself to diminish the disparity
actualization, which may act as the sole motivation for therapy. These forces drive the individual to expose his own attitudes and their relationship to reality.

Thus, the growth of counselee is affected by his motives and powers. This growth is completed in five situations –

1. First situations in which the counselee presents himself before the counselor for help.

2. He discloses all his emotional attitudes.

3. In the third situation he tries to explore himself.

4. After exploring he makes a positive planning and takes action.

5. In the fifth situation, he reaches the adjustment and stop going to the counselor and the counseling comes to an end.

Types of Counseling –

There can be counseling in different fields of our life like vocational, marital, placement, educational, family, psychological and clinical counseling, but according to the nature basically there are two kinds of counseling – Directives Counseling and Non-Directive Counseling.

1. Directive Counseling - In directive counseling the counselor is very important. He gives directions and solutions for the
problems of the counselee. The counselor puts more emphasis upon the problem and for this he uses interview and questionnaire techniques. It is also called as problems centered counseling.

2. **Non-Directive Counseling** – This type of counseling is the counselee or the client centered counseling. It is also known as individual counseling. In this, the counselor directs his client to self-realization, self-actualization and independence. In this the emphasis is put on the feelings and emotions of the counselee. The counselor should respect the clients feeling and emotions with tolerance so that he can express them freely in a permissive environment and the counselor can get an idea of the total personality of the client.

**Group Counseling** –

In modern era, group plays a very important role in an individual’s life. From his cradle to the grave, an individual remains in different groups in one form or another “persons in all walks of life share the need for meaningful relationsh.ps the significance and purpose of life itself. Hence, the interest and increase in the use of what is known as group counseling.” (Cemp, 1966).
Groups are of two types – primary and secondary. The group counseling has certain important bases, which should be considered –

1. Knowledge of limitations and capabilities of individuals in the groups.
2. Fulfillment of the possibilities.
3. Effect of individual differences.
4. Group experience in the developmental process.
5. Direct knowledge of an individual and the changes, which takes places due to group.

There are three models of group counseling which are based on group interactions. They are –

1. Group guidance model
2. Group process model
3. Group counseling model

Thus, counseling is a growth experience in which the counselor promotes a situation that enables the clients striving towards maturity to proceed, free from obstructions that have been hampering it. The basis to successful counseling is an understanding of the counselee’s concept of himself, his readiness for action, his inner conflicts and suppressed
desire’s, his unwanted feeling of guilt, his inner springs of conduct why he behaves as he does. His physical condition and his concept of the counselor’s role also are important (Brayfield, 1950).

**Progressive Muscular Relaxation**

Progressive muscular relaxation involves sequential tension and relaxation of individual muscles. Tension is included to help the patient focus attention on specific muscles or identify the sensations of a tense muscle. Variants of progressive muscular relaxation differ with respect to how many muscle groups are practiced in a session. Some work with one or a few muscles during a session; others focus on total body relaxation during the first session.

Voluntary HIV counselling and testing (VCT) is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.

HIV counselling has been defined as “a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV & AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.
The objectives of HIV counseling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested, and to provide support and facilitated decision-making following testing.

With the consent of the client, counselling can be extended to spouses and/or other sexual partners and other supportive family members or trusted friends where appropriate.

Counsellors may come from a variety of backgrounds including health care workers, social workers, lay volunteers and people living with HIV, members of the community such as a teachers, village elders, or religious workers/leaders.

HIV counselling can be carried out anywhere that provides an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Counselling must be flexible and focused on the individual client’s specific needs and situation.

In some settings HIV counselling is available without testing. This may help promote changes in sexual risk behaviour. In one rural area, community-based counselling significantly increased rates of condoms use among adults.
Confidentiality

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. VCT services should therefore, always preserve individuals' need for confidentiality. Trust between the counsellor and client enhances adherence to care, and discussion of HIV prevention. In circumstances where people who test seropositive may face discrimination, violence and abuse it is important that confidentiality be guaranteed. In some circumstances the person requesting VCT will ask for a partner, relative or friend to be present. This shared confidentiality is appropriate and often very beneficial.

The Counselling Process

The VCT process consists of pre-test, post-test and follow-up counselling. HIV counselling can be adapted to the needs of the client/s and can be for individuals, couples, families and children and should be adapted to the needs and capacities of the settings in which it is to be delivered. The content and approach may vary considerably for men and women and with various groups, such as counselling for young people, men who have sex with men (MSM), injecting drug users (IDUs) or sex workers. Content and approaches may also reflect the context of the intervention, e.g. counselling associated with specific interventions such as
tuberculosis preventive therapy (TBPT) and interventions to prevent mother-to-child transmission of HIV (MTCT).

Establishing good rapport and showing respect and understanding will make problem solving easier in difficult circumstances. The manner in which news of HIV serostatus is given is very important in facilitating adjustment to news of HIV infection. Counselling as part of VCT ideally involves at least two sessions (pre-test counselling and post-test counselling). More sessions can be offered before or after the test, or during the time the client is waiting for test results.

**Pre-test Counselling**

HIV counselling should be offered before taking an HIV test. Ideally the counsellor prepares the client for the test by explaining what an HIV test is, as well as by correcting myths and misinformation about HIV & AIDS. The counselor may also discuss the client's personal risk profile, including discussions of sexuality, relationships, possible sex and/or drug-related behaviour that increase risk of infection, and HIV prevention methods. The counsellor discusses the implications of knowing one's serostatus, and ways to cope with that new information. Some of the information about HIV and VCT can be provided to groups. This has been used to reduce costs and can be backed up by providing written material.
It is important, however, that everyone requesting VCT has access to individual counselling before being tested. People who do not want pre-test counselling should not be prevented from taking a voluntary HIV test (for example people who have had VCT may request testing but not wish to have further pre-test counselling). However, informed consent from the person being tested is usually a minimum ethical requirement before an HIV test.

Post-test Counselling

Post-test counselling should always be offered. The main goal of this counselling session is to help clients understand their test results and initiate adaptation to their seropositive or negative status. When the test is seropositive, the counsellor tells the client the result clearly and sensitively, providing emotional support and discussing how he/she will cope. During this session the counsellor must ensure that the person has immediate emotional support from a partner, relative or friend. When the client is ready, the counsellor may offer information on referral services that may help clients accept their HIV status and adopt a positive outlook. Sharing a seropositive result with a partner or trusted family member or friend is often beneficial and some clients may wish someone to be with them and participate in the counselling. Prevention of HIV transmission to uninfected or untested sexual partner/s must also be discussed. Sharing
one’s HIV status with a sexual partner is important to enable the use of safer sex practices, and should be encouraged. However, it may not always be possible, especially for women who face abuse or abandonment if known to be seropositive. Counselling is also important when the test result is negative. While the client is likely to feel relief, the counsellor must emphasize several points. Counsellors need to discuss changes in behaviour that can help the client stay HIV-negative, such as safer sex practices including condom use and other methods of risk reduction. The counsellor must also motivate the client to adopt and sustain new, safer practices and provide encouragements for these behaviour changes. This may mean referring the client to ongoing counselling, support groups or specialized care services.

During the “window period” (approximately 4-6 weeks immediately after a person is infected), antibodies to HIV are not always detectable. Thus, a negative result received during this time may not mean the client is definitely uninfected, and the client should consider taking the test again in 1-3 months.
Development of Community Awareness

Decision to attend for

Pre-test counselling:
The test process
The implications of testing
Risk assessment
Risk prevention
Coping Strategies

Decision to test

No

Yes

Post-test counselling

HIV-Negative
News given
Risk reduction reinforced
Discussion about
Disclosure of HIV Status

HIV-Positive
News given
Emotional support
Discussion about sharing
Discussion about onward referral

Follow-up counselling and support as required
Counselling, care, and support after VCT

VCT services should offer the opportunity for continued counselling to people whether they are seropositive or seronegative. For seropositive people, counselling should be available as an integral part of ongoing care and support services. Counselling, care, and support should also be offered to people who may not be infected, but whom HIV affects, such as the family and friends of those living with HIV.

HIV Testing

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. There has been a rapid evolution in diagnostic technology since the first HIV antibody tests became commercially available in 1985. Today a wide range of different HIV antibody tests are available, including ELISA tests based on different principles, and many newer simple and rapid HIV tests. Most tests detect antibodies to HIV in serum or plasma, but tests are also available that use whole blood, dried bloodspots, saliva and urine.

HIV Referral

In the context of HIV prevention counselling and testing, referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with...
assistance (e.g. setting up appointments, providing transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with care and support service providers. In this context, referral does not include ongoing support or management of the referral or case management. Case management is generally characterized by an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, substantial assistance in accessing referral services, and monitoring of service delivery.

**Benefits of VCT**

VCT has a vital role to play within a comprehensive range of measures for HIV & AIDS prevention and support, and should be encouraged. The potential benefits of testing and counselling for the individual include:

- Improved health status through good nutritional advice;
- Earlier access to care and treatment/prevention for HIV-related illness;
- Emotional support;
- Better ability to cope with HIV-related anxiety;
- Awareness of safer options for reproduction and infant feeding;
- Motivation to initiate or maintain safer sexual and drug-related behaviours;
- Safer blood donation

A diagnosis of HIV infection or AIDS, or a suspicion or recognition of the possibility of infection, brings with it profound emotional, social, behavioural and medical consequences. The subsequent individual and social adjustments required often have implications for family life, sexual and social relations, work, education, spiritual needs, legal status, and civil rights. Adjustment to HIV infection involves constant stress management and adaptation. It is a dynamic, evolutionary, and lifelong process that makes new and changing demands on the infected individuals, their families and the communities in which they live.

Most people are limited in what they can do, or feel they can do, and what changes they can make in their lives. Whether these limitations are real or imagined, they have to be taken into account and dealt with, if behaviour modification is to be successful and sustained.

During the course of HIV infection, a broad range of physical needs and problems are likely to be experienced. These are not constant, but will progressively become more serious and difficult to handle. The changing
nature of these needs imposes a variety of psychological and emotional strains on infected individuals and those closest to them. These strains may make the infected person feel that he or she is losing identity, independence, privacy, and social status. They can also provoke guilt, anger, and fear of loneliness, dying and death. Dealing with HIV infection also imposes direct and indirect financial costs, which can be particularly stressful if economic productivity is affected by illness. Much of the stress experienced by people infected with HIV may reflect underlying anxieties about economic independence and family obligations. Counselling therefore has to take into account not only the client's immediate social and medical environment, but also his or her social relationships and attitudes and beliefs about HIV & AIDS. Counselling has to provide education and information in a way that is relevant to the day-to-day life of the person concerned. It has to take account of such things as the patient's sexual needs and history, occupation, education, aspirations, and hopes, together with what it will take to inspire a new approach to safer sex and responsible social relationships.

Counselling of the family of people with HIV infection and of their lovers, friends, employers or colleagues, must provide up-to-date and technically correct information. It should take into account the life-style of
the infected person and explore the opportunities for, and constraints on, changes in behaviour and constructive adaptation to HIV infection.

If counselling is to be effective it must be seen by the client as acceptable. Acceptability will be improved if the counselling clearly takes into account the many social relationships, commitments and obligations that the individual has. Each of these relationships may be a potentially motivating and supporting one.

In summary, counselling people about HIV infection is important because:

- Infection with HIV is lifelong
- A person can avoid acquiring HIV infection or transmitting it to others by changing his/her behaviour.
- Awareness of HIV infection can create enormous psychological pressures and anxieties that can delay constructive change or worsen illness, especially in view of the fear, misunderstanding, and discrimination provoked by the HIV epidemic.