Chapter I

Introduction
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The epidemic of HIV and AIDS has attracted much attention both within and outside the medical and scientific communities. Much of this attention comes from the many social issues, such as homosexuality, commercial sex, drug dependence, poverty, sex education, role of youths, law and health care policies etc, are related to this disease. The other important social issues are awareness for HIV/AIDS, the role of counselling and information in enhancing the awareness and impact of counselling on behavior change for the high-risk activities.

HIV (Human Immunodeficiency virus) is the most devastating disease of 21st century; HIV and AIDS appeared in the late 1970s when doctors began to see an increasing numbers of patients with an unusual strain of pneumonia and cancers. (WHO, 1996). Initially the virus was called Lymphadenopathy associated virus and it was identified as a pandemic of historic proportions began to unfold. HIV is a retrovirus that primarily infects vital components of the immune system such as CD4 + T cell (a subset of T cells), macro-phages and dendrite cells. It directly and indirectly destroys CD4 + T cells which are required for the proper functioning of the immune system. When HIV kills CD4 + T cells per micro liter (ul) of blood, cellular immunity is lost, leading to the condition known as AIDS. Acute HIV infection progresses over time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified on the basis of the amount of CD4 + T cells in the blood and the presence of certain infection.

Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms and infections resulting from the specific damage to the immune system caused by HIV . The later stage of the condition leaves individual prone to opportunistic infection and tumors. AIDS was clinically identified in 1983, but medical experts believed that this syndrome existed for many years but it was recognized by cluster of the people infected with what
may have been AIDS in a number of places in Southern and Eastern Africa (Mishra, 1996).

In the absence of antiretroviral therapy, the median time progressing from HIV infection to AIDS is nine to ten years, and the median survival time after developing AIDS is only 9.2 months (Martinez, 2002). However, the rate of clinical disease progression varies widely between individuals, from two weeks up to 20 years. Many factors affect the rate of progression. These include factors that influence the body's ability to defend against HIV, such as the infected person's general immune function (Crytal, 1999). Older people have weaker immune system and therefore have a greater risk of rapid disease progression than younger people. Poor access to health care and the existence of coexisting infections such as tuberculosis may also predispose people to faster disease progression (Green, 1995). The infected person’s genetic inheritance plays important role and some people are resistant to certain strains of HIV. HIV is genetically variables and exists as different strains, which cause different rates of clinical disease progression (Kalichman, 1993). The use of highly active antiretroviral therapy prolongs both the median time of progression to AIDS and the median survival time.

HIV /AIDS no longer occupies the public consciousness in the United States the way it did in the mid – 1980s, but it continues to threaten public health in historical proportion. In the United States, 57853 cases of AIDS have been reported to the centers for disease control and prevention (CDC) by the end of 1999. Majorities (82%) of the cases were men who have/had sex with men (MSM), 25% were drug users, 10% in persons infected heterosexually and 2% in persons infected through blood or blood products. In the United States, AIDS has been identified as a leading cause of death among young adults (men and women aged 25 to 44 years). This age group accounts for about 70% of all deaths from HIV- infection. During 1994 and 1995, HIV was leading case of death among persons 25 to 44 year old. During 1995; HIV caused almost 31,000 deaths, 19% of the total in this age group.
**WHO disease staging system**

In 1990, the World Health Organization (WHO) grouped these infections and conditions together by introducing a staging system for patients infected with HIV-1. An update took place in September 2005. Most of these conditions are opportunistic infections that are easily treatable in healthy people.

Stage I: HIV infection is asymptomatic and not categorized as AIDS

Stage II: includes minor mucocutaneous manifestations and recurrent upper respiratory tract infections

Stage III: includes unexplained chronic diarrhoea for longer than a month, severe bacterial infections and pulmonary tuberculosis

Stage IV: includes toxoplasmosis of the brain, candidiasis of the esophagus, trachea, bronchi or lungs and Kaposi's sarcoma; these diseases are indicators of AIDS.

**CDC (Centers for Disease Control and Prevention) classification system**

There are two main definitions for AIDS, both given by the Centers for Disease Control and Prevention (CDC). In the older definition AIDS was defined by using the diseases that were associated with it, for example, lymphadenopathy, and the disease after which the discoverers of HIV originally named the virus. In 1993, the CDC expanded their definition of AIDS to include all HIV positive people with a CD4+ T cell count below 200 per μL of blood or 14% of all lymphocytes. Majority of new AIDS cases in developed countries use either this definition or the pre-1993 CDC definition. The AIDS diagnosis still stands even if, after treatment, the CD4+ T cell count rises to above 200 per μL of blood or other AIDS-defining illnesses are cured (UNAIDS- 1997). A generalized graph of the relationship between HIV copies (viral load) and CD4 counts over the average course of untreated HIV infection; any particular individual's disease course may vary considerably (NACO ART Guideline, 2007).

Although treatments for AIDS and HIV can slow the course of the disease, there is currently no vaccine or cure. Antiretroviral treatment reduces both the mortality and
the morbidity of HIV infection, but these drugs are expensive and routine access to antiretroviral medication is not available in all countries. Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDS pandemic, with health organizations promoting safe sex and needle-exchange programmes in attempts to slow the spread of the virus (UNAIDS, 2007).

**Symptoms of HIV / AIDS**

The symptom of AIDS is primarily the result of conditions that do not normally develop in individuals with healthy immune system. Most of the conditions are infections caused by bacteria, viruses, fungi and parasite that are normally controlled by the elements of the immune system that HIV damages. Opportunistic infections are common in people with AIDS. (Havens, 2005). HIV affects nearly every organ system.

People with AIDS also have an increased risk of developing various cancers such as Kaposi’s sarcoma, cervical cancer and cancer of the immune system known as Lymphomas. Additionally, people with AIDS often have systemic symptoms of infection like fever, sweats (particularly at night) swollen glands, chills, weakness and weight loss. (Guss, 1994). The specific opportunistic infections that AIDS patients develop depend in part on the prevalence of these infections in the geographic area in which the patients lives.

**Pulmonary Infection**

Penemocystis Pneumonia originally known as pneumocystis Carini Pneumonia, and still abbreviated as PCP, (which now stands for pneumocystis pneumonia) is relatively rare in healthy, immunocompetent people, but common among HIV infected individuals. It is caused by Pneumocystis Jirovecii. Before the advent of effective diagnosis, treatment and routine prophylaxis in Western countries, it is still one of the first indications of AIDS in untested individuals, although it generally occurs unless the CD4 count is less than 200 cells per ul of blood (Glynn, 2005).

Even though its incidence has declined because of the use of directly observed therapy and other improved practices in western countries, this is not the case in
developing countries where HIV is most prevalent. In early-stage HIV infection (CD4 Count > 300 cells per ul), TB typically presents as a pulmonary disease. In advanced HIV infection, TB often presents atypically with intrapulmonary (Systemic) disease a common feature. Symptoms are usually constitutional and are not localized to one particular site, often affecting bone marrow, bone, urinary and gastrointestinal tracts, liver, regional lymph nodes, and the central nervous system (Lisam, 2002).

**Gastrointestinal Infections**

Esophagitis is an inflammation of the lining of the lower end of the esophagus (gullet or swallowing tube leading to the stomach). In HIV infected individual, this is normally due to fungal (Candidacies) or viral (herpes simplez – 1 or cytomegalovirus) infections. In rare cases, it could be due to mycobacterium (Weinstock, 2004). Unexplained chronic diarrhoea in HIV infection is due to many possible causes, including common bacterial (Salmonella, Shigella, Listeria or Campylyobacter) and parasitic infections; and uncommon opportunistic infections such as cryptosporidiosis, Microsporidiosis, Mycobacterium Avium Complex (MAC) and viruses, atrocious, adenovirus, rotavirus and cytomegalovirus, (the latter as a course of colitis).

In some cases, diarrhoea may be a side effect of several drugs used to treat HIV, or it may simply accompany HIV infection; it may also be a side effect of antibiotics used to treat bacterial cause of diarrhoea (common for clostridium difficult). In the later stages of HIV infection, diarrhoea is thought to be a reflection of changes in the way the intestinal tract absorbs nutrients and may be an important component of HIV related wasting (Gilks, 1997).

**Neurological and Psychiatric Involvement**

Toxoplasmosis is a disease caused by the single celled parasite called toxoplasma gondi, it usually infects the brain, causing toxoplasma encephalitis, but it can also infect and cause disease in the eyes and lungs (Luft and Chua, 2000). Cryptococcal meningitis is an infection of the meninx (the membrane covering the brain and spinal cord) by the fungus cryptococcus neoformans. It can cause fever, headache, fatigue, nausea and
vomiting. Patients may also develop seizures and confusion; left untreated, it can be lethal. Progressive multimodal leukencephalopathy (PML) is a demyelinating disease, in which the gradual destruction of the myelin sheath covering the axons of nerve cells impairs the transmission of nerve impulses. It is caused by a virus called JC virus which occurs in 70% of the population in latent form causing disease only when the immune system has been severely weakened, as is the case for AIDS patients. It progress rapidly, usually causing death within months of diagnosis (Sadler and Nelson, 1997). AIDS dementia complex (ADC) is a metabolic encepalopathy induced by HIV infection and fueled by immune activation of HIV infected brain macrophages and microglia. These cells are productively infected by HIV and secrete neurotoxins of both host and viral origin. Specific neurological impairments are manifested by cognitive, behavioural, and motor abnormalities that occur after years of HIV infection and are associated with low CD4+T cell levels and high plasma viral loads.

**Tumors and Malignancies**

Patients with HIV infection have substantially increased incidence of cancer. This is primarily due to co-infection with monogenic DNA virus, especially Epstein Barr virus (EBV) Kaposi’s Sarcoma associated herpervirus (KSHV), and human papillomavirus (HPV) Kaposi’s Sarcoma (KS) is the most common tumor in HIV infected patients. The appearance of this tumor in young homosexual men in 1981 was one of grade the first singles of the AIDS epidemic. Caused by agammaherpes virus called Kaposi’s Sarcoma associated herpes virus (KSHV), it often appears as purplish nodules on the skin, but can affect other organs, especially the mouth, gastrointestinal tract and lungs. In some cases these lymphoma are AIDS defining. Epstein Barr virus (EBV) or KSHV cause many of these lymphoma. Cervical cancer in HIV infected women is considered AIDS defining. It is caused by human papillomavirus (HPV). HIV infected patients are at increases risk of certain other tumors, notably Hodgkin’s disease and anal and rectal carcinomas. Malignancies that affect AIDS patient such as kaposis’s Sarcoma and AIDS related Non Hodgkin lymphoma often arise in the gastrointestinal tract. (UNAIDS, 1999)
Other Infections

AIDS patients often develop opportunistic infections that present with nonspecific symptoms, especially low-grade fevers and weight loss. These include opportunistic infection with mycobacterium avium intercellular and cytomegalovirus (CMV). Penicilliasis due to Penicillium marneffei is now the third most common opportunistic infection (after extra pulmonary tuberculosis and Cryptococcus) in HIV positive individual within the endemic area of south Asia (Skoulidis, 2004). An infection that often goes unrecognized in AIDS patients is parvovirus B 19. Its main consequence is anemia, which is difficult to distinguish from the effects of antiretroviral drugs used to treat AIDS itself.

Causes of HIV / AIDS

AIDS is the most severe acceleration of infection with HIV. HIV is a retrovirus that primarily infects vital organs of the human immune system such as CD4 + T cells and macrophages etc. Once HIV has killed so many CD4+ T cells that there are fewer than 200 of these cells per micro liter (ul) of blood, cellular immunity is lost. Acute HIV infection progresses over time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified either on the basis of the amount of CD4+ T cells remaining the blood and / or the presence of certain infection (USAIDS-1999).

HIV is transmitted when a person had contact with certain body fluids of another person who is HIV positive. Body fluids that can contain and transmit HIV include: Blood wound discharge or pus, semen, vaginal fluids and breast milk. In addition body fluids that can contain and transmit HIV which medical staff may contact include: fluid surrounding the brain and spinal card, fluid surrounding bone joints, fluid surrounding an unborn baby. A brief description of the modes of transmission of HIV /AIDS virus is given below:
Sexual transmission

Sexual transmission occurs with the contact between sexual secretions of one person with the rectal, genital, or oral mucous membranes of another. Unprotected receptive sexual acts are riskier than protected incentive sexual acts and the risk for transmitting HIV through unprotected anal intercourse is greater than the risk from vaginal intercourse or oral sex. However, oral sex is not entirely safe, as HIV can be transmitted through both incentive and receptive oral sex. Sexual assault greatly increases the risk of HIV transmission of HIV. Other sexually transmitted infections (STI) increase the risk of HIV transmission and infection, because they cause the disruption of the normal epithelia barrier by genital ulceration of micro ulceration; and by accumulation of pools of HIV susceptible of HIV infected cells in semen and vaginal secretions. Epidemiological studies from Sub-Saharan Africa (UNAIDS, 2000). Europe and North America suggest that genital ulcers, such as those caused by syphilis and cancroids, increase the risk of becoming infected with HIV by about fourfold. There is also a significant although lesser increase in risk from STIs such as gonorrhea, Chlamydia and trichomoniasis which all cause local accumulations of lymphocytes and macrophages.

Transmission of HIV depends on the infectiousness of the index case and the susceptibility of the uninfected partner, infectivity seems to vary during the course of illness and is not constant between individuals. An undetectable plasma viral load does not necessarily indicate a low viral load in the seminal liquid or genital secretions however, each 10 fold increase in the level of HIV in the blood is associated with an 81% increased rate of HIV transmission. Women are more susceptible of HIV -1 infection due to hormonal changes, vaginal microbial ecology and physiology and a higher prevalence of sexually transmitted diseases (WHO, 1996).

Blood transfusions

This transmission route is particularly relevant in intravenous drug users, hemophiliacs and recipients of blood transfusion and blood products. Sharing and reusing syringes contaminated with HIV infected blood represents a major risk for infection with HIV.
Sharing needles or using syringes and razor blades, needles, syringes, razor blades, and other instruments that pierce the skin (for drug injection, tattooing, piercing, carving scars, circumcision or shaving) can transmit the virus if they were first used by an infected person.

**Mother to child transmission**

An HIV infected woman can pass the virus to her baby during pregnancy through the placenta and during childbirth through exposure to mother’s blood without treatment. Approximately 15 to 30 percent of babies born to HIV positive mother are infected with the virus (UNICEF, 2001). HIV can also be transmitted through breast feeding. Breastfeeding by an HIV positive mother increase the risk of transmission to her baby by 10 to 20 percent (UNICEF, 2001). When combine with the use of safer infant feeding methods it can halve the risk of infant infection.

There are wide spread myths and misconceptions about HIV/AIDS and its mode of spreads. The focus of the awareness programs is making the public aware of the facts. The modes of spread have been described above the following are misconceptions and HIV virus does not separate through, living in the same place with people who have HIV/AIDS, kissing (unless there are open sources on exposure to blood within the mouth), touch (hugging, hand shaking or sports contact), bites from mosquitoes or other insects, shared food, utensils, cups or dishes, shared swimming pools or bathing facilities, sneezes or coughs, hospital visits, sweat, saliva or tears, urine etc.

Various forms of alternative medicine have been used to treat symptoms or alter the course of the disease. Studies (WHO, 2002) indicate that alternative medicine therapies have little effect on the mortality of morbidity of the disease, but may improve the quality of life of individuals with AIDS. The psychological benefits of these therapies are the most important uses; acupuncture has been used to alleviate some symptoms with no success and can not cure the HIV infection. Several randomized clinical trials testing the effect of herbal medicines have shown that there is no evidence that these herbs have any effect on the progression of the disease, instead profuse serious side effects.
Morbidity and mortality among HIV infected adults with adequate dietary nutritional intake is unaffected by multivitamin supplementation. A large Tanzanian trial in immunologically and nutritionally compromised pregnant and lactating women showed a number of benefits to daily multivitamin supplementation for both mother and children. (Feldman, 2005). Dietary intake of micronutrients at RDA levels by HIV infected adults is recommended by the World Health Organization there is some evidence that vitamin A supplementation in children reduces mortality and improves growth. Daily doses of selenium can suppress HIV viral burden with an associated improvement of the CD4 count. Selenium can be used as an adjunct therapy to standard antiviral treatments, but cannot itself reduce mortality and morbidity (World Health Organization, 2006).

Difference between HIV positive and AIDS

The term AIDS refers to an advanced stage of HIV infection, when the immune system has sustained substantial damage. Not everyone who has HIV infection develops AIDS. When HIV progresses to AIDS, however, it has proved to be a universally fatal illness. Few people survive five years from the time they are diagnosed with AIDS, although this is increasing with improvements in treatment techniques. Experts estimate that about half the people with HIV will develop AIDS within 10 years after becoming infected. This time varies greatly from person to person, however, and can depend on many factors, including a person's health status and health-related behaviors. People are said to have AIDS when they have certain signs or symptoms specified in guidelines formulated by the U.S. Centers for Disease Control and Prevention (CDC, 2004).

Global scenario of HIV/AIDS

Worldwide people estimated in the year 2005 about 40.3 million living with HIV/AIDS, 8 million of these were young people in the age group of 14-24 years. The highest burden of HIV/AIDS was in sub Saharan Africa, followed by South East Asia (6.7 million), (CDC, 2006). India has the second largest population of HIV infected persons, at an estimated 2.35 million. (NACO, 2007).
The AIDS was first reported in the ‘Morbidity and Mortality Weekly’ as “Pneumocystis Pneumonia - Los Angeles,” in 1981. Since then, HIV epidemic has posed a serious challenge to public health in many countries. Reports by WHO – Geneva, (2004) say that since the epidemic began; more than 60 million people have been infected with the HIV, from which about one-third aged between 15-24 years. About 95% of new infections have been occurring in developing countries and almost 50% are women (Report on the global HIV/AIDS epidemic.

In India, the first case of HIV infection was diagnosed among commercial sex workers in Chennai, in 1986. Soon after diagnosis of first case, a number of screening centres were established throughout the country, but number of cases increased rapidly (Dakar and Dakar, 2001). Over all 35% persons reported HIV/AIDS cases in India occur among young people in the age group of 15 to 24 years. Consequently HIV/AIDS is one of the most challenging public health problems ever faced by the country.

According to report of “UN Programme on HIV/AIDS, 2004” several serious epidemics have detected in some parts of India due to injecting drugs, which has been playing a major role in India’s HIV/AIDS spread. It claims that in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Tripura and Nagaland, HIV prevalence has crossed the 1% mark among pregnant women. Globally, HIV is spreading rapidly it crosses 1% prevalence in the adult population in six state of India. In Manipur, and Imphal it has risen from 1% to 5%. The other parts of the country are showing equally troubling evidence of transmission through injecting drug use, unprotected sexual intercourse, contaminated bloods and parents to child transmission. (NACO, ART Guideline, 2007).

The National AIDS Control Organization has reported (NACO,2007) that AIDS is prevalent in all most all parts of the country. Though recent in origin in India, it is becoming a major health problem and rapidly acquiring epidemic proportions. WHO (World Health Organization) has warned that India is facing a health disaster for which it is ill prepared. The condition of Haryana is also at alarming stage. Till the last of April, 2009,500 death cases have reported due to AIDS and at present 42000 people have been living with HIV infection.
The HIV/AIDS is spreading from the urban to the rural areas. At least 20 million deaths have occurred globally since the epidemic began and it has orphaned more than 40 million children. The disease has completely devastated families and communities and has reversed decades of progress in all the spheres of life, viz. health, economic and social (USAIDS report, 2004). It has been reported that globally about 7,400 people get infected with HIV every day. Fifty percent of all new patients are women. Women aged 15-24 years are at least three times more likely than their male peers to be infected with HIV.

India records 1.7 lakh new cases of HIV every year of which nearly 40% are women who get infected with their partners who do not use a condoms. In sub Saharan Africa women comprises about 60% of all infected adults. These figures indicate that HIV/AIDS has taken the shape of an epidemic and considering their families who are affected by this devastating disease the picture will be more dreadful. Therefore we need to focus on these people and must find out ways and means to fight/prevent this and improve the quality of life of these people.

**Depression, Suicidal Ideation and Stigma**

Depression is a mood disorder, characterized by sadness and dejection, decreased motivation and interest in life, negative thoughts, physical symptom as sleep disturbances, loss of appetite, and fatigue (Atkinson and Atkinson 1998; Smith, Bem, and Hokes, 2000). Onset of depression is occurring earlier in life today compared to that of past decades (NIMH, 2003). According to the Diagnostic and Statistical Manual of Mental Diseases DSM-IV, (APA,2000) depressive symptoms include feeling of sad or empty, markedly diminished interest or pleasure in activities, weight gain or loss, insomnia or hyper-somnia, psychomotor agitation, fatigue, feelings of worthlessness, diminished ability to think or concentrate, and recurrent thoughts of death (American Psychological Association, 2000). Depression as a disorder is usually defined using the DSM-IV diagnostic criteria for major depressive disorder (MDD) and for dysthymia.

Depression is a mood disturbance in which persons have feeling of extra ordinary sadness and dejection. Some other people experience the other side i.e. elation, joy etc.
Some people experience both of these kinds of mood at one time or another, but other people only experience downside i.e. depression. Depression is mental disturbance in which a person experience deep, unshakable sadness and loss interest in all activities. The term depression is also used to describe the temporary sadness, loneliness that everyone feels from time to time. Severe depression also called major depression can dramatically impaired a person’s ability to function in social situation and at work. People with major depression often have feeling of hopelessness, despair and worthlessness, as well as thought of committing suicide.

According to Ramachandran, Sarada and Arunagiri, (1982) depression is associated with disturbances in family, sex, low social class, widowed state, unemployed condition, low educational level, nuclear family, living alone, and high incidence of physical illness. Sometimes it has been seen that the people who are suffering from HIV disease get economically week and suffer from family burden. Both of these factors come from his negative mind, at that time these people need counselling (Handouts Counselling Training module, 2006, NACO). Stigma, disclosure and social support are domains discussed extensively in the literature as being important in the lives of people living with HIV, and also as factors that are consistently associated with treatment adherence and sexual behavior, two behavioral outcomes that are important to the health and wellbeing of the individual as well as the public health. Coping with the uncertainty of future health and HIV stigma remain the most difficult psychological challenges that permeate many facets of life.

Upon learning the diagnosis the individual is likely to experience alternating feelings of shock, disbelief, panic, fear, guilt, shame, anger, despair, hopelessness, and numbness. Supportive counselling and increased access to existing social support may be sufficient to help individuals cope with these feelings (Havens, 2005). Studies have shown that adults and children living with HIV and/or at risk of acquiring HIV are at an elevated risk of psychosocial distress and psychiatric conditions, particularly depression (Bing, 2001).
Although the specific role of HIV is not clear, a number of these studies have found clear and important associations between the prevalence of psychiatric disorders and psychological symptomatology and poor quality of life, elevated sexual risk behavior, poor adherence, and poor health outcomes. For example, chronic and intermittent depressive symptoms in HIV positive women are associated with disease progression, lower CD4 cell counts, and higher baseline viral load levels; and in general, women with chronic depression have mortality rates twice as high as those with little or no depressive symptoms.

Probably the single most important factor in producing and extending the negative psychosocial impact of HIV and AIDS is stigma. Stigma can be defined as “an act of identifying, labelling, or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and deviant from the social ideal” and as “an attribute that is significantly discrediting (and is) used to set the affected persons or groups apart from the normalized social order (Morgan, 2002). Stigma prevents people from talking about and acknowledging HIV as a major cause of illness and death. Stigma prevents HIV-infected people from seeking counselling, obtaining medical and psychosocial care, and taking preventive measures to avoid infecting others. If one family member exhibits signs and symptoms of HIV, the entire family may face rejection and even violence from the community. The loss of social support results in isolation for the family, which may also fear loss of employment, denial of school admission, or denial of adequate housing. Even if stigma is minimized, an incurable and often fatal disease requires enormous psychosocial adjustment.

Depressed people may interpret a minor failing on their part a sign of incompetence, interpret minor criticism as condemnation. Even a competent and capable person may feel deficient, stupid and guilty of having cursed the problems to self and others. People with depression may experience psychotic symptoms such as delusions (false beliefs) and hallucinations. Brown and Harris, (1979) reported that depressed people tend to view themselves, their environment and the future in a negative light because of errors in thanking. This negative thinking makes situations much worse than they really are and increase the risk of depression especially in stressful situations.
Depression is the downward sign of the mood which is experienced by each and every one but when someone gets stuck there and experience this often and for longer period of time the person is said to be depressed. Depressive feelings can be normal emotional reaction e.g. in different normative crises during an individual’s life cycles (Sethi, 2001). Depressive feelings can also manifest itself as a special symptoms in different mental or somatic disorders as an illness depression is socially debilitating syndrome including clusters of symptoms (i.e. vegetative, cognitive, behavioral and physical features as well as impairment of impulse control in behavior are symptoms). Everyone has his/her life plans and dreams for achieving the targets fixed.

But some of those who all of a sudden come to know that they are having HIV/AIDS and everything lost for them. They are in state of shock and their dreams are shattered, slowly, their health start giving in to disease and in the process they may lose their jobs or their working efficiency also start declining. They face the double burden i.e. their income start declining and expenditure is increased. They also face one more challenge and that is stigma associated with disease. At this stage depression start setting in and they might have suicidal ideation and some of them may even try to commit suicide.

**Family Burden**

Family burden is defined as the emotional, social and financial stresses that an illness imposes on the family. One’s poor social performance in the family has impact on another who has to compensate with the deficiencies experiencing burden. Even when the patient is recovering the burden experienced by the family especially in cases of chronic illness can be tremendous. It is therefore important that whenever a family member is diseased not only the patient but the family should also be supported in order to cope well with the stress of patient care. However, not all caregivers perceive with the same burden of illness because it varies according to their ways of coping and some of the internal traits.
In other words family burden can be defined as a kind of load or weight on an individual that affect his/ her wellbeing. This load also causes limitations and restrictions. Benddell, Stone, Bassal, (2000) defined family burden as the impact of living with disabled persons on the way of his life and health of family members. Goldbort, (2006) defined burden as the adverse effects the disabled has upon his family, have gone a step further and differentiated burden from the term hardship. They reserve this term to signify the prevalence of pre defined household problems while burden refer to that element of the hardship which explicitly is attributable to the disability or disease. Goldbort, (2006) has defined caregiver burden as a high level of stress that may be experienced by people who are caring for another person with some kind of disability. The increasing demands to assist patients in daily activities to maintain their medication and dealing with their problematic behaviors contributes to disruption in the caregivers social, professional and family life. Family caregivers also take information about the childs disability or patient’s disease and the necessary skills to deal with the ill person in daily life.

Though several studies (Maccoby, 1983) have been conducted to examine the effect of the presence of a disabled person in the family on the economic, social, other aspects of family life. There are studies relating to the impact of having a disabled person in family but there are very few studies having an HIV positive person in the family. It is true that having a disable person in the family is seen as kind of stigma but having HIV positive person or having person suffering from AIDS is all the more a source of stigma to the family. It is a kind of double edged sword in the sense that due to the disease the persons efficiency or productivity is declined and so is the case for his income on the other hand the cost on his/ her treatment is mounting, thus the economic condition of the family is shattered. The social relationship in the society is also affected.

Rabkin, (2000) conducted a study as a part of the ‘National Survey of Extent,Pattern and Trends of Drug Abuse in India.’ The study was carried out with 179 women with a male family member currently abusing various substances in 8 centers throughout India were involved in the study, namely Bangalore, Chennai Delhi, Haryana,
Himachal Pradesh, Manipur, Pune and Thiruvananthapuram. The study was exploratory and qualitative in nature. There were 56% housewives of all the women caregivers. The study results found huge burden in the areas of finances, emotional distress, stigma, interpersonal difficulties, and neglect of children, loss of severity, compromised dignity, domestic violence and health risks (including HIV).

Health and Quality of Life

In this competitive era, the life of human beings has become so hectic, that the health has started getting negatively influenced. Speed has become so important that nobody is able to take proper care of his/her health. All this has made it all the more necessary to understand about health. Health can be defined negatively as the absence of illness, or positively as the fitness and wellbeing in any organism and functionally as the ability to cope with everyday activity. Health is a form of homeostasis. It is a state of balance with input and output of energy. Health also implies good prospectus for continued survival, in creatures such as human beings. The concept of health is not easy to define it as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. An understanding of the most comprehensive and often quoted definition of health psychology by Malassiostis,(2001) leads to an insight into the meaning of health. He defined health psychology as “the aggregate of the specific educational, scientific and professional contribution of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction”. Blankson, (2002) clams this to be a comprehensive description of health psychology. This description defines health as broadly as possible, encompassing health and illness, physical and mental health, specific types or forms of illness as well as the general feeling of wellbeing or of not feeling well.

Health is a unity and harmony with the mind, body and spirit which is unique to each person and is defined by that person. The level of health is in part determined by the ability to deal with stress. Health is on a continuum with moments between a state of optimum wellbeing and illness which is defined as degree of disharmony. It is determined
by physiological, spiritual and developmental stage variables. Major components of health are:

Psychological Health: Includes the feelings, emotions, personality and intelligence level.

Physical Health: Includes physical activities free from illness, dietary system etc.

Social health: Includes the prestige, social support status, relationships etc.

Spiritual Health: Includes the religious value of a person, his belief in God.

Every day people work, play, eat, sleep, have fun, and just try to live a healthy, normal life. But in some cases or situations, all these things change and living becomes not so “normal” when a person is affected by a chronic illness. Chronic illness is defined as a long-term health problem caused by an irreversible disorder (Baldewicz, 2002). A chronic illness can alter an individual’s quality of life dramatically.

Quality of life is something that is intensely personal and particular, including the person’s ability to live independently, age, and ability to contribute to society. Some people are able to cope better than others depending on the severity and type of illness, coping strategies, and most important of all, the person’s network of support such as family and friends. Any change experienced in life can be stressful and traumatic. But a downward change in a person’s quality of life can be very difficult, especially knowing that life will never be the same again and the illness is possibly life threatening. Having a chronic illness is very overwhelming and often takes over a person’s life, making the person feel powerless and a lot of fatigue.

Fatigue is very common condition for people with HIV; it can be physical or psychological (Tang, 2003). When HIV virus multiplies, the infected body uses more energy trying to fight it, causing fatigue. But most people have more energy as soon as they start taking their prescribed anti-HIV medications. This is why it is very important as a nurse taking care of an HIV patient to emphasize the importance of compliance to treatment and medications. People with HIV and fatigue tend to get sicker faster than people without fatigue. Anemia is also a common cause of fatigue among HIV/AIDS
patients. Anemia is caused by loss of red blood cell and damaged to the bone marrow caused by anti-HIV medications. It is possible that the patient may need blood transfusion as a treatment for anemia. Another important subject a nurse must emphasize on HIV patients is proper nutrition, because people with HIV require more energy than healthy people. If the patient is not getting enough nutrients, their energy level will be low.

Coulter, (2002) studied perception of HIV related quality of life (HRQOL) varied in population with HIV infection or AIDS. On most HRQOL measures, lower CD4 count was associated with lower HRQOL that is patients who reported having end-of-life discussions with their physicians did not feel more depressed, worried, or sad than those who did not. Patients who recalled such talks were more likely to accept that their illness was terminal and prefer comfort care over life-extending therapies. They received less aggressive medical treatment, such as resuscitation or admission to an intensive care unit, and they were more apt to enroll earlier in hospice programs.

More aggressive medical care, which can cause upsetting side effects and hamper communication with loved ones, was associated with worse patient quality of life and worse adjustment by patients' bereaved caregivers. In one study Mirowsby, (1989) demonstrated that the impact of supportive care on the quality of life in patients with HIV/AIDS, has led to better adherence to treatment regimens, less severity of symptoms of opportunistic infections. It is not that the professional care givers are affected and exhausted and consequently their QOL deteriorates, but those who are the patients near and dear who cares the patients are also adversely affected and the patients and their QOL is adversely affected.

World Health Organization (WHO) define quality of life as individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectation, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, and social relationships of salient features of their environment (Weaver, 2004).
The WHO has developed a comprehensive instrument to gauge the level of quality of life of the people with any kind of physical and psychological anomalies as well as the quality of life of the people who are attached with these people. World health Organization (WHO, 2006) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. It follows that measurement of health must not only include estimate of the frequency and severity of diseases, but also well being and quality of life. This is particularly true for patients with HIV/AIDS because of the chronic and debilitating nature of the illness, stigma, and a high rise of premature death.

With the recent advances in clinical tests and treatment for those suffering from HIV/AIDS, the survival of the patients has been increased and their quality of life has become an important focus for researchers and health care providers. Until recently quality of life was not considered an issue of psychological importance. For many years it was measured mainly in terms of length of survival and signs of presence of disease, with virtually no consideration of the psychological consequences of illness and treatment. However, it was found that medical measures were weekly related to patients or relatives assessment of quality of life. Perhaps the most important inputs for evaluating quality of life stems from the psychological distress chronically ill patients often experience. The chronically ill are more likely to suffer from depression, anxiety and distress. Depression, psychological distress and neuroticism contribute to substantially increased risks for mortality from chronic conditions (Cruess, 2002). Stress exacerbates the symptoms and courses of many chronic illness of stress, reducing stress levels and managing these stressors that cannot be eliminated are permanent for the management for clinic illnesses.
Quality of life is now given attention in the management of chronic illnesses. Quality of life has several components, specifically physical functioning, psychological status, social functioning and disease or treatment related symptomatology. Quality of life among the chronically ill is now assessed with the emphasis especially placed on how much the disease and its treatment interfere with the activity of daily living, such as sleeping, eating, going to work and engaging in recreational activities. For patients with more advance disease such assessment include whether the patient is able to bath, dress, use the toilet, be mobile, be continent and eat without assistance. Essentially then, the quality of life assessment gauge the extent to which a patients normal life activities have been compromised by disease and treatment. A broad array of measures is now available for evaluating quality of life.

There are several reasons for the study of quality of life in chronically ill. First, depression, Moneyham, (1997) study quality of life helps in the documentation of illness effects on vocational, social and personal activities of the daily living which provides an important basis for interventions designed to improve quality of life. Secondly, quality of life measure can help pinpoint which problems likely to be emerge for the patients with a disease. Such a measure, for example, might indicate that sexual functioning is a problem for patient with certain kind of cancer.

Such information may be helpful in anticipating the interventions that are required. Thirdly, such measures help in examining the impact of treatment in quality of life i.e. of the cancer treatment has disappointing survival rates and produces adverse side effects, the treatment may be more harmful than the disease itself (Au, 2004). Quality of life measures and studies have made it possible to assess the impact of unpleasant therapies and to identify some of the determinants of poor adherence of those therapies. Fourthly, quality of life measures have helpful us in examining and comprising the thearuptic effects. Further quality of life information help in knowing about the care that will maximize long-term survival with the highest quality of life possible.
Counselling in relation to HIV/AIDS

HIV/AIDS is a life-threatening, life-long illness. Diagnosis of HIV/AIDS has many implications—psychological, social and physical. Preventive counselling and behavior change can prevent transmission of HIV and improve the quality of life. Counselling is a process of helping/enabling a person/people to solve certain interpersonal, emotional and decision-making problems. A counselor’s role is to help clients to help themselves. Counselling can be done with an individual, group, with couples or families. However, Counselling involves supporting/enabling individuals to take charge of their own life by, providing information, facilitating emotional adjustments, and enhancing mental health, understand and accept the problem, develop resources to take adaptable and realistic decisions, and alter their own behavior to produce relatively enduring, desirable consequence. Though death is the fundamental truth and ultimately all those who have born are to die yet it is human nature that we all are afraid of death. It is not that this fear is related to HIV/AIDS only, rather similar kind of fear is associated initially, when we learns about the fatal disease. There is shock and disbelief but as the diagnosis conforms people go in to deeper level of distress and depression. Slowly the person’s immune system weakness and he/she is trapped by life threatening diseases and ultimately dies. In between this (i.e. on set of the diseases and death) the affected person and his entire family undergoes the pain, agony and their QOL deteriorates, the family members may experience heightened level of anxiety and depression. The person may lose hope and meaning in life and may become pessimistic and all this have adverse affect on the effected persons health. Thus it is not only the treatment whatever level may be antiretroviral therapy; the psychosocial support may have a positive impact on the patients as well as on his/her care givers (NACO, 2006).

Thus counselling of HIV/AIDS patients as well as their care givers is equally important. Spouses/Partners and family members of HIV positives often have great concerns, worries and a sense of burden after learning the HIV diagnosis of their beloved ones. It can be difficult for them to solicit social support and seek empathy from their social network or other family members. Caregivers, who are mainly spouses/partners, may have reduced life satisfaction or even feel burnout in the course of taking care of
their loved ones. Support and counselling to spouses/partners and family members is an important part of the holistic care in management of HIV disease (NACO, A Sheared Vision, 2009).

HIV positive and their families as well as friends have to face many losses in the course of illness. They have to deal with the loss of job, the threat of health and life insurance, the change in close interpersonal relationships and the fear of rejection of friends, and the partners/spouses. In face of multiple losses, one may develop feelings of helplessness, anger and guilt. The most devastating loss is the death of spouses/partners or friend. Support to family includes psychological preparation for possible deterioration, counselling on decision process about "end of life" issues and bereavement counselling.

Since the stressors faced by HIV positive are multiple and chronic in nature, a multidisciplinary team approach has to be adopted in order to cater for their various psychosocial needs. Case management is a client-centered form of care that connects clients with medical, psychosocial and supportive service. This form of service is an effective model that promotes adaptive coping of patients suffering from chronic diseases and HIV infection, in which a case manager takes up a facilitative role in case management.

Counselling in the context of HIV has become important in the provision of prevention, treatment and care services over past years. HIV counselling initially focused on prevention of HIV infection. It deals with emotional and social impact of a HIV positive person. HIV counselling expanded to include counselling on prevention of parents to child transmission of HIV and on care for the baby. Most recently, with the introduction of antiretroviral therapy (ART), the scope of counselling further expanded to include preparedness and adherence counselling for people on ART (UNAIDS, 2007).

WHO defines HIV/AIDS counselling as a confidential dialogue between a client and counselor aimed at enabling the client to cope with stress and take personal decisions relating to problems arising from HIV/AIDS. The counselling process includes the evaluation of personal risk of HIV transmission, facilitation of preventive behavior and
evaluation of coping mechanisms when the client is confronted with a positive result (WHO, 2002).

The HIV/AIDS counselling is aimed at facilitating the decision to undergo HIV testing and providing psychological, social and emotional support for people who have contacted the virus or affected by the virus. HIV/AIDS counselling may also be aimed at preventing transmission of HIV virus by provisioning information about risk behaviors such as unsafe sex, needle sharing and motivating people to take good care of their health. Assisting people to develop personals skills necessary for behavior change and for adopting and negotiating safe sexual practices is also one of the aims for counselling in HIV/AIDS cases. Furthermore, assuring effective uses of treatment programmes by establishing treatment goals and regular follow up is also important. The AIDS action news letter 1994 highlighted that in forming clients about available resources (government and non government) where they can get assistance with regards to social, economic and cultural difficulties is also an important goal of counselling. The counselor can ensure the achievement of these and other objective by providing psychological support, encouraging clients to identify their feelings, empowering clients to explore options to develop action plans to deal with issues of concern and encouraging clients for behavior change as appropriate. Similarly they also need to help clients to draw support from their family, friends and social networks, helping clients to discover meaning of their life and provisioning up to date information of HIV/AIDS preventions, treatments and care are equally important.

Three stages of HIV/AIDS Counselling

NACO Counselling and training guideline 2006 have suggested three stage counselling for HIV/AIDS testing cases. The three stages are:

1. Pre-Test Counselling helps clients to prepare for the test. It explains the implications of knowing that one is or is not infected with virus, facilitates discussion about ways of coping with knowing one’s HIV status. It also involves discussion on
sexuality, relationship, possible sex and drug related risk behavior and how to prevent infection.

It helps to correct myths and misinformation about the AIDS. Pre test is also helpful in taking consent of client for HIV testing. (NACO, VCT, Counselling and Training Guideline, 2006)

2. Post-Testing Counselling helps the client understand and cope with the result of HIV test. Here the Counselor prepare the clients for the result, gives the result and then provides the client with any further information required, if necessary referring the person to other services. The two usually discuss ways to reduce the risk of infection of transmission. Result should be given with counselling. The post test counselling will depend on what the test result is. However, if it is positive, the counselors needs to tell the client clearly each and everything regarding the consequences for the life and should send to the client to the nearest ART centers for the CD 4 counts.

3. Follow up Counselling HIV counselling does not end with the diagnoses of the clients HIV status. The knowledge of the HIV test result has certain benefits, but it also has implications for the person’s lifestyle. Though HIV positive individuals have to effect behavior change, their partners/ spouses also have to make an effort to accept persons living with HIV/AIDS (PLHA) as part of family and help them lead to a comfortable life. To achieve these goals, follow-up counselling is essential. Knowledge of HIV test results identifies not just one infected person but several affected ones who are their close associates. Some important issues to be addressed are deteriorating self- esteem, impaired problem solving abilities, anxiety, dealing with real and perceived social rejection, immediate sense of loss or grief, anticipation of the worst, depression, and impaired social and occupational functioning.

Counselling for HIV Positive Patients and their Caregivers

The economic and psychosocial consequences of HIV/AIDS patients and their caregivers of HIV infected cases may be similar to the problems concerning non-infected children (Hunter, 1990), although one might assume that the impact would be at least
greater in HIV infected children. Few studies however have been done considering the problems and worries of caregivers of children infected with HIV. HIV infected patients in general reported feelings of guilt, loss, loneliness, hopelessness about the future and fear (Mukisa, 1980).

Panton, (2002) conducted a study to determine whether the implementation of provider-initiated HIV counselling would increase the proportion of tuberculosis (TB) patients who receive HIV counselling and testing. Knowledge of the problems, worries and needs of the caregivers of HIV infected persons may improve the care for them as well as for the infected persons and it may also improve the follow-up process. This seems to be especially important, since a small study confirmed the experience of pediatricians in a hospital setting in Kampala that a considerable number (about half of the cases of the sample) of HIV infected children are ‘lost’ during follow-up, which means that they do not return after one to three visits for unknown reasons. Counselling of caregivers of HIV infected children in health care settings often is short, individual-based and focused on practical advice. The psychological and social sequel of HIV and AIDS infection is devastating to children, adolescents, women, and their families. HIV and AIDS is a chronic/terminal illness that forces individuals and their families to cope with an uncertain progression of disease, complicated medication regimens, and the grief related to the loss of health and possibly the loss of family members. (NACO, 2007).

Unlike other chronic/terminal illness HIV and AIDS infection is further complicated by the stigma related to the transmission of HIV infection i.e., sexual activity and intravenous drug use). Due to disclosure fears and stigma associated with HIV and AIDS, many families isolate themselves from their extended family and communities to protect themselves and their children from maltreatment. Thus they are out off from valuable support. In conjunction with coping with the psychological and emotional ramifications of being infected with or affected by HIV and AIDS, these individuals are forced to deal with a multitude of stressors with little support. These factors place these individuals and their family members at risk for mental health problems (e.g., depression, post-traumatic stress disorder, and anxiety), developmental deficits, and behavioral problems (e.g., drug or alcohol use, school failure, inability to maintain a job, and
criminal behavior). These issues complicate the HIV and AIDS infected children, adolescents, and women’s ability to access medical care and comply with complicated medication regimens. There are complex psychological and social issues that impact a family’s ability to cope with HIV and AIDS infection. (NACO, 2006).

Psychosocial assessment of newly diagnosed HIV-infected patients the initial counselling and assessment given to newly diagnosed patients is of paramount importance. The objective of the intake assessment is to understand the needs and current functioning in each aspect of life, such as occupational functioning, social functioning, and source of supports. After this initial assessment, an agenda is set up to priorities areas of needs and services required. Referrals to other professionals, including, clinical psychologist, social worker and dietitian may be necessary, when needs are identified in the interview. Knowledge about HIV infection and their current health status is reinforced, myths and misunderstandings are clarified, and realistic expectations are set with patients. Other relevant information, such as that on mental health, substance use, skills in independent living, is also provided (NACO, 2004). A supportive and nonjudgmental attitude of the health care workers during the first encounter with the newly diagnosed HIV positive patients is crucial in order to build rapport and establish partnership of care between each other. Patients are encouraged to discuss openly and frankly with the health care workers about their concerns and worries.

Individuals who participated in high-risk behavior that lead of HIV infection may experience intense guilt, shame, and anger. These emotions may be intensified for women who transmit HIV infection to their children. Furthermore, the stigma related to HIV infection may lead to social isolation. Often, families do not disclose their HIV status to family members, including the infected child, and their community for fear that they and their children will mistreated. This isolation prevents families from obtaining valuable social support during difficult times (Faithfull, 1997). Here confidentially plays an important role as has been outline that it is important for members of civilized society in general and medical community in particular to be aware of the fears of these families may have regarding disclosure, as women may not utilize services if they believe that their HIV status will be disclosed. HIV and AIDS infection is viewed as a
multigenerational illness. Individuals may be overwhelmed by the loss of a number of family members, as well as coping with their own diagnosis. Illness and grief interfere with a parent’s ability to provide consistent care for children.

Due to illness or death of the parents, primary care responsibilities often become the primary responsibility of the caregiver for multiple children. Loss of parents and changes in caregivers interfere with mastery of developmental milestones and coping abilities of children and adolescents. Parent’s failure to develop a permanency plan (create a will identifying a legal guardian for their children) further complicates this issue, particularly for children who have HIV and AIDS infection for numerous reasons. The reasons include denial of the severity of illness, fear of disclosure, health status of parents and HIV infected child, lack of reliable adult to provide care, psychological adjustment of parents, and domestic violence in the home (Chalfin, 2000).

Individuals often struggle to cope with problems in their homes, schools and neighborhoods that increase their chances of participating in high-risk behaviors. Examples of the problems that they face include single parent families, domestic violence, physical abuse and neglect, substance abuse, and mental health diagnosis. To complicate matters many of these individuals suffer from cognitive and behavioral delays related to HIV and AIDS infection, and a history of physical trauma. These factors further place these individuals at risk for mental health illness (e.g., depression, post-traumatic stress disorder, conduct disorder, and anxiety), developmental deficits and behavioral problems. The progression of HIV infection to AIDS infection has been associated with central nervous system dysfunction. The signs and symptoms of HIV related CNS infection include cognitive impairment (i.e., short term memory deficits and confusion), changes in personality (i.e., apathy and erratic behavior), psychotic symptoms (i.e., hallucinations and suspiciousness), and motor symptoms (i.e., ataxia, and weakness). Careful assessment of symptoms is necessary to distinguish central nervous system dysfunction from the effects of mental health illness (i.e., depression and anxiety), as well as other factors that effect neuropsychological functioning. These factors include, but are not limited to, prescribed and recreation drug use, stress of living with a chronic/terminal illness, and nutritional deficiencies (DiMatteo, 1993).
HIV and AIDS infected individuals and their families are forced to cope with a multitude of stressors. Supportive psychotherapy may be utilized to improve quality of life, increase compliance with medical care and medication regimens, and address mental health disorders. Historically, traditional psychotherapy and psycho educational interventions have not addressed the ethnically and culturally diverse issues often relate to HIV and AIDS infected individuals to efficient coping and management skills (Chassin, 1995) psychologists and mental health counselors may help to foster a relationship between the medical care providers and the children, adolescents, and women who are HIV and AIDS infected to ensure that patients and their families are able to access and comply with appropriate medical care (Faithful, 1997).

Anyango, (2003) has highlighted the plight of HIV infected people and their caregivers. He reported that the lives of many older people in developing countries are dramatically, and, most frequently, negatively, influenced by the social and economic changes that accompany the development process. Young rural adults migrate to the cities, undermining the traditional extended family system. In sub-Saharan Africa the HIV/AIDS epidemic magnifies the problems that elders face when the younger working population is dying from HIV/AIDS. Older women are especially vulnerable when they become the caregivers for the sick and the surviving children whose parents have died of AIDS. Poverty becomes the major risk for these ageing populations. This clearly indicates the need for support of these including counselling.

HIV/AIDS is often associated with a range of psychosocial squeal that must be addressed throughout all stages of the infection. Psychological support is therefore critical for helping individuals, couples, and families affected by HIV to cope with their emotions and psychosocial needs. Very often the counselling component of counselling and testing interventions is minimized and greater emphasis is given to the need for an HIV test and the provision of test results. The longer-term psychological needs of persons with HIV/AIDS are often overshadowed by physical and social needs in a setting with limited resources and are often ignored. Development of counselling in relation to HIV/AIDS has occurred in hospital settings in communities (Hampton, 1990) as a response to psychosocial needs generated by individuals with HIV/AIDS and their
families. Several authors have noted cultural issues that may have impact on counselling in relation to HIV/AIDS, including the importance of the economic and emotional aspects of sexual relationships, the strong cultural links between women's status and childbearing and fatalistic acceptance of misfortune.

NACO (2006) described a counselling approach with a strong education component where complex issues were simplified to content that could be understood; this is an important factor in encouraging persons with HIV and communities to take a proactive approach in decreasing the spread of HIV/AIDS. Empirical data support the need for client-centered counselling in the African setting. Provision of factual information needs to be balanced with a person-centered approach; exploring the client's conception of the problem and helping the client identify persons in their network who can give further psychosocial support (Lie and Biswalo, 1994). Evidence indicates that a comprehensive community based, and culturally sensitive approach towards care of persons with HIV can increase community acceptance of these individuals and improve disclosure, with a large proportion of persons with HIV being able to move beyond sero-positivity to planning for the future. The initial counselling and assessment given to newly diagnosed patients is of paramount importance. The objective of the intake assessment is to understand the needs and current functioning in each aspect of life, such as occupational functioning, social functioning, and source of supports. Eighty seven percent of interviewees had received some pre-test counselling and 78% post-test counselling. The vast majority found the pre-test counselling to be either very helpful (71.7%) or somewhat helpful (13.4%), while 78.1% found the post-test counselling to be very helpful and 10.7% found it to be somewhat helpful in coping with their positive diagnosis (Sethi, 2008).