Unraveling Counseling Practices in HIV Prevention Targeted Intervention in India

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Research Article

Keywords: Counselors, counseling, HIV prevention, targeted intervention, culture, constructivist grounded theory, India

Posted Date: July 13th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-664012/v1

Abstract

Counseling is an essential strategy for preventing sexually transmitted infections, including human immunodeficiency virus (HIV). However, research on counseling practices in targeted HIV prevention interventions is limited. We conducted a grounded theory study to develop a theoretical model explaining HIV counseling practices within Targeted Interventions (TI) in Gujarat. Using constructivist grounded theory methodology, we conducted in-depth interviews of 14 counselors and observed counseling sessions of five counselors. Data were analyzed using a constant-comparative method, performing four levels of coding: open, axial, focused, and theoretical. Our theoretical model illustrates key culture-specific features in HIV counseling and how counselors facilitate the counseling process in the local cultural context and programatic environment. Present study reveals the values and practices reflective of the Indian culture that inform the counseling process and yield behavior change in clients. In the end, authors highlight challenges and recommendations for HIV counselors.

Introduction

Counseling plays an essential role in mitigating the spread and management of HIV/AIDS. The National AIDS Control Organization (NACO)'s National AIDS Control Programme (NACP) has counseling as one of the key strategies for preventing and controlling HIV in India. NACP has adapted counseling for prevention in HIV Testing Centres, known as Integrated Counselling and Testing Centres across district hospitals in India, and Targeted Interventions with most at-risk populations, care, and treatment services like Anti-retroviral Centres and Associations of People living with HIV across all states (NACO, 2019).

The NACO supports approximately 1443 targeted interventions in India to prevent and control HIV with the most-at-risk population (MARP) such as Female Sex Workers (FSW), Men who have Sex with Men (MSM), Injecting Drug Users (IDUs), Truckers, and migrant workers (NACO, 2019). Essential services under TIs include reaching out to the most-at-risk populations, referral service to STI clinics, HIV test centres and anti-retroviral therapy (ART) centres, condom demonstration and distribution, counseling, distribution of materials related to information, education, and communication (IEC), and behavior change communication (BCC). Counseling in TI focuses on bringing change in risky behaviors MARP by adopting preventing alternatives.

In India, these TIs are implemented through civil service organizations and community-based organizations. With more than two decades of experience of HIV prevention, critical insights into the need for behavior change have focused on strengthening counseling to reduce HIV prevalence among the MARP. The NACO has introduced an HIV counseling module for counselors working with TIs and integrated HIV testing and counseling centre (ICTC), anti-retroviral treatment centre (ART) in 2011. Saksham Program implemented by Tata Institute of Social Sciences (TISS) has developed resources for ICTC counselors and trained ICTC counselors in the country. At the same time, Saksham Program, in collaboration with UNODC, designed a counseling module for injecting drug users.

Studies have shown the importance of counseling as a preventive mechanism to reduce Sexually Transmitted Infections, including HIV (Kumar & Parashar, 2012; Miranda & Barroso, 2007). However, research on counseling practices in targeted interventions, both in Indian and international contexts, is scarce. In India, most researches are primarily conducted in hospital settings to understand counseling in the context of pre and post HIV test, treatment of STIs and adherence to ART (Agarwal et al., 2019; Duggal et al., 2018; Kanekar, 2011; Pendyala & Lewis, 2020).

Research on the effectiveness of HIV counseling and behavioral interventions in the hospital setting (voluntary counseling and testing centers-VCTCs, prevention of parents to child transmission centers-PPTCTs, STI clinics, and ART centers) has been largely conducted in the Western and African countries (Grinstead & Van der Straten, 2000; Liechty, 2005; Solomon, 2002). Various behavior change models (such as Becker's (1974) Health Belief Model, Fishbein and Ajzen's (1975) Theory of Reasoned Action, AIDS Risk Reduction Model by Catania, Kegeles and Coates (1990), and Trans-Theoretical Model (Prochaska & DiClemente, 1982) and counseling approaches such as Rogers's (1951) person-centered counseling, Hogmann's (2011) cognitive behavior theory have been applied to HIV prevention. These models and theories have been replicated in developing countries without rigorous attention to cultural appropriateness in counseling (Kalichman, 2007; Solomon, 2002). In the absence of empirical research on HIV counseling practices in TI, examining HIV counselling practices is crucial in generating a theoretical framework of culturally grounded counseling and understanding counseling practices in the Indian cultural context.

Methodology

The present research adopted a qualitative design guided by Charmaz 's (2006) constructivist grounded theory. A constructivist grounded theory is evolved from systematic data collection, researchers' interactions with the field, participants, and carefully applying data analysis techniques. Using theoretical sampling, 14 counselors were interviewed. The sample represented six geographical locations of the Gujarat State, namely, Vadodara, Anand, Mehsana, Surat, Bhavnagar, and Rajkot, four typologies of TIs such as Core TIs (exclusively working with MSM, FSW or IDU population) and Core Composite TI s (TIs that are working MSM and FSW TI) and diverse educational backgrounds (high-school educated, graduates, psychology post-graduates and post-graduates in other fields). Table 1 presents demographic details.

The data collection process was facilitated by data collection protocols, which were pilot tested before its use. During the entire data collection process, field observations were done and recorded as per the data collection protocol. Data collection involved an iterative process. Out of 14, 5 counselors representing four typologies of TI, five geographical locations, and pragmatic counseling approach were purposively selected for participant observations of the counseling sessions.

Data collection was continued until theoretical themes were saturated. Each interview and participant observation of the counseling session was analyzed before conducting another. As a result, the

researcher introduced new elements into the subsequent data collection phase, which were 'grounded' in the information collected before. Data (audio and text) were transcribed, translated, and coded as collected. Based on Charmaz's (2006) coding framework, the data were coded, and categories were developed. The data were re-coded by two external coders, and codes were compared. Based on the comparison of external coders' coding with the researcher's coding, the coding scheme of the research was revised.

Preliminary data analysis of each interview and participant observation was shared with each participant to get their feedback on codes and analysis. Their feedback was incorporated, and individual analysis was transported into cross-case analysis using the triangulation method. Using a constant comparison method, categories were compared to find similarities and differences in meanings to develop conceptual and contextual categories. Based on these categories, theoretical frameworks were developed. Preliminary findings of the study were again shared with participants to seek their feedback and ensure that the theoretical frameworks that emerged from the research are grounded in the information they have shared.

Results And Discussion

The research evolved a framework of HIV counseling in the Indian cultural context. Figure 1 illustrates HIV counseling in an Indian cultural context.

Counseling and sexual behavior in the Indian cultural context

Culture, in general, is understood as a set of shared values, mentalities, and beliefs that characterize national, ethnic, moral, and other group behaviors (Craig & Douglas 2006; Faure & Sjostedt, 1993; Shweder, 2003; Valsiner, 2009). Review of research on Indian culture suggests that Indians are fundamentally interconnected and interdependent (Chaudhary, 2004), collectivist and individualistic (Sinha, Sinha, Verma, & Sinha, 2001), yet 'dividuals' (Marriott, 1990) and pragmatic (Chong & Liu, 2002; Kakar & Kakar, 2007). One primary cultural feature is that Indians have learned to "co-exist," which has resulted in a cultural context that invites relationships to be shaped despite disagreements and an atmosphere filled with contradictions (Arulmani, 2009; Chaudhary, 2011). The second cultural feature is that Indians are fundamentally interconnected and interdependent (Chaudhary, 2004). This is relevant to sexual behaviors of most at-risk populations. Same-sex sexual activities, sex work, multiple sexual partners exist dominantly despite social and cultural prohibitions. The third cultural feature is that Indians are collectivistic and individualistic at the same time (Sinha, 2014; Sinha, Sinha, Verma, & Sinha, 2001; Verma, 2020;). Family and caste and kinship bonds could be examples of collectivistic orientations while being independent, moving from one place to another in search of a job, preferring sexuality as an agency to fulfill sexual needs or earn money could define individualism (Arulmani, 2009). India is a hierarchical society where roles are well-defined, so major life decisions are often collective in nature, and for Indians, family approval is important (Kakar & Kakar, 2007, Ruth, 1998; Sinha, 2014). This tendency plays out in

most hierarchical relationships (e.g., teacher-student, boss-employee). Further, Indian people hold cultural values that promote respect toward authority figures and tend not to question or challenge authority (Raney & Cinarbas, 2005). The fourth feature of Indian culture is individualism (Marriott, 1990). Indians can be better characterized as 'dividuals' and not individuals, due to the fundamental 'otherness' of community life around hierarchy –which imply that individuals are defined by whom they are related to and whom they spend time with (Dumont, 1970; Marriott, 1990). This characteristic is well reflected in this research. Many clients sought counseling in a pair; clients brought their friend, spouse, or lover and expected them to accompany them during the counseling process. This implies a sense of relatedness with other people. The fifth cultural feature is pragmatism (Chong & Liu, 2002; Kakar, 1997; Kakar & Kakar, 2007). It reflects that Indian people value practical help. Seeking help, guidance, and advice from their immediate social networks such as elders, family members, friends, and teachers are culturally desired. Hence even in counseling situations, the client looks upon the counselor as the one who knows more and is there to guide and give advice about the right path or solution to a problem (Kakar, 1996). This cultural context raises questions about the applicability of Western counseling theories and principles in India.

Indian sexuality

Many studies on culture and sexuality reflect that cultural values and mentalities shape sexuality (Akintune & Ayanta, 2005; Hogan, 1982; Shweder, Goodnow, Hatano, LeVine, Markus, & Miller, 2007). Indian cultural values and mentalities shape the expression of sexuality in one context and inhibit its expression in another context. Sexuality is organized around social norms. Although homosexuality and sex work existed in ancient India, it never attained social and legal approval in the Indian society. Hence sexualities (such as premarital, extra-marital, prostitution, and same-sex sexual acts) are not expressed publicly.

Conversely, it is important to note that few forms of sexualities are culturally accepted in tribal Indian societies. No quantitative estimate of the sexual practice is available for India's rural or tribal community, but casual reports indicate that sexual practices such as premarital, extra-marital, prostitution are common (Verma & Schensul, 2004). Indian sexuality in the context of HIV can be understood by examining the social organization of sexuality, sexual culture, and sexual grammar.

Sexuality is organized into two spaces: social (public) space where individuals express socially accepted sexuality such as heterosexual marriage, sexual relationship within marriage; and private space where inhibited and prohibited sexualities (such as sex outside marriage, multiple sexual partners, sex with sex workers, sex work and same-sex relationship) that are nurtured privately (Hirsch, 2003; Hirsch, Wardlow, Smith, Phinney, Parikh, & Nathanson, 2009; Pandya, Pandya, Patil, & Merchant, 2012). The social organization of sexuality is an intricate balance between socially acceptable sexuality and privately nurtured sexuality that creates a context of risk for HIV and other STIs to the most at-risk population.

Sexual culture is defined as a culture where prohibited sexualities are expressed within a group of like-minded people. Indian sexual culture includes men with diverse sexual and gender identities, for example, Koti are feminized men who are receptive during anal sex. “Ghadiya” is a label used by Koti for those men who penetrate. Hijra prefers the female role and is primarily engaged in sex work, and is usually receptive. Many men, hijras and transgender are also engaged in sex work, and their sexual practices vary based on clients’ requests. Female sex workers are categorized as street-based, brothel-based, hotel/Dhaba-based, home-based, beauty /massage parlor-based sex workers. Such sexual culture normalizes risky sexual practices that heighten HIV risks. The most common sexual practices observed among MARPs are group sex, anal sex among MSM, Hijra, and FSWs. The use of alcohol was also a common practice.

Sexual partners are sought from cruising places. Cruising places are hotspots where people gather and find sexual contact. MSM, Hijra, and FSWs have their cruising sites such as bus depot, garden, open ground, empty buildings, which are known among the popular sexual culture. Sexual activities usually happen at perceived safe places such as lodges, home, highways, public toilets, and empty buildings.

In the present study, sexual grammar is defined as the meaning and value that clients place on the sexual practices and use of language to express one’s sexuality. For example, many clients mentioned during the counseling session that safe sex means sex that can be hidden safely from the family and society, rather than sex that carries no risk of infection (STIs/HIV). They perceived disclosure of secret sexual activities to be dangerous, as it could cause social risks to themselves as well as their families. FSWs and MSM, TG/Hijras, have a code language to convey sex that keeps their pursuance a secret. Counselors need to keep abreast with specific meanings related to sexual practices and language used by clients. The social organization of sexuality, sexual culture and sexual grammar, altogether create a risk context for STIs and HIV transmission to the most-at-risk population.

HIV counseling context

HIV counseling takes place in the context of lack of adequate education and qualification, lack of regulatory body, adequate infrastructure for counseling, the organization of the professional relationship between counselor and client, and the counseling orientation of the counselor and client.

Most counselors in TI were not qualified. Many were graduates or post-graduates in social work, commerce, or another field, while few were from the community who had up to high-school education. It was noted that the TI lacked adequate counseling set-up due to a lack of budgetary provision for setting up a counseling room with audio-visual privacy. As a consequence, the counseling sessions were conducted primarily at STI Clinic, DIC, and office and in the field (e.g., under the tree, client’s home, open ground), where ideal audio-visual privacy was not maintained. Many counselors expressed the need for a counseling room and minimal requirements such as a round table and three similar chairs (one for counselor and two for counselees) for informal sitting arrangements, table and chair for counselors to do everyday documentation, cupboard for keeping general counseling documents, and lock and key cabinet to keep confidential documents).

Due to the lack of accreditation of counselors in India and the lack of a governing body, counseling is not systematized, and counseling practice varies from region to region (Smoczynski, 2012). As a result, there is no standard counseling training curriculum. Counseling training in India varies from five days of counseling skills training, two weeks' certificate course and six months' diploma course to a two-year Masters in counseling and clinical psychology (Arulmani, 2009). There is no supervised counseling practice in either the short-term training courses or the full time two-year long course, or the accredited mandatory continuing professional development courses. Hence, each counselor practices counseling on his/her own terms. In a way, the absence of accreditation of counselors and governing body provides the opportunity to accommodate nuanced cultural practices which are effective in reaching out to the clients. With reference to training for counseling, it is thus vital to recognize nuanced cultural practices and incorporate them into the counselors' training programs.

The TI lacked the adequate infrastructure necessary for counseling. As a consequence, the counseling sessions were conducted primarily at STI Clinic, DIC, and office and in the field, where ideal conditions for maintaining privacy are absent, thereby violating recommended professional standards. One counselor said,

…proper counseling room in TI is far from reality…I counsel in the outreach workers' room. When clients come, I ask outreach workers to vacate the room…sometimes, due to work, I counsel clients in the corner of the room. TI program does not have the budgetary allocation for developing a counseling room with audio-visual privacy…

Counseling in the field appears to work as many clients fear facing people or are hesitant to access HIV prevention services. One counselor mentioned, "I have to counsel clients in the field because clients do not turn up in the office for counseling, and we have a target to reach." Counseling clients at their convenient place and their preferred time are programmatically functional; however, it does not minimize the need for safe space for clients. Many counselors expressed the need for a counseling room and minimal requirements such as a round table and three similar chairs (one for counselor and two for counselee) for informal seating arrangements, table, and chair for counselors to attend to everyday documentation, a cupboard for keeping general counseling documents, and a lock and key cabinet to store confidential documents). Adequate budgetary allocation for such facilities is thus required for any public program that involves counseling as an important component should have an adequate budget allocation for minimal infrastructure and requirements for counseling set-up.

There is much research within counseling psychology and psychotherapy about the importance of the relationship between counselor and client (Larsson & Tryggved, 2010). Building a professional relationship is crucial for effective counseling (Ponton, 2006). In keeping with the cultural value of respect toward authority figures, clients perceive counselors as "authority figures," more knowledgeable and wiser by clients. Therefore, Indian clients prefer directive and action-oriented counseling approaches (Mocan-Aydm, 2000). In the TI context, counseling service is free for clients, but clients often do not seek the service. Counselors from the TI have to reach out to them in the field. In this sense, counseling is imposed

on clients from the project. Thus, clients are often passive receivers of the counseling service that is project-driven and hierarchical in the form of a provider-receiver relationship.

Counseling as a concept is still relatively new to India, hence clients are not entirely familiar with the concept of counseling. Often clients perceive counselors as health advisors. Counseling as practiced in the West requires the client to be independent and self-sufficient. Therefore, individual counseling, during which the counselor is not expected to give advice but lead the client to find his or her answers can be quite foreign to Indian clients. Counseling is synonymous with “advice.” During participant observation of counseling sessions, clients referred counselor as “HIV advisor.” They often ask for advice by saying, “tame to mota saheb chho, salah aapi sako. Mane salah apo ne.” (You are a master, you can provide advice. Advise me). The Gujarati translation of counseling is “paramarsh,” however; most clients (and counselors) were using the term “salah,” which literally means “advice.” As a consequence, Indian clients expect immediate solutions or advice on their problems with counselors. Counsellors are considered to be more knowledgeable and wiser.

India is relationship-centered society (Laungani, 2009), where relationships are valued and maintained. It is not uncommon for clients to carry forward the relationship established during counseling as a sign of respect and obligation. For example, clients often invite counselors to their social functions. Refusal to such invitations may be perceived as an insult. Many counselors in the study reported a dilemma regarding the closure of counseling relationships, thereby raising the question of relationship boundary.

The counseling orientation was primarily solution-focused and client-centered. The solution-focused orientation was evident in that counselors provided workable solutions and alternatives to clients. Counselors defined HIV counseling as “a process of interaction with clients, providing correct information on HIV/AIDS and STIs, removing misconceptions, identifying their risk factors, discussing strategies to reduce risks and empowering clients to make appropriate decisions.” At the same time, counselors emphasized clients’ needs and need-based risk assessment, which reflects client-centered orientation. In line with their definition of counseling, they defined their role as educators, teachers, supporters, and advocates.

Counseling practice

Counselors used various HIV specific and non-HIV specific

counseling. HIV-specific counseling included project mandated counseling services such as preventive, STI, and crisis counseling whereas, HIV tests and supportive counseling emerged as a response to the demand of the TI context. Few counselors provided individual psychological counseling and group counseling. Many counselors considered group counseling as an effective strategy for HIV prevention, which is also supported by a few studies (Branson, Peterman, Cannon, Ransom & Zaidi, 1998; Hedge & Glover, 1990; Petersen et al., 2014; Maldonado, Gore-Felton, Durán, Diamond, Koopman, and Spiegel, 1996).

Counselors used a pragmatic approach, in which the counseling process (such as rapport building, exploring problems and risks, exploring alternatives, developing an action plan and planning follow up), skills (questioning, listening, non-verbal, and empathy), and techniques are directive and solution-focused. Many counseling strategies used in the Indian cultural context were similar to the Western counseling process and methods, but the counselors improvised these to suit the local cultural context. For example, demonstration techniques were used to explain the importance of HIV prevention. The link between STI and HIV was similar to the confrontation technique proposed in psychotherapy, such as Adlerian psychotherapy, Gestalt therapy, and Rational Emotive Behavior Therapy. Confrontation involves making a client face his or her weaknesses (Salizman, 1979).

In the HIV counseling context, counselors have attempted to confront clients' misconceptions and attitudes. Storytelling included telling a story based on a client's risk assessment to convey how preventive strategies are beneficial in the client's case and the consequences of not adhering to HIV prevention strategies. Storytelling is also relevant in HIV context particularly in the Indian culture as Indians do not prefer direct reference (Manzar & Chaturvedi, 2017; Nishimura et al., 2008) and also most clients have low education levels and better understand concepts related to HIV/AIDS and STIs through stories. Positive effects of stories in counseling and psychotherapy are well established (Bavelas, Coates & Johson, 2000; Sunwolf & Frey, 2001). Another most widely used technique was that of giving examples during counseling. It included sharing an instance of another client (third person) who is practicing safe sex, which protects from HIV.

Counselors used opportunistic information sharing, provided short and specific information about HIV/AIDS/STIs and risk reduction alternatives as and when required. This educational strategy is relevant in the Indian context because clients expect immediate answers to their questions or problems. Clients are more passive and dependent; therefore, counselors, most of the time, impose decisions on clients about when to access HIV testing and prevention services that counselors call it,opportunistic decision making.

One practice that in which counselors engage was that of labeling. Counselors labelled clients based on clients' characteristics, for example, using the term "cheaters" for clients who concealed knowing their serostatus during counseling and "liars" for those who concealed risk behavior in counseling. Further, counselors judged clients based on their motivation to seek counseling and access HIV prevention services. In many instances, judgmental statements about clients were related to the counselors own moral views. For example, few counselors believed, "Koti will never reduce sexual partners no matter what may come. They cannot behave like a normal man." (Koti is an identity some feminine same-sex men identify with. They are a passive sexual partner who get penetrated by another male partner). Although none of the counselors shared these statements with clients, such interpretations may well influence the counseling process. Counselors reported labeling and judgments as strategies to deal with clients. It is not clear how this impacts the counseling relationship and needs to be further explored.

Considering pragmatism as a cultural feature of Indian people, clients prefer counseling to be solution-focused, time-bound, and directive. Hence, the counselors' directive role, giving advice, and offering direct suggestions are culturally appropriate for the initial phase of counseling. This directive role may be transformed into a non-directive and collaborative one following the client's progress (Dwairy & Jagelman, 1998). Solution-focused orientation is reflected by focusing on providing workable solutions and alternatives to clients and emphasizing clients' needs and need-based risk assessment, which reflected client-centered orientation. Such culture-specific counseling strategies can be viewed as culturally appropriate approaches. However, blind use of such strategies, such as derogatory labeling and advice without assessing underlying problems, must be avoided.

Counseling process

The present research revealed various culture-specific practices that fit well in the local cultural context but may not adhere to Western counseling standards. The present research has revealed three counseling styles, counselor-led, client-led, and counselor-client led counseling, and combinations of the three were used as the counseling progressed. Counselling usually began with a directive (counselor-led) approach and moved toward a collaborative (counselor-client led) approach by encouraging the client's engagement in counseling. When the client acts actively toward the counselor, the counselor needs to act comparatively passively in return in order to balance the relationship. The relationship must be adjusted as per the three different counseling styles. For this, counselors should recognize clients' weaknesses, strengths, and needs to help the clients achieve their needs. Counselors demonstrated supportive and empathic characteristics in the beginning while remaining critical and passive during the middle and end phases of the counseling session. Demonstrations of these characteristics were found relevant to the cultural context. For example, despite repeated discussion about preventive alternatives, clients may not adopt prevention strategies. In this context, being critical to clients' indifferent attitude and showing authority may help clients realize it and modify risk behaviors.

Challenges And Recommendations

Counseling needs to be shaped within a given cultural paradigm that reflects the values and practices of the culture. However, this may raise the question of 'good' versus 'best' practices. For example, advice-giving practice may seem appropriate and effective in the Indian context, however, to what extent is labeling and judging clients appropriate, even though it may facilitate the counselors in identifying the client's background? It is difficult to judge whether existing counseling practices should be primarily accepted based on the acceptability and effectiveness in a given cultural context, thereby raising the issue of the form and extent to which existing (predominantly Western) professional standards should be adhered to. In such a context, what would constitute the best practices or strategies of counseling? A related issue that emerges is the balance between culturally sensitive practices and ethically appropriate practices of counseling. Thus, it is necessary to create a framework that is sensitive to cultural sensibilities and ensures that the process does not violate ethical principles. Another critical aspect of concern is the notion of expertise. Ground-level practitioners bring in their local cultural expertise, and it is

crucial to know and document their views and practices. Counseling should thus encompass a judicious combination of core counseling skills and principles and counseling strategies that are practiced effectively in a given cultural context. Notably, the counseling training modules (for TI counselors) must advance from clear philosophical and theoretical orientations rather than a mere amalgamation of a set of skills that are essentially based on Western perspectives. The theoretical frameworks that have emerged from this study represent an attempt to embrace such aspects to unravel counseling practices that are culturally grounded.

Conclusions

HIV counseling encompasses culturally grounded practices. Many counseling strategies used were similar to that of a Western counseling process and methods, but counselors improvised these to suit the local cultural context. HIV counseling and strategies largely overlap with already established theories and strategies; however, these are adopted and applied in culture-specific ways.

Declarations

Funding: No funding was received to assist with the preparation of this manuscript.

Financial interests: The authors have no relevant financial or non-financial interests to disclose.

Non-financial interests: None

Declaration of competing interest: None

Ethics approval: Approval was obtained from the ethics committee of the Maharaja Sayajirao University of Baroda. The procedures used in this study adhere to the tenets of the Declaration of Helsinki. Written informed consent was received from all participants.

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Tables

Due to technical limitations, Table 1 is only available as a download in the supplementary files section.

Figures

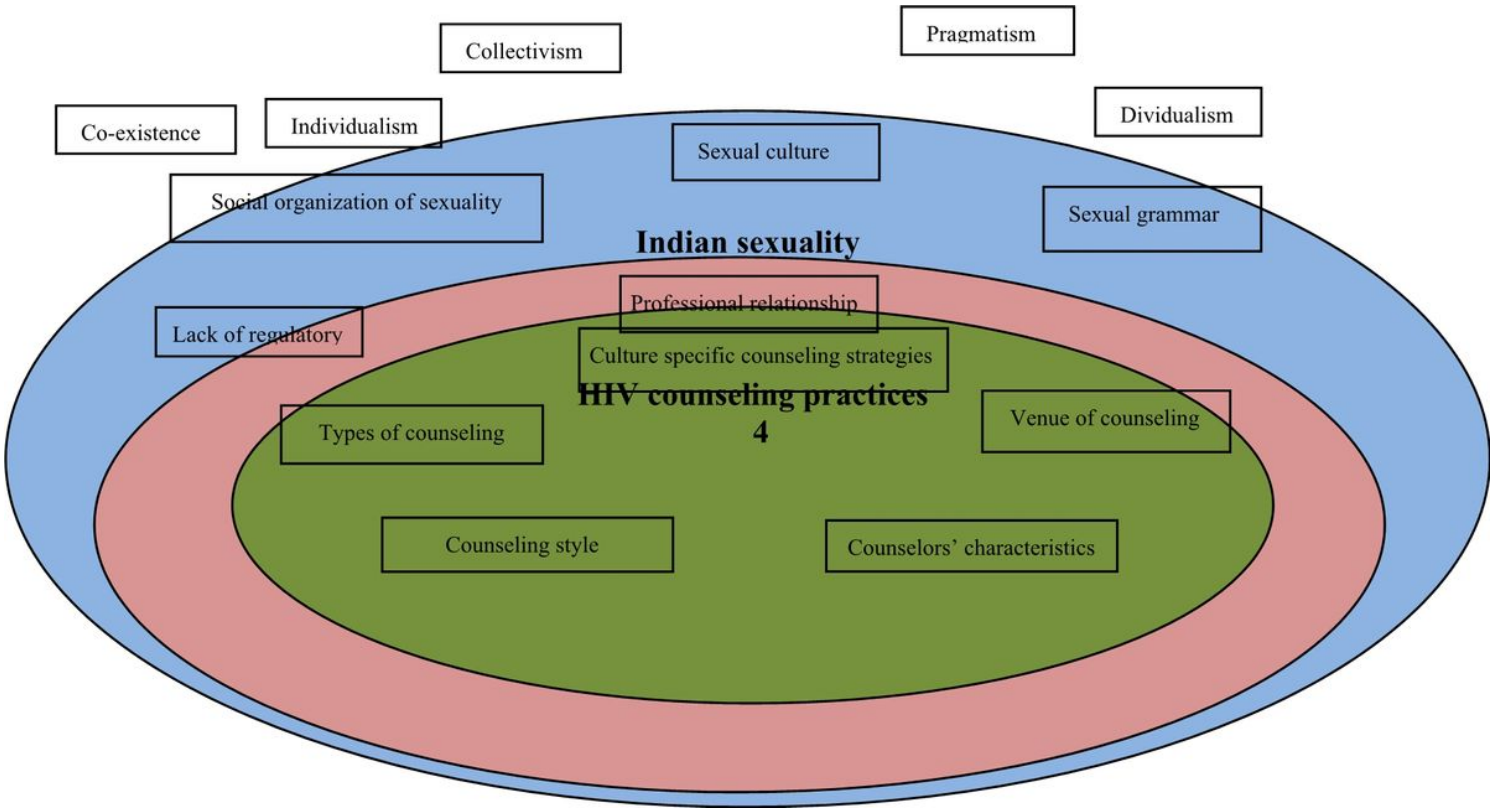

Figure 1

Key features of HIV Counseling in Indian Cultural Context

Supplementary Files

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- Table1.Demographicprofileofstudyparticipants.docx